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Feelings of Incompetence among Experienced Clinicians: A SubstantiveTheory

Abstract

Feelings of incompetence (FOI) are an ongoing part of the private experience of being a therapist. Although normative, they are often linked to therapist distress and to negative therapeutic processes. Yet systematic inquiries into the subjective judgment of oneself as inadequate in the role of therapist are scarce for experienced therapists. A qualitative approach was used in this study to obtain rich descriptions of experienced therapists' encounters with feelings of incompetence. Twelve therapists with over ten years of experience were recruited for the study. They were each interviewed for ninety minutes using a semi-structured interview protocol. The resulting transcripts were analysed with procedures based on grounded theory methodology (Strauss & Corbin, 1994). A dynamic, pan-theoretical, and multidimensional theory of therapist feelings of incompetence is presented. The substantive theory describes the relationship between the four main categories of intensity of self-doubt, sources of feelings of incompetence, mediating factors, and consequences. The theory offers a structure with which to understand and diffuse this most serious hazard of our profession. It has immediate and practical relevance for psychotherapy practitioners, educators, and supervisors.

Introduction

The practice of psychotherapy can be a hazardous undertaking (Brady, Healy, Norcross, & Guy, 1995) with almost three quarters of therapists reporting some level of role-related personal distress (Guy, Poelstra, & Stark, 1989). Among the elements that contribute to therapist distress, feelings of incompetence (FOI) figure markedly. Feelings of incompetence (FOI) refer to a therapist's belief that his or her ability, judgment, and/or effectiveness as a therapist is absent, reduced, or challenged internally (Theriault & Gazzola, 2005). The literature that examines topics such as the therapist's experience of therapy, therapist self-care, and the hazards of practicing as a psychotherapist is peppered with allusions to FOI (Daniels, 1974; Deutsch, 1984; Farber & Heifetz, 1982; Guy, 2000; Mahoney, 1991; Mearns, 1990).

As early as 1969, Howard, Orlinsky, and Hill found that therapists identified moments of subjective self-recrimination and self-doubt as being among the most difficult to cope with. In that groundbreaking study the researchers described a factor labelled sense of failure. It was characterized by such items as disappointment, inadequacy, frustration, apprehension, and anger (Howard et al., 1969). This represents an important study because it established the therapist's subjective experience of therapy as a legitimate topic for empirical inquiry. Subsequently, explorations of therapist struggles uncovered constructs such as professional doubts (Daniels, 1974; Farber & Heifetz, 1981; Hellman, Morrison, & Abramowitz, 1986) and sense of low mastery (Orlinsky et al., 1999) that overlap with FOI. For example, Davis et al. (1987) gathered a series of 125 examples of challenging moments from seven experienced therapists in an effort to develop a taxonomy of therapist difficulties. The group of therapists then extrapolated a set of categories from the initial item pool. Nine categories of difficulties emerged, one of which was labelled T- Incompetent and defined as follows:

The therapist questions or negatively evaluates his or her skills/performance/adequacy as a therapist. The therapist's expressed concern is not with the consequences of this deficiency for the patient but with his or her own narcissistic injury. The therapist's confidence in self is undermined (Davis et al., 1987, p.118).

Research and self-reported professional accounts have collectively underscored that therapist FOI create considerable distress for therapists (Dryden, 1992; Kottler, 2002). For example, Mahoney (1997) surveyed 155 mental health professionals regarding personal problems and career patterns and concluded that therapist doubts about their own therapeutic effectiveness ranks among the top five reported personal problems. They were reported by 42% of doctoral and 40% of nondoctoral therapists in his sample. Not surprisingly, FOI were linked to impairments such as stress and burnout (Daniels, 1974; Deutsch, 1984; Farber & Heifetz, 1982), sexual involvement with clients (Wood, Klein, Cross, Lammers, & Elliott, 1985), depression (Mahoney, 1991) and, indirectly, to alcoholism (Thoreson, Nathan, Skorina, & Kilburg, 1982). FOI were also related to a growing number of psychotherapy process disturbances such as premature or delayed termination (Brady, Guy, Poelstra, and

Brown, 1996), as well as ruptures in the therapeutic alliance and untimely interpretations (Strean, 1993). The perception that "one's efforts were inconsequential" seems to be a common denominator among therapists suffering from burnout (Farber & Heifetz, 1982). The authors concluded that this perception could impact therapy in several ways, including therapists: (a) becoming cynical about their clients, (b) blaming their clients for their difficulties, (c) using derogatory terms to describe their clients, (d) increasingly using technical jargon, and (e) referring to clients in diagnostic terms.

While the aforementioned empirical references to feelings of incompetence are compelling, they are scattered within studies that focussed on related phenomena.

The main objective of this study is to contribute to the existing body of knowledge regarding experienced therapists feelings of incompetence. Drawing from the literature reviewed above, we decided that it would be useful to design a study that is subjective, in-depth, highly structured, and that is exclusively focused on FOI. A discovery-oriented approach that eschews theoretical moulds or pre-established structures was adopted. Furthermore, the present study examines FOI from the perspective of experienced therapists, an under-represented viewpoint in counselling research. Since a significant number of clinicians continue to feel incompetent despite their years of experience and because we remain unclear about the nature and impact of FOI, the study was based on three main questions: (a) What is the nature of the experience of FOI for this select group of practitioners? (b) How and why do seasoned therapists experience feelings of incompetence? (c) What happens when seasoned therapists feel incompetent?

Methodology

A tripartite rationale indicates that a qualitative approach is warranted: The domain is virtually unexplored, the nature of the material is subjective, and the level of insight sought is 'deep' or 'thick' (Strauss & Corbin, 1998). Grounded theory (Strauss & Corbin, 1994) was selected because it offered the opportunity for a profound exploration and a systematic approach to extricate patterns and to formulate theory about this discriminate and very private phenomenon.

Participants

Criteria for involvement in the study.

A basic set of criteria for the selection of participants reflected the ideology of the study: (a) a minimum of 10 years of clinical experience (b) presently practicing psychotherapy and (c) a minimum educational requirement of a Master's degree in either clinical or counselling psychology. The latter reflected the minimal entry requirements to gain licensure as a psychologist in the province of Quebec at the time of the study. This criterion was established to offer some uniformity to the sample base.

Sampling and recruitment .

The sample was purposive: Participants were chosen because of their potential to provide rich descriptions of their experiences with FOI (Patton, 1990). Half of the participants (six) were acquaintances; they were clinicians with whom the principal author had studied during a Master's program or alongside which she had previously worked. Colleagues referred six other participants to the author because they fit the criteria of the study. They were all approached through a telephone conversation and asked to volunteer.

Participant Demographic Data .

The participants included three men and nine women whose years of post-Master's clinical experience ranged between 10 and 29 years, with a mean of 15.7. Five of the participants were in the 30-40 age range, five were in the 40-50 age range, and two were in the 50-60 age range. A variety of theories were proposed as the participants' guiding framework as revealed on a structured questionnaire: Cognitive (3), Rogerian/ Humanistic (3) Narrative (2), Eclectic (2),
Behavioural (1), and Feminist (1).

Researcher as Instrument

The interviewer and first author was a 37 year-old female psychologist with 10 years of experience as a therapist at the outset of the study. Years of witnessing colleagues struggling with self-doubts in internships and in supervision and observing the consequences of these insidious struggles gave rise to the interest in the topic. While well woven into the fabric of the profession, fears of being incompetent appeared to be secretive and were infrequently broached directly during conferences, in supervision, and in the empirical literature. Assumptions were noted before the outset of the studies and discussed with a colleague familiar with the project. The auditor was the second author, a longstanding colleague with over 12 years of postgraduate experience as a researcher and clinician who shared a profound interest and curiosity in therapist identity and development.

Data Collection

Structured Questionnaire

A structured questionnaire was used to gather basic demographic data about the therapists who participated in the study (see participant demographic data for a summary). These questionnaires were mailed to the participants several weeks before the scheduled interviews and were returned at the interview.

Semi-Structured Interviews

The interview protocol devised on the basis of suppositions derived from prior experience as a therapist, in consultation with other therapists, and from the information gathered in the review of the literature. The interview protocol served as a flexible guide from which the interviewer steered the exchange. Specific prompts and in-vivo analyses influenced the exchanges as well. Twelve participants were interviewed once. The authors judged that theoretical saturation was reached after eight interviews. Four additional interviews were conducted to confirm that this was the case. The interviews ranged from 45 to 90 minutes and were recorded on audiocassettes and subsequently transcribed verbatim.

Data analysis

Coding and Auditing

The grounded theory procedures of open coding and axial coding were employed to analyse the verbatim transcripts (Strauss & Corbin, 1994). The first author coded the twelve interviews while concurrently setting up a provisional structure outlining the categories, their properties, and the relationship between them. The second author audited the transcripts and the resulting conceptual scheme. Two types of minor modifications were made to the conceptual structure. Several of the subcategories were moved under different categories and several labels were replaced with more succinct labels. The auditor performed a last audit on the resulting extant substantive theory that had evolved from the findings of the twelve interviews.

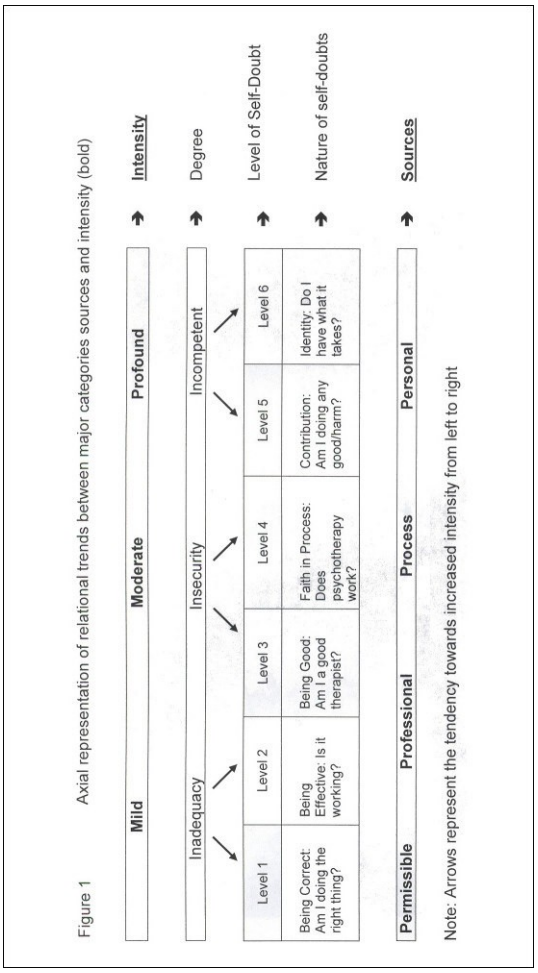
Results

The analysis yielded four higher order categories: (a) intensity, (b) sources, (c) mediating factors, and (d) consequences, organized around the main category of intensity (see Figure 1). These four major categories are presented discretely and in detail. The fine analysis yielded subcategories, multiple elements that together made up the major categories. These subcategories, their dimensions, and properties will be presented and described thoroughly. A substantive theory that depicts the relational trends between the major categories is then proposed.

Main category 1: Intensity

The theme of intensity was universal: participants reported that they commonly experienced self-doubts that were qualitatively and experientially varied. They described links between the nature of the self-doubt and the potency of the FOI. The self-doubts and FOI that were related were best represented on a continuum from less to more intense.

The range of the self-doubts was organized hierarchically in six levels of progressively troubling questions about their self-perceived competence. Three variations of experiences of FOI represent the continuum of intensity: inadequacy (levels one and two), insecurity (levels three and four), and incompetence proper (levels five and six). The three types of FOI were ordered and defined as degrees (see Figure 1).



The first degree, inadequacy, was a sense of discomfort about one's effectiveness that stemmed mainly from self-doubts regarding

procedural decisions, including technical preoccupations (Level 1 - being correct) and the immediate outcome of these choices (Level 2 - being effective). The second degree, insecurity, extended beyond the intervention and encapsulated therapist self-evaluations (Level 3 - being confident). Disillusionment with psychotherapy and questioning whether psychotherapy even works were at the next level of self-doubt (Level 4 – wavering faith in the process). Increasing levels of intensity led to progressive movement towards core self-reflective and evaluative mechanisms, with the third degree, incompetence proper, representing concerns about one's contribution to client's growth (Level 5 - contribution / attribution) and concerns about one's personal shortcomings, worth, and self-definition (Level 6 - identity). At the most profound level, the fears about incompetence threatened an integral part of their identity as in the example below.

> *Participant:* So, when I base so much of who I am on what I do as a counsellor, those feelings of incompetence, sometimes, if they gnaw at that foundation, everything could fall apart.

Main category 2: Sources

The second major category to emerge was sources of FOI. Therapists described a variety of occurrences that initiated the FOI. These sources of FOI were grouped along four contributing categories: (a) Permissible, (b) professional, (c) process issues, and (d) personal. The sources had the potential to elicit different levels of intensity of FOI. The actualising of that potential depended on mediating factors which is the third major category of the findings section.

The *permissible* category represented items that the participants described as natural aspects of their role such as "not knowing it all" and being fallible. Therapists accepted that the ambiguous nature of the work and understood that therapy would be replete with moments that were indeterminate. These sources were perceived as either positive or acceptable.

The *professional* category encapsulated all the items that were precursors to the work of performing therapy. Lack of knowledge regarding a client's identified problem, an underdeveloped repertoire of techniques, incomplete training, and a lack of sophistication in the management of cases and files were identified as weaknesses in professional preparation that left therapists vulnerable to FOI.

Process issues represented elements in the dynamic exchange between clients and therapists that triggered FOI. For example, this may have included client resistance, difficulties in establishing a relationship, and communication barriers. Many therapists discussed a process of projection or resonance where they believed that they had introjected client emotions of confusion, helplessness, or sense of defeat and failure. Therapists often spoke of discrepancies between process and outcome, that is, differences between what they expected based on their contribution and the observed outcome. In one instance a client's ultimate fate forced the therapists to struggle with the cognitive dissonance produced by the competing emotions of having performed well as a therapist yet bearing witness to pain and tragedy despite her best efforts and intentions. She reported, "It's very saddening that you might do the right things and clients will still go out and kill themselves."

The issue of assuming responsibility for change, progress, and movement was a pervasive motif across interviews and generated a large number of vivid examples. All therapists reported a variety of ongoing struggles with decisions about responsibility and concomitant attempts to establish boundaries to outline the division of therapeutic labour. Personal factors, the last category regrouping sources of FOI, were more difficult for participants to discuss and affected them at a more profound level than the previous categories. Therapists made links between feeling incompetent in therapy and personally sensitive topics and vulnerabilities (i.e., their personal moments of upheaval). Katherine provided the following example:

> *Participant:* I was in a period of my life where I had been through hell...
>
> *Interviewer:* Personally?
>
> *Participant:* Personally, hell. Really, hell. (Participant's emphasis).
>
> *Interviewer:* Were you vulnerable?
>
> *Participant:* Very. And I just began to work again and ... um ... I was functioning at a minimum level...

Three therapists spoke both of functioning sub-optimally and of being increasingly self-critical and prone to FOI after experiencing the death of loved ones, divorce or separation, and personally traumatic experiences. Typically, they expressed an increased sense of vulnerability during these times as well as an increase in applying self-protective mechanisms that they felt had handicapped their therapy. Therapists' discussed changes in their way of relating, limiting their investment in the therapy, withholding in therapy, and becoming more directive and technique-dependent. While the actual impact on the client's progress remains unclear, therapists at these

times felt incompetent because the modification of usual ways of practice was not based on the therapeutic issues at hand but rather on personal reactions and influences.

Beyond personal struggles that were related to life events, therapists reported other challenges posed by their own growth and insightful strivings towards self-understanding. Certain participants made links between familial relationships (family of origin) and feelings of inadequacy, insecurity, or incompetence. Therapists felt incompetent when personal values interfered with their therapy by hijacking the agenda, when characteristic self-critical tendencies manifested, and finally when prone to self-doubts by states such as fatigue or illness.

Third Main Category: Mediating Factors

Mediating factors is the third major category of the findings. It represents the active ingredient in the interrelationship among sources, intensity, and consequences. Mediating factors subsume a variety of mechanisms and conditions that had an impact on how therapists experienced FOI on a moment-to-moment basis by acting as catalysts for FOI. The mediating factors described were: (a) cognitive management (and mismanagement) of FOI, (b) therapist level of experience, (c) the role and stance adopted by the therapist, (d) the different forms of pressure experienced by the therapist, (e) the impact of insight and awareness, and (f) the impact of having received training or supervision regarding FOI. This last mediating factor was examined for the protection it offered against FOI.

Cognitive management. When FOI surfaced during therapy, therapists reported a variety of cognitive efforts used to contain them and to minimize the level of disturbance they caused. All therapists described internal dialogues that they used to normalize their FOI. Some engaged in prayer, others soothed themselves using encouraging words (e.g., it's ok, just keep going, you're good), while others called forth images of a role model who had successfully handled difficult moments in therapy. Therapists also coached themselves away from the distraction of FOI and gave themselves directives to focus on the here and now, the client, and the goals of therapy. However, there were times when therapists engaged in cognitive processes that were detrimental to themselves or the process. These incidents of mismanagement of FOI included distancing from the emotion by, for example, blaming the client for their difficulties, rumination, mind racing, and incessant self-flagellation.

Other cognitive processes that mediated how rampant FOI would be allowed to become during sessions included therapist attribution processes and self-control. The ongoing internal debate regarding the client's responsibility for the success of therapy had a mediating effect; when therapists were able to cognitively re-ascribe the impetus for change to the client, FOI were assuaged.

Ralph provides a succinct example of this:

> *Participant:* Whereas ten years ago it might have been "Christ, this kid is not getting better, I feel incompetent ". It's not like that anymore.
>
> *Interviewer:* You've seen an evolution?
>
> *Participant:* "This kid's not getting better. I wonder what she wants to do about it?" No sweat. Go home and never think about her again.

The self-control category relates to instances where the therapist consciously decided to put aside FOI to protect the process with the intention of dealing with them later, during a post-session debriefing.

Therapist experience and regression to prior ways of operating. As therapists gained experience, they described, retrospectively, an increased orientation towards process issues and away from self-concerns. As such, they had evolved away from frequently putting their whole worth back into question; they more easily attributed responsibility for change to clients, and were more adamant about establishing boundaries with clients. However, at times, they were catapulted back into earlier ways of being when they were more vulnerable to experiencing FOI and could experience profound FOI with little provocation.

Pressure. Therapists exerted pressure on themselves, which at times exacerbated FOI. The most common form was a self-imposed pressure to "Do something!" or to "Say something brilliant," and "Fix it!" Therapists were also conscious of accountability issues and were mindful of proceeding with integrity. Common examples were the fear of doing harm and the prescription to only work within the limits of one's competence. Self-monitoring practices had an impact on the extent to which FOI would manifest. Rigid internal standards, expectations about performance, as well as the strength and direction of self-critical judgments were all were capable of magnifying FOI. Therapists in private practice were conscious of the client as a paying customer and consequently, they exerted pressure on themselves to give their clients their money's worth.

Pressure also originated from external avenues. The interference by third parties such as supervisors, professional associations, agency evaluators, and referring medical personnel introduced conditions that made therapists more prone to experiencing FOI. For example, Employee Assistance Programs at times dictated conditions that artificially constricted therapeutic manoeuvring by imposing time limits and theoretical prescriptions. Therapists also felt external pressure when they believed their reputation was at stake. For example, when cases had high visibility within their communities, therapists were more prone to FOI. Clients were also candidates for putting pressure on therapist by providing negative feedback.

Role and stance. While some therapists had clearly seen an evolution from a more dysfunctional and vulnerable stance toward a way of being (i.e., of positioning oneself vis-à-vis the client) that was both more fruitful and less inducing of feelings of incompetence, others continued to struggle with role-related issues such as feeling isolated and lacking a clear, theoretically anchored role definition. For example, several therapists described having felt burdened by either their clients or by self- expectations that dictated that they ought to be all-knowing specialists. Others had at least temporarily been able to resists the invitation to be the great expert. For example, Ralph said:

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

When therapists adopted an expert role they expected to single-handedly rectify client life situations or problems. Therapists could get very attached to this image of themselves as the dispenser of corrective/remedial experiences. Cameron explored this issue:

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

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

Closely related to the above struggles between expert vs. dummy and being vs. doing was the oft internal conflict between sensing one's role or impact as central to clients' quality of life (present and future) or judging one's implication to be of peripheral importance.

Awareness and insight. Ongoing reflections on process offered therapists a measure of protection against looming FOI. Therapists who were more introspective and focussed on process were better able to triage their FOI as they occurred. They were able to discern when: (a) the emotion signalled that they were moving beyond their competency, (b) it signalled that insecurities had been triggered. Introspection helped them ascribe a meaning to the emerging FOI that made it easier to manage.

Training and supervision. While only a quarter of the therapists spontaneously mentioned that they had received training and supervision regarding FOI in graduate school or during subsequent supervisory experiences, those that did were able to recall those learning moments with clarity. The relief generated by those exchanges were still palpable in the retelling, some over fifteen years later.

> *Participant:* I usually say to myself the same thing. I quote XX (graduate program professor) in my head (laughs). I say to my self: "Clients are forgiving. Umm, and one bad moment or one session doesn't make or break a therapeutic alliance nor your ability to help."

Fourth Main Category: Consequences

The fourth and final major category was consequences of experiencing FOI. This section is presented in terms of the impact on: (a) the therapists' emotions and feelings about their clients, (b) the therapists' imminent in-session actions, (c) clients and on the therapeutic relationship, (d) therapists' long-term well being, and finally, (e) the positive outcomes of FOI.

Therapist emotional responses and feelings about their clients. Therapists inevitably had a range of emotional responses when experiencing FOI: Anger, guilt, betrayal, exploitation, emotional depletion, discouragement, experiencing defeat, and being bored are among the often-disclosed emotions. Therapists also had strong feelings about clients as a result of FOI. They often disliked clients who seemed to induce FOI. They resented them and at times blamed them for their difficulties. Therapists admitted to experiencing

anticipatory dread and secretly wishing that these clients would cancel.

Imminent actions. Therapist FOI had an immediate bearing on therapeutic interventions, decisions, and choices about how to work with clients. For example, when experiencing FOI therapists often changed the pace of therapy. They described it alternately as "slowing down" or "speeding up." In slowing down, therapists described pulling back, delaying actions, buying time to regain their composure and their therapeutic direction. FOI's effects on imminent actions were diametrically opposed for other therapists; they increased their level of activity in order to compensate and resented that they "worked harder" than their clients. Therapists also proactively switched their focus from the content or problem to the process of therapy when FOI emerged. In doing so they were often able to use their FOI therapeutically by disclosing them, asking for feedback, or confronting the client. These interventions often drew forth some rich material and provided some movement in the otherwise stalemated process.

Impact on client and relationship. The most often cited process disturbance resulting from therapist struggles with FOI was the introduction of distance caused by therapists being distracted by their internal dialogues and struggles. Self-preoccupation was an impediment to intimacy. Therapist attachment to clients was also more complicated and precarious. Therapists described "shutting down," and "backing off." Generally, therapists experiencing FOI had difficulties with being authentic. They reported experiencing a sense of vigilance and mistrust, which created obstacles to a genuine encounter. Several therapists disclosed an outright rejection of the client and a desire to terminate the relationship. The issue of referral surfaced within that context and was followed by ensuing doubts about the motivation for the referral. While referral is commendable within the context of working within one's field of competency, some therapists wondered whether the decision to refer was made to protect the therapist against FOI.

Becoming transparent was another common response to FOI. Therapists shared their internal struggles with clients, inviting them to explore the process meaning of feeling "lost," "confused," or "stuck." Some therapists perceived their clients' response to these FOI disclosures as generally liberating for clients. While one therapist described her client's response to FOI disclosure as anxious, most perceived their clients to be accepting of their limits and willing to shoulder some responsibility for FOI inducing impasses.

Compromised well-being. Most therapists related stories of personal upheaval related to FOI and were able to identify consequences of FOI on colleagues and friends. Ongoing struggles with issues of professional self-doubts and FOI were directly linked to self-depreciation, low self-esteem, loss of self-confidence, and feelings of immobilization, inertia, and self-protective preclusion of therapeutic activities. Therapists relayed incidences of emotional depletion, depression, and burnout related to ongoing and incessant worrying about their effectiveness and competence. Therapists alluded to the concept of the "impostor phenomenon" and described feeling deceitful in holding their titles and credentials. These therapists feared being exposed as frauds and that their "ignorance" will eventually be discovered. Witness J who stated, "there's always that anxiety…that, oh my god! I am the only one who doesn't know what the hell they're doing! Everybody else has it perfectly under control, I am an idiot!"

Positive consequences. While therapists deplored the anxiety produced by FOI, several were equally alarmed when colleagues appeared unconcerned with their competence and displayed no signs of self-doubt whatsoever. While participants were not prompted to discuss the positive aspects of FOI, they inevitably valued the experience because FOI motivated them to engage in self-exploration and to proactively seek growth-promoting activities. Participants revealed that they reached out to other professionals as a result of FOI. For instance, they sought feedback, supervision, consultation, training, support, and reassurance. They invested in their own professional growth and felt that, when they were not intense and immobilizing, FOI spurred creativity and action. Participants also valued the humility it afforded them as well as the opportunity to continuously keep the limits of their competency in the forefront of therapeutic consideration. In short, they considered that FOI were valuable sources of information and motivation.

Substantive Theory

The preceding pages described the crucial dimensions of feelings of incompetence: intensity of self-doubt, sources, mediating factors, and consequences. These four major categories, although presented discretely, are in fact intricately interwoven. The following discussion and diagram represent an initial understanding of the interrelationships between the four major categories and together form a substantive theory (see Figure 1).

Intensity is the critical idea around which other elements are organized. There is a multiplicity of FOI ranging from mild to more intense. All participants directly or indirectly referred to this

spectrum concept and attributed differing characteristics to the points along this continuum, hence, the plurality of the basic experience of feeling incompetent. The mediating factors will ultimately impact where the therapist's lived experience can be classified on this continuum. That is, the relationship between intensity, sources, and consequences is not absolute and can be either magnified or reduced to result in more or less profound experiencing of FOI.

The following verbatim demonstrates the interrelationship among the four major categories. For illustrative purposes, several examples of the different levels involved in the coding procedures are included in parenthesis (major category-subcategory-code).

> *Participant:* Screw that. (Laughs). I just beat myself (major category = consequences, subcategory = compromised well-being, code = self-esteem/self-depreciation). No, I can't be that bad (major category = mediating factor, subcategory = cognitive containment, code = soothing internal dialogue) because I probably would have quit years ago but it's more, much more … especially when I have a client and I have no idea where I'm going with this client (Major category = source, subcategory= process, code=undefined goals). I understand why the client is there, but I don't get a) that I can possibly help this person, b) that anybody could help this person uhm... And it's weird because I go through this thing in my head, you know, part of the reason people come to see a therapist is because talking helps. And just talking helps, and they could talk to a plant and it would help and yet that is the first thing I forget. And if I can remember that, then I feel much less incompetent, because I know that at least that's a big part of the therapeutic process. I've got to say 50 to 60 % in my own head, or maybe even more, of why people get better is they talk about it. But if I forget that, and I do that all the time, and I focus on 20 to
> 30 % of skills and information giving, and reflection and uhm in my case cause I do cognitive work uhm… homework and behavioural changes and all that stuff and if I don't have that under control then I'll feel like a complete quack, a complete idiot (major category = intensity, subcategory = level 6-identity, code = something wrong with me).

Discussion

Feelings of incompetence are the result of complex internal processes that call upon the four major categories identified in the study: intensity, sources, mediating factors, and consequences. These four categories and the dynamic process of interaction among them form the substantive theory of experienced therapists' feelings of incompetence. This pan-theoretical and multidimensional theory is grounded in 12 participants' accounts of their self-doubting experiences. It supports the notion that therapists continue to doubt their competence well into their careers and proposes that that feelings of incompetence (FOI) vary in degree, in nature, and in kind.

The main significance of the study is that it isolates feelings of self-doubt and incompetence (among experienced clinicians) for a microscopic, first person, discovery-oriented inquiry. While previous studies underscored that FOI are identified among sources of stress and distress and that they may cause personal and professional disturbances, our study's contribution is in its' exclusive focus on FOI among experienced clinicians. As such it provides a more focused perspective that can be used to qualify previous findings. For example, while our study demonstrates that most experienced therapists continued to have level one (being right) and level two doubts (being effective) self-doubts, these types of self-doubts became acceptable to therapists and with time did not produce important levels of anguish. Experienced therapists may ask themselves the same questions as novices (e.g., "Am I doing the right thing here and now?") but these doubts do not contaminate their self-judgment. Therapists' retrospective self-analysis led them to declare that those types of self-doubting experiences seem to be more easily contained with professional maturity. However, this may not be true for the deeper levels of self- doubt and experiences of FOI. Therapists did not seem to develop an accepting attitude towards more intense levels of FOI. For instance, self- doubts stemming from personal issues such as historical wounds continued to be quite potent despite years of experience and had important ramifications for the therapists and the therapy. Also, several therapists reported that their self- evaluative criteria had in fact become more stringent and severe and that their self- expectations were higher. This made them more vulnerable to more profound FOI in later years of practice. Furthermore, therapists can, under certain particular conditions, be brought back or "regress" to previous levels of vulnerabilities and ways of experiencing themselves and their incompetence that are more typical of their earlier years. Under these conditions, the experience level of the therapist would not be a buffer against FOI.

The identification of the four major categories that are organized to form a substantive theory is the second important contribution. The theory provides a template from which to derive rich and textured meaning from raw experience. It provides an ordered, contextualised, and dynamic structure

that can be of immediate and practical use in understanding self-doubting processes among seasoned clinicians. It leads us to analyse FOI with a level of conceptual complexity that moves beyond viewing feelings of insecurity or incompetence as unidimentional and static. Our theory allows for a more nuanced understanding of FOI because it outlines conditions and interactions among conditions that give rise to this complex phenomenon.

Limitations

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

Another limitation stems from conducting discovery-oriented interviews with a semi-structured interview protocol. While the protocol served as a guide from which the interviewer is free to depart, there remains the danger of prefiguring the categories when the domains of interest are predetermined. Finally, half the participants were known to the author, possibly creating demand characteristics. On the other hand, this may have assisted the participants in lessening their inhibitions when discussing FOI.

Implications for Counselling and Psychotherapy

Therapist self-care issues have been identified as a priority by the few researchers who have focused on the area of therapists' experience of therapy and on the stresses inherent in our work (Dryden, 1992; Guy, 2000; Mahoney, 1997; Norcross, 2000). This study has begun to address the issue of therapists' judgments about their lack of competence; an issue that has been linked to stress, burnout, depression, premature career abandonment, and other therapists' problems identified in the literature and confirmed by the results of this study.

The theory of feelings of incompetence can be of immediate use to practicing clinicians. Peering into this hitherto unexamined world of self-doubts will primordially normalize and hence diffuse the negative impacts of FOI for seasoned clinicians. Recognition and acknowledgment bring relief. Being able to dissect the FOI experience into its constituent parts will afford a deeper level of introspection and self-awareness to therapists. This mindfulness can then be translated into better self-care choices and steer related therapeutic manoeuvres. For example, when therapists accept that they will experience self- doubts and know that these are not indicative of their actual performance, they feel less shame. They are more apt to disclose these struggles to peers and supervisors. They engage in deeper levels of exploration and are able to pinpoint why and how the FOI arose. Subsequently, they can make enlightened choices about how to cope and whether some aspects of the FOI experience are "grist for the therapeutic mill'.

Another use of the results would be as an educational tool: to prepare therapists in training for the inevitable encounters with feelings of incompetence. Perhaps incorporating articles such as this one in a compulsory course's required reading list would offer students an opportunity to explore and discuss the topic openly. Indeed, the therapists who mentioned having dealt with such issues in their training certainly appeared to endorse the notion that this prior knowledge facilitated their efforts to cope with FOI. They continued to draw comfort from these lessons, some over fifteen years later.

The theory of FOI can also be useful to individual supervisors who are supervising seasoned clinicians. Supervisors could use the structure as a map to help their supervisees disclose and explore their experiences with self-doubts. Understanding the multiple components of FOI and their dynamic nature may help supervisors move beyond simply equating confidence with experience. Having a more sophisticated tool to analyse FOI could motivate them to help therapists develop specific and effective mechanisms to cope with the multiplicity of feelings of incompetence in their distinctive forms. For example, if the source of supervisees' FOI is professional, supervisors can guide them towards appropriate professional development activities such as training workshops or topical readings. If the source of the FOI is personal, however, the optimal supervisory intervention would reflect this nuance. A more suitable response could include recommendations for sustained introspection or personal therapy.

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