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DEFINING AND EVALUATING NON-ACADEMIC (IN)COMPETENCE AND PERSONAL (UN)SUITABILITY IN CLINICAL TRAINING: EXPLORING THE ROLE OF PERSONALITY AND INTERPERSONAL SKILLS

by

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A Dissertation
Submitted to the Faculty of Graduate Studies and Research
through the Department of Psychology
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the Degree of Doctor of Philosophy at the
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2004

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Abstract

The present study represented an attempt to define what individuals involved in the human service professions believe are the necessary personal and interpersonal skills required to demonstrate "clinical" or "non-academic" competence. Participants' opinions of the importance of these personality dimensions and interpersonal skills, as well as their perceptions concerning their assessment, teaching, and remediation were explored.

The participants were 26 faculty, students, and practitioners within Clinical Psychology, Nursing, and Social Work, and one client presently receiving therapy. A qualitative approach was used in which information was gathered from participants using a semi-structured interview, and the constant comparative method was employed to analyse the information they provided.

The results of the present study suggest that there is meaningful agreement among various clinical professions concerning the nature of the personal and interpersonal skills required for competence. A total of 55 clinical skills were delineated by the participants, including such skills as empathy, comfort with intensity, creativity, maturity, humility, and self-awareness. The descriptions provided by the participants were used to create a model summarizing the five underlying dimensions necessary for clinical competence; alliance-specific skills, non-alliance-specific skills, professional skills, cognitive skills, and role management skills.

Participants also asserted the critical importance of these skills in the assessment of a clinician's overall level of competency. Unfortunately, the consensus opinion of the respondents was also that, while essential, these skills have been and continue to be

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almost completely ignored in traditional clinical training programmes. A variety of negative comments concerning the training experiences of the participants were expressed, irrespective of discipline, institutional affiliation, and historical context of training. Participants went on to make recommendations for improvement, articulating the characteristics of the teachable student and the clinical-skills friendly training programme that might best facilitate the teaching of these skills.

Finally, the opinions and responses of the participants were used in the creation of the Clinical Skills Appraisal Tool, an instrument offered by the researcher as a means of acknowledging the critical importance of these skills, and as a potential method for making a personal, interpersonal, and qualitative appraisal of what are essentially personal, interpersonal, and qualitative skills.

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CHAPTER I

Introduction

The defining and evaluating of clinical competence remains one of the central and perhaps most vexatious issues facing clinical psychology (Claiborn, 1982; Overholser & Fine, 1990; Procidano, Busch-Rossnagel, Reznikoff & Geisinger, 1995; Sakinofsky, 1979; Shaw & Dobson, 1988; Stevenson & Norcross, 1987). The fundamental debate which has plagued the study of competence concerns the relative importance and assessment of its "academic" and "non-academic" components. While there is a general recognition within the discipline that both academic and non-academic abilities are important in defining and measuring competence, training programmes have traditionally focussed on academically-acquired skills such as the attaining of an adequate general knowledge base and specific technical skills. In contrast, non-academically or experientially acquired components of clinical competence, primarily involving the ability to establish and engage clients in an effective therapeutic relationship, have been neglected (Beutler, Machado, & Allstetter-Neufeldt, 1994; Sakinofsky, 1979). Furthermore, the evaluation of the prerequisite components necessary for academic competence (primarily academic intelligence), as well as academic success (grades, successful completion of degree requirements) have proven relatively unproblematic.

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However, there is little agreement concerning which specific components are prerequisite for non-academic competence (therapist personality qualities and interpersonal skills) or how to measure non-academic success (effective therapeutic relationships with clients) (Fordham, May, Boyle, Bentall & Slade, 1990). Consequently, there appears to exist a tacit agreement within the profession to avoid explicit definition, measurement, and confrontation of non-academic (in)competence and personal (un)suitability for clinical training.

Research in this area has also been limited by a lack of psychometrically valid and reliable measures of the global construct of clinical competence (Neufeld & Norman, 1985; Scofield & Yoxtheimer, 1983). While measuring academic aspects of competence is relatively uncomplicated, the lack of conceptual and definitional clarity concerning its non-academic components has necessarily limited the construct validity of methods for assessing this dimension (Fordham et al., 1990; Stevenson & Norcross, 1987). Reliability of measures has also been compromised as there is generally little agreement among raters regarding the non-academic competency of a specific student and little agreement within the same rater when using different sources of data (Chevron & Rounsaville, 1983). As Stevenson and Norcross (1987) concluded, "until...a consensual definition of the competent clinical psychologist is achieved, we are on shaky footing whenever we assert that our measures are valid" (p. 98). As a result of these conceptual and methodological problems, there are presently no organized and standardized means of training or assessing the full range of competence in clinical psychology graduate students or procedures for adjudicating instances of incompetent behaviour (Claiborn, 1982). In

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addition, this struggle to define and confront non-academic (in)competence and personal suitability has not been limited to clinical psychology. Other disciplines where personality and interpersonal skills are essential components of competent work, including nursing, social work, and medicine, have also been required to deal with these issues (GlennMaye & Oakes, 2002; Hojat, Veloski, and Borenstein, 1986).

The non-academic competency of graduate students and the adequacy of training programmes in teaching or screening for necessary interpersonal and personal skills are more often assumed than verified. Few studies have directly investigated the incidence and prevalence of non-academic incompetence in students (Stevenson & Norcross, 1987). In one of the more recent studies, Procidano et al. (1995) surveyed seventy-one American and Canadian doctoral programmes in psychology to assess the incidence of students' professional deficiencies and to examine existing departmental procedures for detecting and addressing such problems. They found that 89% of all departments surveyed reported one or more instances of non-academic, professional deficiency in the past five years, including limited clinical skills (46% of programmes) and personality/emotional problems (34%) (Procidano et al., 1995). The authors also found that most programmes (87%) had some means for screening to eliminate "inappropriate" applicants, primarily through the use of interviews (75%), as well as procedures for evaluating the work of students already admitted (89%), mainly through clinical supervisors' assessments (46%) (Procidano et al., 1995). Unfortunately, the deficiency categories used in the study were provided to respondents by the authors and "limited clinical skill" was not clearly defined. It is also unclear whether the respondents themselves may have included additional "deficiencies"

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that were not adequately covered by the categorizations. Nevertheless, this study suggests that professional or non-academic deficiency may be a potentially widespread problem in graduate psychology programmes.

Defining the dimensions of competent professional work in clinical psychology, and specifically those aspects of competence related to the more problematically assessed personal and interpersonal qualities of the therapist, is an essential first step toward detecting incompetence or unsuitability in graduate students. Explicit definition is also integral to the process of formally evaluating and comparing training programmes (Stern, 1984). The current status of training evaluation is unfortunately characterized by a reliance on informal, impressionistic, and non-specific methods that vary considerably across institutions (Stevenson & Norcross, 1987). Thus, it is impossible to state with certainty whether one type of training approach or one programme is better than another in terms of producing more competent clinicians, when there is no adequate definition of what "competent" means. Furthermore, as a service profession struggling to defend and expand its role, clinical psychology must explicitly define the uniqueness of the service it provides. In this sense, definitions of competence represent the profession's self-definition (Stevenson & Norcross, 1987). The current emphasis on quality assurance and fiscal restraint have made it even more imperative that psychology clearly define its professional and practice standards (D. Anderson, 1992). Such standards are also essential in protecting the consumers of psychological services (Johnson & Campbell, 2002; Overholser & Fine, 1990). Thus, to permit the evaluation of students, training programmes, and the discipline, as well as to protect the status of the profession and those

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who benefit from it, it is essential that explicit criteria for both academic and non-academic competence be defined, that means of assessing both dimensions be developed, and that procedures for dealing with incompetence be established.

Defining Competence: Some Proposed Models of the Dimensions of Competence

Much research has been conducted with the aim of empirically or intuitively categorizing the dimensions of competence in clinical psychology. Several models have been proposed and, despite disagreement concerning terminology, there has been general consensus regarding the overarching dimensions of competence.

Through the process of literature review, Overholser and Fine (1990) described a five-component schema for categorizing the elements of competence necessary for the provision of adequate psychological services. In their model, *factual knowledge skills* referred to the ability to acquire and maintain information relevant to clinical activities, including basic clinical knowledge and information specific to assessment, diagnosis, and psychotherapy. Competence in *generic clinical abilities* involved those skills used in basic interviewing and the establishment of a productive therapeutic relationship. Competence in *orientation-specific technical skills* concerned the ability to use special procedures or techniques in clinical practice. *Clinical judgement* was described as the ability to apply knowledge and clinical skills in the assessment and treatment of a particular client. Finally, *interpersonal attributes* referred to therapists' personality characteristics, social skills, and emotional/psychological problems that may interfere with professional functioning (Overholser & Fine, 1990).

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Using an empirical methodology, Ross and Altmaier (1990) applied the critical incident technique, a widely accepted method of job analysis, to determine the fundamental dimensions of performance among psychology interns. In face-to-face interviews, training directors of university counselling centres were asked to specifically and concretely describe incidents they had observed that characterized both successful and unsuccessful behaviour on the part of interns. Sorting of these discrete incidents resulted in the categorization of seven mutually exclusive classes of behaviour. *Clinical skills* included the demonstration of effective therapeutic skills involved in assessment and psychotherapy. A second dimension concerned *commitment to one's own professional development*. This involved an intern's ability to identify training needs and be open to feedback and suggestions. The *ability to respond effectively to crisis and emergency situations* was categorized as a separate performance dimension. The interns' demonstrations of appropriate interpersonal skills with staff members were classified on the *interpersonal relationships* dimension. *Knowledge skill* included a demonstration of both broad and specific knowledge relevant to psychology. *Professional and ethical behaviour* was described as the ability to complete tasks on time and to respect confidentiality and organizational policies. Finally, the ability to develop and administer psycho-educational programmes and respond effectively to consultation requests was categorized on the performance dimension of *programming and consultation skills* (Ross & Altmaier, 1990). These dimensions reflect skills necessary to successful job performance in internship settings and thus inherently emphasize aspects of clinical competence, rather than academic competence.

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Peterson and Bry (1980) developed an empirical and inductive definition of professional competence by first asking supervisors of advanced trainees in professional psychology to specify the dominant characteristics of competent and incompetent trainees with whom they had worked. Then, a rating scale based on these descriptive terms was used to evaluate later trainees and resultant ratings were factor analysed to define the principal dimensions of competence. Four factors emerged including *professional responsibility* (integrity, conscientiousness, psychological soundness), *warmth* (sense of humour, openness, compassion), *intelligence* (articulateness, creativity, clarity of thought), and *experience* (self-assurance, technical skill, self-sufficiency) (Peterson & Bry, 1980). Qualities of the "competent" student appeared to be based first on intelligence, then on various interpersonal and motivational characteristics. While the characteristics of "incompetence" were also based first on lack of knowledge, personal disturbances interfering with professional functioning, including defensiveness, poor motivation, anxiety, irresponsibility, psychological disturbance, interpersonal awkwardness, immaturity, manipulativeness, and insensitivity came a close second (Peterson & Bry, 1980).

In a similar study, Fordham et al. (1990) factor analysed the ratings of experienced supervisors of trainee clinical psychologists along several dimensions. Supervisors' judgements of "good" and "bad" trainees fell across two interpretable domains. The first factor related to *personal presentation and interpersonal skills* and included scales such as warm-cold, good-poor physical appearance, communicative-reticent, accepting-rejecting, tolerant-narrow-minded, and relaxed-tense. The second factor related primarily

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to *organizational skills* and included scales such as meets deadlines-late with assignments, punctual-unreliable about timekeeping, attends regularly-unreliable in attendance, and formulates-does not formulate plans. The interpersonal skills dimension was found to account for most of the variance in supervisors' ratings (Fordham et al., 1990).

Lambert and Bergin (1983) classified important therapist characteristics along two dimensions; static versus process factors. *Static traits* include therapist demographics such as race, gender, age, and socioeconomic status; personality qualities including personal adjustment; personal qualifications such as type of training, and professional affiliation; and variables such as values, expectations, and experience level. *Process variables* include stylistic qualities such as rate of speech, and sentence length; techniques related to the specific therapy school ascribed to; and relationship variables such as empathy, warmth, and genuineness.

Using a similar list of variables, Beutler et al., (1994) articulated perhaps the most detailed taxonomy of therapist variables that may play a role in psychotherapy outcome and hence are relevant components of competence. They categorized variables along two dimensions which varied according to whether the qualities were observable by an external rater or garnered by self-report (objective vs. subjective), and whether they were traits or states of the therapist (cross-situational vs. therapy-specific). In their model, *objective, cross-situational variables* included demographic factors that therapists bring to the treatment setting, such as age, sex, and ethnicity. *Subjective, cross-situational variables* included personality and coping patterns of the therapist, emotional well-being,

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values and beliefs, and cultural attitudes. *Subjective, therapy-specific variables* concerned the therapeutic relationship, social influence attributes, expectancies, and therapeutic philosophy/orientation (Beutler et al., 1994). Finally, the fourth category in Beutler et al.'s taxonomy concerned *objective, therapy-specific states*. These are described as including professional background, therapeutic and interpersonal style, and therapist skill and interventions (1994). Significant differences were found by the authors concerning the relationship of these specific variables with therapeutic effectiveness and outcome.

Even in other disciplines such as nursing and medicine where similar problems have been encountered concerning the defining of competence, comparable subscale dimensions of competent practice have been identified. For example, in order to develop a competency-focussed psychiatric nursing clinical evaluation instrument, Bondy, Jenkins, Seymour, Lancaster, and Ishee (1997) categorized 80 intuitively identified and agreed upon dimensions of competency into six subscales. These included *knowledge base/critical thinking* (e.g. using knowledge from relevant theories and models to guide actions, recognizing ethical and legal factors); *nursing process* (e.g. effective practice of specific nursing interventions involved in assessment, diagnosis, and evaluation); *nursing interventions* (e.g. identifying client needs and limitations and responding effectively); *communication skills* (e.g. using appropriate communication techniques to create a therapeutic relationship with the client; communicating clearly with peers); *professional socialization behaviours* (e.g. conveying professional behaviour, using resources, participating with staff); and finally *self-evaluation* (e.g. identifying own strengths and weaknesses, seeking supervision, self-correcting own performance) (Bondy et al., 1997).

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Similarly, Hojat et al. (1986) factor analysed the clinical behaviour ratings made by directors of medical education programmes of physicians graduating from a medical college. Three factors emerged from their analysis including two that specifically relate to clinical competence. One factor reflected a cognitive dimension concerning *data gathering and processing skills* (skills in diagnosis, physical examination, knowledge of basic science), and a second factor reflected noncognitive aspects of competence concerned with *interpersonal and attitudinal factors* (relationships with other staff, ability to work with patients and families).

More recently in Canada, the various provincial regulatory bodies made some effort to come up with an agreed-upon set of core competencies in clinical psychology to allow for cross-jurisdiction licensing recognition (Psychology Sectoral Workgroup on the Agreement on Internal Trade [PSWAIT], 2001). The Mutual Recognition Agreement identified six core competency conditions: *interpersonal relationships*, defined as the ability to establish and maintain a constructive working alliance and possession of adequate cultural competency; *assessment and evaluation*, defined as the ability to draw on diverse methods of evaluation and make appropriate selections; *intervention and consultation*, defined as competency in the activities that promote, restore, sustain, and/or enhance positive functioning and a sense of well-being in clients; *research*, defined as a basic understanding of and respect for the scientific underpinnings of the discipline, knowledge of methods so as to be a good consumer of its products, and sufficient skills to develop and carry out professional projects; *ethics and standards*; and *supervision*, involving competence in the skills needed to manage the services provided under one's

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guidance (PSWAIT, 2001).

A review of the literature leads to the conclusion that while a wide variety of competence classification systems have been proposed, there are indisputable commonalities between the various systems. While the terms may be different, these models ascribe to the same basic underlying dimensions. Thus, based on this previous research, three dimensions of competence may be labelled and differentiated; "knowledge mastery" which is acquired through formal academic training, "technical skills" which are acquired through formal academic training and refined through clinical practice, and finally, "clinical skills" which are generally assumed to be acquired through applied clinical experience. Given the definitional problems which have plagued this area of research, and recognizing that these three terms have been used by different researchers to refer to quite different skills, it is essential that the usage to be made of these terms with respect to the present study is explicitly defined.

Defining Competence: Three Underlying Dimensions

Knowledge Mastery

Some dimensions of competence are clearly more easily defined, monitored, and assessed than others. Academic criteria provide a readily-available and uncomplicated means of measuring competence. Thus, it is not surprising that clinical training programmes have traditionally relied almost exclusively on measures of academic achievement, including grades, standardized test scores, and completion of academic criteria such as course work and theses requirements, to assess competence and successful

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programme completion (Peterson & Bry, 1980). Selection to graduate programmes relies almost exclusively on academic requirements, especially undergraduate grade point averages and scores on the Graduate Record Examination (GRE) (King, Beehr, & King, 1986). Similarly, criteria for awarding the Ph.D. mainly involve satisfactory completion of academic requirements, a written comprehensive examination, and an oral dissertation defense (Peterson & Bry, 1980). It is likely that more students are dismissed from graduate school on the grounds of academic failure than for professional ineptitude (Peterson & Bry, 1980).

With respect to knowledge, trainees are expected to acquire adequate levels of factual information concerning basic psychological processes, as well as information relevant to the services they provide, including the areas of assessment, diagnosis, psychotherapy, and ethics (McNamara, 1975; Overholser & Fine, 1990). Furthermore, knowledge acquisition in these areas can be directly tested through the use of written examinations and assignments (Schoon, 1985). Incompetence in this area can be readily defined as the failure to achieve academic goals or meet academic requirements. Such incompetence is more easily remedied, primarily through the use of re-education and continuing education programmes (Jensen, 1979).

Technical/Conceptual Skills

Competence in technical and conceptual skills refers to the ability to appropriately use special procedures, interventions, and techniques in the clinical setting. These are highly specific and highly focussed skills that are developed through both didactic and

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experiential aspects of training (Overholser & Fine, 1990). Technical skills have been described in the literature as "specific" factors contributing to therapy outcome and include skills such as the ability to administer, score, and interpret specialized assessment instruments, as well as the ability to utilize specialized therapy techniques such as hypnotherapy, biofeedback, or sex therapy (Overholser & Fine, 1990).

Conceptual skills refer more specifically to the ability to apply knowledge and orientation-specific skills to assess or treat a particular client (Overholser & Fine, 1990). These higher-level components are more sophisticated than specific technical skills because they require the therapist's flexibility in adapting to the unique demands of each client (Loveland, 1985). These skills involve the ability to utilize a theoretical and conceptual framework to guide interactions; skillfully and appropriately use various interventions; establish connections between symptoms, affect, and behaviour; conceptualize client functioning and dynamics; develop a clear and coherent description and integration of client history with diagnosis; and develop appropriate treatment plans (Liston, Yager, & Strauss, 1981; Overholser & Fine, 1990; Shaw & Dobson, 1988). The use of such skills invokes a cognitive problem-solving approach where therapists must formulate hypotheses, test their assumptions, and refine their views according to the needs and dynamics of the individual client (Overholser & Fine, 1990). Similarly, a parallel process exists within medicine, where the competent physician must possess adequate data gathering and processing skills, involving the ability to collect data via physical exam and patient history, develop and verify hypotheses, and engage in an organized and thorough process of differential diagnosis (Hojat et al., 1986).

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With the development of highly detailed and specialized treatment manuals, technical skills are increasingly being evaluated by assessing therapist adherence to specified treatment protocols (Horvath, 2001a; Shaw & Dobson, 1988). In training programmes, technical competence is more informally assumed through examination of the student's successful completion of course requirements in various theoretical domains. Incompetence in technical and conceptual skills is evident when a therapist fails to recognize or utilize appropriate orientation-specific techniques, holds a narrow and limited perception of client difficulties, or maintains a rigid and inflexible approach to psychotherapy (Overholser & Fine, 1990). Training programmes tend to give greater emphasis to the development of technical and conceptual skills than to the final class of abilities necessary for competent practice, the clinical skills (Shaw & Dobson, 1988).

Clinical Skills

Clinical skills are essential ingredients of competent clinical practice that are typically not formally taught or acquired during academic training and are instead presumed to be developed during clinical experience (Shaw & Dobson, 1988). A variety of terms have been used to describe these non-academic aspects of competence, including psychological fitness, non-specific factors, professional skills, relationship skills, interpersonal skills and personal suitability. Competence in clinical skills is primarily reflected in the ability of therapists to foster productive therapeutic relationships with clients (Overholser & Fine, 1990; PSWAIT, 2001; Sakinofsky, 1979). This has also been described as the ability to develop rapport or a therapeutic/working alliance.

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Psychotherapy in this perspective is viewed less as a technique or specific orientation, than as a specialized human relationship which a skilled therapist develops, maintains, and manages with therapeutic goals in mind (Lambert & Barley, 2001; Strupp, 1986). Using this perspective, the skillfull therapist is one who seeks to create a positive therapeutic climate in which clients will feel free and safe to confide, unburden themselves, and abandon various maladaptive ways of functioning (Strupp, 1986). Moreover, therapy fails if such a positive interpersonal base cannot be created (Strupp, 1986).

The crucial role of clinical skills is supported by at least two decades worth of research significantly linking the quality of the alliance between the therapist and client with therapy outcome (Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland. 2000; Horvath, 2001a, 2001b; Lambert & Barley, 2001; Martin, Garske, & Davis, 2000; Norcross, 2001; Wampold, 2001). While most researchers agree that the quality of the therapeutic relationship is critically important, it has proven difficult to functionally define, teach, and evaluate those components that facilitate or hinder its development, particularly those contributory components related to the therapist's interpersonal skills and personality characteristics (Ackerman & Hilsenroth, 2001). While we have compelling research support for the essential role of the relationship, we have been unwilling to go further and examine the actual components responsible for building or destroying this essential relationship, or in effectively integrating or applying the findings from the few studies that have been done (Ackerman & Hilsenroth, 2001).

There has been longstanding general consensus within the discipline of clinical

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psychology that the therapist's personality and interpersonal skills are crucial in terms of the essential role they play in facilitating or hindering the development of the therapeutic relationship (Lambert & Bergin, 1983; Sakinofsky, 1979; Truax & Carkhuff, 1967). For example, in a 1959 survey, 84% of respondents from a sample of 100 members of the Clinical Psychology Division of the APA (Division 12) agreed that a formal personality evaluation should be used as a criterion for selecting applicants for graduate study (Berger, 1959). In fact, Strupp (1978) argued that the *person* of the therapist is far more important than his or her theoretical orientation and that without the therapist's basic "reverence for life" (p. 315), therapy remains a technical operation rather than a living human experience. He added that little information is communicated by therapists' theoretical orientations and that "good" therapists of whatever school are more alike than different (Strupp, 1978). Even the current emphasis on manualization and uniformity of therapeutic protocols has been unable to completely eradicate the role of the individual therapist. Such manuals and guidelines reluctantly acknowledge the importance of the therapy relationship, but few go on to specify the precise therapist qualities or in-session behaviours that might facilitate the development of a curative relationship (Norcross, 2001).

Incompetence in clinical skills is evidenced when emotional/personality problems or poor interpersonal skills interfere significantly with the therapist's ability to establish an effective therapeutic relationship. It is important to note that it is not unethical for psychologists to be emotionally or interpersonally distressed per se, as there must necessarily be a continuum of effectiveness within the profession, as there would be in

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any other discipline. However, when interpersonal and personal deficiencies significantly interfere with professional functioning in a manner that harms rather than helps clients, incompetence in such clinical skills becomes a grave issue. Thus, in assessing competence of graduate students, we can conclude that clinical skills should play at least as central a role as the acquiring of technical and academic skills. In fact, research suggests that clinical skills may actually play *the most important role* in determining the effectiveness of a therapist (Barber et al., 2000; Horvath, 2001a, 2001b; Lambert & Barley, 2001; Wampold, 2001).

The Relative Importance of the Dimensions of Competence

Some Issues in Assessing the Dimensions of Competence

Assessing the relative importance of knowledge mastery, technical/conceptual skills, and clinical skills has proven to be a challenging task as the state of the evaluation of competence is clearly more of an art than a science (Sakinofsky, 1979). The major obstacle has been the difficulty defining and measuring both predictor and criterion variables. No single method has proven effective in evaluating the full range of prerequisite skills necessary for competent clinical practice (Norman, 1985). Rather, different evaluation methods must be used to assess different predictors of competence. As a predictor variable, knowledge mastery can be relatively easily assessed by examining academic grades. Mastery of technical/conceptual skills is readily reflected in the trainee's cognitive understanding of and adherence to different theoretical orientations and treatment techniques. However, the valid and reliable assessment of the interpersonal

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qualities and personality characteristics which make up the clinical skills dimension of competence has proven more problematic. Related to this issue, depending on what one defines as "success" in psychology, competence criterion variables can range from measuring success in graduate school to psychotherapy outcome (Hofer, Stallings, Reynolds, Cliff, & Russell, 1994). Again, while academic success is more easily evaluated (i.e. obtaining the Ph.D.), treatment effectiveness and outcome are much more difficult to define and measure.

While we would expect a relationship between knowledge mastery and academic success, the logic of examining the relationship that technical, and even more so, clinical skills have with academic success is less apparent. Similarly, examining the relationship between clinical competence and academic success seems incidental, when clinical psychology is, at its core, a service discipline. Ultimately, it is the client who is the final judge of therapist competence, not the awarded degree (Stern, 1984). Thus, to determine the robustness of the service-oriented foundations of psychology, it seems essential to know whether the clinical and technical skills of the therapist have a significant effect on the outcome of psychotherapy, rather than on whether one obtains a Ph.D, gets a good job, or publishes a journal article (Shaw & Dobson, 1988).

Outcome-based measures of competence are ideally constructed based on a scientific understanding of psychotherapy and the therapist characteristics that are related to positive outcomes (Stern, 1984). Such evaluations examine the capacity of the individual therapist to function as an agent of psychological change, that is, to produce significantly positive changes in a client's emotional, cognitive, and interpersonal

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functioning (Shaw & Dobson, 1988). Using such methodology, competence can be demonstrated by showing that knowledge mastery, technical skills, and clinical skills are associated with improved client status and/or that the lack of such knowledge, skills and abilities is detrimental to client welfare (Loveland, 1985). Basically, clear relationships must be established between clinical activities and client improvement or deterioration.

As a construct, competence may be viewed as the characterization of many different performances, over a wide array of situations, and through extended periods of time (Peterson & Bry, 1980). Comparisons can be made not only between different individuals, but also of the same individual over time (Sakinofsky, 1979). Consequently, the reliability of ratings is an essential concern and, unfortunately, interrater agreement in ratings of competence using various approaches has been uniformly low. This low reliability is likely a consequence of the poor definitional validity of the construct. There is much disagreement between therapists about what competence looks like in actual practice. As Liston et al. (1981) state, "one person's 'empathy' may be another's 'countertransference problem'" (p. 1073). Fortunately, when considerable effort is made to train different raters in the definitions of competence to be employed, significantly more consistent ratings are made (Bondy et al., 1997; Liston et al., 1981).

Poor interrater agreement is, unfortunately, not the only reliability problem in the assessment of competence. Chevron and Rounsaville (1983) found poor agreement among assessments of the competence of therapists based on different sources of data. Specifically, they found that supervisor ratings based on a review of videotaped sessions were uncorrelated with the same supervisors' ratings based on therapists' reports of what

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happened in the session. Furthermore, only supervisor ratings based on therapists' reports of the sessions were significantly correlated with patient outcome, as measured by changes on self-report scales assessing depressive symptoms and social adjustment.

In a review of four journals that regularly report studies that include an evaluation of counsellor or therapist effectiveness, Scofield and Yoxtheimer (1983) identified 235 instances of competence measurement during the period from 1977 to 1982. Of these, 91% assessed interpersonal competencies such as empathy and interpersonal behaviours. The kinds of measurement used consisted mainly of rating scales, which were used 70% of the time, behaviour counts and classifications (11%), and written, objectively scored tests (8%). Interestingly, only 58% of the studies provided some evidence of the reliability of their measures, while only 12% made any attempt to directly assess or cite evidence for the validity (Scofield & Yoxtheimer, 1983).

The poor reliability and validity of competence ratings coupled with the seeming neglect in the research literature of directly addressing these issues continues to present a significant challenge to the assessment of the relative importance of the dimensions of competence. With these cautions in mind, the variety of ways in which the role of the various dimensions of competence has been measured can be more thoughtfully evaluated.

Research on the Importance of the Dimensions of Competence

Not surprisingly, predictors such as undergraduate GPA and GRE scores have been found to be related to academic success in psychology, including grades in graduate

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school, length of time to complete the degree, and rates of publication (Hofer et al., 1994). However, it is questionable how well academic predictors relate to non-academic criteria such as instances of ethical behaviour and self-ratings of competence in professional performance (Hofer et al., 1994). Knowledge may be necessary to the practice of good clinical work, but it is certainly not sufficient as an indicator of clinical competence (Stevenson & Norcross, 1987).

King et al. (1986) examined the relationship between several predictor variables available at the time of admission to a clinical Doctor of Psychology programme and programme performance two years later. They found that while undergraduate GPA, graduate GPA, GRE total scores, and interview ratings were significantly correlated with faculty ratings of academic ability two years post-admission, none of these predictor variables was significantly correlated with faculty ratings of professional potential (King et al., 1986). They concluded that academic performance was not necessarily predictive of professional performance.

The role of professional background, therapist orientation, and therapist interventions have also been examined. There have been mixed results concerning the relationship between these variables and therapy outcome. Generally, theoretical orientation has not been found to be strongly related to treatment outcome (Beutler et al., 1994; Lambert & Barley, 2001). While clinicians have steadfastly asserted that the particular techniques associated with their "school" of therapy are the critical ingredients responsible for therapeutic change, there have been no convincing demonstrations that any one form of therapy is consistently superior to others (Lambert & Barley, 2001; see

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the Consumer Reports study, November, 1995, as reviewed by Seligman, 1995; Strupp & Hadley, 1979; Wampold, 2001). In fact, it was discovered early on in the history of outcome research that the unique contribution of the relational style and personality characteristics of a particular therapist were often more powerful than the presumed treatment technique under investigation (Beutler et al., 1994; Lambert & Bergin, 1983; Norcross, 2001). Decades of research have rather convincingly suggested that perhaps the main curative component in the therapy process is the nature of the therapeutic relationship (Horvath, 2001a; Lambert & Barley, 2001; Norcross, 2001).

Review of Research Regarding the Clinical Skills Implicated in the Development of the Therapeutic Relationship

Therapist-offered characteristics likely play a major role in determining therapy outcome through their role in influencing the development of a good therapeutic alliance (Lambert & Barley, 2001; Strupp, 1986). The contribution of the therapist as an individual is evident in the simple fact that across modalities, some therapists consistently produce more positive effects than others, and conversely, some consistently produce more negative effects (Beutler et al., 1994; Lambert & Barley, 2001; Luborsky, Crits-Cristoph, McLellan, Woody, Piper, Liberman, Imber, Pilkonis, 1986). As Luborsky et al. (1985) concluded, the therapist is not simply a transmitter of a standard therapeutic agent, but an independent agent of change, with the ability to magnify or reduce the effects of therapy. Generally, research has not found consistent or strong relationships between therapist demographic variables such as age, sex, and ethnicity and the efficacy of therapy

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(Beutler et al., 1994; Lambert & Bergin, 1983). Similarly, research concerning variables such as the coping patterns of therapists, values and beliefs, and cultural attitudes has also been characterized by mixed results. While a large variety of therapist characteristics have been intuitively implicated in the literature, only a few have been studied with any systematic rigour (Beutler et al., 1994; Johnson & Campbell, 2002).

There has been much debate as to whether there exists a "counsellor personality" that distinguishes good from poor therapists (Arbuckle, 1956; Overholser & Fine, 1990). Some of the qualities which have been intuitively associated with this concept include sensitivity, creativity, compassion, dedication, warmth, and openness, (Peterson & Bry, 1980; Sakinofsky, 1979); understanding, sympathetic attitude, friendliness, stability, patience, common sense, and objectivity (Arbuckle, 1956); communicativeness, acceptance, tolerance, self-confidence, and a relaxed manner (Fordham et al., 1990); honesty, personal security, and stable identity (Klein & Babineau, 1974); easy-goingness, perceptiveness, naturalness, and spontaneity (Mintz, Luborsky & Auerbach, 1971); dependability, sincerity, directiveness, respect, and interest (Spilken, Jacobs, Muller, & Knitzer, 1969); as well as decency and humanity (Frieswyk, Allen, Colson, Coyne, Gabbard, Horwitz, & Newsom, 1986). Competent therapists must also possess the capacity for self-scrutiny and must be able to deal effectively with their own interpersonal concerns and conflicts (Ross & Altmaier, 1990). They must be able to honestly analyse their own emotional and behavioural responses to clients (Buckley, Karasu, & Charles, 1979). Finally, they must not be burdened by personal problems or characteristics that may interfere with clinical judgements and interventions (Rogers, 1957).

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A study by Luborsky, McLellan, Woody, O'Brien and Auerbach (1985) found that therapists who were more effective as assessed by self-reported changes in patient psychological functioning, were rated by their peers as being better adjusted, having more skill, and being more interested in helping patients than those who were less effective. Wogan (1970) found that therapy outcomes were positively related to therapists' level of anxiety and negatively related to therapists' level of repressiveness. Therapists who were well liked by clients and who seemed to be more effective in therapy were those who felt comfortable acknowledging a certain amount of dysphoria and "pathological" concerns while filling out the MMPI. They were also found to be more socially outgoing, and they did not go to great lengths to deny feelings of discomfort (Wogan, 1970). Other studies have also found that clients themselves clearly feel that the personal qualities of the therapist are more important than specific technical factors in causing personality changes in their clients (Lambert & Bergin, 1983).

The role of therapist mental health has also been extensively investigated by examining the relationship between personal therapy of the therapist and treatment outcome. Garfield and Bergin (1971) found that personal therapy of the therapist was related to client outcome in that the clients of therapists who had no personal therapy consistently demonstrated the greatest amount of change in MMPI scores on the depression and K scales. When the MMPI scores of 10 therapists who had received varying degrees of personal therapy (including no therapy) were examined, the trend was for the healthier or less disturbed therapists to secure greater positive change in their clients. Upon further analysis it was found that the poor results of the high personal

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therapy group were not due to their being more disturbed in their MMPI scores than the others (Garfield & Bergin, 1971).

The authors were perplexed by the result as it runs contrary to the commonsense notion that a psychotherapist will gain a more complete understanding of her or his own personality dynamics and reduce her or his personal blind spots by going through personal therapy (Garfield & Kurtz, 1976). However, as Beutler et al. (1994) noted, the absence of a clear relationship between therapist personal therapy and outcome is inconclusive because those therapists who utilize therapy most are not necessarily the ones who need it most. Related studies have also consistently suggested that therapist well-being and emotional health facilitate treatment outcome and, moreover, that therapists who lack emotional well-being actually inhibit client progress (Beutler et al., 1994; Lambert & Bergin, 1983).

Strupp and Hadley (1979) compared the relative contribution of "specific" factors concerned with the therapist's technical skills and "non-specific" factors which concern the qualities inherent in any good human relationship to outcome in time-limited individual psychotherapy. Comparable patient groups were treated either by highly experienced psychotherapists or college professors chosen for their "ability to form understanding human relationships." While the experienced therapists were expected to provide clients with an optimal combination of both technical and relationship factors, the professors were only expected to contribute their ability to form warm, understanding, and empathic relationships. The results showed that patients treated by the professors showed on average as much improvement as patients treated by professional therapists (Strupp &

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Hadley, 1979). Outcome was measured by examining both quantitative and qualitative changes in patients' feeling states (anxiety, depression, worrying, self-confidence, etc.) and social functioning (assertiveness, satisfaction with interpersonal relationships, social isolation, etc.). They concluded that their study lent no support to the assumption that given a benign human relationship, the technical skills of professional psychotherapists produce measurably greater therapeutic change. The positive changes experienced by patients appeared to be generally attributable to the healing effects of a benign human relationship, maximized when the patient was both capable of taking advantage of such a relationship and the therapist's interventions were experienced by the patient as expressions of caring and genuine interest (Strupp & Hadley, 1979).

In a sample of 31 male and female university counselling centre clients, those who terminated later in therapy (after six or more sessions) reported significantly higher levels of belief that the therapist respected them, was warm, and was competent than did early terminators (Hynan, 1990). These late terminators also provided more positive ratings of therapist trustworthiness and therapist response to client verbalizations (Hynan, 1990). The researchers concluded that client perceptions of therapist characteristics may contribute to a positive treatment alliance, which is in turn related to an adequate duration of treatment (Hynan, 1990). In fact, client perceptions of the relationship often correlate more highly with outcome than objective judges' ratings (Lambert & Bergin, 1983).

Hayden (1975) found that therapists who are regarded by their colleagues as more effective scored highest on ratings of empathy, positive regard, and genuineness based on independent observer evaluations of the therapists' responses to audiotapes of a therapy

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session (Hayden, 1975). Luborsky et al., (1985) also found that the major agent of effective psychotherapy was the personality of the therapist, in particular the ability to form a warm and supportive relationship with patients. Patient scores on an early in-treatment measure of the strength and positivity of the therapeutic relationship were found to be significantly correlated with seven month outcome measures of patients' employment, legal status, psychological functioning, and drug use (Luborsky et al., 1985). In a related study, Luborsky et al.(1986) also found that variations in the success rates of psychotherapists compared across four different treatment outcome studies were mainly determined by the therapist's ability to establish a positive helping alliance and the purity of therapist technique (Luborsky et al., 1986).

Henry, Schacht and Strupp (1986) found that good versus poor therapeutic outcome, as measured by changes in MMPI profiles and ratings of target complaints and global change made by patients, therapists, and independent clinicians, was differentiated on the basis of several therapist-offered interpersonal process variables. More positive therapeutic outcome was associated with therapists who demonstrated greater levels of helping, protecting, affirming, and understanding, and significantly lower levels of blaming and belittling. In this study, the Structural Analysis of Social Behaviour scale, developed by the authors, was used to code transcripts of third sessions (Henry et al., 1986).

In a recent review of the literature concerning the role of the alliance in influencing treatment outcome, Horvath (2001b) concluded that the ability to generate a good working alliance involves at least two interlocking dimensions. The first was

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described as an interpersonal skill component which involves maintaining open and clear communication, conveying understanding, an ability to assess the relationship from the client's perspective, transmitting messages of support and respect, the capacity to express sensitivity to the client's needs, awareness of the client's need for a psychologically safe environment, the need to maintain a sense of hope, and the ability to respond to these challenges appropriately. The second dimension was described as intrapersonal and primarily involved the specific psychological make-up of the therapist. Horvath (2001b) acknowledged that few in-depth studies exist which explore this dimension.

Ackerman and Hilsenroth (2001) approached the relationship between therapists' personal attributes and the therapeutic relationship from the point of view of identifying those therapist factors that lead to the deterioration or disruption of the alliance. In a review of studies conducted between 1988 to 1999, they found evidence for significant relationships between therapist rigidity, aloofness, tense demeanour, uncertainty, excessive self-focus, and criticalness and a weak alliance or the deterioration of an already existing alliance (Ackerman & Hilsenroth, 2001). In addition, they found that therapist techniques such as over-structuring the therapy, inappropriate self-disclosure, unyielding use of transference interpretation, and inappropriate use of silence also made significant negative contributions to the alliance. Furthermore, the authors found very little variation between different theoretical orientations regarding the therapist's negative impact on the alliance, providing further evidence for the belief that the alliance is a "pan-theoretical construct impacting psychotherapy process on multiple levels" (Ackerman & Hilsenroth, 2001, pg. 183).

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Other factors which have been negatively related to the establishment of an effective therapeutic relationship have included: the overuse of intellectualization, inability to tolerate silence or aggression in clients, and therapist attempts to satisfy their own needs for affection and approval from their clients (Buckley et al., 1979); defensiveness and poor motivation (Peterson & Bry, 1980); and argumentativeness and passive-aggressiveness (Stone, 1975). Traits including therapist coldness, hostility, obsessionalism, seductiveness, lack of interest or warmth, pessimism, sadism, narcissism, greed, and absence of genuineness have been related to the exacerbation of existing symptoms and the appearance of new symptoms in clients (Beutler et al., 1994; Hadley & Strupp, 1976). In fact, personality and interpersonal traits of the therapist are cited most often as the sources of negative effects in psychotherapy (Hadley & Strupp, 1976).

The Specific Examples of Empathy, Warmth, and Genuineness

Adequate levels of empathy, warmth, and genuineness have been consistently identified as essential interpersonal skills, playing a central role in promoting safety, freedom and openness to experiment, depth of self-exploration, understanding, trust, and compliance in clients (Overholser & Fine, 1990; Strupp, 1978; Truax, Carkhuff & Douds, 1964). Of course, no one has emphasized or expounded more upon the role of empathy, warmth, and genuineness than Carl Rogers. It can be argued that openness to the role of relationship factors in the psychotherapeutic endeavour really began with Rogers and the evolution of the "Third Force" humanistic movement in psychology, particularly in the movement's representation of an alternative to the cold, blank slate of the psychoanalyst.

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Rogers believed that empathy, warmth, and genuineness were both necessary *and* sufficient to bring about constructive personality change in clients (Rogers, 1957). In Rogers' client-centered model of therapy the therapist must be a congruent, genuine, and integrated person whose experience accurately reflects self-awareness. He or she must also experience unconditional positive regard for clients that is evidenced by a warm acceptance of each aspect of a client's experience. Finally, the therapist must develop an accurate empathic understanding of the client's internal frame of reference and be able to communicate this understanding in an effective way (Rogers, 1957). Rogers believed that if these conditions were present, regardless of the mode or techniques of therapy, constructive personality change would occur, and furthermore, with a greater degree of these conditions, more marked changes would result (Rogers, 1957).

Since Rogers first articulated these conditions, empathy, warmth, and genuineness have become the cornerstone skills viewed as mandatory in the establishment of an effective therapeutic relationship (Norcross, 2001). The capacity for accurate empathy in particular has been described by others as not only an essential counselling skill, but as the foundation for all human relationships and a sign of overall psychological health (Hatcher, Nadeau, Walsh, Reynolds, Galea, & Marz, 1994). The roles of the interpersonal skills of empathy, warmth, and genuineness have been examined more extensively than any other clinical skill (Lambert & Barley, 2001; Lambert & Bergin, 1983; Norcross, 2001). In summarizing this area of research, Patterson (1983; as discussed in Beutler et al., 1994) states "there are few things in the field of psychology for which the evidence is so strong [as that supporting the] necessity, if not sufficiency, of the

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therapist conditions of accurate empathy, respect, or warmth, and therapeutic genuineness" (p. 243). The significance of these variables has been shown to traverse theoretical schools, theory-specific concepts, and a diversity of measurement procedures (Beutler et al., 1994). Furthermore, the research evidence to date indicates that these relationship variables are positively correlated with client outcome over a wide variety of clients with a wide variety of problems (Patterson, 1984). The defining, measurement, and impact of these three skills will now be reviewed to exemplify some of the common issues and difficulties faced in exploring the role played by the person of the therapist in treatment outcome.

Definitions. Empathy is a multidimensional construct that can be defined on many levels. It may be seen as an ability, a communication style, trait, response, skill, process, or an experience (Wheeler & Manhart-Barrett, 1994). Similarly, the construct of empathy comprises a complex set of cognitive, emotional, and behavioural components (Evans, Stanley, & Burrows, 1993). Thus, depending on which dimensions of the construct are emphasized, empathy can be defined and measured in a variety of ways. Some researchers have suggested that because of the complexity of the construct, empathy should be tapped using a variety of both pencil and paper and behavioural measures (Evans et al., 1993).

Empathy has traditionally been described as the ability to be sensitive to another person's current feelings and thoughts, and the verbal capacity to communicate this understanding to the client in an effective way, demonstrating concern for the client's language and the timing of such communications (Greenberg, Watson, Elliott & Bohart, 2001; Mitchell et al., 1977; Spilken et al., 1969; Truax & Carkhuff, 1967). In displaying

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empathy, the therapist concentrates completely on the client as a person and tries to take him or herself out of the picture (Finke, 1990). This process involves therapists' abilities to allow themselves to experience the experiences of the client, reflect upon this experience while suspending their own judgements, and tolerate any anxiety they might encounter while engaging in this process (Carkhuff & Berenson, 1967). The absence of empathy is demonstrated when the therapist can only identify with clients' experiences on a purely intellectual level, or when the therapist is obviously insensitive to client cues and lacks an accurate understanding of clients' experiences (Spilken et al., 1969). The expression of empathy can also be maladaptive when therapists wholly identify with clients, losing their individuality and their ability to maintain the "as if" quality of the client's experience (Cooper, 1970; Rogers, 1957; Spilken et al., 1969).

Therapist-offered warmth refers to the extent to which the therapist communicates a non-evaluative, nonpossessive, and unconditional caring, respect, and positive regard for the individual worth and uniqueness of the client (Carkhuff & Berenson, 1967; Farber & Lane, 2001; Finke, 1990; Mitchell et al., 1977; Spilken et al., 1969; Truax & Carkhuff, 1967). Warmth is demonstrated when the therapist feels comfortable with and likes the client, is reassuring and encouraging to him or her, and refrains from expressing spontaneous value judgements or preferences (Finke, 1990; Spilken et al., 1969). For Rogers (1957), warmth was expressed in the concept of unconditional positive regard, involving an acceptance of clients' experiences without any conditions, and a non-possessive caring for clients where they are permitted to have their own feelings and experiences. He recognized that this degree of warmth likely only exists in theory and

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that, instead, an effective therapist is one who is able to experience this unconditional positive regard during many moments of contact with clients. Lack of warmth is demonstrated when therapists express no liking or affection for their clients and seem cold and unresponsive (Spilken et al., 1969). Similarly, warmth can be demonstrated inappropriately when the therapist is infantilising, fosters dependency in clients, promotes inappropriate intimacy with clients, or otherwise uses the client to satisfy his or her own needs (Rogers, 1957; Spilken et al., 1969).

Finally, genuineness refers to the extent to which the therapist is sincere rather than defensive or phony in his or her interactions with clients (Mitchell et al., 1977). It is also the therapist's capacity to appropriately communicate his or her personhood to the client (Klein, Michels, Kolden, & Chisholm-Stockard, 2001). When therapists are being genuine or authentic, they are being themselves and their statements are reflecting or are congruent with their own true feelings (Rogers, 1957; Truax & Carkhuff, 1967). Some have argued that genuineness is the primary interpersonal skill because true or accurate warmth and empathy cannot be experienced when a therapist is being phony (Truax & Carkhuff, 1967). Genuineness is expressed when therapists accurately and honestly reflect their own feelings and experiences to clients in a sensitive manner. This means that the therapist must occasionally withhold some very genuine responses if they will be unduly hurtful or critical of a client (Rogers, 1957; Truax & Carkhuff, 1967). Lack of genuineness is displayed in superficiality, deception, or therapist role-playing, while extremes of genuineness are reflected in inappropriate openness, personal confession, and self-revelation (Spilken et al., 1969).

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In the medical field, Yager (1989) provided some concrete suggestions concerning ways to maximize rapport with medical patients using empathic, sensitive, warm, and compassionate responses. For example, he suggested physicians express tangible supportive behaviours to patients, including a warm handshake, a smile, or a touch on the shoulder. These behaviours convey a human caring that can reduce feelings of aloneness or alienation and reduce interpersonal distance or status differences between the doctor and patient. He also suggested that doctors engage in particular verbal responses such as giving patients a chance to correct distorted information, asking patients what their most pressing concerns are, allowing patients an opportunity to express their belief systems and perspective on their diagnosis, and conveying a real interest in patients' day-to-day human world by asking about their family, social roles, and how their illness has impacted their life. He also suggested that doctors leave patients with something concrete, a formulation of what they can expect now or a plan for future action (Yager, 1989). Although these suggestions were made in reference to medical settings, they seem equally applicable to therapy and counselling situations.

Measuring empathy, warmth, and genuineness. While the importance of empathy, warmth, genuineness and related interpersonal skills has been agreed upon, there continues to exist a lack of valid and reliable means of measuring these constructs as they relate to clinical competence. A variety of measurement approaches have been attempted. For example, global personality scales such as the MMPI, the Personal Orientation Inventory, and the California Psychological Inventory have been used to measure a range of interpersonal and personal skills (Woodward & Gerrard, 1985). While these paper and

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pencil tests allow for ease of administration and scoring, there is little evidence for their validity with respect to clinician-client relationships (Woodward & Gerrard, 1985). Similar limitations are encountered when rating scales are used to measure specific skills such as warmth or empathy. These tests seem to tap cognitive aspects of these constructs rather than the ability to actually feel or display these skills effectively (Bennett, 1995).

Scores on discrimination and formulation tests in which students are asked to respond to simulated client statements also lack clear relationships with therapist behaviour in real clinical settings (Woodward & Gerrard, 1985). A student may be able to formulate the "correct" response to a client statement but this does not mean that he or she will be able to do this or to communicate this statement effectively in a real clinical situation. Ironically, supervisor ratings based on direct evaluation of therapist-client interactions are also limited because of poor interrater reliability, a consequence of the lack of specificity in defining the interpersonal skills to be evaluated (Liston et al., 1981).

The difficulty in measuring interpersonal and personal skills is reflected in the history and outcome of research into the construct of empathy. Empathy in particular has received significant research attention since Carl Rogers' original writings concerning its important role in psychotherapy (Duan & Hill, 1996). Unfortunately, research activity in this field has dropped off considerably in recent years as a result of the lack of clear or consistent findings and effective research tools, and an increasing emphasis on technical skills. The confusion of findings in empathy research seems to reflect the diversity of ways in which empathy has been conceptualized: as a personality trait or stable ability; as situation-specific; as a cognitive, affective, and/or verbal quality; and as a multiphased

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experiential process (Duan & Hill, 1996). Because the same term has been used to refer to a wide variety of different constructs, it has led to considerable conceptual and methodological confusion, as well as incomparability across studies.

The diversity in the definitions of empathy has had a profound effect on the development of adequate measures (Chlopan, McCain, Carbonell, & Hagen, 1985). Consequently, there are as many available scales for measuring empathy as there are definitions of the construct. No single measure of empathy seems sufficient. Instead, different instruments must be used to tap its different aspects (Bennett, 1995; Marks & Tolsma, 1986). Furthermore, measures are available which rely on self-report, client-report, or supervisor/observer report, as well as self-report scales, direct performance evaluations, and even physiological measures of empathic behaviour. Each measure and methodology appears to tap a different aspect of the global construct of empathy (Marks & Tolsma, 1986).

One of the more popular measures of empathy is the Truax-Carkhuff scale of accurate empathic understanding (see Bennett, 1995; Marks and Tolsma, 1986). Completion of the scale involves written responses to 16 statements by a hypothetical client to a therapist. The "empathy" of the written response is rated by a specially trained judge. The scale has been criticized for merely reflecting a cognitive appreciation of empathy where one simply has the ability to know which verbal responses convey empathy and which do not, rather than actually feeling empathy or understanding (Bennett, 1995). Another frequently used tool has been the Barrett-Lennard Relationship Inventory (RI) which taps both the client's and the therapist's perceptions of the

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therapist's empathy (Barrett-Lennard, 1962). Therapists rate how much they think they understood, and clients rate how much they felt understood in a given session. This scale conceptualizes empathy as a subjective and cognitive state experienced by the therapist for his or her client (Duan & Hill, 1996). It does not allow for ratings by external evaluators or supervisors.

The Questionnaire Measure of Emotional Empathy (QMEE) is a 33 item test which has been used to specifically assess the empathic emotional response, rather than the cognitive dimensions of empathy (Mehrabian & Epstein, 1972). With items such as "I like to watch people open presents" and "Another's laughter is not catching for me," this scale does not seem relevant or face valid with respect to the therapeutic relationship. Davis' Interpersonal Reactivity Index (IRI) has been used quite frequently to measure the multidimensional components of empathy (see Davis, 1983). The scale has been found to be correlated with other measures of empathy such as the QMEE, but again, the relationship of some of its scales such as Fantasy (ability to transpose yourself into the feelings and actions of fictitious characters) and Personal Distress (self-oriented feelings of personal anxiety and unease in tense interpersonal relationships) with the clinical processes involved in establishing an effective therapeutic relationship is questionable (see Chlopan et al., 1985; Davis, 1983).

Furthermore, the accuracy of client or therapist self-report is limited by human perceptual errors and social desirability, while observer/supervisor ratings seem to capture the outward expression of inward empathic experiences, which may be confounded with therapist communication skills (Duan & Hill, 1996). Thus, the reliability and validity of

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even these more popular scales is questionable (Duan & Hill, 1996; Scofield & Yoxtheimer, 1983). Moreover, in the context of psychotherapy, empathy as an affective phenomenon has not been given much research attention (Duan & Hill, 1996).

In sum, although a considerable amount of effort has been directed at assessing empathy and other interpersonal and personal skills relevant to clinical competence, valid and reliable measures of specific skills, and global measures of clinical competence are still lacking. The primary obstacle has been the lack of consensual definitions of the relevant interpersonal and personal skills necessary for clinical competence. Thus, it is necessary to first specify exactly what is to be measured before any measures can be developed (Duan & Hill, 1996). Similarly, researchers must develop and choose instruments which specifically fit the use that is to be made of the test, and the kinds of questions to be asked (Bennett,1995).

Empathy, warmth, genuineness and therapeutic outcome. In a recent (2001) special issue of the journal *Psychotherapy: Theory, Research, Practice, Training*, several articles were devoted to reviewing the state of the research on the relationship between empathy, positive regard, genuineness and therapeutic outcome. Greenberg et al. (2001), reviewed a total of 47 studies and found a medium effect size of .32 (r) between therapist empathy and treatment outcome. They concluded that empathy as a whole accounted for almost 10% of outcome variance, as much and probably more variance than is accounted for by specific interventions (Greenberg et al., 2001). Furthermore, client measures of empathy predicted outcome best, followed closely by observer-rated measures, and therapist measures. Similarly, Farber and Lane (2001) reviewed the results of 16 studies

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published since 1990 concerning the relationship between positive regard, or warmth, and outcome. They found the results to be evenly split between those finding a positive relationship, and those with non-significant effects. No recent study found a negative relationship between positive regard and outcome. They concluded that the therapist's ability to provide positive regard seems to be significantly associated with therapeutic success, specifically when the client's perspective is taken on the nature and strength of the therapist's positive regard (Farber & Lane, 2001). Finally, Klein et al. (2001) reviewed a total of 77 research results concerning the relationship between congruence or genuineness and outcome. They found that 34% of these studies showed a positive relationship, while none were negative. They concluded that there was enough evidence that a "revival" in research pertaining to the role of congruence was warranted (Klein et al., 2001). Interestingly, all three reviews noted the significant decline in research on the role of these variables since the 1970s.

Why are Clinical Skills so Important?

Interpersonal and personality skills are believed to be a central factor in influencing therapy outcome because of the direct role they play in the development of a positive therapeutic relationship. These therapist-offered conditions are so important because they provide clients with the freedom and safety of a warm, accepting, trusting, reliable, and honest relationship within which to openly explore and experience both positive and painful emotions and thoughts (Truax et al., 1964). Empathy, warmth, genuineness, and related characteristics are skills and attitudes which elicit client

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exploration, reduce anxiety in clients which is in itself reinforcing, shatter clients' experiences of isolation and hopelessness, elicit reciprocally positive affect in clients, and permit the therapist to become a personally potent reinforcer in the client's life (Carkhuff & Berenson, 1967). Furthermore, a good therapist is able to optimally use the base of such a positive therapeutic relationship to effectively deploy orientation-specific technical skills (Strupp, 1986).

Other explanations of the effectiveness of interpersonal skills and personality traits stem from the belief that the major cause of many kinds of psychological disturbance is related to the absence of good human relationships (Patterson, 1984). In this perspective, psychotherapy can be seen as providing a new relationship to correct the ill effects of previous negative relationships in a client's life (Patterson, 1984; Strupp, 1986). The client undergoes a corrective emotional experience in the context of the therapeutic relationship and the therapist simply becomes a better mentor than significant figures in the patient's past (Strupp, 1986).

Henry, Schacht, and Strupp (1990) used the theory of interpersonal introjection to explain why the interpersonal and personal skills of the therapist exert such a powerful influence on therapy outcome. The basic principle of this theory is that people learn to treat themselves as they have been treated by others. The authors did find evidence of a significant relationship between therapists' interpersonal behaviours and the ways in which patients acted toward themselves (Henry et al., 1990). For example, there was a high degree of correspondence between patient self-blaming and therapist statements subtly blaming the patient (Henry et al., 1990). Patients who experienced change engaged

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in therapeutic interactions with the therapist that were almost completely devoid of disaffiliative therapist behaviours such as hostile blaming and ignoring. They found that, whereas the absence of a negative interpersonal process may not be sufficient for therapeutic change, the presence of even relatively low levels of negative therapist behaviour may be sufficient to prevent change (Henry et al., 1990).

Clinical Training and Clinical Skills

There has been much debate concerning the extent to which interpersonal and personal skills are trainable or whether they are pre-existing personality traits within the student (Johnson & Campbell, 2002; Sakinofsky, 1979). Determining whether dimensions such as empathy, warmth, and genuineness are trainable skills is essential to the discipline of psychology because this will influence the relative importance to be assigned to screening procedures in graduate school. Similarly, the "teachability" of these traits has important implications for the design of training programmes in clinical psychology and related human service professions. Generally, research has failed to find a conclusive relationship between amount of clinical training and therapist expertise in a variety of disciplines including psychology (Beutler et al., 1994); social work (Dickson & Bamford, 1995), medicine (Hojat et al., 1986), and nursing (Armstrong & Kelly, 1993; Wheeler & Manhart-Barrett, 1994). However, other studies have found that the use of interpersonally-specific training techniques such as modelling, role playing, rehearsal, and systematic instruction are effective in increasing empathic responses in clinical psychology, nursing, and medical student trainees (S.A. Anderson, 1992; Dalton Jr. &

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Sundblad, 1976; Hatcher et al., 1994; Stone & Vance, 1976; Truax & Carkhuff, 1967; Uhlemann, Lea, & Stone, 1976; Wolf, Savickas, Saltzman, & Walker, 1984). On the other hand, warmth and genuineness appear to be less amenable to training effects (Mitchell et al., 1977).

It has repeatedly been suggested that experiential rather than purely didactic training is the best context within which to learn interpersonal and personal skills (Truax et al., 1964; Wheeler & Manhart-Barrett, 1994). Teaching self-awareness to students is viewed as the key component of such experiential training (Anderson & Gerrard, 1984; Armstrong & Kelly, 1993). It has been argued that clinical training programmes should direct considerably more effort toward the development of the clinician as a person who values others, understands his or her own emotions, and is willing and able to enter into a helping relationship (Lambert & Barley, 2001; Lambert & Bergin, 1983; Wheeler & Manhart-Barrett, 1994).

Ironically, there has even been some evidence that the interpersonal and personal qualities which graduate students do learn and develop in typical training programmes are actually the opposite of those qualities necessary to establish positive relationships. Increased dogmatism, dominance and control have been correlated with clinical training (see Beutler et al., 1994). In one study, Henry, Strupp, Butler, Schacht, and Binder (1993) examined changes in therapist behaviour after a year-long manualized training programme in time-limited dynamic psychotherapy. While they found that therapists' technical interventions had changed in line with the protocol, there was an unexpected decline in certain interpersonal and interactional aspects of therapy. Although the changes

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were not significant, the trend was toward less warmth and friendliness, and greater expression of negative attitudes. After training, therapists were judged to be less optimistic, less supportive of patients' feelings, and more authoritarian. They also demonstrated less overt approval and were more defensive (Henry et al., 1993).

As a result of the questionable relationship between training and interpersonal and personal skills, some have suggested that gate-keeping into the profession must be more strict and that students must be screened for their capacity for empathy, warmth, and genuineness and related skills before they are admitted to graduate school (Peterson & Bry, 1980; Procidano et al., 1995; Sakinofsky, 1979; Stevenson & Norcross, 1987; Strupp, 1978). Sakinofsky (1979) believes that graduate students must already possess certain pre-existing personality characteristics if they are going to be able to learn how to manifest essential interpersonal and personal skills. He wrote:

> [the student] must already be a concerned, compassionate, intelligent, and sensitive human being before his [sic] training even begins. Training may mature and refine the experience of his concern and empathy, but it cannot supply what does not exist in the first place (p. 195).

Currently, few programmes directly screen applicants for these skills or have specific policies or uniform guidelines outlining what is expected of students (Johnson & Campbell, 2002; Procidano et al., 1995). Nevertheless, training programmes seem an ideal place where impairment can and should be identified because early recognition of problems is essential to effective remediation (Hurwitz, Beiser, Nichol, Patrick, & Kozak, 1987).

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The Present Investigation

The present study represented an attempt to specifically define what various individuals involved in the human service professions believe are the necessary variables required to demonstrate "clinical" or "non-academic" competence. Participants' perceptions of the role of relevant personality dimensions and interpersonal skills such as empathy, warmth, and genuineness in displaying clinical competence were explicitly explored. These skills have repeatedly been found to play a significant role in determining therapist effectiveness and influencing psychotherapy outcome via the therapeutic relationship. However, as mentioned above, clinicians and training programmes have traditionally avoided directly defining, teaching, or evaluating these qualities in trainees. The purpose of the present study was to address this shortcoming primarily by developing a consensual and specific definition of the personal and interpersonal dimensions of non-academic clinical competence as they relate to clinical work. Thus, the purpose of this study was primarily definitional; to promote a shared system of language and meaning in the evaluation of clinical competence. This may be seen as a first step in a research programme ultimately intended to develop an effective and useful tool for assessing this dimension of clinical competence.

The present study represented a unique approach to this research area for several reasons. First, while previous studies have focussed on developing global definitions of competence reflecting academic, technical/perceptual, and clinical skills, this investigation focussed specifically on the latter dimension. The personality factors and interpersonal skills which are deemed necessary for clinical competence were defined by

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the participants, and specific examples were given of how these skills are demonstrated in clinical work with clients and in professional relationships with colleagues. Specific definitions of incompetent behaviour along each dimension were also developed.

Secondly, participants in the present study included clinical faculty and students from a variety of clinical disciplines where interpersonal interaction is an essential component, including clinical psychology, psychiatric nursing, and social work, as well as clients of mental health services. Past studies have focussed on one profession, with little interdisciplinary integration. Additionally, researchers have tended to neglect the opinions of students and clients in formulating definitions of competence. Thus, the present study provided a comprehensive, multi disciplinary, and consensual definition of non-academic clinical competence and incompetence.

Furthermore, interview information gathered from the various participants was used to develop a qualitative assessment tool which may be used by faculty and students in evaluating non-academic clinical competence. This assessment tool represents a guide to evaluating competence in the personality and interpersonal dimensions specified. Such a format allows for a more qualitative evaluation of competence and incompetence in clinical skills. The relevance of making quantitative distinctions of clinical competence, represented by Likert-type measures, is questionable given that a range of competency must necessarily exist within the profession. As in any other profession, some clinicians must necessarily be better than others. Instead, the most important and relevant distinction to be made is that between competent and incompetent behaviour. A qualitative assessment tool allows clinicians to evaluate the overall quality of their

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performance in these skills, assessing for a "minimal" level of competence, rather than making distinctions between levels or degrees of competence. This is similar to the philosophy behind using pass/fail grade systems rather than letter grades, which has been adopted by many graduate training programmes. The assessment tool developed in the present study requires further investigation regarding its in-practice applicability and effectiveness.

Finally, the present study also offers suggestions as to how such a tool might be used within professional training, and more specifically, possible procedures for addressing incompetence in trainees. Participants were asked to reflect upon ways of addressing incompetence, including whether problematic personality characteristics are amenable to change and whether interpersonal skills are trainable. The intuitive understanding of the relationship between clinical training and clinical competence was attentively explored.

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CHAPTER II

Method

This study investigated subjective definitions of the variables necessary for demonstrating non-academic clinical competence and incompetence, as defined by faculty, practitioners, and students involved in the training and provision of clinical services and by clients of such services. The study involved two primary tasks: 1) an analysis and consolidation of information gathered from all participants concerning their definitions of and experiences with clinical competence and incompetence; and 2) the practical integration of this material into a qualitative clinical assessment tool that might be used to assess trainees' performance in this domain.

Purpose

The primary purpose of the study was to explore in detail the perceptions of clinical faculty, students, and practitioners, as well as clients of clinical services concerning the nature of the personal and interpersonal skills necessary for effective clinical practice; to define specific examples of behaviours representing competence and incompetence within these skill categories; to determine the importance assigned to the clinical skills dimension of competence; and to explore perceptions concerning the

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assessment, teaching, and remediation of such skills.

Recruitment of Research Participants

Participants were recruited via both formal and informal procedures. A purposeful sample of faculty, students, and practitioners within Clinical Psychology, Nursing, and Social Work was selected according to their willingness and ability to participate. These professions were chosen because they involve disciplines in which clinical interaction with others is an essential component. In addition, as described earlier, previous research has suggested much conceptual similarity between the three disciplines in terms of their underlying dimensions of clinical competence (see for example Bondy et al., 1997; Hojat et al., 1986).

Within the university setting (the University of Windsor, Windsor, Ontario, Canada), participants were primarily recruited via an information sheet which was placed in the mailboxes of faculty and students in a theoretically diverse clinical psychology training programme. Those persons interested in participating were asked to provide their name and phone number to the principal researcher. Interview times were then arranged at the participants' convenience. In the clinical practice setting (primarily the Royal Ottawa Health Care Group, Ottawa, Ontario, Canada), participants were gathered in a similar manner. The Royal Ottawa Hospital is a multidisciplinary mental health setting employing individuals with varied backgrounds, training credentials, and theoretical allegiances. Individual employees were approached by the principal researcher and provided an information sheet. Again, those interested in participating were asked to

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provide their name and phone number to the principal researcher in order to arrange a convenient interview time. Other participants were then recruited through more informal word of mouth procedures ("I heard about your study from X and would like to participate...").

Clients were recruited through referral by their primary therapists. Therapists were given general information concerning the nature and purpose of the study (see Appendix A) and were asked to speak to clients whom they thought might be interested in participating in such a study. To ensure non-coercive participation, clients were asked to indicate on a piece of paper whether they wished to participate or not and if so, to provide their phone number. This information was then given directly to the researcher. Thus, therapists did not know whether or not their clients participated in the study. Interested clients were then contacted by the researcher to set up an interview time.

Such purposeful sampling was used to ensure the contextual representativeness and appropriateness of the opinions expressed by these participants (Lincoln & Guba, 1985; Morse & Field, 1995). All of these individuals have direct and complementary involvement and investment in the effective training and practice of clinicians and therefore have relevant knowledge and insight for the purposes of the study.

An emergent sampling design was employed where more participants were recruited on an as-needed basis in order to extend information already obtained, to obtain additional information, or to fill in gaps. Thus, sampling was conducted to the point of saturation, so that sampling was terminated only when no new data was forthcoming and information being obtained was perceived as redundant (Lincoln & Guba, 1985; Morse &

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Field, 1995). This ensured that enough data was gathered in order to develop a full and rich description of the dimensions of clinical competence and incompetence. This sampling methodology is consistent with a qualitative approach to research in which meaning and informational considerations are paramount (Lincoln & Guba, 1985; Morse & Field, 1995).

Demographic Characteristics of the Research Participants

The participants in the present investigation were 26 faculty, students, and practitioners within Clinical Psychology, Nursing, and Social Work, as well as one client presently receiving therapy. These participants were selected according to their willingness and ability to participate.

Participants ranged in age from 26 to 60, with an average age of 45 (see Table 1). Nine (34.6%) participants were male, while 17 (65.4%) were female. A total of 4 (15.4%) of the participants identified themselves as students, 7 (26.9%) identified as faculty, and 17 (65.4%) identified as clinicians (see Table 1). Three people identified themselves as both faculty and clinicians. Finally, a total of 1 (3.8%) individual identified herself as a client presently involved in clinical treatment. This client indicated that she had been in therapy for five months and that she found it helpful. Demographic data, including field of practice/study, level of education, experience supervising others, and years in the profession are summarized in Table 1.

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Table 1

Summary of the Demographic Characteristics of the Participants

Variable	M	SD	Range
Age	45.04	10.38	26-60
Number of Students Supervised	111	413	1-2000
Years Within the Profession	17	9.09	2-30

Variable	n	%
Level of Education		
Bachelor	3	11.5
Master's	8	30.8
Doctoral	8	30.8
Doctoral IPR[a]	4	15.4
Other[b]	3	11.5
Status[c]		
Student	4	15.4
Faculty	7	26.9
Practising Clinician	17	65.4
Client	1	3.8
Field		
Psychology	15	57.7
Nursing	7	26.9
Social Work	3	11.5
Experience Supervising Others	22	84.6

[a] denotes that the degree is in progress
[b] including "Registered Nurse" and "Diploma in Nursing"
[c] totals are greater than 25 because 3 people identified themselves as both clinicians and faculty

note: n for the variables Age, Status, and Level of Education is 26, n for all other variables is 25 (minus the client)

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Inclusion of the Client

Unfortunately, as a result of practical limitations, only one client participated in the study. Although this number is significantly less than desired, the comments of this client were deemed substantially meaningful to the study and were nonetheless included in the analysis. However, this client's comments cannot be assumed to be representative of all clients' experiences.

Procedure

Information was gathered from all participants using a semi-structured interview. This approach was employed to ensure that the data gathered were relevant to the questions posed by the study, while also allowing respondents the opportunity to freely respond and illustrate their unique opinions, beliefs, and concepts. Along with ensuring a rich depth of information, interviewing also allowed for immediate processing opportunities, clarification, and summarization (Lincoln & Guba, 1985).

At the beginning of each interview, an explanation of the study was given and written consent to participate was obtained (see Appendix A). All participants were informed that they were not required to participate, that they could stop the interview at any time, and that they could refuse to answer any of the questions. The participants were also informed that the interview would be audio recorded and that the tape would be erased after the study was completed. They were further assured that the information they provided would be confidential and that only the principal researcher would be able to connect their name with the information they provided. They were also informed of the

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opportunity to receive feedback upon completion of the study.

Next, background data were obtained concerning the individual's age, sex, level of education, and university department/major (see Appendix A). For faculty, additional information was obtained concerning years of practice within their profession. Both students and faculty were also asked about supervisory experiences, including approximate number of students supervised. For the client, specific information was obtained concerning length of time in therapy and subjective perception regarding whether therapy had been helpful or not (see Appendix A). This information was used to describe the sample and if applicable, to compare responses provided by participants with varying background data.

After background information was collected, participants were interviewed. The semi-structured interview was developed to explore a variety of topics related to the definition and measurement of the personal and interpersonal clinical skills necessary for competent practice (see Appendix A). Each interview covered all of the questions listed but additional questions were asked in response to the statements made by the participants so that each interview was unique. The wording of the interview questions was also altered depending upon the status of the participant (faculty, student, practitioner, client). The interviews lasted from approximately 30 minutes to one hour. Location of the interviews was negotiated with the participants. All interviews were conducted by the principal researcher. The study was cleared by the Ethics Committee of the University of Windsor and all relevant ethical guidelines were followed.

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Overview of the Analysis

The interviews were transcribed verbatim from the audiotape, with names and other identifying information deleted. Transcriptions were then reviewed in a disciplined and systematic manner to: 1) determine overarching categories of clinical skills (e.g. "patience"); and 2) to define examples of specific behaviours representing these overarching skills (e.g. "ability to tolerate silence" as a specific behaviour representing the clinical skill of "patience"). These general categories of skills and specific examples of behaviours then formed the basis for the items included in the qualitative assessment tool developed by the researcher.

In analysing each transcript, five content areas of information were explored including: 1) requisite personality and interpersonal skills essential for clinical practice, including specific examples of behaviours representing competence and incompetence in these skills; 2) the importance of these clinical skills in assessing overall clinical competence; 3) the measurement or assessment of such skills; 4) the teachability of these skills, including their role in formal training programmes; and 5) procedures for addressing incidences of trainee incompetence.

Analysis of the qualitative interview data occurred in three stages. The first stage involved initial coding of each transcript in terms of the relevance of participant statements to a specific content area described above. Then, units of information relevant to a particular content area were summarized onto index cards. In the second stage, the index cards relevant to the content area were combined and sorted. Finally, the properties of the sorted piles were extrapolated in order to determine potential category labels,

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qualities, and relationships (see Table 2 for an illustration of this procedure).

Analysis of the Qualitative Data: The Constant Comparative Method

The constant comparative method was used to reduce and analyse the qualitative data in the present study. The primary features of this method are its inductive and comparative nature; categories are derived from the data via inductive reasoning and constant comparison of all units of information. Thus, data collection and processing occurred simultaneously and the meaning of new information was always perceived as relative to that already collected. See Lincoln and Guba (1985) and Chenitz and Swanson (1986) for a detailed discussion of this procedure.

The first task in the constant comparative method involved "unitizing" the information provided by the participants. This was conducted in two stages. The first stage of data reduction involved reviewing each participant's entire transcript to code naturally occurring segments in terms of their intrinsic relevance to one of the five content categories described above. Relevance was noted using a colour-coded highlighting system (i.e. all words relevant to content area one were highlighted in orange).

In the second stage, an analytic-inductive approach was used to define the units or incidents of information that later served as the basis for defining categories. A "unit" can be defined as the smallest piece of information about something that is interpretable in the absence of any additional information (Lincoln & Guba, 1985). It is also heuristically useful and is aimed at achieving some understanding sought by the investigator (Lincoln & Guba, 1985). In the present study, "units" primarily referred to

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Table 2

A Description of the Data Analysis Procedure

Stage	Tasks
Stage 1 unitizing	1. Coding (highlighting)for content area (1-5) 2. Locating and transferring units of information onto index cards
Stage 2 sorting	1. Place cards in piles on a "looks/feels like" basis 2. When several cards are in a pile, write out the rules for inclusion/the properties of the pile 3. Place cards according to the rules for inclusion 4. Review all cards in each pile to ensure they meet the rules for inclusion
Stage 3 defining	1. Explicitly label the thematic category represented by each pile

* adapted from Lincoln & Guba (1985)

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specific examples of behaviours which reflect competence and incompetence in various overarching categories of clinical skills (e.g. the statement "Doesn't interrupt others" would be considered a unit of information). After such a unit was identified, it was transferred onto an index card, along with information concerning the respondent number and page number within the transcript. The process of identifying and transferring these units occurred separately for each of the five content areas.

Next, the sorting stage of the constant comparative method was initiated. For each of the five content areas, the investigator read each one of the available index cards and placed it into one of various separate piles representing emerging categories. While placing the cards, the investigator compared each card with others previously placed (hence the term "constant comparison"). Initially, cards were placed in the same pile simply on a "looks like/feels like" basis. However, after a significant number of cards had been placed in one pile, the investigator reviewed the cards and began the process of delineating the properties of the category represented by the cards as well as writing the rules for inclusion. This information was recorded on a separate index card placed adjacent to the category. Thus, further sorting was based on adherence to inclusion rules rather than on a "looks/feels like" basis. Finally, after all the sorting was completed, the investigator reviewed each category and ensured that all the cards within the pile met the inclusion criteria. The result of this stage of analysis was many separate piles of index cards for each of the five content areas.

Finally, the last stage of analysis involved explicitly labelling and defining the various categories represented by the units of information within each pile, as well as

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conceptualizing possible relationships between them. The investigator reviewed all of the cards within a pile, the inclusion rules and pile properties, and used inductive reasoning to determine a category label for the pile. To illustrate, a card with the statement "Aware of how your emotions and internal responses get played out in the relationship with the client" was combined with other cards in content area one such as "Recognize your issues versus their issues," and "Awareness of how you interact with others"; and the thematic category of these statements was defined as "Ability to be aware of countertransference issues." Thus, the final result of the analysis for content area one was the delineation of a variety of participant-defined categories of essential clinical skills, as well as specific behavioural examples of competence and incompetence within each category.

In the last stage of the study, the researcher integrated the material gained from the analysis into a more practical and applicable qualitative Clinical Skills Appraisal Tool (CSAT) that might be used to assess trainees' performance in this area of competence. This tool consists of the categories of clinical competence and incompetence provided by the participants within the context of their opinions on the potential usefulness of this kind of tool in training and evaluation.

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CHAPTER III

Results

Reflections on the Sorting Process

The process of sorting unitized pieces of information into meaningful categories proved to require almost perpetual repetition by the researcher throughout the entire course of both the analysis and write-up of the results. Initially, effort was made to sort into the most categories possible, so the creation of rather fine lines of meaning distinction was necessary (e.g. Warm, Friendly, Kind, and Caring were separate categories). Despite this attempt at meticulous differentiation, certain units of information were nonetheless difficult to place and seemed to vacillate day-by-day among several related categories. An external consultant, a clinical psychology graduate student who did not participate in the study, reviewed these initial categories. Units were shifted based on consensus between the consultant and the principal researcher. As a result, at least 70 categories of competency skills were initially created.

After this initial process, a new re-sorting occurred in which the category headings (i.e. Warmth, Kindness, Sincerity) now became the "units" of information. As a result, some categories were combined, some new ones were created, and pieces of paper were redistributed. This process was repeated several times until a total of 66 categories were

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delineated. The external consultant again reviewed these categories and additional changes were made based on discussions with the researcher.

Finally, the last re-sorting of units and categories occurred during the actual process of writing the results section. As categories were described in great detail in a written format, certain pieces of paper suddenly did not seem to fit in a given pile, and were thus placed in another category, or into a stack labelled "Where do these go?" This pile ultimately included those units of information sorted last. The external consultant reviewed these remaining units of information, and discussions with the principal researcher continued until consensus was reached on the final placement of each unit of information.

Sorting the skill categories of competency and incompetency proved to be the most demanding task in the study. While the same sorting strategy was used for the other areas addressed in the project, these areas generally had fewer units of information to be sorted and less overarching categories to be created.

Much focussed attention, patience, painstaking conceptualization, time, and consultation occurred throughout the sorting task, and as a result, the researcher confidently submits the following results.

Organization of the Results Section

The results section will first summarize the information collected with respect to the three major areas examined in the study: 1) the nature and importance of the qualities and skills which participants identified as necessary for clinical (interpersonal and

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personal) competence, 2) participants' perceptions and experiences concerning the past and present state of clinical training, and 3) the participants' recommendations concerning future clinical training. Therefore, the relevant research questions that will be reviewed in each of these three sections include:

I Clinical Competence:

Question One	What interpersonal/personal qualities and skills demonstrate competency and incompetency?
Question Two	How much weight do you place on this dimension versus academic and technical skills?
Question Three	Are these qualities trainable?

II State of Clinical Training:

Question Four	In your own training, do you feel that enough attention was placed on this dimension of competence?

III Future Training Recommendations:

Question Five	If there was a way of measuring people's performance with respect to these qualities and skills, how do you feel such a tool might best be used in the training of clinicians?
Question Six	What are the roles and responsibilities of the supervisor in best implementing such a tool?

Finally, the last section of the results chapter will be used to propose a possible method of assessment of these clinical and interpersonal skills, based on the findings of this investigation.

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Foreword

Respondents provided many eloquent and articulate descriptions concerning competency, clinical training, and personal experiences in their profession. As such, quotations from the participants will be provided as much as possible in order to honour these thoughtful contributions.

I Clinical Competence

Question One: What Interpersonal/Personal Qualities and Skills Demonstrate Competency and Incompetency?

Summary of Findings

Over the course of the interviews, it was quickly discovered that views of interpersonal and personal competency in clinical training were quite consistent across all demographic categories, including age, sex, discipline, place of practice, and years in the profession. Even those clinicians who had not had any direct supervisory experience expressed views that were congruous with those who had extensive experiences. It appears that beliefs about interpersonal and personal competency are actually quite well developed in clinicians, despite the fact that little effort is made to explicitly teach or assess these qualities (see results of question 4). Many respondents acknowledged that their opinions reflected more of an intuitive understanding of the skills required for success as a clinician, rather than the results of a body of empirical research which they had been exposed to in their own training. Participants readily provided a comprehensive list of a range of qualities, and a total of 55 categories of interpersonal and personal skills

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were ultimately delineated by the investigator. These are summarized in Table 3. The researcher further analysed the commonalities and conceptual overlap between the 55 individual skills and identified a smaller subset of five underlying clinical competency dimensions. Thus, each skill was seen as representative of one or more of the five underlying competence dimensions. These dimensions are summarized in Table 4.

Each of these 55 qualities and skills will now be summarized in a hierarchical manner, based on the number of cards in the category pile, with the most discussed qualities first. Note that this is not intended to reflect the importance of any one skill or quality, given that participants may simply have had "more to say" about one topic over another. In fact, participants did not rank-order their responses to this question, and instead, the pervasive belief was that all of these skills are equally important.

In addition to describing the competent demonstration of these skill categories, incompetency in each area will also be described. Respondents generally had much less to say about incompetency. Given that competency questions were asked first, incompetency was most frequently described by participants as "the absence of all those things I said before." Nonetheless, those additional comments and descriptions made by respondents will be included in incompetency discussions wherever possible.

Finally, after each of the individual skills has been throughly described, their underlying conceptual similarities will be identified, and the five underlying dimensions will be defined. These dimensions represent a condensed descriptive model of the interpersonal and personal skills, attitudes and behaviours necessary to demonstrate clinical competency.

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Table 3

Summary of the 55 Interpersonal and Personal Skills Necessary for Clinical Competence[a]

1. Empathy
2. Warmth
3. General ability to communicate
4. Respect for the client
5. Humility and knowing your limits
6. Ability to engender comfort, safety, and good rapport
7. Promoting client-directedness
8. Insight and psychological mindedness
9. Non-judgementalism
10. Basic skills and professionalism
11. Genuineness
12. Respecting the client's humanity
13. Self-awareness
14. Ability to get along with colleagues
15. Flexibility
16. General listening skills
17. Awareness of personal issues that can impact therapy
18. Commitment to ongoing learning
19. Ability to define the therapeutic contract, set goals, and stick to them
20. Ability to maintain objectivity
21. Ability to be challenging and confrontational
22. Maintain a frame of positivity and hopefulness
23. Psychological healthiness
24. Patience
25. Ability to set appropriate limits and boundaries
26. Active participant and invest yourself in the process
27. Communicate confidence in your therapeutic skills
28. Ability to work under a framework
29. Know when to seek supervision and seek it
30. Critical thinker
31. A life experienced
32. Dedication and devotion
33. Having a sense of humour and using it appropriately
34. Good technical knowledge base
35. Ability to create equality in the therapeutic relationship
36. Genuine concern for people and humanity
37. Overall intelligence
38. Demonstrating focus and presence in sessions
39. Time management skills
40. Ability to get and keep clients motivated
41. Capacity to use oneself in the therapy
42. Being relaxed
43. Matching yourself appropriately with your chosen modality
44. Therapy magic
45. Creativity
46. Foster a sense of teamwork
47. Remaining calm
48. Comfort with intensity
49. Maturity
50. Common sense and good judgement
51. Generally interested and curious
52. Ethical
53. Awareness of countertransference issues
54. Awareness of transference issues
55. Comfort in the role of provider

[a] note that these skills are listed in order, based on the number of cards in the category pile, with the most discussed qualities first. This is not intended to reflect the importance of any one skill or quality, given that participants may simply have had "more to say" about one topic over another. In fact, participants did not rank-order their responses to this question, and instead, the pervasive belief was that all of these skills are equally important.

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Table 4

The Five Underlying Dimensions of Clinical Competence

Dimension	**Definition**	**Example Skills**
Alliance-Specific Skills	Skills specific to and essential for the process of building an effective therapeutic relationship.	*Empathy, Warmth Non-judgementalism, Foster Teamwork*
Non-Alliance Specific Skills	Those skills which are "therapeutic," but reflective of more general therapeutic processes and clinician attitudes.	*Patience, Comfort With Intensity, Remaining Calm*
Professional Skills	Skills which are deemed compulsory for functioning appropriately and effectively within a clinical profession.	*Dedication and Devotion, Interested and Curious*
Cognitive Skills	Skills which primarily utilize clinicians' rational and logical abilities to think and perceive, as opposed to their capacity to feel.	*Flexibility, Capacity to be a Critical Thinker, Creativity, Objectivity*
Role Management Skills	Skills necessary for the appropriate defining, management, and use of the distinct roles of "client" and "clinician."	*Comfort in Role of Provider, Self-Awareness*

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1. Capacity to be Empathic

The capacity for empathy was endorsed as an essential interpersonal skill by all participants in the study. Most responses reflected a fairly classical Rogerian view of empathy as the ability to, *"put one's self in the client's shoes."* Similar responses included, *"connection with the emotional state that the client is experiencing,"* *"really able to tune into [the client],"* as well as the ability to *"appreciate,"* *"recognize"* and *"understand"* what is happening *"with and to the client inside."*

Many participants went on to include the capacity to *"reach into yourself and find some experiential referent for what the client is experiencing"* in their definitions of empathy. They emphasized the importance of accessing one's own life experiences to intensify the depth of the clinician's personal understanding of the client's experiences. A few participants went on to suggest that the clinician actually *"experience the kinds of pain, and the emotional states with the client."* However, this was an uncommon view, and was considered by most clinicians as irresponsible. One practising psychologist and faculty member described an experience where one of his first-year counselling students reported to him that she was *"upset because she couldn't cry when the client was crying and feeling sad."* He communicated that he had to clarify for the student the importance of maintaining a mix of both attachment and detachment in empathic processes.

The majority of responses noted the importance of the use of *"tempered empathy,"* and the ability to maintain some separation from the client's emotions and experiences. Judgements must be made in the course of therapy regarding when a primarily empathic means of responding is more appropriate, versus maintaining a more objective perspective

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so the clinician may provide an alternate view, or directly confront some aspect of the client's functioning. As one clinician stated, *"You have to know, have a feel for, an understanding of, how much empathy somebody might require at a given time...because you can make people less powerful and dependent on you."*

Responses regarding empathy reflected a multi-levelled understanding of this interpersonal skill. It was commented that clinicians must not only be able to relate to what the client is feeling, they must also possess the ability to express this understanding to the client in an effective manner (appropriate language, timing, intensity, non-verbal-verbal congruence). The importance of the client's need to be both heard and understood by the therapist was expressed as the ultimate objective of an empathic way of relating. Thus, good communication skills are essential to the competent demonstration of empathy.

Incompetence. When participants were asked about incompetence, a variety of responses were given with respect to a lack of empathy. The incompetent therapist has *"difficulty being truly connected to another human being,"* and is *"lost on an emotional and interpersonal level."* The incompetent clinician does not have the capacity to accurately *"see things from another person's point of view."* Additional terms used to describe the incompetent clinician included *"insensitive,"* *"unsympathetic,"* and *"not really encountering the person."*

2. Capacity for Warmth

A variety of synonyms for warmth were provided by participants including *"nice,"*

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"friendly," "soft," "gentle," "compassionate," "sympathetic," "caring," "concerned," and *"kindness,"* qualities which mimic the Rogerian concept of unconditional positive regard. Most respondents highlighted that the clinician must genuinely feel a *"liking of"* the client, at least at a *"minimal level."* Faking this kind of caring would be antithetical to genuineness. Similarly, the therapist must be able to communicate these feelings appropriately and consistently to the client.

The intangibility of this quality was demonstrated in comments such as *"warmth is demonstrated by being able to show, not really consciously, caring about someone else,"* and *"when someone walks in the room, you just make them feel that they are wanted there."* Other responses were more concrete and centered on the demonstration of caring by nonverbal signals such as "*openness in voice, eye contact, and appropriate body language."* Adjectives such as *"quiet," "soft,"* and *"gentle"* were also frequently used by respondents to describe the overall physical demeanour that must be present in order to communicate warmth. The client in the study stated that warmth *"engenders a feeling of genuine concern and interest"* on the part of the therapist.

Incompetence. The emotionally cold clinician makes no *"gestures of friendliness,"* demonstrates *"flatness of affect,"* and appears *"blank"* and *"non-responsive."* The clinician is not really *"engaged with what they are doing,"* or *"in the process"* of therapy. They are experienced as distant, detached and aloof by clients.

3. General Ability to Communicate

A large proportion of clinicians' responses were devoted to skills reflective of the

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therapist's overall communication ability. Abilities in this category included: utilizing a respectful and friendly frame of communication; responding to the client in a relevant, thoughtful, and beneficial manner; knowing when to respond in a *"highly direct [manner], or when a more gentler [sic], or more supportive"* response is required; the ability to communicate assertively and ask clients to repeat or explain something; the ability to communicate with the client even when the clinician is uncomfortable; the ability to maintain appropriate eye contact and congruent body language; as well as allowing clients to express their feelings and concerns in their own way, without *"corrections"* by the therapist. One participant emphasized the importance of clinicians' self-monitoring skills, particularly of their own nonverbal cues and reactions. This is essential when the client presents material that might be shocking, disturbing, or somehow unsettling to the clinician. Reactions of shock or disgust with client behaviour do not bode well for the development of safety and trust in the relationship.

Another frequently mentioned skill in this category included the ability to adapt your language in order to *"speak to the person's ability to comprehend."* This might involve using a more concrete, direct, and precise language style versus being abstract and employing devices such as symbolism and metaphor to communicate with the client. Furthermore, this may also include the capacity to reframe *"tough issues"* so that the person is better able to *"swallow them, understand them, and maybe do something with them."* In order to achieve this, the clinician must be willing to try various methods of communication if they find that the client is not understanding. Similarly, the therapist must also *"validate the information that you think you are getting from the client."* They

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must repeatedly check and recheck the accuracy of their understanding of the client's story. The ability to communicate at the client's level seems to be related to the clinician's level of experience. A psychology faculty member noted that a common mistake of novice therapists is responding to client inquiries (i.e. "So why are we doing this?") with a response that comes straight out of a textbook (i.e. *"We're going to access your emotion schemes."*), and that *"most clients don't have a clue what that means."* In summary, effective communication includes the therapist's ability to use appropriate language, as well as to confirm whether or not they have been interpreted correctly.

Incompetence. A clinician with poor communication skills will do such things as use *"inappropriate language,"* *"say things that make the client gasp,"* and abruptly interrupt or *"cut off"* clients. They may be too interrogative and *"simply [ask] questions and [wait] on responses,"* or, in some caricature of Rogerian technique, they will *"just parrot what the client is already saying."* The incompetent clinician may also talk too much and *"ramble on and on,"* or too little. Their speech may be characterized by mumbling, disjointedness, and inaudibility. The therapist may be *"profoundly vague...and unclear"* in their communications, thus *"leaving the client with a sense of bewilderment."* They do not *"speak everyday language,"* and instead use psychological language and meaningless technical jargon to explain and interpret client functioning. Finally, it was also noted by respondents that such an incompetent clinician does not speak at a level that matches the *"educational and functional level of the people [they] work with,"* such that *"everything goes over their [clients'] head...and you've lost them."*

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4. Respect for the Client

Issues concerning the importance of respecting clients were reflected in comments that the clinician must validate clients' experiences and always treat clients' perceptions of their experiences as *"legitimate in [their] own right."* The client's viewpoint, his or her *"place in their own process,"* and his or her way of functioning must be validated as important and worthy of esteem. While nonjudgementalism is the taking on of a neutral position in relation to clients and their experiences, respect presumes an acceptance, validation, and honouring of the client's perspective. As one psychologist stated, *"There must be a capacity to accept the other person's point of view, even though that point of view seems really wacky from where I stand, or where conventional wisdom stands."*

In an increasingly diverse population of clientele, respect has taken on the additional undertone of cultural sensitivity, awareness, and acceptance. Clinicians are expected to at least acquaint themselves with issues of ethnicity, social stratification, sexual orientation, etc., in order to better understand the client's experience, and be respectful of differences in custom, social interaction, and expectations that may arise from the backdrop of the client's life.

Incompetence. Respondents described the clinician who demonstrates a *"lack of respect"* as patronizing, condescending, prejudiced, and *"not culturally sensitive."* Many participants noted the inappropriateness of *"laughing at the client,"* and *"making a joke out of something that the client said."* Similarly, disrespect may also be shown when the clinician discusses clients with colleagues in a *"derogatory manner,"* and *"jokes and puts down clients in a disrespectful way."*

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5. Humility and Knowing Your Limits

Humility, in a variety of contexts, was a frequently mentioned requirement for competence. Generally, the clinician should *"give [yourself] permission to not be perfect,"* and must have the capacity to be *"critical of yourself, of what you are doing, and what is going on"* in the therapeutic context. Clinicians must be able to non-defensively accept misunderstandings with their clients, have the capacity to acknowledge to the client if they have made a mistake, and be able to discuss this openly. They must also be willing to admit to their clients if they are truly unsure of how to proceed and be able to recognize when such an impasse has been reached. Clinicians should possess an impartial awareness of their strengths and weaknesses; must know the limits of their expertise, knowledge base, and conceptual and technical skills; and be able to acknowledge that there may be some clients or issues that they simply are not able to effectively connect with. A particularly important aspect of this is the trainee's ability to hear and make use of both positive and negative feedback provided by colleagues and supervisors. Finally, some participants commented that therapists must humbly make the effort to refer and find someone better to work with the client when they are unable, for practical or more personal reasons.

Incompetence. *"Arrogant"* clinicians have *"no insight into [their] own limitations,"* and *"assume they know things that they don't know."* As a result, they will *"practice kinds of therapy that they haven't had enough training in,"* and will work outside their *"area of expertise"* because they are simply not aware, or are unwilling to acknowledge, that they lack a particular kind of *"conceptual or technical expertise."* The

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immodest clinician believes he or she is *"God's gift to the world,"* is certain that he or she *"has all the answers,"* does not listen to the feedback of supervisors, and gives advice to clients with a *"tremendous sense of rightness."*

6. Ability to Engender Comfort, Safety, and Good Rapport

The importance of a strong and healthy alliance between clinician and client is integral to therapeutic success. A client's sense of safety within the therapeutic relationship was seen by participants as essential to creating such a positive alliance.

The ability of the clinician to *"develop a healing rapport," "elicit a sense of trust," "facilitate comfort in the patient," "provide emotional safety,"* provide a *"feeling of security,"* and come across as *"nonthreatening,"* illustrate some of the comments made by participants with respect to this area.

Trust in the therapist's ability to handle and contain client emotions and maintain confidentiality were viewed as crucial to creating a therapeutic environment where clients can feel free to communicate whatever is on their mind, including the most protected, vulnerable, and intimate aspects of themselves. The client in the study also noted the importance of such an environment in helping a client make productive use of a particular technique such as a two-chair or empty-chair, without shame or fear of being overwhelmed with emotion.

In addition, while nurses also tended to regard safety as a high priority, they also used the term specifically to refer to their own safety with clients. All the nurses in the study were on-ward psychiatric nurses who have likely experienced situations where they

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felt physically threatened or saw someone else endangered. This concern was not overtly expressed by the psychologists, students, or social workers in the study.

Incompetence. Participants in the study acknowledged that a lack of rapport may be produced by a variety of clinician behaviours. Therapists will be perceived as unsafe for clients if they seem to be *"intruding into the person's privacy,"* and say *"painful,"* *"mean,"* or *"demeaning"* things *"on a regular basis."* They seem to take on an *"antagonistic stance"* toward clients, and use *"confrontation as a first resort."* Similarly, they appear hostile and *"edgy"* in sessions, and have a tendency to *"be angry with clients."* Finally, some participants suggested that an incompetent clinician can make people feel uncomfortable by demonstrating a sort of interpersonal *"weirdness"* or *"creepiness,"* ostensibly more subtle than that demonstrated in professional/ethical violations.

7. Promoting Client-directedness

Many of the participants' responses were reflective of the notion that the competent clinician must generally *"step back"* from the therapeutic process and allow the client to guide and direct the course and pace of therapy. The therapist must, at the very least, include the patient in the treatment planning and prioritizing and in doing so be responsive to his/her general patterns and style (e.g. sharing easily vs being more private). One psychologist noted that the treatment planning must come from the client because *"it [should not be] about what I enjoy doing as a therapist, or what's easiest for me to do."*

Other responses included in this category emphasized that the therapist should

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hold a fairly selfless motivation for providing treatment and must maintain a stance of being *"of service"* to the client. In essence, therapists should become *"bland, personality-wise...their own personality characteristics drop into the background,"* and the therapist's *"needs or desires become difficult for the client to see."* Again, clients should always get the feeling that they are the focus of attention, and that their needs are primary. Clients must be encouraged to make their own decisions, and must not feel restricted in any way in terms of what they may or may not talk about. They must never be made to feel that their role is to somehow please the therapist.

Incompetence. A lack of client-directedness in the process of therapy occurs whenever clinicians *"put their own needs ahead of the client's,"* and *"feel they know what is best for the client, regardless of the client, or colleagues."* Such a clinician has an *"agenda for the person"* that may not be *"in keeping with the client's."* Incompetent clinicians tend to assume that they *"know more than the client in terms of that person's life and their particular experiencing."* As a result of this attitude, inquiries into the client's feelings are few, and clients' needs are not explored and are essentially dismissed in the process of treatment planning and goal setting. Similarly, clients' styles of relating are not respected, and as a consequence, their "readiness" is not considered and they may not be given enough personal space to make any decisions.

On the other hand, some participants identified that a clinician whose treatment planning is not directed by the client's needs may sometimes have a *"rosier picture than what is practically possible for the person....and embellish the qualities that would enable the patient to be coping in the community."* As a result, clients are prematurely

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terminated without necessary tools for coping and without support. In any case, treatment failure is likely.

8. Capacity for Insight and Psychological Mindedness

A number of different personal skills of the therapist were subsumed under this general category. Responses of the participants grouped naturally into four areas. First, the clinician must possess excellent perceptual skills that allow him or her to *"watch for signs"* and *"perceive [when] something important or meaningful occurred."* Second, the therapist must have a *"multi-levelled understanding of what the client is living,"* and be able to see *"behind"* things, and at a *"deeper level."* Third, he or she must be able to both *"hear and feel what the client isn't saying directly, but is only implying - the stuff that's just beneath the surface, behind the defense,"* in effect to see beyond the client's words. Finally, by employing their capacity for insight, clinicians should *"always be able to add a new dimension to what [the client] is talking about or experiencing."* This class of skills reflects the therapist's capacity to act as a tool of growth for the client by being able to *"add something new"* to the therapeutic work, an ability tagged by most as fundamental. Interestingly, these "higher level" abilities were seen by participants as having little to do with training (see section on training at the end of the Results section).

Incompetence. An individual lacking in insight and psychological mindedness was seen by participants *as "preferring concrete tasks, and getting solid, seen, and measurable results."* They are *"superficial,"* and are thus unable to *"help clients process at a deeper level."* The clinician misses both *"obvious things the client is saying,"* as

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well as the *"little nuances and subtleties."* Similarly, they are *"unaware of...complexities,"* and may both *"overanalyze...and make too much of things,"* or *"underanalyze...and make too little of something."* Generally, such clinicians were seen as *"poorly grasping things around them in relationships,"* a quality acutely visible in their interactions with both clients and colleagues.

9. Non-judgementalism

Another frequently mentioned classical Rogerian quality of the clinician was non-judgementalism. Clinicians reported that a therapist must keep an open mind and be able to *"suspend judgement on the person, their [sic] acts, and the situation that brought them [sic] into therapy,"* in effect, to maintain neutrality.

An additional layer of non-judgementalism included the ability to be *"open to whatever person walks in, regardless of social class, ethnicity, or sexual orientation."* Such openness to varied ways of functioning allows therapists to fully utilize their capacities for understanding, warmth, and empathy and allows clients to honestly and freely express their thoughts, feelings, and experiences without fear of censure or disapproval. One social worker in the study acknowledged, however, that there are inherent limits to one's ability to be completely non-judgemental; *"The clinician should have as little bias as possible."* In this case, the relationship between non-judgementalism and genuineness becomes more complicated. Ideally, competent clinicians should have no biases, but perhaps more realistically, they should at least be able to keep any personal biases out of their work. In the words of one participant, they

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should be able to *"transcend that, to dispense with that, and maintain their objectivity."*

Incompetence. In short, with respect to this category, the incompetent clinician was described by participants as *"judgemental,"* and *"very opinionated,"* with many *"biases in thinking."*

10. Basic Skills and Professionalism

Perhaps some of the most concrete and readily definable responses to the question of competency had to do with the clinician's basic professionalism. These skills included such basic matters of integrity as showing up on time for sessions, returning phone calls in a timely fashion, not cancelling sessions, not going over time in sessions, setting clear expectations with clients regarding where and when therapy will occur, following through with commitments to clients, summarizing at the end of a session, and maintaining consistency in structural routines. Many of the social workers and nurses in the study emphasized the clinician's responsibility to organize baseline questions well in what are often quick, on-ward, initial interviews, as well as knowing when to stop the interview due to fatigue or increased agitation on the part of the client. Another basic skill noted by all professionals in the study as important was *"remembering what it is that you [the clinician] said last time,"* as well as *"remembering what people [clients] tell you from week to week."* The competent clinician must be reliable, dependable, and responsible, qualities necessary to denote respect to the client.

Incompetence. Participants reported that an incompetent clinician who is lacking basic skills of professionalism will *"forget stuff,"* *"[not] get to the work,"* *"[not] follow-*

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up on referrals," "*keep people waiting*," "*not remember clients*," be "*late for clients all the time*," "*look at [his or her] watch consistently*" in a session, "*badmouth other [colleagues]*," end sessions abruptly so that the client is "*brought out and then left hanging*," and finally, "*look like a bum!*"

11. Genuineness

Respondents used a variety of terms to describe their conceptualization of genuineness. "*Transparency*" and "*honesty*" were most frequently used to describe the state of being honest in your thoughts, feelings, and reflections to the client and being open about your treatment formulations and plans. In addition, some respondents noted that genuineness also referred to clinicians' ability to acknowledge to clients that they felt challenged or misinterpreted by a particular comment or behaviour. Of course, clinicians cautioned that such honesty must always be "*within the boundaries of not hurting the client.*" The clinician does not therefore impose his thoughts, feelings, reactions, and opinions on the client, but rather responds honestly when questioned. One respondent defined genuineness as "*not saying things that you don't believe to be true, [and not] expressing sentiments that you think you should feel, but don't actually [feel].*"

One common misunderstanding that early trainees make is in their belief that this concept means that the therapist should say everything that comes to his or her mind, regardless of its potential impact on the client and the relationship.

Finally, many respondents also included the belief that the clinician should generally be "*the same person both in and out of therapy,*" in their definitions of

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genuineness. There should be no element of performance, or the taking on of a persona in the clinician's interactions with the client. This ability is often particularly challenging for novice therapists who struggle simultaneously to develop some sort of professional identity, while still trying to "be themselves." One psychologist expressed that *"who you are, and what you feel with the client, what you think, [should not be] behind some mysterious veil."*

Incompetence. Therapists lacking the quality of genuineness may appear to clients as exceedingly *"clinical and hyper-professional."* There is little authenticity in their interactions, and they seem phony and dishonest, *"doing things that the client can't see."* The incompetent therapist seems to be *"performing for the client, and not really hearing what is being said."* They are present in the session only so far as their persona allows.

12. Respecting the Client's Humanity

Regardless of discipline, many participants underscored the need to engage clients in a "human" relationship, as well as a "clinical" one. The client in the study poignantly described the importance of this feeling of being recognized as an individual:

> I think one of the biggest things is that...the relationship can be person-to-person [sometimes], as opposed to therapist-to-client. And that's important because it establishes me as a person....[To be able to feel] that your therapist is a person too. It's sort of two people talking, one of whom is a trained individual in a helping relationship, the other who has issues to work out. But when it comes down to the bottom line, we are still two people talking....[Your problems] take on very much

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of a human dimension, as opposed to a medical or a technical or psychological dimension.

Many clinicians also contemplated the importance of being non-evaluative, non-reductive, and non-pathologizing, *"not boiling down human experience into banal terms,"* and *"not pressing the client's experience into different moulds."* Correspondingly, the clinician's interventions must not be apathetically proscriptive, advice-giving, or sermonizing. The client must be seen as a whole, unique, and individual human being.

In some aspects, these abilities are related to more general attitudes of respect and non-judgementalism, but they take on an additional, transcendental recognition of and reverence for our humanness. As one participant described it:

> The clinician must be able to appreciate the complexity and richness that another human being may convey to you in their descriptions of themselves and their lives...and that our job is fostering a compassionate view for you [the clinician] of the client; and for client[s] of themselves and their loved ones.

Many responses also reflected a more existential perspective on the human struggle, and the innate movement toward positive growth, a la Abraham Maslow (1971). The competent clinician must believe that *"people have a constructive purpose, but may be misguided,"* and must allow his or herself to *"recognize that this is a fellow human being who is struggling, and to acknowledge their [sic] struggle, pain, and joy."* Such meta-awareness is made personal when the clinician embraces a sense of being truly honoured by the client's presence, and is conscious that it is always *"a privilege to have someone come and talk with you in this way."*

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Incompetence. Most responses concerning incompetency in this category emphasized the tendency to *"pathologize"* clients, depriving them of their uniqueness, individuality, and humanness. The incompetent clinician is overly evaluative, and will *"slot the person's experience."* Judgements are made concerning what labels and classifications best fit the client, *"as though they are an answer to the person's dilemma."* Using such a scheme, clients are often viewed as *"inferior, sick, bad, and contagious,"* and the therapist's relationship to the client is based on *"the extent to which [the client] is typical of some kind of disorder or condition."* The therapy session becomes a classroom in which the therapist gives quick advice, and delivers sermons and lectures. Clients are seen as objects, and clinicians are seen as *"technicians...and mechanics of the brain."* The incompetent clinician is simply *"not interested in clients as people,"* and the human relationship is nonexistent.

13. Self-awareness

Participants across all categories believed that competent clinicians must possess, throughout their careers, both the willingness, and the capacity for honest self-reflection. The novice therapist should ideally have already done some self-examination and hold at least a minimal body of self-knowledge and *"awareness of who [sic] you are as a person."* They must be *"in touch"* with themselves as one social worker described it. Important areas to examine included your *"awareness of your own internal states,"* *"having a good appreciation for...how your thinking is tainted by conventions,"* and the ability to *"monitor your own health status, mental health, and sense of well-being."* One

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participant stated that self-examination is *"not just having knowledge, but...really doing an inventory of your own experience, and your level of tolerance. We don't look at that much [in nursing]...[but] your own frustration, and lack of fulfilment has [sic] to be acknowledged."*

One participant expressed that the ability to do an honest self-examination is determined by the clinician's ability to *"see yourself as a whole person, not just the part that they see in the clinical setting."* This is sometimes particularly problematic for therapists early in training as they are often utterly immersed in the academic and training environment and tend to hold an understandably constricted view of themselves during this period. Similarly, novice therapists are typically young and may have had a limited range of experiences from which to draw an awareness of themselves.

The therapist's capacity for and comfort with self-examination is crucial to his or her ability to encourage self-reflection in clients. Again, novice counsellors frequently neglect or overlook this domain, most often due to evaluation anxiety and fear of appearing *"crazy."* Such counsellors will attempt to take clients further than they themselves have gone. It can be debated whether this is possible or not (see Yalom, 2003).

Incompetence. Participants indicated that a lack of self-awareness of your own *"emotional state,"* *"issues,"* and *"feelings,"* is an indicator of incompetence. In addition, it was rather decisively stated by one student in the study that an individual who is truly *"fearful to touch on [his or her] own issues, shouldn't be in this programme."*

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14. Ability to Get Along With Colleagues

Not all of the qualities identified by participants as essential to clinical competence were related to direct clinical work. The ability to get along with your colleagues was also identified as important. The emphasis on this ability is not surprising given the fact that most participants in the study worked on "teams" in a psychiatric hospital. Thus, qualities such as *"getting along with colleagues, as long as the clinical environment is good, [and] it's a good team that promotes growth,"* and being *"team players"* were identified. More generally, the clinician must be *"humble and respectful of what other colleagues have to offer,"* be *"open to the ideas of other professionals,"* be able to *"critique other professionals constructively,"* and resist competing with colleagues, or attempting to be superior and have *"the best formulation"* on the team. The same kinds of communication skills that are essential for competent practice with clients were also stressed in creating positive relationships with colleagues. Colleagues must be supportive, warm, friendly, genuine, non-judgemental, and accepting with each other. Moreover, it was identified as important to *"put effort into establishing [good] relationships"* because the clinician must also be open to seeking advice, support, and opinions from other colleagues as needed. Obviously, collegial relationships become particularly important within the context of a treatment team. Nevertheless, independent practitioners, perhaps even more so than clinicians on a team, must also invest time in establishing a network of professionals from whom to seek support or supervision, as well as clinicians to make appropriate referrals to when the therapist is unable to meet the client's needs (see section #5 Humility and Knowing your Limits).

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Incompetence. Clinicians are not going to get along well with colleagues if they are *"disrespectful of other professions"* and professionals, are *"jerks with them [their peers],"* have an attitude that *"they are right, and are just tolerating [the] opinions [of their colleagues],"* and are *"too competitive."* With respect to a clinical team environment, such a clinician does not bother to *"get information from the rest of the team members,"* or may *"seek support from colleagues for decisions that are not clearly clinically or safety based, but are done on a more emotional level."*

15. Flexibility

Despite the emphasis in training on finding a modality that fits for the student, most clinicians believe that the competent clinician must always retain some flexibility and openness to different perspectives, approaches, and techniques. They should not be *"stuck in [their] ways,"* and should be open to experimenting, making quick adjustments, and *"stretching themselves a little bit,"* particularly if their way isn't working. Other participants used flexibility to refer to the need for clinicians to be chameleons of sorts with respect to their style and even their personality. While this may seem contradictory to genuineness, it is not that clinicians should take on some relational style that is completely foreign to them, but more that therapists may, at times, have to utilize one aspect of their personality more so than another with a specific client. The visible colours might change in reference to the environment, but the lizard remains the same.

Participants noted the importance of maintaining a balanced perspective and not overly identifying with a particular approach so that clinicians *"selectively listen for what*

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would make sense to them from a theoretical point of view," and narrowly *"look[s] for the stuff that fits with their formulation."* Competent clinicians may identify with one modality more than others, but must retain an unbiased openness to understanding the unique person and problem in front of them, so they may accurately determine, with the help of the client, the best approach to treatment.

Incompetence. Respondents described the incompetent side of flexibility as being *"strictly rule-bound*," *"adhering to every tiny rule and policy*," and *"being entrenched in one particular way of doing treatment."* Such a therapist is likely to be so *"indoctrinated with a particular perspective"* that everything is made to fit in this predetermined box. In fact, the therapist becomes *"lost or confused if something does not fit with the protocol."* One participant described such clinicians as *"wooden in their approach*," while another offered the additional quality of *"perfectionism*," as a manifestation of inflexibility.

In contrast, a clinician who is overly flexible, is likely to be inconsistent, vacillating, and arbitrary in their treatment planning. Clients are likely to feel confused and disoriented by their therapist's inability to maintain consistency in treatment planning and processing. Such a therapist also tends to come across as scattered, unfocussed, and lacking in confidence.

16. General Listening Skills

Beyond the most obvious clinical skill of *"being a good listener*," some participants went on to identify more specific aspects of this essential skill. First of all, the clinician must really take the time to listen to what the person has to say and be able to

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take in a lot of information in a fairly short period of time. It was noted that listening does not just mean *"keep[ing] quiet while the other person is talking."* It is not a passive activity but requires an active utilization of a variety of senses beyond hearing. The clinician must monitor the client's reactions and nonverbal cues to recognize when the client may be frustrated; needs a break; is particularly emotional about a specific topic, feeling, or individual; and when the client has not comprehended something. Active listening allows the clinician to pick up on manners of expression that are unique to the individual client. Cues of good listening which participants listed included *"leaning in closer,"* *"nodding your head,"* and appearing receptive and open in your body language. Good listening coupled with good communication (see section #3) are key in the negotiation process whereby two individuals attempt to establish a shared system of language and meaning.

Incompetence. Poor listening skills are demonstrated by *"appearing bored,"* and not paying attention. The clinician is not really present, is not monitoring the client's verbal and nonverbal communications, and is likely unaware of his or her own. The result is a rather obvious failure to respond appropriately to what was said or asked, and to maintain conversational threads.

17. Awareness of Personal Issues That can Impact Therapy

There is some overlap between this category and that of general self awareness, described above (section #13). The distinction is that this category refers to those personal issues within the clinician that may specifically have an impact on the

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therapeutic relationship. Thus, clinicians should *"do some thinking about where [they] stand on 'uncomfortable issues' such as sex and spirituality."* They must have an appreciation of their sensitive areas, their own issues, and any generalized feelings of anger or resentment. They must use their general self awareness to assess how their experiences may have shaped any personal expectations and their level of tolerance for differences. Generally, clinicians must be able to acknowledge their own values, biases, and belief systems so they will, firstly, know when they are encountering a client with a different ideology and, secondly, *"compensate and be careful"* about imposing their views on the client or using their philosophy as the ultimate standard to judge the client against.

> For example, one participant illustrated this in her thought-provoking example:
>
> Not everyone will be destined to work for one reason or another, but we live in a culture where people define and are encouraged to define themselves by...the work they do. [If the therapist] can't conceive of the client having a life outside of that, and if all he or she can think about is how you'll get them back to work, and you can't conceive of helping them develop a life that does not include work without that being some kind of second place finish, I think then you're...doing them a disservice.

Incompetence. Incompetency is demonstrated when the clinician lacks self-awareness of personal issues, values, biases, and belief systems that may have a direct impact on the therapeutic relationship. Unfortunately, lack of awareness of these issues is inevitably accompanied by their somehow finding their way into the therapeutic process.

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18. Commitment to Ongoing Learning

An openness and commitment to lifelong learning were identified by most participants as essential to competency. Clinicians must make an effort to *"keep up to date"* with their field, and actively *"seek out information on a new way of doing things."* Idealistically, there should hopefully be a *"continuous increase or improvement in knowledge"* over time. Opportunities for learning are numerous in the therapist's life, and every client encounter is an occasion for *"learning about, and refining your communication style."* Similarly, much is to be learned from the occasional therapeutic "misunderstanding" and "mistake," if the individual is humble enough to contemplate his or her imperfections. Humility, described above (section #5), plays an important role in promoting the search for knowledge. A social worker in the study noted that the clinician must never assume he or she is an *"expert in an area [because] there is always something more to learn, and someone to learn it from."*

In addition to keeping up with the research, it was also noted by some respondents that clinicians must maintain a *"willingness to grow"* on a more personal level. They must take advantage of opportunities for self-learning, such as supervision, meditation, workshops, and personal therapy in order to *"try to understand themselves better"* and refine their self-awareness.

Incompetence. Clinicians who believe that they are *"at the point where [we] think we know everything, and have reached some level of perfection where we don't need to progress beyond that"* are unlikely to seek or welcome opportunities for learning and growth, or to *"set goals for their development."* Such intellectual and personal stagnation

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will likely lead to the clinician's falling behind with respect to knowledge, and a constricting ability to empathize with human processes of growth, change, and development.

19. Ability to Define the Therapeutic Contract, Set Goals, and Stick to Them

Both personality and professional training play a role in the therapist's ability to effectively utilize therapeutic contracts. With respect to training, the clinician must be able to clearly identify the needs of the client, and use this to set appropriate therapy goals and *"create an agenda in terms of the wellness of the client...[and] helping them attain a better life,"* and to concretely *"prioritize and articulate what's do-able and what isn't."* Expectations and time lines on the part of the client and the therapist should be clearly stated and solidified. The method(s) of choice for carrying out treatment must also be agreed upon and clearly outlined. Additionally and hopefully as a result of their training and experience, clinicians will also possess some kind of clearly explainable *"reason for doing what you are doing,"* other than an intuitive belief and trust that somehow, therapy helps. As described earlier in the communication section (#3), this is a notoriously difficult skill for novice therapists who tend to err on the side of either providing an extremely vague explanation ("to help you get better"), or providing a complicated textbook quote ("to process and work-through your dysfunctional object relationships").

The aspect of this category that is more so a reflection of personality skills is the therapist's ability to actually stick to and remember the agreed-upon agenda in every session with the client. Again, therapists early in training have difficulty maintaining

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session-to-session connectiveness. Instead, they easily become overwhelmed by the client's immediate affect or complaints in each session and lose sight of their overall purpose and goals. As a result, the therapy often becomes disjointed, unorganized, slow, and unthematic. This is often a function of fear of ignoring the client's immediate needs and consequently not being liked, as well as a maturing ability to delineate a rational personal philosophy of how therapy works.

Incompetence. Although participants did not make any specific references with respect to incompetence in this area, it can be concluded that clinicians who do not have this ability will be unable to develop an appropriate agenda, prioritize and set appropriate goals, adhere to a time line and methodology, or be able to articulate a well-defined rationale for why they do what they do. Such an inability is likely to impede the therapeutic process, if not lead directly to treatment failure.

20. Ability to Maintain Objectivity

While empathy, warmth, nonjudgementalism and respect pull both the therapist and the client into the therapeutic relationship ("one foot in"), competent clinicians must concomitantly be able to retain a level of professional objectivity and distance that allows them to pull back from the relationship and spectate ("one foot out"). Becoming too personally involved with the client and the process compromises the therapist's ability to maintain the professional perspective necessary to legitimately conceptualize client issues and to make the most effective treatment judgements. One psychologist expressed that it is objectivity that prevents the clinician from *"drowning in [clients'] experiences,"* and

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thereby becoming incapable of offering an alternative perspective. Effective clinicians must maintain a balance of empathy and *"thick skin,"* being able to *"detach themselves from the client's distress."* As an added bonus, this objectivity also prevents clinicians from becoming overly invested in the client's opinions, so they may be *"ego-free enough"* to *"not take it personally if it isn't working out."*

Incompetence. Respondents in the study expressed that objectivity is compromised when the clinician cannot keep some kind of distance, and as a result, *"both people end up distressed,"* and this level of distress is *"mutually reinforcing"* within the relationship such that movement toward growth is stagnated. Such clinicians were described as *"overemotional,"* *"too touchy-feely,"* and inappropriately *"emotionally reactive."* They have lost the capacity to pull back and spectate objectively on the situation. They have become as distressed, hopeless, and helpless as the client.

21. Ability to be Challenging and Confrontational

A competent clinician must possess the ability to challenge and confront most clients at some point in the therapeutic process. In fact, challenge may be considered essential to any therapeutic interaction in so far as it expands the client's typically narrow perspective. Obviously, this ability to be *"assertive,"* *"frank"* and *"blunt"* with clients should always occur within the interpersonal context of warmth, empathy, and safety in the relationship. Therapeutically effective challenging, questioning, and confronting must occur in a *"constructive and non-hurtful way,"* in which the client feels safely supported to look at issues or assumptions in a novel manner. The therapist is able to *"push the*

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person in a way that stretches them [sic], rather than threatens them."

Assertiveness more generally helps clinicians to openly acknowledge the negatives in the client's situation or way of relating, to *"politely say to someone that they have to move on"* to a different topic of focus, and to be able to *"cut the bullshit and get to the real stuff with the client."* This skill is particularly anxiety-provoking for novice therapists who often believe that they must be sycophantically agreeable with everything their client feels or says. One student, in her fifth year of a doctoral programme in clinical psychology noted that until she began an internship she *"didn't really realize that it's also important to have some ability to be assertive and confrontational...and confident in what [you] believe, and interpersonally...to get confrontational when [you] have to. That's my biggest stumbling block."*

Comments that novice students frequently make when supervisors ask them to be more challenging include their fear that they will be leading clients somewhere and putting words in their mouth, or that they are concerned about clients' fragility and feel they must *"treat them more like spun glass that might shatter,"* as one psychology supervisor expressed. In such cases, discussions about Respecting the Client's Humanity (described in section #12), and Creating Equality in the Therapeutic Relationship (described in section #35) will aid in facilitating a more realistic view of clients.

Incompetence. Unassertive clinicians are *"overly passive"* in the therapy, and *"too concerned about hurting people's feelings, or being cruel."* They are incapable of challenging the client to expand awareness, or to acknowledge destructive patterns of thinking and feeling. As one nurse in the study noted, *"it is not very helpful for anyone*

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who is in therapy to be agreed with all the time."

22. Maintaining a Frame of Positivity and Hopefulness

Not surprisingly, a good therapist should be encouraging, optimistic, positive and hopeful about the client's situation and the potential for change. The emphasis on positivity is not a function of the clinician's confidence in him or herself, but a confidence in the client's ability to *"overcome certain obstacles in their lives."* (see section #12 Respecting the Client's Humanity). In addition, this is not a faked optimism, it is a genuine and realistic hopefulness that is provided *"without a dependency or a promise about the future that you can't guarantee."* The ability to tune into and convey such hopefulness is a function of the clinician's ability to focus on emphasizing the client's strengths, as well as weaknesses, *"doing your best to reframe positively for the patient,"* and maintaining and conveying hopefulness in the face of the client's despair and discouragement. Clients who have achieved a strong bond with their therapists will often look to him or her to reassure and reinforce a sometimes waning sense of hopefulness and determination.

Incompetence. Respondents did not make any comments specific to incompetence in this area. It can be inferred that a clinician who does not possess such a frame of positivity, may be negative and pessimistic about the client's ability to change, a framework unlikely to enhance success.

Another issue relevant to this topic is that of therapist neutrality, or the "blank screen" analyst. Some might argue that while this is acceptable as a process framework, it

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nevertheless becomes untenable when clients inevitably express intense feelings of hopelessness and suffering and do not encounter their clinician's active efforts to redirect toward hopefulness and resolution. Clients may interpret this as a breach in empathy and warmth and a general lack of caring.

23. Psychological Healthiness

The competent clinician should be, at least *"minimally,"* psychologically healthy. The therapist should have dealt with any important personal experiences and issues, particularly those that might have an impact on therapy (see section #17). One participant emphasized the importance of such healthiness by stating that *"to monitor our own health status [and] mental health...that's an ethical issue, as well as a personal issue."* Clinicians should be well-rounded, *"interesting person[s] with lots of outside relationships,"* and have the ability to *"take care of themselves."*

Another critical issue which many participants identified was the need for self-esteem, and a more general *"sense of your own well-being"* apart from your role as a therapist. Comments by participants were reflective of a somewhat utopian view of human development and the goals that everyone, including clients, ultimately strives for. Thus, competent clinicians should be *"happy with [themselves] to some level,"* they should also be *"very at peace with themselves,"* they should be *"comfortable"* in themselves, and *"centered."* One participant openly acknowledged that this level of healthiness is comparable with Maslow's (1971) notion of the fully self-actualized person, which Maslow himself conceded was an exceptional occurrence!

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Discussion of clinicians' psychological healthiness is often a precursor to debates about the controversial topic of mandatory therapy for clinical trainees. While most participants in the present study described personal therapy as significantly enhancing to clinical effectiveness (see section regarding training issues), training programmes across disciplines vacillate with respect to the official incorporation of therapy into their approach. Some more formally require students to participate in a self-development class, which is effectively a kind of student-led group therapy. Most psychology programmes, for example, have a more informal approach in which therapy is *recommended* only after a significant problem area has been identified in a student. Nevertheless, roadblocks to a student's pursuit of personal therapy, even on a voluntary basis, are many, including considerable financial and time constraints.

Incompetence. Incompetent therapists are those who *"haven't dealt with their own shit."* Personal problems, background issues, untreated clinical disorders, unresolved feelings and experiences have not been dealt with, and have the potential to interfere with the therapist's overall functioning, particularly his or her ability to be empathic, maintain objectivity, and demonstrate focus and presence in the sessions. Some participants noted the specific phenomenon of "caregiver burnout" which may occur after years of practice and result in emotional exhaustion and emotional unavailability of the clinician. Others emphasized the hazards of the *"distracted"* therapist who is unable to focus due to ongoing personal stressors such as illness, divorce, and substance abuse.

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24. Patience

The competent clinician must be patient, particularly in both allowing clients to tell their story at their own pace and in allowing clients to set the speed at which they might progress through various therapeutic stages. In addition, therapists should avoid making premature formulations and conclusions about a client and attempting to *"jump in and fix it"* before they have even heard the whole story. Pressure to make quick judgements and move things along has increased exponentially with the advent of the managed care system. But in an ideal situation, the clinician must *"let things unfold, sometimes at a rate that you may not be accustomed to."*

Incompetence. Hurried and impatient clinicians appear anxious and pushy. They do not *"take the time to stop and really listen to clients."* Instead, the entire therapeutic process may be compressed into a session or two, as the clinician *"jumps to too easy answers,"* *"rushes to evaluation,"* and *"jumps to conclusions."* Resistance and defensiveness in the client are likely results.

25. Ability to Set Appropriate Limits and Boundaries

Limit and boundary setting are part of a triad of skills required to "walk the line" between hyper-professionalism and enmeshed intimacy in the therapeutic relationship. While Maintaining Objectivity (section #20) refers to the ability to be an impartial observer of the process, and Awareness of Personal Issues (section #17) refers to completing an inventory of one's own values and beliefs that might impact on therapy (both skills are described above), the actual setting of limits and boundaries involves the

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ability to define interpersonal and ethical boundaries, and to keep these personal issues out of the therapy. Participants noted the importance of setting such boundaries as a way to *"protect clients, the public, and yourself."* In practice, this requires maintaining a keen *"distinction between your issues, and the person you are trying to help."* Inappropriately intimate relationships with clients, with respect to both ego and sexual boundaries, obviously complicate the process of therapy by introducing a morass of intricate interpersonal needs, wants, expectations, and obligations, on the part of both the client and therapist. Therapy cannot proceed effectively if such boundaries have been violated, as the clinician is no longer objective, client-directedness of the process has been destroyed, and therapeutic roles and goals have been distorted. However, some participants also noted the importance of some flexibility, in that these boundaries should not be so *"strict,"* and *"rigid,"* that genuineness, warmth, and safety are compromised. Again, appropriate boundary setting may be quite difficult to navigate for the inexperienced clinician. There is not a definitive nor universally absolute mark to be drawn between the extremes of the detached, icy, and dissecting clinician versus the clinging, gushing, and enamoured friend/lover. Instead, appropriate boundaries exist within a range, somewhere around the middle of these two extremes. Each clinician must find his or her own unique position within this range, depending on such factors as personality, interpersonal comfort level, a specific client's tolerance for closeness, and the clinician's chosen modality.

Incompetence. Problems with respect to boundary and limit setting range on a continuum from negligible therapeutic breaches (giving a client a hug after a particularly

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difficult session), to violations of ethical and professional codes. Respondents in the study stated that incompetence in this area occurs at the most basic level when a clinician is not aware of the importance of interpersonal boundaries and what boundary issues are. Violations occur when clinicians have *"personal issues that interfere with therapy,"* and when they use their clinical work as an opportunity *to "meet their own needs, rather than the client's,"* sometimes by *"dumping [their] own problems on the person."* Boundary violations also occur when the therapist has *"excessive boundaries,"* and may *"hide behind professionalism as a way to maintain distance."* Limits are also obviously breached when the clinician develops a personal relationship with the client that results in a level of *"attachment that compromises clinical judgement."* Some respondents noted that difficulties always result when a therapist acts more *"like a paid friend to clients"* than an agent of change.

26. Be an Active Participant and Invest Yourself in the Process of Therapy

Participants in the study, including the client, identified the importance of clinician investment in the therapeutic process. A variety of phrases were used to suggest that the therapist must be genuinely willing to *"invest a lot of time and energy"* in the therapeutic process, to *"go the extra mile,"* and to *"make the effort to find out that person's experience."* The clinician's more general attitude should be active, enthusiastic, and high energy. They must show initiative in pursuing different paths, and trying new techniques. The client, in particular, acknowledged the importance of feeling like her therapist is really involved and is participating in the session, rather than

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passively reacting to client comments and feelings. A psychologist in the study noted that *"you need to often go beyond the expected in order to make a difference....you have to work with all the leads and opportunities that present themselves to you, giving 100 percent."* The process of therapy requires a considerable amount of emotional and practical energy expenditure from both the therapist and the client. The process of therapy is heavily reliant on momentum, so if one half of the relationship is not fully investing this energy into the work the overall energy and momentum are weakened.

Incompetence. Therapists who are *"not really interested in getting to know each client"* are obviously not investing themselves in the relationship. They do not put in *"any more effort than they absolutely have to,"* are *"un[able] or unwilling to take risks,"* and are not *"giving of themselves personally."* Incompetent clinicians appear non-involved, and never show any signs of their *"personality and individuality."*

27. Ability to Communicate Confidence in Your Therapeutic Skills

It is important that clients have a strong sense that their therapists are confident in their clinical skills, as well as in their ability to offer help to the client. The clinician must come across as competent, knowledgeable, and self-assured to the client. They must be able to communicate their self-confidence to the client, in both verbal and nonverbal ways. The therapist's self-confidence plays a pivotal role in making clients feel safe, reassured, and contained within a session. They trust that no matter how emotional, irrational, and complex they become in the session, their therapist will be able to handle it, contain it, and prepare them for re-entry into the real world.

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Self-confidence is important not only for the client's sake, but also for the therapist. Many participants stressed that a clinician must sincerely be *"very confident in your conceptual understanding and skill,"* as well as in *"your ability to assist."* Such confidence is primarily a product of clinicians' training experiences, the effort they made in selecting a modality that they truly believe in, as well as more general self-esteem and confidence issues. Not surprisingly, participants noted that self-confidence tends to increase with experience.

Incompetence. Insecure clinicians communicate a sense of inadequacy to clients by being extremely tentative, ambiguous, and cautious in their interventions with the client. They seem to be *"unsure of their knowledge base,"* and appear awkward, ineffective, and overly apologetic. Clients are unlikely to feel reassured and safe with such a therapist, and will lack confidence in his or her ability to help them.

28. Ability to Work Under a Framework

An additional more cognitive-level skill required for clinical competence requires the ability to utilize some kind of framework for understanding and conceptualizing the client, his or her issues, and the direction of treatment. Participants in the study noted that clinicians must have some kind of theoretical perspective that allows them to have an *"intellectual and abstract understanding of what is going on with the client."* None of the respondents singled out any particular perspective as superior, but simply noted the importance of a theoretical frame of understanding that contains within it a consistent way of defining the issues, processing information, identifying client patterns, understanding

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"how and why [clients] are doing things," and *"pulling common threads through into a comprehensible, meaningful, whole."* Furthermore, this system of meaning should guide clinical choices, goal setting, and the application of specific techniques at specific times. In essence, the competent clinician must also be able to put theory into practice, to translate from the classroom to the office.

Conceptualization is the process of creating a system of meaning from observations and interactions with the client. Good conceptualization is the difference between meandering, haphazard, session-by-session, and anticlimactic work and a thematic, methodical, and ultimately fulfilling therapeutic process where each session builds upon the previous. The ability to conceptualize effectively increases with knowledge of various modalities, choice and adherence to a particular frame, and experience. Novice therapists have much difficulty with this concept, particularly since they tend to adhere rather loosely to any theoretical perspective depending on the course they are taking at the time or their current supervisor. The concept of "eclecticism," perhaps the orientation of choice for every novice therapist, further erodes the capacity of the novice to ultimately choose a discriminating and internally consistent system of understanding and being.

Incompetence. Clinicians who *"don't know what they are doing,"* are those who lack conceptual ability and a framework for therapy. As a result, they are unable to formulate and adhere to a treatment plan regarding the process and purpose of therapy. Time lines are not delineated, goals and expectations are not agreed upon, and clients are frequently misunderstood. Such a clinician operates on blind luck, as they have *"stopped*

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being reflective on what they are actually doing...and are not thinking about why what they are doing is having any impact at all." Incompetence is also seen when clinicians adopt one *"faddish"* approach after another, or *"belief systems with no good evidence for [them]."*

29. Know When to Seek Supervision, and Seek It

Along with being humble and knowing your limits, the competent clinician must have *"no problem coming to a bunch of people and saying 'I'm having a really difficult time with so-and-so. I suggested this, and it didn't seem to work. Does anybody have any suggestions?'"* Clinicians must not be afraid to both recognize when an impasse has been reached and to ask for and receive problem-solving help from peers when they don't know what to do. They must be genuinely open to feedback and criticism and be able to *"use it constructively, as part of a learning process."* In addition, the clinician does not go to peers only after a problem has occurred but also readily *"enlists assistance from colleagues in a [particular] area of expertise"* simply to get more information and a different perspective. Some respondents acknowledged that feedback can also come from clients and that this must also be used for the process of growth.

Access to supervision presents a much more difficult issue for the independently practising practitioner. They must make their own effort to *"develop a good directory of support [within their community] to reach out to when something arises that [they] are not sure how to handle."* Many participants acknowledged that formal supervision should not end once the practitioner is no longer a student. There are obstacles to this,

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however. As one psychologist stated:

> Once you are a staff member, I mean who knows what people are doing? I shudder to think....If you don't have peer supervision or whatever, you just don't look at it. And if you did, I think younger staff would be like 'Oh okay, this is a good idea,' because they are closer to having been evaluated, whereas the older staff would be saying 'This is an intrusion on my professionalism.'

Incompetence. Incompetence in this category is demonstrated by not knowing when one is in need of supervision, not seeking supervision, being *"unable to listen to the input of other colleagues,"* and generally *"not being open to feedback"* even when given expected supervision.

30. The Capacity to be a Critical Thinker

Perhaps somewhat moderately related to training, therapists must have the ability to be organized, logical, clearheaded, rigorous, and disciplined in their way of thinking. There is a self-selection factor involved here in the sense that presumably only those students who have this capacity will make it far enough in the academic stream to be in the position of becoming a clinician. Respondents in the study acknowledged that the discriminating clinician can *"absorb and utilize academic and technical qualities,"* be *"organized in their thinking, formulation, and treatment planning,"* and be *"precise in the way they conceptualize...formulate and test hypotheses."* She or he must be able to both analyze information and observations into the smallest critical components, as well as *"amass information and make sense out of it in a methodical way."* A psychologist in

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the study described this as a *"personal science,"* and went on to state that:

> I believe in the scientist-practitioner [model of training], because I think what it does is it allows people to be critical and clear in their thinking, even though it doesn't necessarily mean they will be effective, but at least they are able to reflect on what it is they are trying to do. And I think that ultimately translates into a connection with the patient.

The scientist-practitioner model of clinical training continues to be the dominant programme approach, at least within the field of clinical psychology. Most programmes, whether in psychology, nursing, or social work, require the completion of some kind of well-researched major paper or thesis necessitating the use of a scientifically-minded, rigorous, abstract, and critical level of thinking.

Incompetence. A clinician who is unable to think critically was described by some respondents as *"simplistic"* and *"too fuzzy on the facts."*

31. A Life Experienced

Interestingly, many clinicians, across all disciplines, regarded *"a certain degree of personal life experience"* as necessary for competence. This is particularly noteworthy because this reflects a condition of competence that is entirely outside the realm of training. It was suggested that the clinician should accumulate *"enough life experience and skills to be able to help people with the range of problems you are going to run into."* As one nurse in the study stated, *"I don't believe that someone who has not worked outside the home, someone who has no children, has had no jobs outside of school...and*

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just gone through a protected academic environment will be able to help people." Similarly, a psychologist noted that *"life experience allows you to empathize. You have to think about what is the equivalent in my experience...and you have to have those sorts of analogies in your head."* Another participant noted that it is often a critical life experience that turns a person toward this particular career direction. This is a more subtle version of the adage that people become helpers to help themselves.

Obviously, it is not simply the accumulation of experience that is crucial here, it is also the clinician's propensity to have learned something from these experiences (see section #17 Awareness of Personal Issues). One clinician disagreed with this assumption. Instead, she expressed that:

> I think it is easier to do the job, given a variety of experiences. However, I think you can be a new therapist and still be effective if you are...well-read, if you've listened well to friends and family, if you have been able to learn to some extent vicariously, through other people's experiences....If you're a good listener, both in therapy and outside of it, well then you can do good therapy and be 24 years old.

The viewpoint she expressed likely provides a sigh of relief to novice therapists who typically start clinical graduate training in the "inexperienced" age range of 22 to 25 years old.

Incompetence. While it seems absurd to refer to clinicians with a *"narrow range of life experience"* as incompetent, this was nonetheless viewed by some participants as a potential impediment to competent clinical functioning, specifically in its impact on the ability to relate to others (empathy).

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32. Dedication and Devotion

Participants in the study expressed that a clinician can only be competent if he or she holds a true commitment to the work and is not in it to pursue some self-interest. Clinicians should *"really love what they do"* and be genuinely interested in doing and learning about their profession. Appropriate reasons given for being involved in the profession included *"for the sake of providing assistance to other people,"* *"[having] a desire to help, to be a provider,"* a *"commitment to helping,"* and a *"devotion to...trying to provide something for the patient."*

The strength of one's dedication and devotion to the profession is sometimes a good barometer of that clinician's level of "burnout." While you do not encounter this in novice therapists, years of intense experience with clients may temporarily drain the clinician of his or her level of devotion.

Similarly, those therapists who enter the field simply for financial or ego-related reasons, will likely (and hopefully) have limited success when dealing with clients. Nevertheless, as one therapist noted, there must be at least some self-serving element in choosing to be a clinician, *"it could never be 100% for the client, the therapist's needs have to come in somewhere, otherwise why would you be doing the work?"* Therapists are human too and, like their clients, they have human needs to be appreciated, admired, and rewarded.

Incompetence. Participants reported that unseemly reasons for becoming a clinician included; *"being there for the money, prestige, title,"* *"just want[ing] to demonstrate how clever [you] are,"* *"lik[ing] the idea of being a doctor and having*

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people tell [you] intimate things," for the opportunity to *"show and tell*," being *"in it for [your] own 'feel good' feelings*," and being a clinician so you might *"be delighted with [your] own formulations."*

33. Having a Sense of Humour and Using it Appropriately

Competent clinicians should not always take themselves and their work too seriously. They should have the capacity, within sessions, to laugh when something really is funny (and the client is also laughing), when they make an amusing mistake, and to use humour appropriately to perhaps lighten the intensity at the very end of a session. Such appropriate displays of humour are congruent with the therapist's level of genuineness and transparency in the session. Humour also provides another means of protecting against clinical burnout. One nurse in the study remarked that *"Sometimes, it really takes clients ten times before they are really able to get it and are able to do it...and sometimes, this is where humour can come in...so it doesn't feel like a waste of time."*

Novice therapists sometimes have difficulty distinguishing between "real" laughter and nervous or defensive laughter in the client. Cautions against the therapist's tendency to simply mirror the client's inappropriate laughter and thereby reduce the overall tone of seriousness of the session, and of the client, are often helpful.

Participants in the study who work within a psychiatric hospital setting also acknowledged that "back-room" humour and joking about clients are often used as a way to de-stress after a difficult encounter. Of course, it was cautioned by many of these respondents that there is a limit here, and disrespectful comments and jokes are always

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inappropriate, even in private.

Incompetence. As expressed above, the use of humour was viewed as incompetent when it crossed the line into disrespectfulness.

34. Possessing a Good Technical Knowledge Base

Though participants in the study were asked to reflect on personality and interpersonal skills, nearly all included some more technical and knowledge-based skills in their responses. Competent clinicians must have a fairly good grasp of the knowledge base in their area. They should be grounded in the relevant literature and possess an explicit understanding of various techniques. These factors are determined by training, although some element of dedication and a commitment to learning are involved. In addition, technical competence requires that the clinician have an *"awareness of a lot of different ways of human functioning,"* garnered from both personal experiences and *"diverse training experiences."*

Incompetence. Respondents did not make any specific reference to incompetence in this category. However, it can be inferred that not having a good technical knowledge base is a negative quality in a clinician as it leads to an impoverished ability to explore and process client issues and dynamics, and therefore, to ultimately help clients.

35. Ability to Create Equality in the Therapeutic Relationship

Participants noted that the competent therapist must *"come across as human, not holier-than-thou, or perfect"* in comparison to the client. More than not appearing to be

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the all-knowing expert, *"[therapeutic] power relations should be interrupted or dissolved"* so clinicians *"see the client as a human being, no better or worse than them, on their [own] life journey."* Transmission of this idea of equality comes through in the therapist's openness to viewing the therapeutic relationship as one in which the opportunities for learning are open at both ends, or in *"espousing the value that often our clients are our best teachers."* In terms of communication style, the clinician does not interrupt clients; correct clients' descriptions of their experiences; dictate clients' next moves; and does not condescend to or patronize the client from a position of some kind of developmental, intellectual, or evolutionary superiority.

Incompetence. Equality in the relationship is compromised when clinicians have *"a superior attitude,"* and *"see themselves as above [their] clients."*

36. Genuine Concern for People and Humanity

Some participants in the study suggested that the competent clinician must uphold a personal ideology of overall warmth and caring *"about the world and the plight of people."* The therapist should at least have an *"interest in people,"* and should *"like people!"* Most participants' beliefs went further than this minimal level and suggested that a clinician should *"love"* people, *"believe in people, and in humanity,"* and possess a *"genuine caring for the well-being of others."* The relevance of one's sentiments toward humankind to therapeutic competence is fairly obvious. One would be hard-pressed to find a successful therapist who doesn't really like people. Most novice therapists are able to express this general concern for humanity in their frequently stated motivations to enter

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the profession because they want to help people.

Incompetence. Participants reported that clinicians who *"don't give a damn,"* *"don't really want to be there,"* and *"don't even really seem to like people very much"* are unlikely to be competent clinicians.

37. Overall Intelligence

In order to demonstrate competence, participants reported that the clinician must have the cognitive abilities required to *"grasp complex issues, problems, concepts, and interpersonal relations,"* to *"integrate complex information intellectually and emotionally,"* and to basically *"get what the client is putting out."* Presumably, those students who do not possess these abilities are unlikely to make it into a graduate programme.

Incompetence. Participants expressed that being *"scattered,"* *"absent-minded,"* an *"obnoxious dullard,"* or a *"screwed-up goof ball"* does not bode well for success as a clinician.

38. Demonstrating Focus and Presence in Sessions

Across disciplines and approaches, participants in the study noted that the clinician should *"emanate attention on the client, like an energy you give off."* Maintaining a real presence with the client, being *"fully there,"* being *"in the moment,"* and being *"in tune"* with the client are necessary aids in establishing, as well as maintaining, a strong therapeutic alliance. In order to emanate such an intense presence,

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therapists must be capable of *"moment-by-moment self-awareness throughout sessions"* where they can attend to the natural fluctuations in their level of focus, and make appropriate attempts to get back in the room. Possible distractions are many, including personal problems of the clinician, thinking about relevant literature, making analytical and conceptual links, and anxiety about evaluation. Early in training, lack of presence in the therapeutic encounter is a frequently seen difficulty, conveyed in anxious body language, awkward posture, nervous glances at the camera, and interrupted or clumsy speech. Most students in supervision acknowledge an awareness of having had many intrusive thoughts about evaluation while in a session with a client.

Incompetence. Difficulties maintaining focus in a session can occur for a variety of reasons. However, the most frequently cited reason provided by the participants occurs when clinicians are *"distracted by their personal life,"* which reflects some of the issues mentioned in the Limit and Boundary Setting category discussed earlier (see #25).

39. Time Management Skills

Basic organizational and time management skills go a long way in helping the competent clinician *"facilitate faster resolution of patients' problems."* Participants noted that the therapist needs to complete the initial assessment as quickly and throughly as possible. This will allow the development of the basic treatment structure early in the therapy so the client and therapist may *"get to the work"* more quickly. As stated earlier, much of the progress of therapy depends on momentum, and as such, it is helpful to expedite the client's sense of progress as quickly as possible. Similarly, the ability to

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prioritize main issues, both early on and through the course of therapy, is essential in maximizing time usage. More practically, the competently organized clinician completes notes after sessions, maintains good and easily accessible records, remembers what works from one week to the next, respects agreed-upon time-lines, and does not consistently extend sessions. The 50 minute hour was initiated with the purpose of providing the clinician a break to collect thoughts and organize preliminary notes, before the next client knocks on the door.

Incompetence. The only additional information that came up with respect to this category was the difficulties that may result when a clinician *"adheres too strongly to a time frame,"* and thereby risks becoming out of touch with the client's moment-by-moment, potentially changing needs.

40. Ability to Get and Keep Clients Motivated

The maintaining of motivation is essential throughout what can sometimes be years of therapeutic process. Many respondents acknowledged the importance of first lessening the client's sense of hopelessness and inertia, and then *"maintaining a balance between smothering and being totally objective."* This requires the capacity to negotiate a somewhat subtle *"balance between tension and support so as to maximize progress."* While clients need support, giving, and containment, they also need to experience their distress and dissatisfaction in order to impel them toward change. Otherwise, the client becomes dependent on the clinician for emotional support and reassurance, like a child to a parent. The process of therapy, like the process of raising a child, is to encourage clients

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to eventually leave and take care of themselves and their own feelings.

Incompetence. Respondents identified that the major impediments to client motivation stem from the clinician's tendency to be *"too helping,"* *"suffocating,"* and *"rescuing, rather than empowering."* This kind of behaviour is facilitated by the therapist's *"poor judgement about when to back off, and when to be there to help."*

41. Capacity to Use Oneself in the Therapy

Some participants emphasized the importance of sharing something of yourself with clients. Beyond being genuine, competent clinicians are able to *"share their own experience in an appropriate way to the situation."* Appropriate self-disclosure, as well as comfort in acting as a role model for the client, were seen as reflective of this *"personal element of sharing and relating."*

Incompetence. Participants reported that the inappropriate and untherapeutic *"sharing of one's personal details with the client, for example responding with 'Oh ya, that happened to me one time and here's what I did...'"* are inappropriate and incompetent.

42. Being Relaxed

The competent clinician should at least be able to appear relaxed to clients, whether or not this is the case internally. However, it is quite difficult to fake relaxation. Some expressions used by the participants suggested that the therapist be *"laid-back,"* *"informal,"* *"easygoing,"* and have the ability to *"let their hair down."* A relaxed

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presence is an additional relationship-building skill that helps clients to feel safe and invited to communicate their story openly and at their own pace.

Incompetence. *"Anxiety,"* *"nervousness,"* *"fear,"* and being *"uptight"* was defined by participants as demonstrations of personal incompetence in this area.

43. Matching Yourself Appropriately With Your Chosen Modality

As one participant in the study stated, *"it is certainly useful to have techniques, but the real challenge for the therapist in terms of techniques and theoretical perspectives is to find the one that fits for you."* Choosing the right modality was seen by participants as a process based on the *"fit between your work, your own life experiences, your education, and your personality."* Modality provides a system of meaning, as well as a language of communication between the clinician and the client. One respondent eloquently captured this in her statement that your modality *"becomes the vehicle that allows you to utilize the attributes that you have in a way that's helpful...and it allows you to understand the difficulties that people have in life in a way that's most meaningful to you."*

Incompetence. An incongruence between the clinician and his/her chosen modality will be reflected in an overall discomfort, apathy toward the process, a lack of self-confidence, knowledge and technique deficiency, a lack of genuineness and investment, and rigidity of application, to name a few. The clinician who is not well-matched to their modality will have difficulty making sound judgements about appropriate techniques, conceptualizations, and goals. Over time, disinterest and dissatisfaction with the

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profession are likely to occur when there is *"not a good fit between the person's motivations, goals, and what they are doing."*

44. Therapy Magic

Some participants' responses were not readily definable as they appeared to reflect much more esoteric and intangible qualities of the therapist. Nevertheless, since these kinds of responses came up fairly frequently, they were collected under this heading. The common characteristic of these qualities is that they seem to tap into an almost charismatic quality of a therapist that is indefinable, and consequently untrainable. One student reported that the therapist has a *"good ability to make you talk about yourself, without you really realizing it."* A similar response noted that they *"always manage to suck something out of you."* Another respondent stated that *"you don't see what it is they are doing...it is almost invisible what it is that they are tapping into, which I find kind of fascinating."* The clinician with these mystical abilities is able to *"take a client a little bit past the edge, past the border of experience."* One response that was at least somewhat definitive expressed that the *"magic"* involved a kind of transcendental melding and blending of the *"interpersonal people skills"* and the *"theoretical perspective."* They went on to express that *"defining the issues comes through the theoretical perspective, but accessing the issues is some kind of magic."*

Incompetence. Respondents did not refer to incompetence in this area. However, it may be inferred from the above descriptions of "magic," that the so-called "incompetent" clinician lacks charisma and mystique, and may be just plain ordinary.

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45. Creativity

Creativity, capacity for innovation in approach, and a sense of playfulness in applying techniques were reported by some respondents as essential to competence. These skills were linked to the "artistic" side of the therapeutic endeavour, rather than to the scientific dimension. As one respondent noted, *"the therapist must be a humanistic artist, not simply a technician or a mechanic of the brain,"* and another, *"they must be able to apply their skills and techniques in an artful manner, to really put theory into practice."*

Incompetence. Once again, participants in the study did not specifically refer to this category when discussing incompetence. The clinician who is not able to be creative may be seen as unoriginal, traditional, and unaesthetic.

46. Ability to Foster a Sense of Teamwork

The importance of equality in the therapeutic relationship has already been discussed above (#35). When the client and therapist are both able to see each other in this way, as equals in the sense of their ultimate "humanness," a true feeling of teamwork is established.

It is through the collaborative effort of both that a climate of *"shared space, shared feeling, and shared thinking"* can be created where both client and therapist participate to facilitate change. Teamwork was designated as important by some participants in that it ensures a mutual understanding of the journey involved, as well as encourages the need for both parties to contribute suggestions, to *"try out strategies,"* and

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to utilize *"trial and error"* until something works.

Incompetence. Respondents did not specifically refer to this category. A lack of teamwork and collaboration between client and clinician may result in some kind of pseudo-dictatorial process system, lead by either the clinician or the client.

47. Remaining Calm

In addition to being relaxed, the therapist must remain calm in the face of such intense events as uncontrollable emotional displays, outbursts of anger and hostility, and disclosures of suicidality or homicidality. Participants noted that this calmness is typically displayed in a soft-spoken, steady voice and an enduring quiet demeanour and body language. Maintaining calm helps clients to feel contained by their therapist("He/she will manage my feelings if I can't."), safe in the relationship ("He/she won't abandon me if I act crazy."), and confident in the therapist's ability to handle them.

Incompetence. The clinician who has difficulty remaining calm in the session will likely encounter frequent escalations of intense emotions in their clients, whereby the client and therapist feed off of each other's anxieties, leading to potentially dangerous and explosive situations.

48. Comfort with Intensity

Some participants acknowledged that the therapist must have the willingness to explore *all* aspects of the patient's functioning, and *"not be afraid to go into the depths of people."* This was noted to be particularly true for those issues, thoughts, and feelings

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which might be particularly difficult/ scary to acknowledge and deal with. As one psychologist described, *"clinicians must be capable of recognizing the dark side in people, and in themselves, without judging or freaking out, or trying to control it."* When starting out, it is often difficult for novice clinicians to go below the surface and explore these kinds of motivations and feelings. Instead, there is a tendency to emphasize the positive that goes beyond optimism and into an active twisting of facts to maintain an idealized sense of humanity. For example, one counselling student refused to believe, despite all of the confirming evidence, that her client had negotiated a deathbed resolution with her estranged mother for the sole purpose of financial gain. Instead, she clung to the belief that her client "couldn't be that bad" and that there was "no way she could do anything like that." In this case, she ended up simply colluding with the client's distorted perspective that she really just loved her mother, despite having suffered years and years of abuse at her hands. Little was accomplished in the counselling, other than adopting a thin, superficial veneer of improvement. Such clients tend to return to therapy in the future, until the more "disturbing" core beliefs are acknowledged and processed.

Incompetence. Clinicians who cannot cope with intensity are seen as incompetent in that they cannot cope with aspects of the client's emoting that are powerful, painful, and potentially overwhelming. Similarly, they are unlikely to deeply explore experiences in the client's background that may have been horrifying, repulsive, or threatening. The avoidance of such rich and obviously meaningful content areas is likely to result in neglectful and incomplete conceptualization and emotional processing.

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49. Maturity

Participants frequently stated that the counsellor must possess a certain level of maturity, specifically emotional maturity, in order to be perceived as competent. Rather than being viewed as a specific skill, maturity was regarded as an overarching construct that served the clinician's ability to fully demonstrate other specific skills (empathy, comfort with intensity, flexibility, capacity for self-reflection, etc.). Of course, maturity is hard to train but is assumed (at least) to occur over the years a student is involved in a training programme. This provides some support for the argument that the longer the student stays in school, the better the clinician! However, some would counter that while physical maturity is related to time, emotional maturity has little to do with the passing of years.

Incompetence. Immaturity and naivete were seen by participants as contrary to clinical competency.

50. Having Common Sense and Good Judgement

Even "immature" people should at least possess some degree of commonsense that allows them to think on their feet and make good judgements. Again, these skills presumably have little to do with training and instead seem to represent the possession of a more mundane resource of intellect.

Incompetence. One respondent reported that incompetence is obvious when the clinician is *"missing certain practical applications that fall under common sense."*

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51. Generally Interested and Curious

Some participants reported that a clinician should have a genuine and general curiosity, and should be *"interested in a lot of things."*

Incompetence. Respondents did not refer to this specific area. Generally, a clinician who is apathetic, passive, and disinterested in life is unlikely to be very motivated or successful as a clinician.

52. Ethical

Adherence to ethical and professional standards was specifically mentioned by a few respondents. While this is important, it is not directly within the realm of personality and interpersonal skills, although certain skills previously mentioned do play a role in an individual clinician's ability to adhere to these standards.

Incompetence. Respondents provided a variety of examples of serious ethical violations that are quite obviously contradictory to competence. These included; *"actively abusing drugs or alcohol,"* being a *"predator," "dangerous,"* or a *"psychopath," "manipulating and exploiting people,"* becoming *"sexually involved with clients," "abusing clients,"* and *"inappropriate interpersonal advances"* or *"profound personal violations."*

53. Awareness of Countertransference Issues

A few respondents noted the importance of having an awareness of *"how you perceive other people's interactions with you"* within the therapeutic context, regardless

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of chosen modality. Along with having some self-awareness of one's own unresolved issues, the clinician must be *"aware of how your emotions and internal responses...are activated....and get played out in the relationship with the client."* Awareness of these issues is critical to maintaining objectivity in the relationship.

Incompetence. Countertransference issues become a source of incompetence when the clinician *"reacts based on stuff that is going on with them, rather than being able to separate that out of the therapy. They let it permeate the relationship,"* and as a result *"their issues make them incapable of hearing what the client is saying."* Again, objectivity and boundaries are compromised.

54. Awareness of Transference Issues

A few respondents stated that it was important that a clinician maintain an awareness of transference issues and *"take them seriously."* One respondent stated that the therapist *"must be aware of how you are perceived by clients, and how that might affect the interaction."* While transference has, in the past, been most often associated with the analytic approach, more clinicians are acknowledging that it might play an important general factor in all interactions/approaches with a client.

Incompetence. Clinicians are incompetent if they *"don't appreciate what their impact can be on others."*

55. Comfort in the Role of Provider

Finally, some clinicians stressed the importance of being comfortable in their role

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as helper, and with the overall therapeutic situation. That is, the therapist should be comfortable being in the "unnatural" interpersonal position of having to almost exclusively serve the needs of someone else.

Incompetence. Discomfort with being a helper is a contraindication to even entering professions where clinical work is the focus. The clinician who doesn't want to help and doesn't like helping is unlikely to be successful.

The Five Underlying Dimensions: A Model of Clinical Competence

Respondents provided rich and detailed descriptions of a variety of interpersonal and personal attitudes, skills, and behaviours which are necessary to demonstrate clinical competence. In fact, the quantity and range of individual clinical skills delineated by the participants, while supporting the view of the researcher that these skills are substantial, pleasantly exceeded pre-research expectations. In the process of making sense of the abundance and complexity of this qualitative data, and in the interests of enhancing its manageability and applicability, effort was made to distinguish the smaller subset of underlying dimensions represented by these individual skills.

The first step taken in this reductive process was to eliminate those skills which were deemed more reflective of technical and knowledge-based competence rather than clinical competence, as well as those skills which are likely to be captured by other existing training evaluation measures. Through this process, a total of six residual skills were removed, including the ability to define the therapeutic contract, set goals, and stick to them; the ability to work under a consistent framework; basic skills and

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professionalism; possessing a good technical knowledge base; behaving ethically; and overall intelligence. Thus, a total of 49 specific skills remained.

In the next step of analysis, the descriptions provided by the participants regarding competence and incompetence for each skill were carefully reviewed, and the researcher was able to identify five underlying dimensions. These are presented as a model of the five overarching categories of skills required to demonstrate clinical competence.

1. Alliance-specific skills. Skills specific to and essential for the process of building an effective therapeutic relationship. These are the skills which are traditionally thought of under the rubric of clinical skills and include empathy, warmth, and genuineness. Effective use of these skills results in the establishment and maintenance of a strong working alliance and therapeutic rapport.

2. Non-alliance-specific skills. Those skills which are "therapeutic," but reflective of more general therapeutic processes and clinician attitudes. This category includes skills such as maintaining a frame of positivity and hopefulness, comfort with intensity, and appropriate use of humour. Such skills serve to establish the therapeutic ambience of the overall clinical environment.

3. Professional skills. Skills which are deemed compulsory for functioning appropriately and effectively within a clinical profession. These skills represent the quality of clinicians' relationships with their discipline. Such skills include dedication and devotion to the profession, ability to get along with colleagues, and effective use of supervision. The quality of the relationship between the individual clinician and his or her discipline is directly reflected in both the quality of the relationship between the

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clinician and his or her client and the therapeutic work the pair engage in.

4. Cognitive skills. Skills which primarily utilize clinicians' rational and logical abilities to think and perceive, as opposed to their capacity to feel. Such skills include maturity, life experience, psychological mindedness, and critical thinking. Clinically, these skills are used to access relevant concepts, experience-based schemas, and intuitive models of understanding necessary for the effective and appropriate application of the more interpersonal and personal skills such as empathy.

5. Role management skills. Skills necessary for the appropriate defining, management, and use of the distinct roles of "client" and "clinician." These skills relate primarily to the establishment and maintenance of therapeutically and ethically appropriate boundaries. They include comfort in the role of provider, capacity to use one's self in the therapy, and fostering of teamwork.

Each of the 49 clinical skills can be classified as representative of one or more of these underlying dimensions. This model permits a parsimonious summarization of a clinician's functioning in the five key areas necessary for clinical competence, enhancing its functionality and applicability in the process of evaluation. This will be discussed further in the section on the development of the Clinical Skills Appraisal Tool. A summary of the 49 skills and their relationship to each of the 5 underlying dimensions is provided in Table 5.

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Table 5

The 49 Skills and Their Relationship With the 5 Underlying Dimensions of Clinical Competence

Skills	Role Management Skills	Cognitive Skills	Professional Skills	Non-Alliance Specific Skills	Alliance-Specific Skills
capacity to be empathic					
capacity for warmth					
respect for the client					
non-judgementalism					
genuineness, transparency					
ability to engender comfort, safety, good rapport					
humility and knowing your limits					
respecting the client's humanity					
foster teamwork					
ability to create equality in the therapeutic relationship					
ability to set appropriate limits and boundaries					
awareness of transference issues					
awareness of countertransference issues					
patience					
being relaxed					
remaining calm					
comfort with intensity					
maintain a frame of positivity and hopefulness					
having a sense of humour and using it appropriately					
therapy magic					
ability to be challenging and confrontational					
promote client-directedness					
ability to get and keep clients motivated					
maintain focus and presence					
be active and invest yourself in the process					

Skills Continued	Role Management Skills	Cognitive Skills	Professional Skills	Non-Alliance Specific Skills	Alliance-Specific Skills
capacity to use one's self in the therapy					
self-awareness					
awareness of personal issues that can impact therapy					
psychological healthiness					
dedication and devotion					
genuine concern for people and humanity					
generally interested and curious					
ability to get along with colleagues					
communicate confidence in one's therapeutic skills					
commitment to ongoing learning					
know when to seek supervision and seek it					
time management skills					
general ability to communicate					
general listening skills					
maturity					
life experiences					
flexibility					
creativity					
matching yourself appropriately with your modality					
capacity for insight and psychological mindedness					
capacity to be a critical thinker					
common sense and good judgement					
ability to maintain objectivity					
comfort in the role of provider					

Note that the highlighted areas indicate which of the 5 dimensions each skill pertains to. For example, the ability to foster teamwork is both an Alliance-Specific Skill and a Role Management Skill.

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Question Two: How Much Weight Do You Place on This Dimension Versus Academic and Technical Skills?

After being asked about personal beliefs concerning the qualities of clinical competence and incompetence, participants were asked how much weight they place on this dimension, specifically when compared with the clinician's professional knowledge base and the clinician's technical skill level. In effect, they were asked how important this particular dimension was to them in assessing a clinician's performance.

Summary of Findings

The majority of respondents acknowledged that all three dimensions were equally important and that weaknesses in any one area have a detrimental and cumulative effect on a clinician's overall level of competence. Respondents were reluctant to separate or rank-order the importance of each of the three dimensions to competence, although they acknowledged that performance in one dimension was not necessarily correlated with performance in another.

1. Knowledge Base is Most Important

Most notably, of all the participants, only one respondent declared that a clinician's knowledge base is the most important indicator of clinical competence. However, the individual, a psychiatric nurse, qualified her statement with the ambiguous comment that while *"your knowledge base"* is the most critical factor, *"if you don't have the ability to establish a positive rapport, then you really aren't able to work in a*

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satisfactory manner."

2. Interpersonal and Personal Skills are Most Important

In comparison, many of the participants emphasized the key importance of the nature of the relationship between therapist and client in determining treatment outcome. As a result, qualities and skills which are crucial to the development of a good therapeutic relationship were perceived as the most important. This was reflected in statements such as *"when you really get down to a relationship between two people that has to be a trusting one, the person's personality and interpersonal skills are the most important - that's the engaging quality between two people,"* and *"I put a lot of weight [on the interpersonal/personal dimension]. It is one of the most important things, being able to use oneself in that interpersonal aspect of the relationship."* One participant went on to assert that interpersonal skill alone can result in significant client improvement because *"there is just something about sharing [and] knowing that someone cares for you."*

Generally, the interpersonal/personal dimension was viewed by these participants as the *"core"* and the *"essence"* of therapy, and as skills that were mandatory in order to function as a clinician. As one participant put it *"they are extremely important. Like, if you don't have them, well then out you go, this is not the profession for you,"* and another, *"oh, they're very important, they're everything."* In addition, many respondents expressed that there was a need for much more research into this area of competence, and specifically in identifying and defining the critical qualities. Particularly relevant to the present study was the lament of one psychology faculty member that *"to me, these*

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[interpersonal and personal skills] are very important, but are not something that we assess much. Which is one of the things that I hope comes out of your project."

One of the participants reflected on the fact that many clients are themselves quite well educated concerning theories, techniques, and diagnoses. She noted that *"that's not what they come for. They come for the interpersonal, the relationship, the support, the encouragement."* Intriguingly, this view was also revealed in the comments of the client in the study, an educated and informed woman with long-term experience in therapy. She asserted that if she had to choose between a therapist with impressive academic and technical skills, and one with *"good"* personal qualities, she would definitely choose the latter.

3. All Three are Equally Important

The majority of participants across all three disciplines reported that clinical competence as a global construct must be seen as an equal synthesis of all three dimensions; including knowledge base, technical skills and the interpersonal/personal skills. These respondents felt that attempting to separate and quantify the importance of these qualities in assessing competence would be artificial, given that the dimensions are intricately connected. For example, one respondent stated *"I can't imagine a way to rank order them, it's more like they are all essential and the moment a therapist has a significant weakness in any, that drags down their overall competence."* This general perspective was reflective of the pervasive scientist-practitioner philosophy of clinical training, where equal weight is placed on the development of both the "softer" personal

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and interpersonal qualities necessary for practice, as well as the "harder" empirically-validated skills and knowledge. This is captured in the statement of one participant that *"therapy is an art and a science, if it's all 100% science, you miss the art part of it."*

Several participants noted that while all three dimensions were important, the interdependence of the constructs was low, so that a high level of functioning in one area does not necessarily correlate with a high level of functioning in another. Some examples included the comment by one clinician that *"someone who knows everything from the textbooks, may still be a terrible therapist,"* while another commented that *"being bright does not necessarily make you a good clinician,"* and that the interpersonal/personal dimension accounts for *"more than 50% [in the measure of competence], otherwise you are a book."*

Most clinicians acknowledged that the three dimensions each make a unique contribution to overall competence, but placed particular emphasis on the importance of the interpersonal and personal skill area. A curious manoeuvre that was frequently encountered was an initial reluctance on the part of participants to bluntly assert the primary importance of the interpersonal/ personal dimension of competence, but then to go on to make comments that ambiguously supported the belief that this was in fact the case. Some examples included comments such as; *"I think I'd put them on the same level as knowledge, maybe even a little bit higher," "[interpersonal and personal skills] are 50 to 75% important," "these qualities would be rated at least as high as being a knowledgeable therapist,"* and *"they are fairly important. If I stacked them up against some of the other things you mentioned, I'd rate it fairly high."*

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Other respondents went on to articulate a personal system of rank-ordering the three dimensions or understanding their unique contributions. A nurse in the study commented that *"I think you gain trust more by using those types of skills in conjunction [with the others],"* while the client in the study noted that *"you want a basic level of competence, and once that's established, and it's more of a do-no-harm thing, then the personal qualities are important."* One participant summarized the hierarchical/ synthesis view particularly well in his comment that *"the therapist, above all, needs to be warm and validating, then they need to be able to be empathic in an advanced way. Finally, last of all, but crucial to the equation, they need to be smart and have a good grasp of some knowledge."*

What Can Happen if One of the Three Dimensions is Missing?

In addition to assessing the relative contributions of each of the three dimensions of competence, many respondents also contemplated the impact of incompetence in one or more of these areas on the clinician and the client. Generally, it was agreed that weaknesses in any of the three dimensions would limit a clinician's effectiveness, and that performance would decline further as the number of areas of incompetence increases. Several respondents stated that the *"most dangerous"* state of incompetence occurs when a therapist has a good knowledge base and well-developed technical skills but is missing the interpersonal/personal core. One participant warned that in this situation a clinician *"cannot only do bad therapy, but can cause damage [to the client]."* Clinicians without interpersonal and personal skill were viewed as *"wooden"* and impersonal in the therapy

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setting. Conversely, one respondent stated that a clinician who is able to relate well with clients and establish a strong therapeutic relationship will be unable to achieve successful therapeutic outcomes if they do not have the knowledge base necessary to identify client patterns and dynamics or to utilize techniques appropriately. Similarly, competency in only the technical dimension was also viewed quite negatively as participants noted that *"if you just have a framework...your effectiveness is limited to certain people, certain situations. It's like you got to the port, but you missed the boat."* Nevertheless, these conditions were viewed as the least alarming of all the various possible combinations of incompetence. In terms of training issues, one doctoral student went further and stated that, *"[Intellectual] brightness can almost be a detriment. You can use that, and it can inhibit people from developing the other part of the skills."*

Question Three: Are These Interpersonal and Personal Qualities Trainable?

In addition to being asked to reflect on their individual beliefs about the interpersonal and personal qualities necessary for competence, participants in the study were also asked whether they believed that the qualities they had mentioned were trainable or teachable, specifically within the context of some kind of clinical training programme.

Summary of Findings

As with much of the present study, responses to this question were often more complicated than the question itself. None of the respondents declared, unequivocally,

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that these skills were untrainable. Instead, the majority opinion was that you could train *some* of these qualities, in *some* individuals, by using *some* specific teaching strategies that do not typically occur in the context of traditional clinical training programmes. Typical responses included *"they are trainable, within limitations,"* *"I think there are things that you can teach, and there are things you just can't,"* and *"I guess yaa, [they are trainable], in the sense that it's not something you can read in a book."* Participants went on to describe the qualities of the student and the qualities of the training programme that are most likely to facilitate the learning of these skills. These are summarized in Figure 1.

You Cannot Train These Skills in School

Most respondents listed some interpersonal and personal qualities that they deemed necessary for clinical competence but that are not amenable to clinical teaching or training. Interestingly, the most frequently mentioned "untrainable" skills were also the most frequently mentioned skills considered necessary for competence, primarily empathy, warmth, and nonjudgementalism. A nurse in the study commented that while some skills are trainable:

> when you really get down to a relationship between two people that has to be a trusting one...that I believe cannot be taught, you either have it or you don't....[and] if you don't have...the ability to communicate with your colleagues and clients, you can't learn that.

Other comments included; *"things that are difficult to train have to do with warmth, a*

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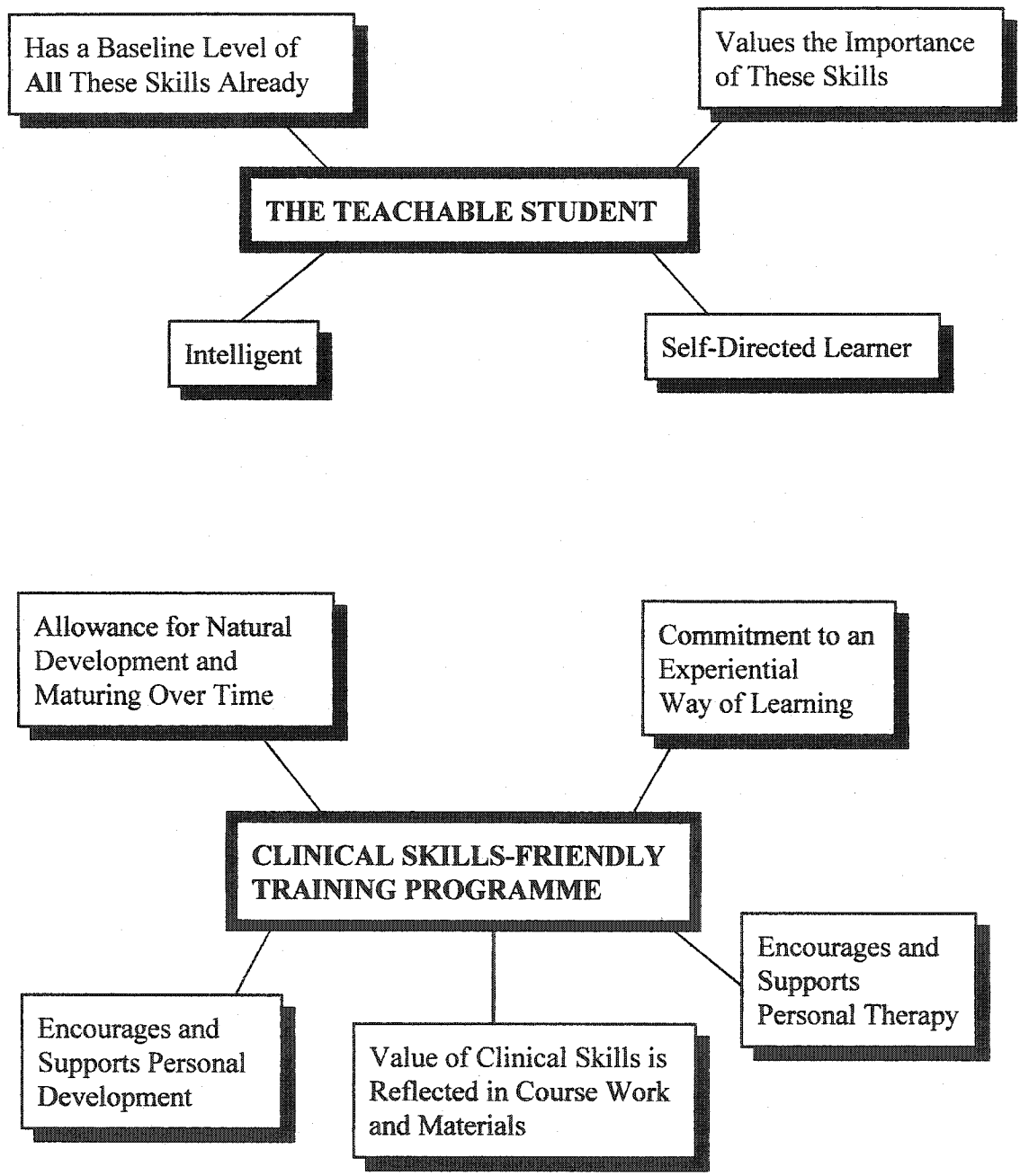
Figure 1

Qualities of the "Teachable" Student and the Clinical Skills-Friendly Training Programme



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sense of humour...and flexibility," *"I doubt you could teach 'advanced empathy' to anyone,*" and *"the interpersonal stuff is the hardest to train...I really don't think you can train someone to be warm."*

Other skills that were mentioned as untrainable included the ability to take oneself out of a situation and spectate on it (objectivity), curiosity, and as one psychologist stated, *"you can't train a person to like people, they [sic] either do or they [sic] don't."*

You Can Train These Skills in School

Participants in the study naturally spent much more time listing the qualities that they did consider trainable, rather than the ones they did not. These skills were much easier to describe because they were almost exclusively confined to the more tangible dimensions of competence, those pertaining to knowledge skills and technical skills. As one psychologist stated, *"I think that the only things that can really be taught are the knowledge-based stuff, research, conceptual approaches, techniques."* This sentiment was echoed by other participants, *"I think the theory and techniques can be easily learned,*" and *"clinical knowledge can be learned, if you don't know it, you can learn it."* Additional skills viewed as academically trainable included time management, rigorous thinking, active listening, and the components of good communication, such as the use of open-ended rather than closed questions.

Some individuals suggested that it might be possible to teach some students how to *"fake it,*" at least to a point. As one clinical student explained, *"I think you can get people to fake it...you can cut apart what makes someone look warm or empathic."*

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Another clinical student commented that *"for some therapies, some problems, some clients, 'pretending' you have [these skills] might be enough to have a positive effect, for more technical therapies."* Yet another clinical student expressed a competing view, stating that *"usually, we pick up [empathy, warmth, etc.] on a much more gut level, not really consciously. So, I think clients would pick up on that, that you are faking it."*

As a caution, some participants acknowledged that there is a vested professional interest in believing that you can train these skills. One psychologist, a faculty member in a clinical training programme commented that *"we like to believe these qualities are trainable, because there are people who come in [a training programme], and don't necessarily display them....but we neglect it, because we worship technique."* On a more personal level, respondents acknowledged the need to believe that these qualities are trainable in order to justify both therapeutic and personal processes of growth; *"I believe people can change their behaviours, they can learn,"* *"I think all behaviour is modifiable to some extent....in general, if people are willing, people can learn a lot of things."*

*You Can Train **These** skills, But Not in School*

The majority of participants agreed that while most of the qualities necessary for clinical competence were academically untrainable, they were personally *"learnable,"* if the student takes the initiative to seek that kind of clinical training outside of academia. This view was captured most powerfully and provocatively in a statement made by the client in the study:

I think that all of the things that make for good therapy, are probably things that

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> are taught out of school.... Actually, a lot of the stuff I am talking about I think would be *contrary* [emphasis added] to the kind of training that therapists actually receive.

Some respondents emphasized the importance of the student's taking responsibility for their own learning by actively seeking such knowledge, as one nurse explained regarding her own training, *"because of my own personality, I could go and seek [this kind of knowledge] out, because of my outspokenness and way of being."* The distinction between training and learning is made crucial here; where training refers to the process by which a student passively processes information received second-hand from another individual, learning is an active, firsthand process requiring the collecting of knowledge through immediate experience.

The Teachable Student

Intriguingly, respondents in the study identified that an essential prerequisite to the learning of the skills necessary for clinical competence was the existing personality and interpersonal qualities of the trainee. It was repeatedly noted, across all participants, that an individual was amenable to training and learning these clinical skills only if he or she possesses at least a baseline level of them already, before even entering a programme. The student must have *"some kind of material to work with,"* and the process of training was seen as the *"refinement," "enhancement," "development,"* and *"nurturing"* of these pre-existing *"seeds."*

If the student does not have this baseline level of clinical skill, *"well, they*

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probably won't be a good therapist [sic] no matter what you do." In a similar vein, a social worker in the study stated, *"I think there are some people you could never train to be empathetic, so maybe they can use rational-emotive therapy instead (ha ha)*," while a psychologist in the study expressed his view of the limits of training like this, *"[Can] training make a skilled therapist out of an obnoxious dullard? No, not at all."* The next question that logically followed for one participant was *"So, I guess the idea is what are the qualities of the person who is trainable?"*

Participants in the study provided many examples of the qualities they felt were necessary for a student to possess in order to benefit from clinical training. A nurse in the study summed up these qualities eloquently, *"If someone is just coming in as a basically good, interested, relaxed, educated sort of person... then they are going to get the skills."* Other responses covered the qualities of the "teachable clinical student" more specifically. One psychologist noted that the student must possess *"a high intelligence, to be able to grasp, understand, integrate, and apply all of this. Good therapists have to be very smart to begin with, to get all this stuff."* Similarly, another psychologist stated that *"it comes back to having a degree of psychological mindedness, and being able to think in an abstract manner and have a certain level of intellectual functioning, you have to have that."* Other responses noted that the student must have qualities such as *"genuine caring*," a *"capacity to appreciate*," the ability to *"understand other people's feelings*," and, of course, a valuing of the importance of these skills. A psychologist in the study acknowledged that *"some people need to be convinced, by a study or something, that these have been identified as important qualities...so it's about starting where they're at,*

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which may be giving high value to... academic learning, and incorporating that with other qualities."

However, the quality that was most frequently identified as essential to trainability was openness to learning, as one participant stated, *"you have to be open to the teaching, if you think you are god's gift to the world, then you are not trainable."* Participants also described the teachable student as curious, and having the ability to be a *"self-directed learner"* who can seek out appropriate learning experiences. This requires that the student be humble enough to *"really look at themselves,"* and *"view their mistakes as well as their successes."*

Along with voicing their descriptions of the appropriate clinical training student, the self-selection factor was also recognized. One participant acknowledged that *"the helping professions have a tendency to attract people who maybe either have those qualities, or have the potential to develop those qualities....people who are maybe a little more softer [sic]."* In addition, enrolment of the unsuitable student was estimated as an infrequent event due to this self-selection; *"there are some personalities that just aren't trainable, most of them don't even get into this field, and aren't interested in this kind of thing,"* *"some people do wind up in the profession by accident, who maybe haven't selected themselves well for it."*

The Learning of Clinical Skills

Given that the new student possesses a baseline level of the appropriate qualities, and is open and willing to learn these valued skills, what then? Respondents in the study

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were quite open in discussing suitable methods in which they felt they themselves learned these clinical skills, as well as other important considerations.

The experiential way of learning. Most respondents strongly felt that hands-on, real life, experience-based learning was the most appropriate way to develop the interpersonal and personal skills necessary for competence. As one psychologist expressed, *"people who have these qualities build on them through experience, and, as their self-confidence improves."* In fact, the role of internship and practicum experiences within a clinical training programme is to provide this direct, on-the-job learning where students' work can be closely monitored, with consistent feedback from supervisors. One participant commented that:

> You can teach empathy, compassion, from a commitment to an experiential way of learning. We [trainers] have an obligation to create as many of a variety of learning experiences [for trainees], so that they can build some of these skills, and expand their awareness....If you don't use an experiential way of learning, you end up with someone who is technically empathic, but doesn't have the emotionality behind it.

It was also noted that such a learning environment must be safe and supportive for the student, one where they feel comfortable in both getting feedback, and experimenting with new behaviours.

Roles of development and maturity. To complicate the clinical training process even further, some respondents believed that *"many of these things are a function of maturity,"* so that *"[at a] certain point, if they don't have it then, they're never going to*

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have it." Some likened the process to physical development, where students go through distinct developmental stages as a result of real-life experiences and the passage of time. One nurse cautioned that *"most of the 21 year olds that I know, have got, for the most part, little compassion, because developmentally that's not where they're at."* Others softened this view by stating that while different learning does occur/is appropriate at different developmental stages, this process occurs throughout the entire life of the clinician, so that any one stage is no more essential than the rest.

Get therapy. Some participants believed that their own personal therapy played a significant role in their learning of clinical skills.

Personal development. Even if one does not actually undergo the formal process of therapy, many respondents agreed that self-exploration and questioning were essential to learning clinical skills. Experiences through reading, consciousness raising, workshops, and meditation were highly valued. In accordance with this view, a psychologist in the study expressively described clinical training as the process of *"helping [the student] in their personal evolution."*

Role of academia. Of course, respondents also believed that academic training had some potential role in training the interpersonal and personal skills necessary for competency. Course work and readings can at least make the student aware of these qualities, and their importance. Supervised role-playing, modelling, and communication labs were also mentioned as potential learning tools. One psychologist noted that his discipline had a lot to learn in this regard from the para-professionals, like the distress centres, who have developed explicit and intensive "classroom" programmes for teaching

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some of these interpersonal communication skills.

II The State of Clinical Training

Question Four: In Your Own Training, Do You Feel That Enough Attention Was Placed on This Dimension of Competence?

Summary of Findings

In order to get a sense of typical clinical skills training practices, respondents were asked whether they felt that enough attention was placed on the interpersonal and personal dimension of competence in their own training. A minority of respondents indicated that they felt that enough attention was placed on personality and interpersonal skills in the context of their own training programmes. However, these programmes did not generally appear reflective of typical training approaches. Instead, the majority of participants rather vehemently expressed their dissatisfaction with their own training programmes in the teaching and evaluating of clinical skills. Given the diversity of training programmes and backgrounds represented by the participants, it is clear that dissatisfaction with clinical training occurs across discipline, specific training institutions, and historical context of training. Respondents were quite forthcoming and provided additional descriptions of a variety of both negative and positive experiences in their own training. Commonly voiced complaints included limited and ineffective supervision, emphasis on self-report and self-evaluation, too much focus on other areas such as technical skills and research, devaluing and ignoring of clinical and interpersonal skills, harshness of the training approach, and flawed training philosophies.

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Yes, Enough Attention was Placed on It

A minority of the participants felt that enough attention had been placed on clinical skills in their own training. And again, all of these responses were equivocal. A psychologist in the study stated that:

> [Interpersonal skills] was the bulk of one course out of about ten clinical courses, and one of about four required psychotherapy courses. That was clear enough to make the point for me and my colleagues. But, was it directly taught or modelled? Not always. Was it taught in terms of a textbook and course content? Yes.

In addition, a nurse in the study who felt that she had received sufficient training in this area went on to describe her experiences in a rather unique, and perhaps atypical training programme:

> It was done in a very strict fashion. I trained in a small catholic hospital with nuns. Psychiatry was treated with enormous regard, and we went through a very structured clinical education in psychiatry, with examinations and observations before we were given any kind of clinical assignment or allowed to be on the floor in a practical way. We were expected to spend two hours every week going to psychotherapy, it was mandatory in our training. It was a formal requirement of graduation....[the sisters that taught us] were in the forefront of nursing knowledge in psychiatry.

The third participant who responded affirmatively to this question was an individual practising in a psychology department who had received a Master's degree in Counselling Psychology, through the Faculty of Education. She described some of her

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experiences of this programme:

> In the programme, there was a lot of personal feedback, and videotaping, and an openness to recognizing and looking at [the individual student]....We looked at personality type dimensions and there was attention paid to who [*sic*] I was and what I was, and it was always done in a way that never made me feel stupid. It was very open. It wasn't too structured and we could go in many directions.

Unfortunately, these positive descriptions can hardly be considered typical for the average clinical training student today. This was certainly reflected in the present study where the majority of participants fell into the next category.

No, Not Enough Attention was Placed on It

A variety of emphatic negative responses were received when participants were asked about their own training experiences in the interpersonal and personal skills of clinical competency. In two cases, the question was met with laughter! Other responses included *"no, definitely not,"* *"absolutely not,"* *"no attention was placed on it at all,"* *"none was paid,"* *"no, not in my education. They certainly did not, no, they did not really teach this side,"* and *"in terms of the other qualities, such as interpersonal skills, warmth, and empathy, I don't think my training programme did anything for me, or very little."* Even the students in the study who were still undertaking their training reported, *"I don't think that we really do evaluate this in our programme, or if we do, it's very little,"* and *"I think that in our programme, it doesn't really deal with these issues."* Similarly, a psychologist directly involved with clinical training for a number of years stated that

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"most training programmes are notoriously deficient [in this area], it doesn't matter what programme you are looking at."

These assertive responses are quite telling, as they suggest that little has changed in clinical skills training over at least the past 50 years or so. More disturbingly, they imply that this status quo has been maintained despite the perceived importance of these skills and despite the laments of both students and supervisors within these programmes. However, while participants were quite open in voicing their discontent to the researcher, there is no reason to assume that these private laments were ever openly disclosed within the training setting.

Some Positive Training Experiences

In addition to some of the positive comments described in the section "Yes, Enough Attention was Placed on It," other respondents had at least a few positive comments to make about aspects of their training experiences. A social worker and a psychological associate in the study both emphasized the role of supportive supervisors and mentors in facilitating their learning of clinical skills; *"I think that through my supervisor...you discuss these issues as they come up, and you are always willing to look at that,"* and *"as we went along in the programme, you were assigned a research advisor, who, depending on the person, we could meet [more or less] frequently, so it was much more of a mentorship."* Other respondents expressed how certain components of their training were particularly meaningful with respect to learning these skills, a nurse who had returned to school to complete a Master's in Education, noted that it was only in her

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counselling courses, required as part of her degree, where she felt there were real opportunities for learning and feedback concerning interpersonal communication processes. Several clinical psychology students stated that the only place in their programme where interpersonal and personal skills were really focussed on was in their internship placements, mostly occurring in the latter portion of their training years. Finally, another social worker in the study described how she and some of her colleagues took charge of their own clinical training toward the end of their programme:

> I remember in the last days of the programme, some of us were talking about how here we are now in a field placement, kind of thrown into the real professional world, having to interview clients, and it was like 'How do you do this?' So some of us got together with the instructors and developed a course on interpersonal communication skills....We helped develop this, using lots of audio and visual equipment, and doing a lot of role playing and modelling. And that was very, very helpful.

Some Negative Training Experiences (i.e. Complaints)

Echoing statements that have been repeated throughout the results summary, most participants were unhappy with their training in the interpersonal and personal skills required for competency. Again, a diverse range of training programmes, institutional affiliations, and backgrounds were represented by the participants, indicating that such complaints occur across discipline, training institution, and the historical context of training. The many descriptions of these negative experiences are condensed into the

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following primary areas of complaint:

1) Emphasis on self-report. A number of participants in nursing, social work, and psychology remarked that feedback from supervisors was based almost entirely on the naturally biased reporting of the students. A nurse in the study stated that:

> there was...a fair bit of emphasis...on self-evaluation, and, for most of us, this wasn't entirely honest. We tended to evaluate ourselves in a more positive way, with the idea that you had to pass that segment to move on, rather than admitting weaknesses and seeking help.

Another nurse reiterated this statement, *"you may do a...summary of an interview and it will be marked afterwards....But it's your subjective report that someone's critiquing, they don't actually see what you are doing."* Similarly, a social worker stated that *"whether you knew you were empathetic, was strictly your own [judgement],"* while a psychology student said that *"you just show five minutes of your video...and you don't often talk about [or show] the bad stuff, or the scary stuff that happened."*

2) Not enough supervision. Given that most students appear to receive their clinical skills training in supervision rather than academic settings, problems with supervision were emphasized by respondents. Nurses in particular reported that *"there was minimal supervision,"* and *"there is no guidance, unless you happen to be paired up with someone who is more interested in helping new students."* Lack of diversity in supervisors was also noted, and many students felt that their grades were often based on the reporting of only one supervisor.

3) Ineffective supervision. Other complaints centered around ineffectual

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supervision of interpersonal and personal development, most notably because there tends to be an emphasis on what's happening with the client, rather than the therapist, and because *"there tends to be a split between the university and the clinical setting...in the university, the supervisors tend to be quite removed from the clinical setting."*

4) Focus is on other things. Many participants complained that there was little time in their training for interpersonal and personal learning because of the emphasis on other skills or spheres. Nurses in the study reported that *"in clinical work, it was more that there were certain objectives that had to be attained, and those...were often quite task-oriented,"* *"time management was more important than talking,"* and *"they were more worried about how long your skirt was and crap like that."* Other respondents felt that it was the technical and academic side of training that received the most focus, to the neglect of interpersonal and personal skills. As one participant stated *"People will tell you, 'Oh ya, I learned to care about people when I was in my professional training.' Well, I don't think so, because often, it's the technical stuff that gets talked about."*

5) Devaluing/ignoring these skills. Some respondents felt that their programme almost completely ignored the teaching of interpersonal and personal skills; *"part of the difficulty is that these qualities are not often valued in an academic setting,"* *"that was something you weren't supposed to talk about,"* and *"as far as nursing goes, there is a clinical practicum for the skills part, but as far as counselling or mental health...it's 'there you go, go to it.'"* A nurse in the study confessed that the ignoring of this dimension was sometimes the fault of the students as well, *"I think in some cases we didn't even really realize that some of those things are important."* Whether this was a

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pre-existing belief, or one cultivated by the programme is hard to tell.

6) Harshness of training. From the discipline of psychology came these complaints:

> training was brutal...some seem to have these ideas of almost rites of passage, that the person has to be reduced to nothing, then built up, like the marines...it just creates so much unnecessary distress. It takes people off on unproductive detours, it creates anxiety, and gets in the way of learning [these kind of] skills.

and:

> I think a lot of the training programmes are so inhumane. They treat people so much like robots, who have to perform constantly, that they provide little space for personal development. It could actually damage some of the qualities that make someone a good therapist, like warmth, advanced empathy, creativity. It took me about two years after I finished my doctorate to shed most of the brainwashing I got there.

7) Faulty philosophies. A nurse in the study complained that sometimes what you expect to see based on the description of a programme doesn't necessarily filter down into what you get. She noted that while nursing places a lot of emphasis on the "holistic" perspective, that didn't really occur in her experience of training. A psychologist in the study, who had recently graduated, bleakly asserted that

> I think a big part of the problem is at the level of the professions upon which training programmes are based. There are a lot of things wrong with psychiatry, psychology, counselling, and social work, a lot of the problems stem from the fact

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> that these disciplines are often motivated not by a desire to produce good therapists, but to produce people who fit into a mould that is fundamentally faulty....I'm saying that what really makes a really good therapist, most of these professions can't produce based on their current definitions of competency-their conceptual validity is low.

The intensity and frequency of these complaints are unsettling, and sound alarm bells that something is very wrong with the state of clinical training in the various clinical professions. Potential solutions can be hypothesized based on these complaints, and gratefully, participants in the study also provided many explicit suggestions and recommendations concerning ways to improve the future of clinical skills training. These will be reviewed next.

III Future Training Recommendations

Question Five: If There Was a Way of Measuring Performance With Respect to These Qualities and Skills, How Do You Feel Such a Tool Might Best be Used in the Training of Clinicians?

Summary of Findings

Participants in the study were asked how a hypothetical clinical skills assessment tool (i.e. not the specific CSAT to be discussed later) might best be used in clinical training. In addition, they were specifically asked how they felt about using such a tool in

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the screening and/or continued evaluation of clinical graduate students. Mixed opinions were articulated with respect to whether or not a tool assessing interpersonal and personality skills should be used in the process of deciding whether or not to accept a student into a clinical programme. Respondents were generally uncomfortable with the idea of utterly denying a student the "right" to potentially develop in a programme based on one-time results of a nebulous and subjective tool. Participants were much more comfortable with using such a tool in the process of continued evaluation throughout the course of a student's training. It was underscored that such a tool be used positively to promote growth and development, particularly within the context of a healthy supervisory relationship.

Screening

Participants' attitudes were mixed concerning the rather controversial topic of applicant screening based on interpersonal and personal skills. All respondents agreed that some level of screening already occurs in clinical training programmes, incorporating both academic and interpersonal components. Current screening procedures typically involve an initial evaluation based on a perusal of the student's academic record, curriculum vitae, reference letters, and application essays, and then a final evaluation based on a telephone or in-person interview. While interpersonal and personal qualities are not directly screened for, they are obviously implicitly assessed during the interview. The in-person interview was seen as the best available method of screening because "*what people are on paper isn't necessarily what they are in person.*"

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Many participants were fairly comfortable with this current level of screening, as indicated by comments such as *"I don't think we are training a lot of dangerous people. I think they have been 'picked off'*," and "*generally speaking, training programmes do a pretty good job so far in weeding out [inappropriate students].*" Nevertheless, respondents acknowledged that on occasion, inappropriate students do end up in a clinical programme, leaving room for some level of screening improvement; "*Most people seem to be okay. It's just the...individual cases that freak everyone out. There are fewer and fewer of them, but they stand out. Faculty know, students know, internship directors know.*" Thus, early screening would avoid the difficult problem of having to "*kick out*" these individuals years into a programme. Unfortunately, the predictive validity of current screening procedures, including the interview, has not been clearly established (King et al., 1986).

A few participants considered screening a fundamental concern, "*I mean, this is an important task...and you want to make sure the person is suitable to the task*," and felt that it needed to occur at a "*higher level*," or "*more formally*" than it currently is. Thus, while many respondents concurred with the philosophy behind the use of screening instruments, for example "*training programmes should require exceptional individuals on the...emotional and interpersonal fronts....If a screening tool exists that could help [in selecting those individuals], I would be all for it*," there was an unwillingness on the part of respondents to decisively approve of the use of some kind of screening method, unless the researcher presented it as an idealistically "flawless" instrument.

In the use of this "flawless" instrument for screening candidates, many cautions

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and provisos were nevertheless articulated. Some participants were concerned about how such a tool could be administered with the least bias; by self-report, interviewer, and/or by a rater. Many participants commented that the interview process is significantly anxiety-provoking in and of itself and as such, assessments based on it would not reflect the student's normal level of functioning. Others were comfortable with screening, as long as it was not the foremost method of evaluation and was viewed on par with other procedures, or that the incompetencies in the interpersonal evaluation were strikingly obvious, and "*very, very serious.*" One respondent asserted that the telephone interview should not even be an option in the screening process and that face-to-face interactions were essential. Two participants felt that screening should be used simply to acquire a student's baseline level of interpersonal ability, given that *"people will grow exponentially as they go through a programme.*" Four participants noted the potential civil, ethical, and legal issues in eliminating individuals based on their personality.

The most frequent cautions concerning screening centered around the need for more research into what exactly to screen for. It was noted that more information was needed concerning *"what kind of person would make for a good therapist*" and how to access that information effectively. Some participants were comfortable with screening for specific qualities whose validity as indicators of competency was more obvious. Such qualities included "*the potential for learning*," interest in learning, *"ability to be insightful, reflective, or psychologically minded*," "*receptivity to feedback*," "*motivation for being in the profession*," and "*good boundaries*." Nevertheless, these participants noted that they were unsure how such qualities could be measured.

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On the other hand, many respondents were quite adamantly against the use of interpersonal and personality measures in screening applicants. Some of these respondents described simply feeling "*uncomfortable with*," "*leery*," and "*scared*" of such screening. Some participants underscored the need for diversity in students and practitioners, expressing that "*to have cookie-cutter therapists is not a good idea. If you screen, you're starting to cut the cookie. You load everything in the front end and get a certain type of person or personality.*" It was felt by most respondents that there was "*room for a lot of different kinds of personalities*" in clinical work, given that different clinicians are likely to match with different clients. The need to "*assume until proven otherwise that somebody is motivated to do the best job they can, and be the most excellent practitioner that they can*" was also expressed. As one nurse noted, "*I don't think anyone should be precluded from [at least] having an opportunity to develop the [necessary] skills.*"

Evaluation Along the Way

While responses to proposed screening were mixed, every participant in the study agreed that there should be more explicit assessment and evaluation of interpersonal and personal skills throughout an individual's training. Participants advised that such a tool should be viewed constructively, as a developmental and goal-setting tool, and not as a means of punishment. It was expressed that students are evaluated enough without adding the additional pressure of, "*Oh my gosh, my personality is going to be evaluated!*" Thus, the focus of the evaluation should be on noting *both* strengths and weaknesses in

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the individual's interpersonal and personal skills, with the aim of making recommendations for improvement.

As a method of ongoing evaluation, an assessment tool was viewed by participants as being of considerable potential value in the supervisory relationship. In this context it might be used to promote discussions concerning the necessary clinical skills, assessing baseline skill levels, setting corresponding goals for development, and monitoring progress. Many respondents also described the potential use of such an instrument as a *"personal growth tool,"* sparking a "*valuable and insightful process*" of self-introspection in both students and supervisors.

Once again, respondents were careful to provide some precautions and considerations in using such an instrument to monitor trainee development within the course of a clinical training programme. From the supervisor's perspective, it was considered important to formally document these sorts of clinical evaluations and include them in the student's file. However, students in the study cautioned that it was essential that they "*got a chance to see it, to sit and talk about it, and to 'sign off' on it*" before anything went into their file, so that the procedure didn't occur "*behind their back.*" Another student in the study was completely uncomfortable with the idea of placing this information in his file, and felt that he would like to use it more as "*feedback for myself, more informally.*" Hence, such a document might be included in a student's file only if student and supervisor agree on its content or if contentions on the part of the student are also carefully noted and included. Similarly, concerns were raised by both students and supervisors concerning the need for some kind of third-party resolution mechanism if

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such disagreements occur. A psychologist in the study commented on the importance of the quality of what is documented, stating that *"You can place things in a person's file, but with a positive focus, with recommendations, and saying what areas the student was okay in, as well as what they were weak in."* Another clinical supervisor in the study who felt documentation was important, cautioned that, "*it shouldn't be written down before it's talked about [with the student]. Nothing that is written down should come as any surprise to a student that is being evaluated....You don't want to hit them with a hammer.*"

Other repeatedly cited cautions concerned the need to get feedback from more than one supervisor, including "*several people who are measurably different in how they approach their work.*" As a nurse in the study noted, "*the danger is that...[one] supervisor's view of what makes somebody human or compassionate may not necessarily be the world view.*" Both students and supervisors in the study felt that convergence of opinion from a variety of supervisors was essential, specifically in the context of potentially using such evaluations to remove a student from a programme. Respondent statements reflecting this concern included; "*you are at the mercy of someone who may...not be very good, who may have biases, they may have favourites*," "*[the supervisor] might have a particular grudge or something*," and "*the most important criteria is that it has to be someone you respect doing [the evaluation].*" Overall, respondents were generally concerned about the subjectivity of such evaluations, and hence their potential misuse as an ostensibly legitimate means of "*getting rid of someone*" that a particular supervisor just doesn't like.

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Question Six: What are the Roles and Responsibilities of the Supervisor in Best Implementing Such a Tool?

Summary of Findings

Participants in the study agreed that supervisors have the considerable responsibility of recognizing and responding to problems in their students as efficiently and effectively as possible. The difficulty of giving negative feedback to students concerning their interpersonal skills and personality was recognized by all participants. The importance of utilizing essential clinical skills in providing such feedback in a supportive and therapeutic manner was noted. Confidentiality, normalization of the long-term process of training, concreteness, and a constructive focus were also described as key in facilitating the student's acceptance of such feedback. Respondents also delineated some of the factors conducive to promoting growth in weak areas, such as linking students with mentors, providing abundant opportunities for practice, assigning appropriate clients, providing relevant readings, and encouraging personal therapy. In responding to intractable incompetence, respondents favoured re-directing students into non-clinical areas of their discipline, rather than kicking them out of a programme. Finally, participants went on to make a variety of recommendations for clinical training in order to prevent and manage such problems.

Responding to Failure

If we use an assessment tool to measure interpersonal and personal skills, supervisors and trainers must be prepared to deal with those students who are found to be

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unsatisfactory, defective, deficient, mediocre, lacking, or even incompetent in some of these dimensions. This task presents its own unique challenges and concerns for both clinical supervisor and student. As one psychologist and clinical training supervisor noted, *"I don't think we are really trained very well about that. It's easy to be able to respond to success, to recognize it, and encourage it. And with failure, it's a different story."* Not surprisingly, many participants in the present study acknowledged having had to face incidents of the incompetent or deficient student in their supervisory careers, without any real departmental guidelines. A faculty psychologist in the study acknowledged that while there was *"no written policy in this programme,... there is a sort of implicit process.... [where] a few of us will meet with the person and recommend some remediation, sometimes off campus, and then a following up and monitoring of that."* Another psychologist added that she and her colleagues had to come up with an impromptu plan of action for dealing with a student who was having serious difficulties in an assessment course. Thus, while such instances obviously have occurred and continue to occur, there seems to have nonetheless been little movement toward formalizing programme procedures for dealing with such students. Unfortunately, the burden is most often left to the individual supervisor to quickly come up with something when such situations inevitably occur.

The majority of participants in the study were involved in supervisory roles in clinical training, while only four participants defined themselves purely as clinical students. Thus, much of the information garnered in the study concerning what to do about interpersonal and personal weaknesses came from the perspective of the supervisor.

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Participants clearly expressed that it is the supervisor's job and responsibility to "*help [students] recognize their areas that need improvement.....and to recognize [serious problems]...and bring [them] to the forefront, without damaging a person or being overly critical.*" Participants also felt that the first action that supervisors should take when a problem is noted is to express their concern and their observations to the student. One student in the study placed particular emphasis on this step due to her concern that the evaluation process not be conducted *"behind the person's back."* The supervisor must then offer concrete suggestions and guidance regarding how improvements can be made, as well as carefully monitoring the student's progress thereafter. Tracking of student progress is essential and must be carried out in an explicit and formal manner, including thorough review of audio and videotapes, session notes, and behaviour in supervision. In addition, two participants emphasized that the student also has responsibilities to "*find their own solution, so that the supervisor is then...a mentor for these avenues of discovery around that solution,"* and to *"find some way of evaluating how they [themselves] are doing."*

If sufficient improvements do not occur over time, participants commented that the supervisor should then discuss the student's difficulties with the other supervisors involved in his/her training. Respondents felt that there must be ample converging evidence from various supervisors before a student is declared "incompetent," as difficulties in one situation and not another might be "*more a statement about the relationship between yourself [the supervisor] and the student*," rather than the student's ability. Thus, a supervisors' training conference should be held in which evidence for

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and/or against the concerns might be discussed and documented. One participant expressly noted that dealing with student problems must be a "*shared responsibility, and [not] end up falling to only one [supervisor] to say 'You know, here's an area that's really missing'....The student should also get the message [from all supervisors] that what is missing is something important.*"

The heavy burden of this onerous supervisory responsibility was recognized by most respondents. Some participants diminished this heaviness by reflecting that, *"there is a sort of self-corrective mechanism as we move along. Say if the person is in private practice, my belief is that if they aren't effective with people, people won't come and see them.*" Understandably, clinical trainers want to believe that if they don't necessarily catch something, it's okay, because someone else will later down the line.

How Should a Supervisor Give This Kind of Feedback to a Student

Just as supervisors in the study were concerned about their burden in being responsible for making such decisions, they were also concerned about the burden of sharing potentially threatening feedback with clinical students. Students in a clinical training programme expect to be given feedback pertaining to their clinical performance, but criticisms concerning potentially unchangeable personality and interpersonal skills are understandably hard to hear. Some participants consoled themselves by suggesting that, "*If things are not going well, they [the student] usually knows. They are relieved to acknowledge that it isn't working, that '[I am] not having a good time, please help me.'*," and "*If it is painfully obvious to teachers, supervisors, that this person cannot do it, I also*

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think in my gut that it is also very obvious to the student, and they are just waiting for the other shoe to fall." Student self- awareness or not, participants acknowledged the importance of tact and sensitivity in giving such feedback to students, and made several recommendations as to how to approach this challenging task.

One-on-one feedback. Initially, any concerns should be shared exclusively with the student, before any other individuals are informed. Participants felt it was important that such concerns be shared in a "*private*," "*confidential*," and "*personal*" atmosphere.

Student defensiveness. Many respondents reported that "*every student thinks they are doing what they are doing perfectly*," and that "*anybody, faced with [this] kind of criticism, would be very very defensive.*" A student in the study expressed that "*It's really hard not to be defensive, because it is so subjective, that someone could arbitrarily use that to kick you out.*" Therefore, "*for some of these folks, you need to create a very specific kind of climate in order for them to hear the message, or be able to look at who they are.*"

Climate of feedback. Respondents reported that this kind of feedback should be given "*very carefully, with a lot of support*," "*in a kind and generous manner*," "*as non-threatening and nonjudgemental as possible*," "*with empathy, respect, concern, and honesty*," "*with compassion*," and "*with patience*." In essence, a "*kind of therapeutic conversation*" should occur, utilizing the very interpersonal skills identified as essential in clinical practice. The role of a delicate approach was noted as key not only in reducing the emotional impact of the feedback, but also in generating some "*buy-in*" from the student with the problem. The more supported, understood, and respected the student

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(*client*) feels, the more likely they are to absorb the feedback (*interpretations*).

Similarly, some respondents highlighted the more general importance of positive supervisory relationships in effective clinical training. One psychologist stressed that "*a spirit of trust and respect between students and supervisors*" was essential for supervision to be effectively used as a place for honest self-exploration. He added that "*students should not be made to feel like showing vulnerability [in supervision] is automatically dangerous to them, even though ultimately, it may be.*" Another supervisor cautioned that "*issues of power too often play into... [supervisory] situations...that are often very hierarchical. And the [students] are getting crushed.*" If the supervisory climate is hostile or intimidating in and of itself, feedback of any kind is unlikely to be heard or respected.

Monitor initial reactions. Six respondents noted the importance of initial reaction in formulating later recommendations. One psychology student stated that "*If they don't seem to care, well then you have to be very stringent, and move further, much faster...and explore that more with them.*" A supervisor in a clinical setting felt that the individual's receptivity to feedback was critical, "*because it's hard to fix something that you don't acknowledge.*" Her colleague also expressed her expectation that a student in a clinical area must have "*a little bit of insight and willingness to go there with me. Because if you don't have that psychological mindedness, well then what are you doing here?*" A related issue concerns whether or not the student is at all aware of their own difficulties, and can agree with the feedback. Obviously, the more honest self-awareness the student has, the more "remediable" they are.

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Why is the student having this problem? An exploration of possible reasons why the student is having these difficulties should also occur. Students must be looked at holistically, and their overall situation should be explored; "*what's going on in that student's life? Are they genuinely lacking in these interpersonal qualities, or is there some other reason that now in their life, they are not able to demonstrate them.*" It was stated by participants that there may be many other potential factors, such as emotional, financial, or interpersonal stress, that are temporarily impeding the student's clinical ability. Recommendations for change will then depend upon whether the problem is due to these temporary factors (state) or to something more permanently embedded within the student (trait).

Wording the feedback. Several strategies were recommended in framing this kind of feedback. First of all, it was suggested that feedback would be more non-threatening "*if you first of all focus on the positive things that they do, outline the good things, and then introduce areas of improvement.*" Positive and negative aspects should be balanced as much as possible, as it is the strengths that provide the foundation for building upon. This is particularly true for insecure early trainees who seem to lose all ability to hear anything, when given the smallest amount of what they perceive as negative feedback. More generally, the feedback and the training should be presented as a long-term learning process, such that "*nobody is born a therapist.*" Similarly, the feedback should be normalized as much as possible, with the message that *"this is normal stuff, we all go through this sooner or later.*"

The feedback must be given as concretely as possible, which is often difficult to

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do given the nature of these skills. But if possible, specific examples should be provided, including specific segments of audio or video tape, role-plays, etc. where the deficiency was evident. The student must clearly understand what it is they are doing incorrectly, and what it is they are being asked to change, because, as one nurse stated, "*it might not be the whole skill that they are not performing up to par...maybe it's just a certain component or two.*" Finally, it was also emphasized that the supervisor needs to speak "*frankly*," "*directly*," and "*assertively*" with the student, in order to impart the importance and seriousness of the feedback.

What Specific Recommendations and Suggestions Should be Given to the "Unsatisfactory" Student

Participants in the present study described a number of potential remedial recommendations that might be appropriate for the troubled student.

1. Provide the student with a list of appropriate references and literature relevant to the particular difficulty they are experiencing; "*We can expose them [the student] to different kinds of literature around the kinds of things that work in terms of the therapist-client relationship.*"

2. Provide opportunities for practice outside of the therapy setting, such as specific communication labs where they might practice with peers.

3. Link the student with a specific mentor, peer, or supervisor who is able to demonstrate and teach the desired qualities effectively.

4. Assign clients based on their relevance to the student's skill training needs.

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One psychologist felt that at times, depending on the nature of the deficit, it may be more appropriate to restrict the student's access to clients until some improvement has been demonstrated in other settings.

5. Provide more opportunities where the student can directly observe appropriate modelling of skills by supervisors and other peers. As a nurse in the study stated, "*I think role modelling is very important - to be able to identify clinicians that demonstrate these particular qualities, and have others observe and interact with them as a way of acquiring or learning these qualities.*"

6. Recommend personal therapy. Many participants noted that students' difficulties in therapy are frequently related to personal issues and problems. Therefore, personal therapy aimed at addressing these difficulties will likely improve clinical performance. The impact of personal baggage is most obviously seen in problematic countertransference reactions where the student's psychological needs enter into the therapeutic situation. Most participants stated that the more general promotion of self-awareness through therapy was essential for all clinical students. This view was expressed in the comments of a psychologist in the study who expressed that:

> I used to recommend that everybody have the therapy experience, being on the other side, it's a very valuable experience. Being the recipient of therapy makes you appreciate what it is about, what it is you are trying to do, what it's like, what your impact is. And it certainly cues you into what your issues are, your biases. It cues you into your internal dialogue big time.

While some participants suggested that such individual work might safely occur within

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the context of the supervisory relationship, most felt that such personal work was inappropriate in the training context and should occur outside of the academic setting. Participants acknowledged that recommendations for personal therapy are *"hard to say to a person, and even harder for them to hear."* The receptivity of the student to such suggestions is dependent upon a variety of factors, including the quality of the supervisory relationship, as well as the student's existing level of self-awareness.

It was vehemently noted by most participants that the student must be given *every possible opportunity* to change before any further steps are taken. As one nurse expressed it, *"All those areas have to be exhausted before a decision is made that the person just can't cut it."* Similarly, another nurse commented that, *"as a last, drastic measure, if the person doesn't value these qualities [and] is not prepared to work at developing them, then perhaps [they need to question] have they chosen the right field."*

Responses to the Incompetent Student

"And if that whole process goes on over time, and someone clearly continues to be not a good fit for the counselling role, then...that needs to be dealt with."

"If there's some really inappropriate behaviour, you have to act on it, we have a responsibility."

"There is a moral and ethical obligation there, [to do something]."

"....then...somebody has to make a decision, one way or another."

"...at some point, there has to be a point of no return."

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Participants in the study identified two basic responses to the student who has been given every opportunity to change and a sufficient amount of time to change but continues to demonstrate incompetent clinical skills. Respondents were generally reluctant to even contemplate that such a situation might occur and were emphatic that such serious measures were only to be considered as a last resort.

Counsel the student into another area. The option of attempting to redirect the student into a non-clinical area of the profession was favoured by most participants. Understandably, respondents were reluctant to place themselves in the untenable professional position of having "given up" on another individual's capacity to change. As one psychologist noted, "*It's a really tough situation, because that's almost like giving up on people, it's like saying that we can't really change this, and I think that we can.*" Similarly, several respondents stated that dismissal from a programme was simply unethical and illegal, because "*if you let them in, you can't kick them out*," particularly if the student is successful in other non-clinical areas of training. Instead, the more ethical and philosophically acceptable option is to redirect the student into a non-clinical area of the profession, as one psychologist noted, "*the field is quite wide, and because someone can't do some things very well, doesn't mean they won't be able to do other things very well.*"

Unfortunately, redirecting a potentially bewildered and defensive student toward an alternate non-clinical career path is not that easy a task. Again, respondents described the necessity for a kind of therapeutic conversation in which the student is gently "*helped to see*" that this area may not be right for them. Empathy, warmth, focus on strengths, and

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other therapeutic qualities were again seen as essential in facilitating such a difficult discussion. As one psychologist said, "*I try to personalize it, to say, 'This doesn't seem to be working out for you. What is it that you like, because I don't think you are liking this too much?'*" Similarly, another psychologist suggested the use of gentle and tentative phrases such as, "*Is this really working out for you?*," and "*Would you feel more comfortable in another area?*"

While counselling the student into a non-clinical area may be the favoured option on philosophical and ethical grounds, it nonetheless presents considerable personal and professional challenges to the unfortunate individual/s deemed responsible for this delicate task. Interestingly, none of the respondents in the present study entertained the possibility of the student's refusal to consider this an option. Again, participants soothed themselves with the tacit belief that the student must know that they are not cutting it and will therefore feel nothing but grateful relief in having such a conversation with their supervisor.

Kick them out. Few respondents emphatically supported the idea of dismissing an incompetent student from a profession. Some of the more impassioned pro-dismissal responses included, "*Yes! Yes! Yes! A person should be kicked out!*," and "*Yes, there are some people who should not be in this profession!*" Interestingly, while participants were somewhat squeamish about supporting kicking out incompetent students, they were quite ardent about their responsibility to protect the public from incompetent professionals. As one psychologist stated, "*You owe it to the public and to your profession. To pass someone who is not good is irresponsible.*"

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Respondents identified a number of necessary conditions for kicking a student out of a programme for incompetency in their personal and interpersonal skills. These conditions may be summarized under the three following dimensions:

1. Attitude toward their difficulties. The student *"does not value"* these qualities; they lack insight and *"think they are doing great"*; they are *"not prepared to continue to work on improving"* these skills; they are *"not receptive to getting help [for personal problems]"*

2. Quality of their difficulties. Students with *"the personal type problems that are so obvious that it interferes"*; there is *"just not a good fit between the person's motivations, goals, and what they are doing in the therapy,"* they are *"in it for their own reasons"*; they *"lack awareness of their limits"*; they are *"predatory [and they] exploit very vulnerable people"*; they are *"determined to be a threat to the people that they are supposed to be helping,"* they have *"ethical problems or issues,"* or *"it's some really crux thing."*

3. Quantity of their difficulties. Students with *"a number of problems"* that are each nocuous to their competent clinical functioning.

Most participants asserted that the need to take the drastic measure of kicking or counselling a student out of a programme for interpersonal or personal difficulties was a rare occurrence. Unfortunately, as the participants also previously affirmed, the apparent infrequency of having to face such an extreme task is seemingly being used by clinical programmes to justify their continued neglect of this essential dimension in the more general process of student development and training.

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Additional Recommendations for Future Clinical Training

Participants in the present study were generous in providing a number of additional recommendations for improving the state of clinical training. These comments were provided over and above those relevant to the central focus of the present study, the personal qualities and interpersonal skills necessary for clinical competence.

1. Clinical disciplines must openly recognize and value these kinds of non-technical, non-knowledge-based skills. Almost all respondents in the present study reported that there was little attention paid to the teaching of clinical skills in their training programmes, essentially sending the message to students that these skills were unimportant. Therefore, many participants felt that a fundamental shift in training philosophy was essential to truly integrating the teaching and evaluating of interpersonal and personal skills into any clinical programme. As a student in the study expressed, in addition to paying more attention to these skills in the process of clinical evaluation, "*the programme would have to be geared around these qualities, too.*" Similarly, a nurse in the study commented that there "*needs to be a stronger encouragement to develop these qualities that are now called the 'softer side' of the business.*" She went on to add that "*there should be mandatory philosophy, ethics, music appreciation, and art history courses....[as well as looking at] spiritual issues...[all of which] are a nice lead-in to self-reflection, and the creation of a more well-rounded person.*" If students do not actively receive the message that these skills are important, they may passively believe that they are not. As a psychologist in the study stated, "*It is important to be making clear statements about what you regard as important, and [the trainee's] responsibility to*

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provide those things."

2. *Training programmes must validate and encourage self-development and personal growth.* Similarly, respondents in the present study described training as the process of *"learning who you are,"* and noted that programmes must actively support the student's quest for "*self-work in different forms.*" However, the amenability of the heavily scientist focussed "scientist-practitioner" model of clinical training to a positive, supportive, and enabling attitude toward self-development and personal growth in clinical training is dubious. Nevertheless, participants in the present study universally valued activities such as personal therapy, small-group student-led therapy, self-exploration, consciousness-raising, encounter workshops, and meditation in the learning of the interpersonal and personal dimensions of competence.

3. *Students need to get as much practical clinical experience as possible.* Participants acknowledged that the most effective means of teaching skills in this area of competence was experiential-based learning. As a nurse in the study noted, *"We [trainers] have an obligation to create as many of a variety of learning experiences as possible.*" The applicability of knowledge-based book learning was seen as limited in teaching skills that can ultimately only be demonstrated and evaluated in an interpersonal setting. As such, clinical practicum and internship experiences should be given more weight and more time within the course of a training programme. This may be contrasted to the generous amount of time allotted for theses and other research activities, which arguably have little direct influence in post-graduate clinical performance. Unfortunately, if the controversy surrounding the creation of the Doctorate of Psychology degree (a

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doctorate focussing on clinical practice, with limited emphasis on research) is any indication, this shift in focus to a more practice-oriented training approach seems to represent to some a villainous threat to the very foundations of the discipline. Years have been spent debating the best orientation for clinical training, and, if anything, adherence to the scientist-practitioner model has become even more uncompromising in the ferocious battle for legitimacy and niche-carving in the current health care system.

4. *Students need to get as much clinical supervision as possible.* Given that these skills are most obviously demonstrated in the clinical setting, supervision can and should play a pivotal role in defining, discussing, exploring, and teaching these skills to students. Similarly, given the intimately personal nature of these skills, the supervision setting can provide the most appropriately protected and supportive training relationship in which to explore these skills, outside of personal therapy. Respondents in the study lamented their lack of supervision time during their own training, as well as the ineffectiveness of many of their supervisory relationships.

5. *Students need to get as much good clinical supervision as possible.* Interestingly, despite the apparently critical importance of supervision in effective training, little effort has traditionally been made within the academic setting to directly train supervisors in this serious task. Respondents in the present study identified some important considerations in effective supervision. A nurse noted that since self-reflection is obviously critical in evaluating interpersonal and personal skills, supervisors must also be comfortable working within this dimension. Supervision was described by most as a cocoon-like space where genuine interactions were critical, and two-way discussions of

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personal values and beliefs were most facilitative to openness and receptivity. Participants also acknowledged the importance of the supervisor's using more direct methods of evaluating student clinical performance such as thorough review of audio or videotapes and direct observation, rather than relying on student self-reports which are naturally positively biased. Participants also commented on the need for a balanced emphasis in supervision on both the client issues, dynamics, and difficulties, as well as those of the trainees. Finally, comments were also made concerning the appropriateness of utilizing faculty as supervisors, if they are not actively involved in clinical practice.

6. *Academic training should be used to make students aware of ALL the various skills required for competence and their importance.* Participants in the study did not entirely dismiss the role of books and courses in teaching personal and interpersonal skills. Classroom learning tools such as supervised role-playing, modelling, and communication labs, typically used by para-professionals, may also be effectively used.

7. *Training programmes should be more hospitable.* Again, the constructiveness of the philosophy of clinical training as a place where students are to be emotionally and physically broken by a never-ending sequence of academic-performance demands was challenged by several participants. Indeed, participants remarked that such training creates unnecessary distress and anxiety for students that ultimately gets in the way of their learning the very personal and interpersonal skills necessary for clinical competence. Just as a client is unlikely to learn empathy and warmth toward self and others in a therapeutic climate characterized by anxiety, excessive demand, and constant threat of failure, so is a student. While the clinical training environment is not and should not be

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akin to a therapeutic environment, programmes need to monitor the balance of tension and support they are creating for their students. When reflecting upon their own training, positive comments made by participants most often related to their sense of being supported by their programme, feeling that their trainers were open to working with their own unique strengths as well as recognizing their weaknesses, and that such a warm and cooperative climate allowed them to remain open to feedback. As a nurse in the study eloquently stated, "*There has to be a warmer climate for students. A sort of constant environment that promotes growth, like a hot house.*"

8. Procedures concerning the student who is having difficulties in this area need to be formalized. Participants in the present study repeatedly cautioned that the evaluation of interpersonal and personal competence must be a normalized, fully disclosed, and expected aspect of a training programme. Thus, students should be introduced to a tool such as the CSAT (described below) and it's uses as early into their programmes as possible. Similarly, just as they should be made aware of the use of the tool as an indicator of their personal growth within this important dimension of competence, they must also be made aware of the progression of steps that will be taken to address any difficulties within these dimensions. The sequence of next-step procedures identified in the present study included: a one-on-one discussion with the student concerning their difficulties within the context of a positive supervisory relationship; identification of concrete remedial steps to be taken to improve performance (provide appropriate readings, opportunities to practice with peers or observe others who demonstrate the skills, linking with a mentor who can train the specific skills, recommending personal

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therapy); formal identification of an expected time-line for improvement, described by some as a discrete period of "*probation*"; and formal discussion of steps that will be taken if no improvement is forthcoming.

9. Procedures concerning the student who is deemed interpersonally and/or personally incompetent for clinical practice need to be formalized. Again, it is essential that such a process of evaluation be fully disclosed to students with nothing occurring unexpectedly or surreptitiously. Thus, if difficulties in this dimension continue beyond the agreed-upon time frame for improvement, students must be aware of the procedures that may follow. Participants in the present study suggested that the first step to be taken should be a supervisors' conference where different individuals directly involved in the student's training, as well as the student and perhaps other representatives of the faculty and graduate student body, meet to discuss the situation and determine what steps should be taken. These steps might include the extending of additional remedial measures or a determination that the student be advised to look into entering another area of his or her discipline.

More generally, all participants in the study agreed that full-disclosure of the expectations for students within the interpersonal and personal dimension of competency, the procedures for addressing difficulties, and the procedures for addressing incompetence be formally outlined and provided to students as soon as they begin their clinical training.

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The Clinical Skills Appraisal Tool: A Proposed Instrument for Assessing Personality and Interpersonal Skills

The results of the present study indicate that many agreed-upon interpersonal and personal skills play a pivotal, if not primary, role in determining competency in the clinical professions. In addition, the participants in the study repeatedly expressed their dissatisfaction with the lack of focussed inclusion and evaluation of these skills in their own clinical training. As such, some way to assess, explore, and discuss these skills would likely be substantially beneficial in the training of competent therapists. In the words of one psychologist in the study, "*this area [clinical work], has a whole different layer that we have no way to measure, or even to talk about. And yet, we are responsible for that, and students are working on it with their clients.*"

Two main guiding principles based on the results of this investigation were used in the development of a skills appraisal tool: the tool should include the abilities identified by participants as essential skills for clinical competence; and the tool should be primarily qualitative and discussion-provoking, while still allowing for distinctions to be made between competent and incompetent behaviour.

To maintain specificity, it was deemed important to include both the individual skills and the relationship of these skills to the five underlying dimensions in the tool. This allows for dimensional generalization but does not preclude the identification of more specific areas of weakness. Thus, students and supervisors are able to more manageably summarize baseline performance levels and set goals based on the five underlying dimensions, rather than for each of the separate clinical skills. A summary of

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the 49 skills and their relationship to each of the five underlying dimensions is provided in Table 5 on page 126.

In order to ensure as much definitional consistency between supervisor and supervisee as possible, a manual, summarizing the key definitional points provided by the participants, is also included (see Appendix B). Definitions of the 49 skills as well as the five dimensions are provided. The manual is intended to facilitate the development of a shared understanding of each of these skills between the trainer and trainee. Nevertheless, given the essentially qualitative nature of this tool and these skills, some definitional negotiation between parties is anticipated.

Finally, the question of the "scoring" of the tool was contemplated. Three factors were considered; firstly, given that the "level of competence" is less important on such a tool than the competence/incompetence distinction, the scoring options should be kept to a minimum; secondly, given voiced concerns regarding the importance of including positive comments in providing feedback on such a potentially threatening measure, some indicator of "exceptional" performance should be included; and finally, for the purposes of trainee development, a qualitative means of summarizing responses and setting goals should also be included. The result was the creation of a scoring system with three anchor points; unsatisfactory [*incompetent]* (U), satisfactory [*competent]* (S), and exceptional (E). In addition, an area in which to summarize total scores, goals, and means of achieving those goals in each dimension was also included. It should be noted that the possibility of an "Exceptional" score simply provides a way of making such a tool more palatable and innocuous for students. Attaining "Exceptional" scores on all of these

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skills is neither expected nor even considered plausible. As one participant noted, to be exceptional on all of these skills would imply an idealized level of self-actualization that simply does not exist in the real world. Students should be made aware of this and informed that they are simply expected to achieve competence in this domain, rather than to become icons of fulfilled human potentiality.

Similarly, "competence" in the tool is explicitly defined as performance that is equivalent to that expected by an individual in the student's level of training. Thus, students are reassured that they are not expected to be competent in all of the skills as they begin their training, but that a competent(i.e. satisfactory) level of performance is expected in all of the skills by the *end* of their training.

See Appendix B for the visual presentation of the finalized Clinical Skills Appraisal Tool (CSAT).

General Summary of Results

The purpose of the present study was to explore, in a comprehensive manner, what various individuals involved in the human service professions mean by the terms "clinical" or "non-academic" in/competence. Furthermore, perceptions and experiences concerning the training of these skills were also explored. It is the view of the researcher that these skills represent the most important dimension in defining competence and that past and present training programmes have conspicuously avoided both assessing and training these skills in a systematic manner.

The results of the present study suggest that there is meaningful agreement among

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various clinical professions concerning the characterization, nature, and importance of these skills, and that serious deficiencies have existed and continue to exist in the clinical training and evaluation of these interpersonal and personal skills. The main results of the present study indicate that there is considerable consensus among a varied range of individuals involved in the clinical professions, including practitioners, faculty, students, and clients, that interpersonal and personal skills play an essential role in defining a clinician's level of competence. Moreover, there is considerable agreement among these individuals as to what these specific essential interpersonal and personal skills are and how they might be most effectively trained. A total of 55 of these clinical skills were thoughtfully delineated by the participants. These skills represent a range of clinical functioning and included such skills as empathy, warmth, comfort with intensity, creativity, maturity, humility, self-awareness, and commitment to ongoing learning.

The qualitative descriptions provided by the participants representing each skill were further used to create a model which summarizes the five underlying dimensions necessary for clinical competence. In this model, *Alliance-specific skills* refer to those skills specific to and essential for the process of building an effective therapeutic relationship, including empathy, warmth, and genuineness. *Non-alliance-specific skills* describe those skills which are "therapeutic" but reflective of more general therapeutic processes and clinician attitudes. This category includes skills such as maintaining a frame of positivity and hopefulness, comfort with intensity, and appropriate use of humour. *Professional skills* is the term used to describe those skills which are deemed compulsory for functioning appropriately and effectively within a clinical profession.

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These skills represent the quality of clinicians' relationships with their discipline and include dedication and devotion to the profession, ability to get along with colleagues, and effective use of supervision. *Cognitive skills* are those skills which primarily utilize clinicians' rational and logical abilities to think and perceive, as opposed to their capacity to feel. Such skills include maturity, life experience, psychological mindedness, and critical thinking. Finally, *role management skills* are the skills necessary for the appropriate defining, management, and use of the distinct roles of "client" and "clinician." These skills relate primarily to the establishment and maintenance of therapeutically and ethically appropriate boundaries. They include comfort in the role of provider, capacity to use one's self in the therapy, and fostering of teamwork.

Participants in the study also asserted the critical importance of these skills in the assessment of a clinician's overall level of competency. The majority opinion was that these skills are at least as important as the other two dimensions of competence, knowledge mastery and technical skill. Respondents acknowledged that all three dimensions are equally important to competency and that weaknesses in any one area diminish a clinician's overall effectiveness.

Unfortunately, the consensus opinion of the respondents was also that, while essential, these skills have been and continue to be almost completely ignored in traditional clinical training programmes. In fact, a variety of negative comments concerning the training experiences of the participants were expressed, irrespective of discipline, institutional affiliation, and historical context of training. Frequently voiced complaints concerned the lack of effective supervision, emphasis on the use of often

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biased student self-report in supervision, heavier focus on non-clinical activities such as research and academic course work, blatant devaluing and ignoring of the role of personal and interpersonal skills, and an overall harsh and anxiety-provoking approach to training. Some participants went on to question the fundamental validity of the "moulds" into which training programmes attempt to fit their students..

Participants complemented their vociferous complaints concerning their own training experiences with a variety of recommendations for improvement. Respondents acknowledged the difficulties in effectively training and teaching these skills and articulated the characteristics of the student and the training programme that might best facilitate this endeavour. The *teachable student* is one who already possesses a baseline level of all of these interpersonal and personal skills, values the importance of these skills, is intelligent, and has the independence and incentive to pursue his or her own learning. The *clinical skills-friendly training programme* is one that openly values these skills both in theory and practice, is committed to an experiential way of learning, allows for the natural development and maturing of students over time, and encourages and supports both personal therapy and personal growth.

Furthermore, when asked to reflect on the uses of a hypothetical interpersonal and personal competencies assessment tool, respondents generally agreed that such a tool would most effectively be used in the evaluation and monitoring of student development during the course of a programme, rather than in screening new students. While participants clearly noted that certain individuals are more likely to be successful in learning these skills, they felt that the need to provide opportunities for development to as

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many potentially different people as possible was paramount. Instead, participants reported that a clinical skills evaluation tool would most constructively be used as a monitoring and goal-setting instrument, with the aim of guiding student clinical development in the context of the supervisory relationship. They emphasized the critical role of the supervisor in the teaching and remediation of these skills, noting that evaluations of students' interpersonal skills and personality qualities must understandably be made with sensitivity and tact. Such feedback must be given by the supervisor utilizing the same therapeutic skills used in the clinical relationship. Evaluation of strengths and weaknesses must be balanced, and the supervisor must make every effort to genuinely support, guide, and monitor the student's progress.

Finally, participants in the present study went on to consider alternative approaches to the unsatisfactory, and ultimately incompetent student. Respondents were more comfortable with the idea of gently pushing the clinically incompetent student into another area of the discipline such as research or academics, while acknowledging the last resort necessity of kicking incompetent students out of a programme.

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CHAPTER IV

Discussion

Placing These Results in Context

In 1973, Robert Clark pondered the question of what exactly happens to individuals in training as they become clinical psychologists, noting that the traditional answers provided to curious first-year students include, *"A psychologist is a person with certain skills,"* *"A psychologist is you,"* and *"You will see"* (1973). In a winter, 2003 article in Psynopsis newspaper, Lorraine Breault, Practice Leader in the Canadian Psychological Association (CPA) commented that:

> concerted effort is required to develop better devices and procedures that would assess not only knowledge and skills but also attitudes, values, interpersonal interactions, cultural sensitivity, and adaptability from basic training through to retirement of the professional psychologist.... The development of valid and reliable self-assessment measures may be particularly useful in promoting a new culture of assessment with emphasis on lifelong development and learning....The profession has much work to do in defining expected levels of competence and capabilities at various developmental professional levels....Perhaps it is time for Canadian professional psychologists to examine levels of professional competence

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and develop a national research agenda for the development and implementation of valid methods to assess competence and capability.

While we might now at least be able to provide the curious first-year student with a list of theories, techniques, diagnoses, and professional principles they are expected to learn in order to define themselves as psychologists, it appears from the above comments of Breault (2003) that we are still unable to provide any more clarity when it comes to helping them understand exactly *how* they are to carry out those techniques and apply that knowledge in the most effective clinical manner. Perhaps the most revealing finding of the present study is that even after all these years, students and professionals within the clinical disciplines continue to bemoan the same deficiencies in their clinical training programmes as their predecessors. This is particularly the case with respect to the continued lack of personality and character specifications regarding the requirements for competent clinical functioning (Johnson & Campbell, 2002).

A large body of research evidence exists supporting the primary role of the therapeutic alliance in determining treatment outcome (Barber et al., 2000; Horvath, 2001a, 2001b; Lambert & Barley, 2001; Wampold, 2001). While we now appear to be on sure-enough research and theoretical footing to suggest that the therapeutic relationship is *the* crucial curative factor, we have yet to vigorously pursue the question that naturally follows from this recognition - What are the specific personal, interpersonal, and technical factors which can facilitate or hinder the development of this crucial therapeutic alliance?

Unfortunately, as one searches through the competency literature it appears that research attempts toward conceptually and empirically defining the specific nature of the

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personal and interpersonal skills required for clinical competence have declined considerably since the 1970's, a social climate in which questioning the components required for authentic and meaningful human interaction and self-actualization a la the Third Force of Rogers and Maslow, was perhaps more acceptable. There are few recent studies which directly examine the dimensions of personal and interpersonal competency, and even fewer which specifically evaluate the effectiveness of current training programmes in teaching these skills. While some studies exist which look at the impact of very specific therapist-offered characteristics such as empathy and self-disclosure, few studies have been aimed toward simply identifying, cataloguing, and describing the number and nature of therapist interpersonal and personal qualities which might be related to client outcome. We are confident that the relationship is crucial, we are confident that the therapist-as-a-person must play some role in facilitating the development of that relationship, but we are reluctant to pinpoint exactly what that role might be. For a discipline consumed with identifying, cataloguing, and measuring the personality qualities and interpersonal skills of its consumers, we seem noticeably reluctant to turn that same level of attention toward ourselves. As Carkhuff and Berenson (1967) speculated, perhaps this reluctance reflects our fear of discovering that what we do is really quite magical, personal, and intangible, having much to do with who we are as human beings and less to do with who we are as psychologists.

Even the most recent attempt by the various provincial regulatory bodies in Canada to define the core competencies in clinical psychology provides only minimal guidance with respect to interpersonal competency (PSWAIT, 2001). The skills defined

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as necessary to establish and maintain a constructive working alliance include: knowledge of theories and empirical data on interpersonal and power relationships, and therapeutic alliance; knowledge of self, such as motivation, resources, values, personal biases; and knowledge of others, such as macro and micro environmental factors. While the document may be commended for finally recognizing and including this interpersonal dimension in clinical competency definitions, little detail is given concerning the specific definition and evaluation of these skills (PSWAIT, 2001). It appears as though earnest personal and interpersonal clinical competency research was halted somewhere back in the 1970's, perhaps also as a result of an economically-pressured movement toward a more generalized and manualized style of clinical training. Psychology is after all a public and service-oriented profession, and as such, is governed by the demands of the social, political, and economic climate in which it is practised (Clark, 1973; Levy, 1983). As Irvin Yalom (2003) recently commented, "*I worry about psychotherapy - about how it may be deformed by economic pressures and impoverished by radically abbreviated training programmes*" (pg. xv). This impoverishment is most visible in the current research focus on creating and validating explicit, manualized, brief, and symptom-specific therapy protocols and empirically supported therapies (ESTs) which arguably may ultimately be dispensed to the masses by the most minimally trained (i.e. cheap) "service providers." In effect, the unique, and critically important personhood of the therapist, as well as that of the client have been evicted from the office. As Norcross (2001) elegantly noted, impressive attempts have been made in this trend toward emphasis on technique to render individual practitioners as controlled variables, efforts

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that stand in marked contrast to "the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience" (pg. 346).

From the comments of the participants in the present study, it appears that there exist considerable differences between the type of clinical training apparently dictated by the current economic and social climate and the type of training perceived as essential by the practitioners, students, and clients within the helping professions. The type of training research currently being conducted is consequently more geared toward specifying and propping the skills required by this "new reality," rather than those endorsed by the individuals directly involved in these professions.

With respect to the categories articulated by the participants in this study as essential personal and interpersonal skills, there is considerable concurrence between many of these skills and those identified by previous research. Previous studies have identified clinical competency factors such as professional responsibility, integrity, conscientiousness, psychological healthiness, warmth, sense of humour, compassion, articulateness, creativity, (Peterson & Bry, 1980); self-confidence, communication, acceptance, tolerance, staying relaxed, time management skills, planning (Fordham et al, 1990); coping abilities, emotional well-being, personal values and beliefs,(Beutler et al, 1994); professional socialization behaviour, self-evaluation abilities (Bondy et al., 1997); sensitivity, dedication, openness (Peterson & Bry, 1980; Sakinofsky, 1979); friendliness, patience, common sense, objectivity (Arbuckle, 1956); honesty, stable identity (Klein & Babineau, 1974); easygoingness, perceptiveness,(Mintz et al, 1971); dependability, sincerity, respect (Spilken et al., 1969); self-awareness (Rogers, 1957; Ross & Altmaier,

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1990); countertransference awareness (Buckley et al., 1979); and empathy and genuineness (Greenberg et al., 2001; Hatcher et al., 1994; Overholser & Fine, 1990; Rogers, 1957; Strupp, 1978; Truax et al, 1964). Similarly, incompetency factors such as being in it for your own sake (Buckley et al., 1979); coldness, hostility, pessimism, and absence of genuineness (Beutler et al., 1994; Hadley & Strupp, 1976) have also been previously recognized. All of these skills were identified by participants in the present investigation, suggesting convergent validity of these essential abilities. In addition, the present study extended these findings by having participants specify these skills as clearly as possible, as well as identifying an exhaustive list of additional essential skills. Moreover, the present study provides additional support for the notion that these skills represent clinical "basics" that are generalizable to a variety of helping professions including psychiatric nursing, psychology, and social work.

Participants in the present investigation also identified the personal and interpersonal domain as critically important in assessing clinical competency, a finding which has been replicated in a variety of past studies (Lambert & Bergin, 1983; Sakinofsky, 1979; Strupp, 1978; Truax & Carkhuff, 1967; Wheeler & Manhart-Barrett, 1994; Yager, 1989). A more recent study by Urquhart, Smith, and Lancaster (2000), also found that interpersonal skills, particularly those emphasizing communication and rapport, received the highest importance rating in a sample of clinical psychologists in terms of their relevance to professional practice.

With respect to clinical training, participants in the present investigation expressed considerable dissatisfaction with past and present models of clinical training, and

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provided a variety of suggestions for improvement. These criticisms are understandable given that past studies have also suggested that the connection between available clinical training and the learning of these kinds of clinical skills is doubtful, or at best inconclusive (Beutler et al., 1994; Dickson & Bamford, 1995; Hojat et al., 1986; Armstrong & Kelly, 1993; Wheeler & Manhart-Barrett, 1994). A variety of previously presented suggestions for training improvement, similar to those provided by respondents in the present study, include: psychology departments should set explicit goals that indicate the degree of competence and the type of skills that a student is expected to acquire; procedures regarding students having difficulties should be explicitly communicated; less threatening goal attainment scales, similar to those used in monitoring client change, should be used to measure such personal and interpersonal development; and that students should be provided with frequent feedback regarding their performance in this dimension (Levy, 1983; Olkin & Gaughen, 1991; Rosenbaum, 1984). Participants in the present study underscored the importance of clearly defining competency expectations and procedures early on in training and providing consistent feedback to students through the use of a more qualitative and goal-oriented assessment tool. Once again, the finding of the present investigation that individuals are continuing to demand the very same improvements in clinical training as their predecessors is validating, albeit depressing.

The important role of supervision identified by the participants in the present study, in both teaching and assessing personal and interpersonal competency skills, has also received past research support. For example, Bradley and Olson (1980) found that

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exposure to multiple psychotherapy supervisors was the primary factor contributing to students' self-ratings of felt psychotherapeutic competence. Gonsalvez, Oades, and Freestone, (2002), noted that the atmosphere of the supervisor-trainee relationship is understandably emotionally-charged, which supports its potential to significantly affect the student learning process by facilitating or blocking the trainee's processing of relevant personal and emotional material. Interestingly, in their sample of students and supervisors, they found that while supervisors ascribed importance to factors such as self-awareness and interpersonal skills, this was not matched by their employment of appropriate methods to achieve these objectives (Gonsalvez et al, 2002). Trainees in their study specifically complained that less time should be devoted to case discussion in supervision, and more time to skill advancement. In another study, Milne(1989), also noted the importance of supervision as a venue in which to focus on personal issues, in so far as they affect the trainee's clinical work. She went on to comment upon the overall importance of a good learning alliance, so that supervision provides students with an "island of contemplation" in which to safely engage in honest self-reflection (Gore, 1988; as discussed in Milne, 1989).

The present study also lends support to the perceived appropriateness of an experiential, hands-on method to teaching and learning critical personal and interpersonal skills. Role playing, modelling, and rehearsal, mentioned by participants in the present study, have also received previous research support as effective means of teaching these skills (S.A. Anderson, 1992; Dalton, Jr. & Sundblad, 1976; Hatcher et al., 1994; Stone & Vance, 1976; Truax et al., 1964; Wheeler & Manhart-Barrett, 1994).

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In terms of incidence and prevalence issues, the overall attitude of the respondents in the present investigation was that cases of the personally or interpersonally incompetent clinical student were few and far between. However, a study by Biaggio, Gasparikova-Krasnec, and Bauer (1983) found that in a sample of 35 Doctoral programmes and 16 Master's programmes in clinical psychology, a total of 83 dismissal attempts were reported. Furthermore, in 37 of these incidents, reasons such as poor clinical ability, presence of psychopathology, poor interpersonal skills, poor judgement, immaturity, unprofessional conduct, and interpersonal problems were among the reasons cited for dismissal. Olkin and Gaughen (1991) also found that in a sample of department heads in various clinically oriented master's programmes, problem students were identified on the basis of clinical skills 77% of the time, pervasive interpersonal problems 70% of the time, problems in supervision, 58%, and intrapersonal problems 54% of the time, versus academic deficits (88% of the time). They also found that 50% of the respondents reported spending about one and a half hours per month specifically dealing with problem students (Olkin & Gaughen, 1991). This apparent discrepancy between perceived and actual occurrences of clinical incompetency suggest that the problem of the unsuitable student is real but continually underestimated by those involved in the helping disciplines.

Biaggio et al., (1983) found that only 62% of Doctoral programmes and 30% of Master's programmes surveyed reported having a specific set of procedures for dealing with the unsatisfactory student. Several respondents in the present investigation described their own programme's responses to incompetency as implicit and informal. Past researchers have also found that typical attempts to direct the problematic student to

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change included such procedures as mandated leave of absence, formal probation, recommendations for therapy, increased supervision, and limited client contact (Biaggio et al., 1983; Olkin & Gaughen, 1991). Such actions were also included as options by the participants in the present investigation.

Finally, participants in the present study expressed a reluctance to terminating students from a programme until every possible avenue of change has been exhausted. In our increasingly litigious society, it is understandable why trainers are reluctant to dismiss incompetent students from a clinical programme. However, precedence has attested to the courts' unwillingness to overturn professional training decisions when dismissals are contested (Knoff & Prout, 1985). However, to prevent potential problems in the event of student-programme opposition, a conservative process for dealing with personal or interpersonally incompetent students should be followed. From the comments of participants in the present study, as well as those from past research, such a process should at least include the development of a formal policy regarding the role of personal development in the programme, including the minimal (versus ideal) behaviours expected and an official statement that a student may be terminated for not meeting these expectations; the creation of a standing student progress type committee to meet periodically to formally review and provide feedback to students concerning their progress in all competency domains, as well as to mitigate potential disagreements between student and supervisor; formal and timely notification to students when a problem has been identified; the development of a formal and concrete plan for remediation, including specification of a date for further reevalaution; and a sufficient

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opportunity for a student to prepare a response, including the requesting of a formal review, if a decision to dismiss or counsel out is made (Knoff & Prout, 1985; Olkin & Gaughen, 1991). In following such a process, faculty will ensure that they have met the two key requirements for establishing due process, that the dismissal is neither arbitrary nor capricious (Knoff & Prout, 1985).

Limits of the Present Investigation and Areas for Future Research

A qualitative methodology was deemed most fitting for the present study given the breadth and complexity of the issues examined and the lack of previous research upon which to generate specific hypotheses. The intent of the project was primarily descriptive and aimed toward defining and understanding an identified concept, rather than establishing causal relationships. Thus, the primary compromise of such an approach necessarily concerns its potentially limited external validity, rather than its internal validity. Participants in the present study were volunteers, who likely had specific biased interests and beliefs, as did the researcher, regarding the topic of the present investigation that may not necessarily reflect those of the "average" clinical student, supervisor, practitioner, or client. Thus, whether a different researcher, with a different sample, would obtain the same results is uncertain.

Similarly, the inclusion of only one client in the present study, a sample significantly smaller than originally planned, is also limiting. Therefore, while the overwhelming convergence of opinion among those sampled is impressive and sufficient within the context of the emergent sampling method, the generalizability of the present

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results nonetheless requires further verification. Most importantly, the Clinical Skills Appraisal Tool (CSAT) developed by the researcher in the present investigation requires further exploration and verification. Specifically, it is essential that further investigations take this tool back to those involved in developing and using it and evaluate its perceived validity and usefulness within the training context. Re-investigation of the validity of the proposed definitions of each of the identified personal and interpersonal skills, the perceived relevance and importance of each of the skills to clinical competency, as well as the perceived completeness of the breadth of the skills included by the researcher must be checked in order to ensure interpretive validity. In addition, quantitative investigations concerning interrater reliability on the CSAT, factor analyses regarding the five underlying CSAT dimensions postulated by the researcher, and perceived rank-ordered importance ratings of each of the skills might also provide further information.

Finally, an additional area of research suggested by the present study concerns the investigation of the qualities necessary for an effective supervisory relationship. Participants identified supervision as *the* place in which interpersonal and personal skills are best explored, evaluated, and trained. Thus, more research is needed to examine the factors necessary to best utilize this important arena in training, including the manner in which supervisors might be most effectively prepared for this serious responsibility.

Conclusion

In conclusion, the therapist's interpersonal and personal skills play an essential role in the therapeutic process. These skills are conducive to satisfying primary human

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needs for safety, trust, and acceptance in interpersonal relationships. The effective application of these skills allows the individuals involved in the therapeutic relationship to overcome their isolation and meaningfully encounter, perhaps even be transformed by, one another. Psychotherapy, unique from most human encounters, allows participants to dispense with traditional social trimmings and posturing and thereby fully express and utilize these skills in a truly authentic and human manner. Moreover, this is a particularly privileged position for the therapist, given that he or she is asking the other to divulge some of the most frightening, tender, intimate, and vulnerable aspects of one's self. Thus, the responsibility lies with the therapist to use these skills in a manner that creates and sustains an environment in which such an extraordinary task is possible. This responsibility is serious and complex, and it is unfortunate that the current socio-political milieu, as well as past and present clinical training philosophies, do not appear to recognize the true importance of these skills. It is also particularly disillusioning that this lack of recognition continues to occur, despite the opinions and needs of those involved in carrying out this important task. Beyond discipline-wide issues of competency and incompetency, the efficient training and use of these skills can only serve to enhance the functioning of each individual therapist, increasing the likelihood of success in each individual therapeutic encounter. This is certainly a worthwhile aim and imperative demand in both a theoretical and empirical sense.

For the researcher, the purpose of the present project was primarily to investigate a personally perplexing recognition that a dimension that seemed essential to effectiveness as a therapist, if not as a human being, was nonetheless neglected in the process of clinical

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training. I was initially comforted by the fact that nearly every individual I discussed this study with promptly asserted how important and interesting they felt such a topic was and how it was about time that someone openly talked about this. Unfortunately, they inevitably went on to provide me with numerous examples of how they felt that their own clinical training had failed them in this area. Thankfully, the participants also expressed some hope that such an investigation might spark others and eventually result in changes in the approach to training.

As such, the CSAT is offered by the researcher first as a means of recognizing and acknowledging the unquestionably critical importance of these skills in effective functioning as a therapist; and second, as a potential method for making a personal, interpersonal, and qualitative appraisal of what are essentially personal, interpersonal, and qualitative skills. It is intended to fill an identified gap in clinical training, in a manner specifically reflective of the uses and non-uses of such a tool identified by the participants in this study. Therefore, at this time, it is intended to be used a means of promoting growth both within and without the context of a clinical training programme. It is not meant to be used to add an additional intimidating hurdle for successful entrance to, or completion of, such training.

Finally, the CSAT, and this study, are also intended to ignite more discussion, more debate, and more exploration not only concerning these specific skills, but also with respect to the development of a philosophy toward clinical training that truly values and respects these skills. As one participant in the study eloquently suggested:

We all have a lot to learn from midwives. Experiencing midwives working with

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women is a beautiful example of professionals who are very much in tune with the person they are providing care to. They're tuned into what the person's strengths are, to accepting their experience as is, to not judging it, to tailoring themselves to that person's needs...and to treating that experience as legitimate in its own right.

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APPENDIX A

PARTICIPANT INFORMATION

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Appendix A

Participant Information

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General Recruitment Information Sheet

I am conducting a study to determine what students, faculty, and clients in the "helping" professions (Psychology, Nursing, and Social Work) believe are some of the important skills that a clinician must have in order to function effectively.

I am specifically interested in those aspects of clinical competence which have been described as "clinical qualities"; this includes personality characteristics and qualities such as patience, tolerance, sensitivity, honesty, creativity, etc.; as well as interpersonal skills such as empathy, warmth, and genuineness. Members of these disciplines generally agree that these kinds of qualities are critically important in influencing whether a clinician will be effective or not with clients. However, there is a lack of specificity concerning which qualities are important, how we might train or assess these skills, and what we might do if someone demonstrates "incompetence" or "unsuitability" in one of these areas.

The purpose of my study will be to assess the opinions of students, faculty, and clients regarding these various issues. This information will later be used to develop an assessment tool based on these opinions that might be used to help monitor and improve the performance of clinicians in these areas. Participants in this study will be interviewed by the principal researcher concerning their views about these issues. These interviews will be conducted on a one-to-one basis and will require approximately one hour. The interviews will be audio recorded and will be transcribed by the principal researcher. All information provided by participants will be confidential. The tapes will be erased upon completion of the study.

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Consent Form

The purpose of this study is to define and understand the personal and interpersonal qualities which are necessary for counsellors to function effectively. This study is being conducted in partial fulfilment of the requirements for the principal researcher's doctoral degree in psychology.

In this study, you will be asked some questions concerning your own thoughts, feelings, and opinions about the qualities which make someone a good or a poor counsellor. These interviews should take about one hour.

Participation in this study is voluntary and you have the right to decline to answer any question, and to stop the interview at any time, without any penalty or explanation.

I will be tape recording these interviews. Later, the interviews will be transcribed by the principal researcher and all identifying information (names, etc.) will be removed. No one else will hear the tapes and they will be erased upon completion of the study.

All of the information provided will be confidential. Only the principal researcher (Tricia Schöttler, M.A.) will be able to connect your name to the information you provided. The results of the study will be used for educational and research purposes by the principal researcher. However, no identifying information will appear in any reports about this study, published or otherwise. In such reports, individuals will be identified by a numerical code or made-up name.

If you have any questions about this study at any time, or if you wish to get feedback about the study upon its completion, you may contact the principal researcher or the Committee Chair:

Tricia Schöttler. M.A.
Principal Researcher
Department of Psychology
University of Windsor
737-7350 X5571

Dr. Jim Porter
Committee Chair
Department of Psychology
University of Windsor
519-973-7012

If you have any questions concerning the ethics and procedures of the study, you may contact the Ethics Committee of the Department of Psychology at the University of Windsor:

Dr. Sylvia Voelker, Chair of Ethics Committee
Department of Psychology, University of Windsor
519-253-4232 (Ext. 2249)

I, _____, have read this information and voluntarily agree to participate in this study. My signature acknowledges that I have received a copy of the information contained on this form.

Date:_____

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Background Information

Please answer the following questions:

1. Age: _____

2. Sex: _____

3. Level of Education: (if in progress, please indicate what year you are in)

   _____ Bachelor's Degree (B.A., B.Sc., B.Sc.N., BSW)

   _____ Master's Degree (M.A., M.Sc., M.Sc.N., MSW)

   _____ Doctoral Degree (Ph.D., Psy.D.)

   _____ Other (Please Specify) _____

4. **IF STUDENT:**
   a) Please indicate your University Major: _____
   b) Have you had any experience supervising the clinical work of other students? YES _____ NO _____
   c) If YES, approximately how many students? _____

5. **IF FACULTY:**
   a) Please indicate the department you are employed in:_____
   b) Have you had any experience supervising the clinical work of students? YES _____ NO _____
   c) If YES, approximately how many students? _____
   d) How many years have you been practising within your profession? _____

6. **IF PRACTISING CLINICIAN:**
   a) Please indicate the area you are employed in (e.g. nursing, social work, Psychology, etc.) _____
   b) Have you had any experience supervising the clinical work of students? YES_____ NO_____
   c) If YES, approximately how many students? _____
   d) How many years have you been practising within your profession?_____

7. **IF CLIENT:**
   a) How long have you been in therapy? _____
   b) Do you feel that therapy has been helpful to you? _____

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Semi-Structured Interview Protocol

Introduction

I am studying how people define and understand the various personal and interpersonal qualities which are required by clinicians so they may function effectively. I believe that there are basically three categories of skills which are involved in clinical work; 1) academic knowledge which involves learning about various kinds of therapy, theories about personality and dynamics, and information concerning the symptoms of various psychological disorders; 2) technical and conceptual skills which involve the ability to actually carry out certain kinds of techniques in therapy, knowing what kind of a technique to use with a particular kind of client; and 3) clinical qualities which are harder to define but seem to involve the clinician's personality and interpersonal skills. I am interested in this last dimension of competence and that is what I will be asking you about during this interview.

I am going to be asking you some questions about what you think are the important clinical qualities that a clinician must have in order to function competently. Remember, this involves qualities of the clinician as a person, including relevant personality characteristics, interpersonal skills, and whatever else you might think is important. Later in my study, I will be using the information that I get from the people I interview to develop a tool which people might use to improve their performance as clinicians in these important areas.

I have a series of questions written down which I would like to cover, but we don't have to feel limited to these questions. Please feel free to elaborate on anything or to let me know something you feel is important to my understanding of clinician competence and performance. Also, if you have any questions at any time, feel free to ask me. Do you have any questions now before we get started?

Finally, as it says in the consent form which you just signed, you can stop the interview at any time, and you don't have to answer a question if you don't want to.

Questions

Q1. What are some of the personal characteristics and interpersonal qualities which a person must have to be a good clinician?

> If more prompting necessary, individual will be asked to indicate examples of how these behaviours are "seen"; how these behaviours are demonstrated both in contacts with clients and with colleagues

Q2. If you can, think of a person you have had experience with who you would consider to be a competent clinician. What is it about that person's personality and interpersonal skills that makes you think they are competent?

Q3. If you can, think of a person you have had experience with who you would consider

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to be an incompetent clinician. What is it about that person's personality and interpersonal skills that makes you think they are incompetent?

Q4. How important to you are these kinds of personality characteristics and interpersonal qualities in assessing a clinician's performance?

Q5. Are these kinds of qualities trainable?

Q6. In your own training, do you feel as though adequate attention was paid to the teaching and assessing of these kinds of qualities?

Q7. If there were a way to measure or assess people's performance in these qualities, how do you think such a tool should be used in the training of clinicians?

Q8. How do you think supervisors should deal with people who are incompetent or are having problems in any of these areas?

Q9. Have I missed anything that you feel would be important?

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APPENDIX B

THE CLINICAL SKILLS APPRAISAL TOOL

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Appendix B

The Clinical Skills Appraisal Tool (CSAT)

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The Clinical Skills Appraisal Tool

Manual

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What is the Purpose of this Tool?
The Clinical Skills Appraisal Tool (CSAT) provides a method of appraising your performance in demonstrating 49 personal and interpersonal skills, qualities, and attitudes that are essential for competent clinical practice and in setting appropriate goals for professional development with respect to these skills.

Your performance will be compared against that expected of students at your level of training.
Thus, you are not expected to be competent in all of these skills as you begin your training. Instead, you are expected to achieve a competent (**i.e. satisfactory**) level of performance in all of these skills by the *end* of your training.

Instructions
This tool is intended to be used in conjunction with your supervisor. It is intended to provoke discussion between you and your supervisor regarding the nature of these skills and their importance to clinical work, as well as to encourage self-reflection concerning your own strengths and weaknesses within these areas.

Definitions of the skills and the underlying dimensions are provided to ensure as much clarity as possible concerning what is expected of you with respect to these skills. These definitions are offered as guidelines, but you and your supervisor may wish to add more information.

Because of the nature of these skills, it is essential that you and your supervisor agree upon the meanings of each of them *before* any evaluation of your performance takes place.

Definitions
A. The Five Dimensions:

1. Alliance-specific skills. Skills specific to and essential for the process of building an effective therapeutic relationship.

2. Non-alliance-specific skills. Those skills which are "therapeutic," but reflective of more general therapeutic processes and clinician attitudes.

3. Professional skills. Skills which are deemed compulsory for functioning appropriately and effectively within a clinical *profession.*

4. Cognitive skills. Skills which primarily utilize clinicians' rational and logical abilities to think and perceive, as opposed to their capacity to feel.

5. Role management skills. Skills necessary for the appropriate defining, management, and use of the distinct roles of "client" and "clinician."

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Each of the following 49 individual skills belongs with one or more of the 5 underlying dimensions. This is indicated on the tool by the location of the white spaces. For example, the ability to *Foster Teamwork* is scored as both a *Role Management Skill* and an *Alliance Specific Skill.*

B. The Individual Skills:

1. Capacity to be empathic:
• the ability to put yourself in the client's shoes
• the capacity to connect with the emotional state that the client is experiencing
• demonstrating "tempered" empathy - use it appropriately (not smothering the client)
• maintaining objectivity - some separation between you and the client's experiences so you are not overwhelmed by them (one foot in, one foot out)
• able to verbally/nonverbally communicate empathy to the client

2. Capacity for warmth:
• showing unconditional positive regard
• being nice, friendly, soft, gentle, compassionate, caring, kind
• genuinely liking the client, at least at a minimal level
• being able to communicate this warmth to the client

3. Respect for the client:
• demonstrating an acceptance, active validation, and honouring of the client and his or her experiences
• treating the client's perceptions of their experiences as legitimate in their own right
• awareness of sensitivity issues (culture, gender, sexual orientation, etc.)

4. Non-judgementalism:
• suspend judgement on the person, their acts, and the situation that brought them into therapy (neutrality)
• openness to varied ways of functioning
• have as little bias as possible, and be able to transcend that if it is present

5. Genuineness, transparency:
• being honest in your thoughts, feelings, and reflections to the client within the boundaries of not hurting the client
• not saying things you don't believe to be true, or expressing sentiments that you don't really feel

6. Ability to engender comfort, safety, good rapport:
• ability to develop a healing rapport, elicit trust, facilitate comfort, provide emotional safety and security, and come across as non-threatening
• ability to handle and contain client emotions appropriately

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7. Humility and knowing your limits:
• giving yourself permission to not be perfect
• ability to be constructively critical of yourself
• non-defensively accepting misunderstandings and feedback
• acknowledging if you made a mistake, if you don't know how to proceed, then act appropriately
• possessing an impartial awareness of your own strengths, weaknesses, and personal and professional limits

8. Respecting the client's humanity:
• engaging the client in a "human" relationship, as well as a clinical one
• being non-reductive in your evaluation of the client, not pressing their experience into prepared moulds
• recognition that this is a fellow human being who is struggling, and to acknowledge their very human struggles, pains, and joys
• allowing yourself to be honoured by the client's presence

9. Foster teamwork:
• working collaboratively
• creating and sustaining a truly shared space of thinking and feeling, where both client and therapist participate to facilitate change

10. Ability to create equality in the therapeutic relationship:
• not coming across as the all-knowing expert, or from a position of perceived superiority
• an openness to viewing the therapeutic relationship as one in which opportunities for learning are open at both ends

11. Ability to set appropriate limits and boundaries:
• walking an appropriate line between extreme clinical detachment from and enmeshed intimacy with the client
• ability to define and maintain appropriate interpersonal boundaries (ego and sexual)
• maintaining a good distinction between your issues, and those of the client

12. Awareness of transference issues:
• being aware of how you are being perceived by clients, and how that might affect your interactions with them
• not allowing yourself to get caught up and respond from within the transference reaction

13. Awareness of countertransference issues:
• having an awareness of how you perceive other people's interactions with you, and how that might affect your interaction with them
• not allowing yourself to get caught up and respond to the client from within the countertransference reaction

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14. Patience:
• allowing clients to tell their story at their own pace, and to set the pace of their own progress
• avoiding quick judgements, jumping in too soon

15. Being relaxed:
•appearing appropriately relaxed, laid-back, easy-going (even if you are anxious)

16. Remaining calm:
• remaining calm, even in the face of client upset, outbursts, disclosures of suicidality/homicidality
• maintaining a soft-spoken, steady voice, quiet demeanour that makes the client feel safely contained and regulated

17. Comfort with intensity:
• a willingness to fully explore all aspects of the client's functioning, including the "dark side"
• not afraid to go into the shadowy depths of people, to listen to and explore their more dubious thoughts, feelings, and motivations

18. Maintaining a frame of positivity and hopefulness:
• being appropriately encouraging, optimistic, positive, and hopeful about the client's situation, their ability to overcome obstacles, and their potential for change, especially in the face of the client's despair, discouragement, negativity, and hopelessness

19. Having a sense of humour and using it appropriately:
• not always taking yourself, and the work too seriously
• the capacity to genuinely laugh with the client, to use humour to lighten things up when appropriate, within the context of maintaining a serious and professional tone in the work

20. Therapy "Magic":
• charisma, magnetism, dynamism
• using your unique, dynamic self to access the client's issues, to take them past the border of their experiences

21. Ability to be challenging and confrontational:
• ability to be appropriately assertive, frank, blunt with clients in a constructive way
• able to push the person in a way that stretches them, not breaks them
• not agreeing with everything the client says or does

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22. Promoting client-directedness:
• ability to step back, and allow the client to guide and direct the course and pace of therapy
• including the client in the treatment planning, and always being responsive to his or her unique needs
• a selfless stance of being "of service" to the client, so that clients do not feel that their role is to please you somehow

23. Ability to get and keep clients motivated:
• lessen the client's initial sense of inertia, and then maintain a good balance between tension and support
• sometimes letting the client experience their distress in order to provide motivation for change, rather than always rescuing them from their own distress

24. Maintain focus and presence:
• being fully there with the client, being in the moment and in tune with the client
• capable of moment-by-moment self-awareness in the session, attending to fluctuations in your attention and presence level, and re-focussing accordingly

25. Be active and invest yourself in the process:
• being active, energetic, enthusiastic about the therapeutic process
• going the extra mile, work with everything that presents itself to you
• investing practical, as well as emotional energy in the relationship

26. Capacity to use one's self in the therapy:
• ability to share your own experiences in a way that is appropriate to the situation
• engaging in appropriate self-disclosure, letting yourself be a role model to the client

27. Self-awareness:
• the willingness, and the capacity for honest self-reflection
• some awareness of who you are as a person, your issues, your triggers
• some ability to monitor your own mental health status
• seeing yourself as a whole person, not just a therapist, student, etc.

28. Awareness of personal issues that can impact therapy:
• self-awareness of your own sensitive areas, issues, expectations, values, biasses, belief systems that may have a negative impact on your ability to work with a client

29. Psychological healthiness:
• having dealt with any important personal experiences and issues, particularly those that might have a negative impact on therapy
• ability to take care of yourself emotionally, spiritually, psychologically
• a sense of being happy, at peace, comfortable with yourself to some level

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30. Dedication and devotion:
- making a true commitment to the work, really loving what you do,
- devoted to the profession and to clients
- watching for burn out

31. Genuine concern for people and humanity:
- expressing an overall warmth toward, interest in, and caring about people
- expressing a belief in humanity and genuine caring for the well-being of others

32. Generally interested and curious:
- being inquisitive, eager, interested in life and people

33. Ability to get along with colleagues:
- being respectful of what others have to offer,
- being open to the ideas of others
- being able to communicate with others in an appropriate way
- ability to critique others constructively (not always competing)

34. Communicate confidence in one's therapeutic skills:
- presenting as competent, knowledgeable, self-assured
- demonstrating confidence in you conceptual understanding of the client, and in your ability to assist

35. Commitment to ongoing learning:
- demonstrating an openness and commitment to lifelong learning
- keeping up to date, seeking out new information, continuously seeking to increase your knowledge
- showing a willingness to grow on a personal level, to take advantage of opportunities for self-learning

36. Know when to seek supervision, and seek it:
- not being afraid to recognize when you need help, and to actively pursue that help
- being open to feedback, criticism, and guidance from colleagues and clients
- ability to actively use the feedback that has been provided (i.e. not just hearing the "negative")

37. Time management skills:
- establishing and maintaining momentum in the sessions by being able to prioritize, maximize time usage, being fully prepared before-hand, not wasting time
- remembering things week-by-week
- keeping good and prompt notes
- collecting your thoughts so you can get to the work as quickly as possible

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38. General ability to communicate:
• ability to respond in a relevant, beneficial, and articulate manner
• ability to communicate assertively and ask clients to repeat or explain something
• ability to communicate even if you are feeling uncomfortable
• ability to maintain appropriate eye contact and body language
• allowing the clients to express things in their own way, without making "corrections"
• ability to monitor your own verbal/nonverbal cues, particularly when the client says something upsetting or disturbing
• adapting your language to speak to the client's ability to comprehend
• being able to reframe tough issues so the client is better able to hear them
• validating the information you think you are getting from the client - checking your understanding

39. General listening skills:
• actively using all of your senses to really hear what the client is saying
• taking the time to listen
• monitor all the client's communications to recognize if the client is frustrated, needs a break, is particularly emotional (a "hot" topic)
• verbally and nonverbally communicating that you have heard and you understand (i.e. leaning in closer, nodding your head)

40. Maturity:
• possessing enough emotional maturity to handle client feelings and experiences in a sagacious manner

41. Life Experiences:
• possessing an appropriate range of life experiences and skills to be able to deal with a range of people and problems
• and/or the ability to have learned vicariously through the experiences of others
• possessing an ability to make use of such experiences in the process of personal learning

42. Flexibility:
• retaining an openness to trying something different, stretching yourself
• not getting stuck in your ways so that you narrowly look only for those things that fit your formulation, or your attitude

43. Creativity:
• maintaining a capacity for innovation
•maintaining a sense of playfulness in the work
• being able to apply yourself in an artful manner in putting theory into practice

44. Matching yourself appropriately with your chosen modality:
• choosing a way of working that really fits with your personality, your philosophy, and your life experiences

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45. Capacity for insight and psychological mindedness:

• possessing perceptual skills that allow you to watch for signs, to realize when something important or meaningful has occurred
• a multi-levelled depth of understanding of the client
• the ability to hear and feel what the client isn't saying, what is just beneath the surface
• the ability to add a new dimension to what the client is discussing

46. Capacity to be a critical thinker:

• being organized, logical, precise, methodical, clear-headed, rigorous, and disciplined in your way of thinking (a personal science)

47. Common sense, good judgement:

• the ability to appropriately think and respond "on your feet"

48. Ability to maintain objectivity:

• ability to retain a level of professional objectivity and distance (one foot out) that allows you to pull back from the relationship and objectively spectate
• not being too personally involved so that you drown in the client's experiences
• not taking things personally

49. Comfort in the role of the provider:

• comfort in your role of being exclusively of service to others within the therapeutic relationship
• possessing a consolidated and integrated sense of who you are within this role

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The Clinical Skills Appraisal Tool

Supervisee: _____

Supervisor: _____

Year of Training: _____

Date: _____

Legend
U = unsatisfactory performance
S = satisfactory performance
E = exceptional performance

Alliance -Specific Skills	Non-Alliance Specific Therapeutic Skills	Professional Skills	Cognitive Skills	Role Management Skills	Skills
					capacity to be empathic
					capacity for warmth
					respect for the client
					non-judgmentalism
					genuineness, transparency
					ability to engender comfort, safety, good rapport

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Alliance -Specific Skills	Non-Alliance Specific Therapeutic Skills	Professional Skills	Cognitive Skills	Role Management Skills	Skills
					humility and knowing your limits
					respecting the client's humanity
					foster teamwork
					ability to create equality in the therapeutic relationship
					ability to set appropriate limits and boundaries
					awareness of transference issues
					awareness of countertransference issues
					patience
					being relaxed
					remaining calm
					comfort with intensity
					maintain a frame of positivity and hopefulness
					having a sense of humour and using it appropriately
					therapy magic
					ability to be challenging and confrontational
					promote client-directedness

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Alliance -Specific Skills	Non-Alliance Specific Therapeutic Skills	Professional Skills	Cognitive Skills	Role Management Skills	Skills
■		■	■		ability to get and keep clients motivated
■		■	■		maintain focus and presence
■		■	■		be active and invest yourself in the process
■		■	■		capacity to use one's self in the therapy
■		■	■		self-awareness
■		■	■		awareness of personal issues that can impact therapy
■		■	■		psychological healthiness
■	■		■	■	dedication and devotion
■	■		■	■	genuine concern for people and humanity
■	■		■	■	generally interested and curious
■	■		■	■	ability to get along with colleagues
■	■		■	■	communicate confidence in one's therapeutic skills
■	■		■	■	commitment to ongoing learning
■	■		■	■	know when to seek supervision and seek it
■	■			■	time management skills
■	■			■	general ability to communicate

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Alliance -Specific Skills	Non-Alliance Specific Therapeutic Skills	Professional Skills	Cognitive Skills	Role Management Skills	Skills
■	■			■	general listening skills
■	■	■		■	maturity
■	■	■		■	life experiences
■	■	■		■	flexibility
■	■	■		■	creativity
■	■	■		■	matching yourself appropriately with your chosen modality
■	■	■		■	capacity for insight and psychological mindedness
■	■	■		■	capacity to be a critical thinker
■	■	■		■	common sense, good judgement
■	■	■			ability to maintain objectivity
■	■	■	■		comfort in the role of provider
13	16	10	12	19	total possible for each dimension
					TOTAL U (unsatisfactory)
					TOTAL S (satisfactory)
					TOTAL E (exceptional)

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TOTAL Unsatisfactory Responses: /70
TOTAL Satisfactory Responses: /70
TOTAL Exceptional Responses: /70

Recommendations

1. Alliance-Specific Skills

Goals:

Process:

2. Non-Alliance-Specific Skills

Goals:

Process:

3. Professional Skills

Goals:

Process:

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4. Cognitive Skills

Goals:

Process:

5. Role Management Skills

Goals:

Process:

Student:_____ Date: _____

Supervisor:_____ Date:_____

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VITA AUCTORIS

Patricia Schöttler was born in 1970 in Thompson, Manitoba. She received her Honours Bachelor of Arts degree from the University of Western Ontario, London, Ontario, Canada, in 1993. She went on to receive her Master of Arts degree in Clinical Psychology from the University of Windsor, Windsor, Ontario, Canada in 1995. She has been enrolled in the doctoral programme in Clinical Psychology at the University of Windsor since September, 1995.

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