DPY 5360   FINAL DOCTORAL PROJECT

Bridging the gap and continuing to develop professionally:

A pluralist mixed methods study exploring the impact of continuing professional development (CPD) activity on the practice of therapists working in higher education (HE) settings.

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Declaration

This work is original and has not been submitted before in support of any qualification or publication. There is no known potential conflict of interest.

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Abstract

To date, there is limited research relating to the continued professional development (CPD) of qualified counselling professionals employed within counselling services in Higher Education Institutions (HEIs). Drawing on five student counselling professionals thematically analysed interviews, and subsequent survey data collected from ninety student counselling respondents, this research elucidates practitioners' experiences of CPD practice and provision in HEIs. Existing challenges and potential opportunities were identified by participants for continued learning practice in university counselling services (UCS), in line with evolving national CPD strategies for the counselling and allied health care professions. The notable lack of research attending to the experiences of UCS practitioners continues, despite the impact of ongoing context-specific changes such as growing student demand and increased presentations of risk, as well as wider cultural, political, and socio-economic factors.

The results from this two-stage sequential mixed methods exploratory design demonstrate participants' strong commitment to and valuation of CPD activity, with learning needs guided by *interest* (81%, n=73) and *reflection on practice* (63%, n=57). 94% of the participants stipulated *new knowledge* and *skills* as the learning objective yet only 17% engaged in *research-led* CPD activity, despite a national directive for a research-led practice. The study further revealed that

national recommendations for the use of a supervised *personal development plan* (27%, n=24), *appraisal* (18%, n=16) or *performance review* (2%), to ensure CPD is guided by learning gaps, remains underutilised. Qualitative thematic data showed that whilst therapists are committed to their professional development and engage in a range of learning forums, there remains some concern about the lack of accessible and relevant CPD to support the rising complexity of therapeutic work presenting to UCS. This data provides an opportunity to review existing CPD practices in the sector and develop a continuing education programme that promotes best clinical practice in line with national expectations for the healthcare professions.

These findings thereby contribute to an unattended area of clinical practice and provide a practice-based research context to highlight practitioner perspectives, to shape future policy, service delivery, and training provision. Recommendations are made for CPD practice to be the shared responsibility of investors, stakeholders, and partners to ensure that research informed CPD practice is developed and maintained in the sector.

Key words: Continuing professional development (CPD), higher education institutions (HEIs), university counselling services (UCS), practice-based research, mixed methods research (MMR).

(365 words)

Acronyms and abbreviations:

ASC:	Association for Student Counselling
AUCC:	Association for University and College Counselling
BACP:	British Association for Counselling and Psychotherapy
BACP UC:	British Association for Counselling and Psychotherapy Universities and Colleges Division
BPS:	British Psychological Society
BABCP:	British Association for Behaviour and Cognitive Therapy
CCMH:	Center for Collegiate Mental Health
CPD:	Continuing Professional Development
DoE	Department of Education
DoH:	Department of Health
FP:	Final Project
GDPR:	General Data Protection Regulations
HCPC:	Health Care Professions Council
HE:	Higher Education
HEI:	Higher Education Institutions
HUCS:	Heads of University Counselling Services
IAPT:	Improving Access to Psychological Therapies
ICO:	Information Commissioners Office
IPA:	Interpretative phenomenological analysis
IPPR:	Institute for Public Policy Research
MWBHE:	Mental Wellbeing in Higher Education
OfS:	Office for Students
PBE:	Practice Based Evidence
PHE:	Public Health England
PEP:	Practice Evaluation Project
PK:	Professional Knowledge
PRN:	Practice Research Network
ROM:	Routine Outcome Monitoring
RCP:	Royal College of Psychiatrists
RPPL:	Review of Personal and Professional Learning
MM:	Mixed Methods

NHS:	National Health Service
NICE:	National Institute for Health Care Excellence
SIG:	Special Interest Group
TA:	Thematic Analysis
UCS:	University Counselling Services
UMHC:	University Mental Health Charter
UUK:	Universities United Kingdom

The terms clinician, counsellor, counselling professional, heath care professional, practitioner, student counsellor and therapist are used interchangeably throughout the document to represent the diverse range of terms used by professionals employed in UCS.

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Section 1. Introduction

In this final project I explore how therapists working in the HE sector experience their CPD and evaluate its impact on clinical practice with students. I first became interested in practitioners' experiences of post-qualification learning during turbulent times for counselling services in Higher Education Institutions (HEIs). These research findings were captured during a period of national review for health care professionals continued development (DoH, 2017), with emphasis placed on evidence-based practice (NHS England, 2019), and a focus on student wellbeing initiatives rather than mental health provision in the sector.

This research also sits within a personal context. My initial motivation to research student counselling practitioners' professional development stems from my own experience of the fast-changing nature of the fields of education and health, resulting in a more complex and challenging working environment, and the establishment of a "more for less" culture (Dufour, 2020), impacting the provision of accessible and relevant CPD. I therefore open this study with an overview of my own personal history and professional background as an experienced cognitive and psychodynamic therapist and supervisor working in HEIs over a twenty-five-year period. This provides the reader with a foundation from which to gauge where I, as "insider-researcher" (Lees, 2001), might

impact the project with my prior lived-experience and offers a transparent account for my interest to research this specific area of clinical practice.

I believe that with methodological integrity (Levitt, Morrill & Collins, 2019) biases can be mitigated through the skill's "insider" researchers utilise in knowledge production (Strauss & Corbin, 1998). My research findings are intended to be transferable within therapeutic settings and provide a platform for therapists to feed back their experiences in a practice-based context. In doing this, my hope is that practitioners can actively contribute to the progression of a context-dependent understanding of practitioner growth and development.

This research evolved from a small-scale qualitative study (Practice Evaluation Project, or PEP) exploring therapists' experience of CPD in HE settings. The PEP results provided the impetus for the current final project, which aspires to build an awareness of the ongoing development needs of practitioners working in universities counselling services (UCS) and to advocate on their behalf. An explanation of how and why the two stages of research blend together as the final product conclude a summarised version of the PEP (Section 2).

The subsequent sections of the final project comprise:

- A review of the relevant literature (Section 3)
- The design and methodology of the FP (Section 4)
- The ethical considerations involved in the FP (Section 5)
- The results of the FP and explanation of how the mixed datasets complement each other and blend with the findings from the PEP (Section 6)
- A discussion of the results, strengths, and limitations of the research and future considerations (Section 7)
- A chapter dedicated to the products that originated from both stages of the PEP and FP and to future developments (Section 8)
- A final chapter reviews my learning from the experience (Section 9).

1.1 The Role of Personal and Professional Growth

I trained as a therapist in the mid-1990s, qualifying with a master's degree in adult psychodynamic counselling from the University of London in my late twenties. The faculty, unbeknown to me, had a rich history in the development of student counselling training and provision. As a result, many of my training placements were within university counselling services. While the training offered counselling experience in a variety of clinical settings, I was particularly

drawn to clinical work with university students. This may have been because I was simultaneously employed as a seminar tutor on a different university's undergraduate psychology programme and felt out of my depth and incompetent, having received no training for the position.

The academic setting was nevertheless familiar and my experience of one-to -one personal tutorials helped me empathise as a counsellor working with student concerns. I felt relatively comfortable in the student counselling role and setting, despite my novice status. I was interested in the students' presenting problems and motivated to learn how to help them make sense of their difficulties whilst progressing academically; a role that was harder to fulfil as an academic tutor. That was 25 years ago, and since then I have held several university counselling positions, from trainee therapist to Acting Head of Department.

From the very start of my career in student counselling I was attracted by the sense of community fostered among the student counselling practitioners. The profession is relatively small and was founded upon a tradition of practitioners growing and progressing the field – through public presentation, professional association committees and special interest groups (SIGs) in addition to positions of employment (AUCC, 2010; Bell, 1996). These sector-led

development opportunities provided the occasion to engage inspiration from the pioneers of student counselling, many of whom had gone on to publish, to professionalise counselling and train future generations. The professional commitment to enhance institutional knowledge and understanding of the nature of counselling work in relation to the student experience and wider community has been at the heart of student counselling practice since the very beginning (which I discuss in more detail in the literature review). This is not surprising given that HE was one of the key settings, alongside the voluntary sector, that marked the emergence of counselling as a profession in the UK (Bondi, 2005).

The draining, intense and, at times, lonely nature of one-to-one clinical work and counselling service team dynamics was, for me, offset by CPD events and opportunities. The multi-dimensional nature of CPD – the energizing collaboration, networking, and mentoring – as well as the acquisition of new knowledge and skills provided some respite from the work-based challenges. For me, there were also the career-progressing bonuses that I could satisfy the requirement to provide evidence of CPD activity for professional association accreditation purposes and opportunities to show commitment to vocational undertakings.

Over the course of my career, I have committed to a range of sector initiatives, all of which, on reflection, have formed an immensely significant part of my ongoing growth and developing practitioner identity and have contributed to me feeling professionally competent and valued. The decision to follow the trend and become an active member involved in wider professional sector activities and initiatives, in addition to my paid work, came largely through events organised by the Association for University and College Counselling (AUCC), a part of the British Association for Counselling and Psychotherapy (BACP) now known as University and Colleges (UC) division.

As a participant in various professional initiatives, I have made significant connections with others who also invested their time and energy in championing developmental work with young people and addressing the impact of wider socio-political issues. For many practitioners, being a therapist involves a commitment to ongoing learning, evolution, and transformation. With young people in mind, there has been and remains much to advocate for in order to create better ways to live life, as we are all directly or indirectly affected by the structural and systemic inequalities and practices that reside within ourselves, our communities, our institutions, and society at large.

I have personally witnessed many of the changes that have positively contributed to growing awareness of and developments in student mental health. Some, such as the 1999 report *Degrees of Disturbance: the new agenda*, which highlighted increasing degrees of disturbance within the student body (Rana, Walkling & Smith, 1999), date back over 20 years and led to recommendations for the sector (RCP, 2003, 2011). Fast-forward twenty years and those same concerns now underpin a government-initiated mental health and wellbeing directive within our institutions (University Mental Health Charter, 2019). I have no doubt that observing and partaking in some of these sector landmarks is how I came to be an advocate for sound professional development activity and a dedicated participant in collective action.

1.2 My Personal and Professional Context

It was not until I began the Doctorate in Psychotherapy (by Professional Studies) at the Metanoia Institute in the academic year of 2015/2016 that I had the space to reflect on the influence that personal and professional learning has had on my life. The task to review my development required a meaningful examination of these two areas of life, which, in due course, exposed how my specific field of clinical practice (university counselling services), my research interest (the impact of continued professional development), and specific salient childhood events from my past were deeply interconnected.

As I completed the earlier parts of the doctorate, I became aware that I have been *researching* how to make sense of both my identity development and my lifelong quest to hone my intellectual abilities. This search culminated in my becoming a therapist working in HE and helping others navigate the emotional and psychological pitfalls of intellectual development (to which I, myself am not immune). My journey to make sense of the complex process of knowledge procurement originates from a desire to better understand my own "not feeling good enough" shame-based experiences. These feelings are often shared by students undertaking new learning, and I can thus extend my empathy toward them.

As an experienced, qualified psychotherapist, I am no stranger to thinking about the (un)conscious motivations and environmental influences that shape our development, relationships, and world views. The commitment to personal and professional learning over many years of practice refines one's ability to reflect on matters of vulnerability. In my experience the "maturational gain" from doing so in a clinical context has important implications for clinical practice and client outcomes as well as for personal and professional enhancement (McBeath, 2019, p. 385).

The experience of "being vulnerable" and the shame associated with this vulnerability has emerged as a salient theme during the doctoral journey. Growing up in an unconventional environment, with the words "they can because they think they can" by the Roman poet Virgil (70BC-19BC) (among other such atypical artefacts) boldly printed on the wall of the communal house in which I was raised, identified me as different from an early age. Born in the late 1960s to creative parents seeking a different way of life, my childhood experiences were distinctive and unlike those of my inner London school peers. For the first six and a half years of my life my family lived on a remote island in Spain and our subsequent return to the UK, where we lived communally, marked the start of my formal education.

During these early years of life, I learnt the art of survival, quickly and cautiously adapting and fitting into more conventional environments such as school and mixed peer groups. I can see now how immersing myself in other's agendas served to alleviate my own, and to vanquish conflict. At school, I found refuge in belonging to a group where differences seemed to dissipate through the impetus to find commonalities. Our shared interests provided a convenient safety in a potentially unsafe and volatile environment. My childhood-to-adolescent experience – the realisation that my home life was unusual, my existence as an only child, my depressive and displaced mother and the impact

of hormonal growth and development – exposed a deep wish to be accepted and to belong.

Educational institutions provided me with a continuity that was absent in my home life. The environments of both school and university required me to learn the art of belonging and, in doing so, offered an associated experience of reassurance and investment in the collective venture befitting the individual. By contrast, my home community was concerned with differentiating itself from the prevailing culture at all costs. This evoked feelings of danger and insecurity for me as a growing child navigating these two very different worlds.

Looking back, it becomes obvious how and why I was motivated to find a professional home in student counselling. Universities had become a familiar and stable context in which, in addition to gaining an education and a stronger sense of self, I managed to hone my professional skills and be recompensed with a satisfying occupation populated with many like-minded professionals. I felt protected and safe in an environment dedicated to growth and development, which culminated in my feeling more adept as a person and competent as a professional. I had found another group in which to belong and quietly and confidently grow and mature.

I believe these personal and professional experiences shaped my ability to effectively empathise with students as they adjusted and adapted to unfamiliar settings. Students face the daunting task of navigating multiple new contexts and experiences, developing the necessary skills to belong in their new (university) community and manage these inherent challenges as part of their developmental growth and maturation process (Noonan, 1983).

Those individuals who struggle to make the transition from home to university life, to separate themselves from family and the peer groups formed earlier, and to individuate can experience persistent negative feelings (Blos, 1968; Coren, 1977). The shame associated with such feelings, alongside the difficulties of managing academic expectations, can quickly lead to lowered self-esteem and unhelpful coping behaviours, resulting in a vicious cycle of low mood and anxiety (Fennell, 1999).

A large part of my work is providing students and staff with the learning opportunity to discuss and make sense of their personal and institutional anxieties in a safe and confidential environment, so that their confidence and self-esteem can grow in spite of the challenges they face. I myself had no knowledge of such a space and I believe I might have prospered had I done so. This is probably why I connected so profoundly with a vast array of personal

and professional development forums later in my life. These settings offered me an opportunity to build and maintain confidence and professional assurance, both of which are, in my opinion, essential components of practitioner self-care.

During my years as a senior practitioner and supervisor, I have noticed a shift in support towards practitioners' ongoing development and a gradual reduction of institutional support (funds and time in-kind from HEIs) for advancing the specialised role of student counselling practitioners through CPD opportunities. As a result of this diminishing support there is less incentive for hard-working therapists to volunteer to build and maintain sector-specific learning activities and forums.

Meanwhile, in wider society, a more generic counselling and psychotherapy CPD industry has emerged to cater for practitioners' CPD needs. The lack of student-focused learning products and reduction in institutional resources, alongside mounting pressure to meet the demands of students, institutions, and professional practice, presented me with an opportunity to research a set of questions arising directly from clinical practice (Finlay, 2019).

My own experience of the increasingly complex and demanding nature of student counselling inspired this enquiry into the impact of this situation on practitioner development. I am curious about the contemporary role of CPD in effectively supporting the practice of student counselling, given the contextual pressures on the role. In seeking to make sense of others' experiences of CPD and its impact on professional practice, I realise I am also attempting to better understand my own experiences. Likewise, my aspiration to raise the profile of the work, influence the field, and gain wider professional understanding is also an attempt to validate myself and other student counselling practitioners.

1.3 Framing the Research Journey Through the PEP (Stage 1)

The PEP module of this programme provided me with the opportunity to carry out a small-scale preliminary study into the area of my research interest. The module was specifically designed for senior practitioners with limited or no experience of planning and carrying out formal research projects, such as myself. It offered the potential to pilot a study as an additional (preparatory) component of a more substantial in-depth final research project. The modular-based approach to learning made the prospect of undertaking a larger study doctoring the field of psychotherapy more tangible and less anxiety-provoking.

Like many senior counsellors and psychotherapists, my initial training focused primarily on therapeutic knowledge and practice development skills. The study of theoretical modality-focused literature, clinical and experiential practice, and the undertaking of supervision and personal therapy was common amongst many of my peers, but not in relation to the significance of counselling and psychotherapy research.

As a result, many senior practitioners, like myself, have little awareness of the role of research epistemologies and respective methodological approaches. By the same token, the knowledge generated by psychotherapy research is likely assumed to have less value to practice development than clinical experiences (Morrow-Bradley & Elliott, 1986; Riley, Schumann, Formon-Hoffman, Mihm, Applegate & Asif, 2007). This lack of awareness may, in part, explain the scarcity and underutilisation of research in psychotherapy practice (Bager-Charleson, McBeath, & Du Plock, 2018).

My own limited education regarding the role of research in psychotherapy unintentionally reinforced my view that researchers and therapists belong to different professional worlds. In institutions of higher education there is a clear distinction between academic and professional staff, and working in student counselling over many years has only served to strengthen the sense that the

two undertakings are viewed as distinct. An example of this separation is that practitioners employed in university counselling services are not required to undertake formal research. Engagement with research is limited and this appears to be the experience of other professional staff working in HEIs in other countries (Gilbert, 2021).

University therapists, who privately assist academics and students in producing research and disseminating knowledge, must, at times, tolerate a lack of understanding of the counselling work. And this may be as a result of the paucity of research in their professional arena increasing the reported feeling of being devalued by the institutions they serve (Harrison & Gordon, 2021; Mair, 2016). This division of labour generates and maintains a tacit hierarchy of expertise that operates, albeit unconsciously, to conceal and undermine the work of many professional staff in HE (McLeod, 2016).

The growing demand for a research-led attitude and evidence-base in clinical practice, mandated within the NHS and endorsed by government (NICE, 2011) and by professional associations' clinical practice standards (Point 14, BACP, 2018), has precipitated the need for more research in the counselling sector in recent years. In addition, the proliferation of students with mental health conditions (Advance HE, 2018; Thorley, 2017) has led to an examination into

the efficacy of student counselling provision (Broglia, Millings & Barkham, 2018). The lack of data demonstrating the effectiveness of student counselling continues to be a concern (Barkham, Broglia, Dufour et al., 2019).

My colleagues and I have also noticed a lack in both confidence and support when accessing and engaging with the production of meaningful research that can advocate for relevant work-based matters (Dufour, 2020). These core issues inspired me to embark upon this doctorate in order to access research skills and knowledge and respond to this timely professional conundrum. Moreover, I sought the means to build the confidence to collaborate with researchers across academic institutions in order to demonstrate the effectiveness of counselling. I also undertook a mixed methods research design to widen my target audience to academics and therapists, and thereby increase the potential of my research impact.

1.4 Taking the First Steps

The Research Challenges module was my first introduction to learning about historical perspectives within psychotherapy research, and it soon became clear that competing knowledge-producing structures existed within the varied research epistemologies. Epistemology refers to the criteria used to evaluate the truth of testimonies: the worldview one adopts to make sense of reality. Bruner

(1986) highlighted the different knowledge paradigms and "characterized these traditions as constituting discrete ways of knowing: a paradigmatic form of knowing that seeks to explain events in terms of abstract laws, and a narrative form of knowing that seeks to understand events in terms of contextualized, concrete stories" (as cited in McLeod, 2013, p. 85).

My ability to think more critically about different research epistemologies and the purpose behind adopting one approach over another in order to suit a specific research question and purpose or to decide to bring methods together evolved gradually. Crucially, I developed an understanding of the ethical challenges presented by practitioner-led research activities and the importance of reflexivity in qualitative research methodology. Given that I practice as both a cognitive behaviour therapist (CBT) and psychodynamic practitioner and supervisor, I felt drawn to the pluralist and pragmatic perspective that there is no one superordinate source of truth. For me, all sources of knowledge have a potential benefit and require equal critical analysis (Fishmann, 1999).

The aim of my PEP (the first stage of the research that eventually developed into a two-stage exploratory sequential mixed methods design (Creswell & Plano-Clark, 2007)) was to explore how my understudied professional colleagues perceived and experienced their ongoing professional education.

After considering the benefits of and barriers to improvements in student counselling practice, it felt timely to ask my fellow practitioners about their own experiences of development, given the socio-political influences and economic considerations within the sector.

Wider institutional shifts have brought changes such as the introduction of multi-modality and multi-disciplinary teams and short-term practice interventions to the work of student counselling (Bentley, 2018; Caleb, 2014; Mair, 2016). Many of these developments have been in direct response to the socio-political challenge of responding to the increasing prevalence of mental health conditions among students that results from the widening participation initiative (Thorley, 2017). I was curious to know how therapists perceived these changes and whether or not their professional development activities (increasingly delivered by external private companies) supported their evolving practice with this new intake of students, alongside other work-related pressures.

Furthermore, I wondered about the impact the message that “the future may be bleak for any psychological therapy service that can’t provide evidence of its effectiveness” might have on counselling practitioners (McCrea, 2016, p. 87), many of whom are unfamiliar with an evidence-based culture, having trained in

therapies founded upon relational principles that pre-date outcome measure-based models.

Evidence-based practice (EBP) is a problem-solving approach to clinical care based on the best research evidence available. It has been utilised within healthcare provision since the 1990s (Fineout-Overholt, Melnyk & Schultz, 2005). EBP uses information from robust routine outcome data research, clinical expertise, and patient values and preferences to treat common mental health problems (NICE, 2011). Randomised controlled trials (RCTs), originating from medical research, emerged as the gold standard for determining treatment efficacy. In addition, there is a prevailing trend to define mental health disorders according to symptoms (psychiatric diagnosis) rather than reported psychological narratives (case reports). The development of psychological symptom reduction therapies such as CBT prompted the endorsement of evidence-based psychological therapies (Shedler, 2010).

Given this trend, the contemporary recruitment of counselling and mental health practitioners possessing such expertise into student counselling services is seen as strengthening service relations within the institution and wider sector (Bentley, 2018). However, my interest lies in the effects such changes have on

existing student counselling professionals, particularly in relation to the ongoing learning of all practitioners in the sector.

It was with these questions in mind that I chose to begin my first research study. I opted to use the semi-structured interview format to make use of my established skills as a therapist and supervisor. Finlay (2008) draws parallels between the process of therapy and research, although she notes that the practices have different goals. Both forums attempt to further understanding through rich, detailed personal accounts. Furthermore, I felt my finely-honed therapeutic skills aligned well with the methodology of phenomenological qualitative inquiry, a methodology informed by a group of interconnected historic philosophical traditions.

The interpretation of the meaning of texts such as interview transcripts originated from the hermeneutic tradition of understanding the meaning of religious scripture (Gergen, 1988). I felt this approach provided me the opportunity to develop an idiographic understanding of my participants' experience of CPD (Finlay, 2008) based on a variety of strategies accumulated and founded in clinical practice (McLeod, 2013).

Many of the assumptions I hold about learning and practice development are grounded in my own personal and professional experience and are informed by shared experiences with colleagues and supervisees. However, I am equally influenced by literature and the dominant socio-cultural and political narratives operating within the field of psychotherapy research and wider society. A prime example of this is the current threat to university counselling services and personnel in the absence of a strategic approach regarding the collection and evaluation of outcome data in, order to meet existing evidence-based practice expectations and demonstrate good clinical practice (Barkham et al., 2019).

I chose to adopt a phenomenological stance as this provided me with the chance to both cultivate essential research skills as well as evidence my belief that therapists' accounts of their work-based experiences are a valid source of public knowledge (albeit one that is in short supply in the research literature in my professional context). I also demonstrate that this source of wisdom is a useful body of information, providing necessary insight into what has been meaningfully co-constructed for this largely understudied group of practitioners by the current implications for practice development (Finlay & Evans, 2009).

From the very beginning I considered how to increase my study's appeal to my potential audience, having read that therapists in general can lack an affinity

with formal research (Bager-Charleson et al, 2018). For many therapists, the term “research” can evoke a range of feelings such as irrelevance (not related to clinical practice), uncertainty (of what’s involved), shame (of not knowing), and resistance (disengagement), leading to low participation rates (Finlay, 2019). I know before I became a doctoral student I had little interest in formal research articles, feeling they generally didn’t reflect my practice, client group or setting. In addition, I came from a training background that promoted the advancement of knowledge through theoretical textbooks. My lack of engagement changed once my interest in the production of research became something I wanted to emulate, and as a result of my growing awareness of the national expectation for health care professionals to have a research informed practice. For me, the relevance of published research to my practice was key in my investing time in accessing, reading, and integrating the knowledge for my own purposes.

I hoped that by conducting a preliminary study I would gauge levels of interest from the student counselling audience, offering an opportunity to cultivate their attention and curiosity in the subject matter because it related to their clinical practice. I envisaged that the dissemination of the research findings through network events, journals and conferences could encourage greater participation in research activity from student counselling practitioners, not least because of

the relevance of the practice-based information to their clinical work and professional experiences.

The building of a qualitative methodological evidence base is believed to strengthen marginalised forms of knowledge and serve as a counterbalance to the governance of positivist evidence-based research, preserved within the world of academia and formal, funded-research circles (McLeod, 2016, p. 20). My wish was to raise the profile of student counselling practice and simultaneously contribute knowledge that would be attractive to counselling practitioners who might have little affiliation with mainstream research (which is a growing concern given the contemporary focus on a research-led practice (BACP, 2018; NHS England, 2019)).

On this note, I began my research journey to better understand the continuing development of student counselling practitioners with the Practice Evaluation Project, or PEP, that formed the first stage of the final project.

Section 2. The Early Development of the Final Project (FP): The Practice Evaluation Project (PEP)

The title of my first venture into a research study is *Learning to continue to develop professionally: an exploration of therapists' experience of continuing professional development (CPD) in a higher education (HE) setting – a preliminary study.*

2.1 Introduction

Here I present a summary of the PEP for the principal reason that, as previously mentioned, the project provided the means to accrue incremental research knowledge and skills and to test the interest of therapists in the sector. The results suggest there is interest and that CPD is a significant area of relevance to practitioners' professional identities and feelings of competence and an essential component of maintaining an ethical clinical practice in HEIs. The study thereby informed the foundations, rationale, and, ultimately, the shape of the research design of the final project (FP).

This account opens with a summary of the PEP rationale, design, and methodology. The qualitative findings follow, and I briefly discuss the salient points within the context of some of the wider existing literature, before undertaking a more in-depth review of the literature in Section 3 of the FP. The

PEP summary has been presented using the original study format and thematic quotes to keep the integrity of the project and data findings (see Appendix 1), in spite of any flaws and the limitations of repetition. Finally, the section closes with an explanation of how the PEP and FP come together to form the overarching research design.

2.2 Summary of the PEP

2.2.1 Rationale for the study

When I came to write the PEP, there were no studies specifically dedicated to the ongoing professional development experiences or needs of UK therapists working in HE settings. This void existed despite more than a decade of huge structural and aspirational change in the sector that has led to a diverse and more complex student population and consequent challenges to staff working in HEIs (Advance HE, 2018; Brown, 2016; Brown, 2018; Sharp & Theiler, 2018).

This gap in the literature provided the rationale for commencing a study delivering clarification on the experience of therapists' CPD activity and practice within their clinical settings (HEIs). The PEP aimed to explore five university counselling practitioners' lived experiences of their CPD practice. An exploration of therapists' continued learning seemed timely, given the climate of evidence-based expectations, increasing scrutiny of university counselling service provision and a paucity of knowledge in the area of learning

development. The current lack of information on clinical and CPD practice, given these reported changes, means it is difficult to identify areas of good practice or indeed areas in need of development and improvement. Concerns about actual practice versus best practice are common across the counselling professions (Tucker & Leach, 2018).

2.2.2 PEP Design and Methodology

The research design I adopted for the practice study involved a qualitative phenomenological approach that reflected my then-fledgling view of social reality and an assumption that knowledge is socially co-constructed, and experiences subjectively interpreted (Finlay, 2011). I chose to use thematic analysis (TA) to get a sense of the participants' interview transcripts (derived from 60-minute semi-structured interviews) rather than adopting a positivist approach, which tends to arrive at an explanation of the phenomena.

TA is recognised as "flexible, straightforward and accessible" (McLeod, 2011, p. 146) because it offers researchers a six-stage guide to analysing data (Braun & Clarke, 2006). The datasets were colour-coded as the emergent and main themes were generated and comparisons across all five sets were made (Saldana, 2016). To assist with the triangulation of data, two critical friends and my clinical supervisor, all aware of my philosophical stance, read the transcripts

and fed back their own emergent themes, which I compared against my own. This assisted in “bracketing off” my assumptions during the TA and the process of extracting in-vivo examples for the results.

Initially I considered Interpretative Phenomenological Analysis (IPA) and Grounded Theory (GT) as possible research methodologies. However, IPA requires a loyalty to the philosophical foundations of hermeneutics that was not in keeping with the timeframe or objectives of the study and GT seeks to build a hypothesis from the data about the studied phenomena. Neither methodology appeared to fit the purpose of this small-scale study, which aimed to seek common themes across the data set as way of describing the phenomena, as effectively as TA methodology (Tong, Sainsbury & Craig, 2011).

2.2.3 Design

I identified the target population as any qualified therapist working in a HEI. To recruit participants, I sent a research advertisement incorporating an invitation to register interest to several professional networks. I carried out a stakeholder analysis (see PEP: Appendix 6) before starting the research to ensure due consideration of any potential risks and included risk management protocols for the research process. I sent the participants an information sheet and consent

form (see PEP: Appendix 2 and 3) prior to the interview, following a pilot process.

All five participants were informed of data protection protocols (clear information about their participation, withdrawal rights, data encryption, storage and processing of data) and signposted to the Information Commissioner's Office (ICO) and Metanoia Ethics Committee in the event that they had any concerns. All participants were given the opportunity to review the data and offered debriefing sessions.

2.2.4 Method

Brief telephone selection interviews provided the opportunity to discuss the project with interested respondents, providing a space to detect any vulnerability (anxiety recalling learning experiences, confidentiality issues, and concerns about research participation) by following guidance in the literature for minimisation of risk of distress (Bracken-Roche, et al. 2017). I firstly reiterated information provided on the study's objectives and participation criteria in order to develop a rapport and detect lack of clarity. This also enabled me to check each individuals' past experience of research interviews, any adverse past experiences, and whether they had the necessary support in the event that they did experience any difficulty post-interview. The informal 10-minute conversation gave me an opportunity to ensure interested parties had a

good understanding of English language, the projects' aims, and to establish their suitability (in terms of inclusion criteria), consent and confidence in participating in the research.

In keeping with the humanistic philosophical foundations of phenomenological inquiry, and to be as reflexive and transparent as was possible within my researcher remit, I openly shared my membership of the profession and my experience of organising CPD in HE, whilst highlighting the benefit of participating in research and explaining it comprised a recognised CPD activity. Five (purposively) recruited volunteer respondents (all of whom were unknown to me) agreed to participate in the study. Three respondents identified themselves as female and two as male. All the participants reported their ethnicity as Caucasian and there was an age range of between 38-55 years old (*m=46.5).* Two described themselves as integrative practitioners, one practised primarily from a psychodynamic perspective and the remaining two identified as cognitive behaviour therapists. All five were employed as clinical practitioners in UK university counselling services and had had more than five years of post-qualification experience in the sector. They all fulfilled the selection (inclusion) criteria (see Appendix 1: PEP).

During the in-depth, 60-minute, semi-structured, open-ended interviews data was collected using digital recordings and stored securely as audio files (MP3/WAV) to ensure the participants' narratives were faithfully represented. The interview format followed a responsive interview style with open-ended questions designed to elicit a rich, first-person account of recalled CPD activity. Immediately after each interview I recorded my experience of the session in a reflexive journal to ensure my initial thoughts were not lost. I then transcribed the MP3 recordings into WAV files within two weeks of the interview date.

The reflexive journal provided supportive evidence of the codes and themes that emerged during data analysis, serving, alongside supervision and peer-discussion, to maintain quality control (Finlay, 2011). From these reoccurring patterns, sub-themes developed, generating a "thematic map" (McLeod, 2011). This map was later compared to the themes generated by my critical friends and supervisor, providing an objective lens on the initial research and then again on the collected research data provided for the purposes of triangulation and quality control.

The fact that I had assumptions and ideas about therapists' experiences of CPD before, during, and after the data collection (and participants were aware of my membership within the HE community) due to my "insider-researcher" status

(Lees, 2001) means that any pre-knowledge in this study can be considered an integral part of developing the dataset. Fortunately, the sets of data codes and themes seemed to correlate with each other.

Three out of the eleven minor themes produced were identified as major themes. I selected transcript extracts that would exemplify both pre-existing themes that can be found in existent literature on therapists' learning and emerging themes particular to the research aim and question.

2.2.5 Findings

The PEP research was inevitably influenced by my own concerns and interests about CPD provision. However, I did not have a theory about the phenomena. The purpose of the research was to formulate a better understanding of the phenomena of CPD practice in HEIs through the themes identified in the qualitative data analysis. The data was analysed using TA and employed according to the guidelines, as stated above, always directed by the premise that "a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006, p. 82).

This study provided a snapshot of a sub-sample of therapists' experiences of CPD in HE and produced information on their perceptions of what is of benefit and what is a barrier to ongoing development and practice in a rapidly changing climate. At the time of undertaking, it was hoped that the findings would stimulate and provide a platform for a larger, more generalisable exploration that would be of worth to the population.

A superordinate "thematic map" of the analysed data as it related to the original codes resulted from conversations with my supervisor and critical peers. Three meta themes emerged from this process:

Theme 1: Commitment to ongoing development of skills and competency

Theme 2: Practitioner autonomy and consolidation of professional identity

Theme 3: Tensions over time and cost and lack of sector specific CPD

All five individuals who were interviewed had a professional obligation and commitment to their annual professional body CPD requirements. In addition, they each had an informed understanding of a minimum CPD professional requirement (BACP, UKCP, and BABCP) that was essential for maintaining their skills, competency, and accreditation. The data set revealed a high level of commitment to CPD, including personal and professional development (with all five participants undertaking more than 30 hours each year). This can be seen in

the below transcript extracts from participant 001 (a male, Caucasian, CBT practitioner), and 002 (a female, Caucasian, psychodynamic practitioner).

> **Q:** Can you tell me in your own words what you consider and understand CPD to be?
>
> **A:** Outside of it being an ethical requirement of good practice and continuing accreditation, I think it's an opportunity for me to think about my personal and professional needs to continue to work competently and effectively… to identify areas I need to continue developing or areas that perhaps are new to me… keeping myself up to date with client needs… (P001; 02:25).

The response from participant 002 communicates the commitment to "lifelong learning", a key finding among therapists (Rønnestad & Skovholt, 2013).

> **A:** I see it as a kind of process of continuing growth. When I trained to be a therapist I never felt like, right I'm there, I can do this, I always thought it had to be an on-going learning process, so the way I view CPD is a way of, like, keeping that training ongoing and connecting with new people, learning new skills, getting, and generating new ideas from a range of developmental activities (P002; 02:48).

The first thematic finding - T1: Commitment to ongoing development of skills and competency - aligns with existing literature suggesting that therapists as a collective group of professionals are motivated to continue learning and developing throughout their careers (Fender, 2017; Orlinsky et al., SPR Conference, 2017; Rønnestad & Skovholt, 2013). Indeed, all the participants reported engaging in an assorted range of formal and informal CPD activities, as recommended by professional organisations such as BACP, and the participants were mostly supported by their employers, in terms of time and cost, to engage in CPD activity.

Interestingly, all five interviewees stated they rarely planned their CPD activity in advance and candidly admitted that what they did was not usually based on an identified knowledge or skills gap, but rather on personal interest. Comments from a female integrative participant illustrate this, "planning CPD is a challenge and to be honest… what I do is often dictated by what is available at the time and looks interesting and relevant" (P005; 19.17). Furthermore, scant attention was paid to the recommendation to document their activity for reflective practice purposes, as suggested by professional organisations.

When therapists did retrospectively document their CPD activity they all tended to document certified training days, seminars, and conferences for appraisal and

review purposes as opposed to books they had read, recorded therapy sessions they had attended, or peer group discussions they had had. The former activities were perceived to be more legitimate learning pursuits, which lends credence to the idea of a tacit "hierarchy of knowledge" (McLeod, 2016). Similarly, the conclusion from one study into therapist development suggests that "… the professional requirement for CPD hours and the strength of the CPD industry encourages therapists… to take courses and workshops" may promote the value of formal CPD activity over other forms of activity that may be more relevant and therefore more impactful on practice (Fender, 2017, p. 11).

The second superordinate theme - T2: Practitioner autonomy and consolidation of professional identity - suggests the value of CPD activity is perceived to be associated and aligned with clinical autonomy and provides a continuity of connection with clinicians' preparative trainings (such as their modality of practice or philosophical and theoretical loyalties). The following extracts (from participant 003 male, Caucasian, CBT practitioner and 004, a female, Caucasian integrative therapist) indicate the perception of validation that external formal learning grants with regards to clinical autonomy and a sense of professional competence.

> CPD enables me to feel confident and autonomous about my practice with students… interventions and research based therapeutic tools are

continually being improved in CBT… based on researched informed facts not just people's ideas or my ideas like in clinical meetings at work and I like… you know having an informed research practice is what makes me the professional I trained to be…

(P003; 17:37).

CPD and maintaining accreditation helps me to feel part of a wider professional community not just in my place of work (HE)… where often therapists are drawn from a diverse range of backgrounds… some umm... quite different in professional outlooks and training… it helps support one's autonomy.

(P004; 16:01).

The question regarding how CPD impacts the therapist: "Can you describe how CPD has affected you as a practitioner?" elicited one of the male CBT participants to respond that he felt "refreshed with new knowledge that supported his… CBT based practice" (P003). The participant candidly indicated that his autonomy as a CBT practitioner in a university counselling service within a multi-modality team was important because of the tensions between therapeutic modalities he experienced.

This theme of clinical autonomy and professional identity was present in all five participants' transcripts and seems to suggest that CPD provides a valued

respite from professional dynamics (tensions), particularly when the clinical environment is challenging. The external and independent nature of CPD activity seemed to validate the experience of belonging to extended professional networks as well as being an autonomous clinician, as the extract below reveals.

> … not just learning skills or practicing skills, but I also quite like these events in terms of connecting more to your peer group… other counsellors… because I have found over the years it can be quite lonely doing counselling… week to week, day to day, of doing the work with clients and, yes, you have your team in the university service but it's quite nice to have more of a sense of wider community… of counsellors. (P005, Caucasian, female, integrative therapist; 25:03).

The connection between personal and professional development was detected in all five transcripts when the therapists were describing the experience and impact of CPD. All the participants spoke of what they had personally taken away from the activities that they could then put into practice. Subsequently, each described the collaboration between continued personal and professional learning that appeared to constitute the process by which evolving competent practice could be defined.

The third identified theme - T3: Tensions over time and cost and lack of sector-specific CPD - relates to the barriers therapists recognised with regard to their

continued learning and development. Each participant, in their own way, expressed conflict with factors associated with the “time and cost” of CPD activity. Once again, this is a common post-qualification experience across the counselling and allied professions (Castonguay & Muran, 2015) and seems to relate to therapists’ perceptions of how much (or how little) organisational support is available to access relevant CPD activities for developmental purposes within a specific clinical setting.

In HE, arranging time away from clinical responsibilities can often be restricted by systemic factors. Universities are structured around academic terms or semesters. Clinical priorities are often allocated around the high student demand that occurs during these time periods. Consequently, CPD and annual leave are generally assumed to be taken outside of these periods. Similarly, weekends are often when many key CPD events are scheduled. For general consumers who may not want to miss the opportunity of paid employment (private practitioners) this may be more convenient than during weekdays.

However, for therapists in university counselling services or with caring responsibilities this can present challenges. The following extract from one of the male CBT participants demonstrates the pressures involved in requesting leave and financial support to access CPD.

> I think sometimes there is a subtle tension in the service around training on the weekends… I did my training on a weekend in London which cost more because of travel expenses and was across two days that then meant the loss of 10 clinical hours... and that is going to disrupt the client work particularly as we are busy all year round now… it was never you can't do it but subtly culturally there is pressure because you will be out for a period of time.
>
> (P003; 21:18).

The following extract is an example of perceptions around the lack of effective planning and guidance for accessing relevant CPD. The female psychodynamic therapist expressed her frustration (as an experienced therapist) at not receiving appropriate guidance (by her manager or supervisor) in her areas of specific developmental need. She reports:

> I've felt supported in some aspects of CPD, like sometimes in funding certain workshops, events, etc… but not really in how it relates to me as a practitioner. I don't think they are aware of what skills I possess. I mean they do have an idea of what I am supposed to do, but they're not the areas I am necessarily weak in in terms of therapeutic practice… in terms of my clinical practice I don't think they know what I am strong or weak on.
>
> (P002; 19:10).

She continued her point about the need for strategic CPD guidance and planning in terms of motivating her interest to participate in the research study despite the inconvenience.

> I was intrigued by your research subject choice… CPD in the HE-sector and thought that sounding interesting… what exactly is pertinent to HE specifically when often the learning is more general… about a specific presenting factor or intervention…
>
> (P002; 31:04).

The research topic intrigued and focused some of the frustrations the participant had experienced in relation to annual CPD. The notion of sector-specific CPD had never occurred to her before she read the advertisement calling for volunteers in the study. She sensed the relevance of the research not only for herself, in terms of her own continuing growth and competence as an experienced therapist, but also with new staff in mind. The knowledge gaps in (non-educational) student concerns that she noticed in therapists entering the sector from different clinical settings troubled her.

> I am aware of the recent unveiling of BACP UC competencies for HE and FE from the mail base and I know there are grumbles from therapists, but I actually think having standards is really important and from personal experience… and this may only relate to a minority... but there are people who come and work with this age group who have no

> knowledge or training of this age and their developmental challenges and lack real understanding of the work therapeutically as well as contextually.
> (P002; 35:07).

The above extract exposes the paucity of CPD activity that is directly relevant to the emotional and psychologically distinct developmental challenges of students and the knowledge base required by staff working with this particular clinical cohort. This paucity exists in spite of available resources such as BACP UC, sector resource 03, or the competencies guide for further and higher education (BACP, 2018).

The clustering of tensions over time and cost and the lack of sector-specific CPD as a theme emerged because these are superordinate factors relating to therapists' perceptions of the barriers to CPD. However, in retrospect, the study set out to explore therapists' experience of CPD and, given all participants highlighted concerns about the alleged lack of good quality, relevant student focused CPD, a separate standalone fourth theme may have better represented the data.

2.2.6 Discussion

The results of this small-scale qualitative study present a non-representative and therefore non-generalisable snapshot of British HE therapists' experience of CPD. The participants' attitudes and behaviours in relation to CPD practice are summarised below:

- CPD, informal and formal activity, are perceived to be essential and integral to therapists' professional identity and autonomy
- Professional expectations of ongoing development of skills and competencies regularly exceed the minimum-set requirements for CPD

Participants also expressed concerns about access to relevant CPD activity and materials:

- Barriers appear to be associated with limited time and financial resources
- Limited access to quality CPD products relating to nuanced clinical settings and populations

I felt enlivened by the PEP findings as they confirmed I was not alone in wondering about the relevance of CPD to therapists working in HE, given the distinct and diverse nature of student counselling practice and current situational constraints. The PEP results demonstrated I was justified in continuing to look at this area of continued learning practice to gain a deeper understanding of this complex and resource-intense forum. It could be said that CPD provision, like

many other consumables, is driven by the need to maximise profit and minimise cost, which has a subsequent impact on the accessibility, quality, and general provision of the services. Given that results show that practitioners seem highly committed and professionally invested in CPD, any exploration of who is currently benefitting most from CPD has the potential to reveal some uncomfortable truths.

The high level of agency and value placed on the undertaking of a diverse range of annual CPD seems to be perceived by practitioners, professional organisations, managers, and supervisors as a benefit to practice in itself. By contrast, if practitioners consider that CPD activity lacks relevance to actual practice-based concerns and it is not undertaken as recommended by national guidance and professional bodies then CPD will fail to meet its intended purpose of ensuring clinical competence and ethical practice, in our clients' best interests.

Although this phenomenologically orientated qualitative study cannot substantiate any general supposition about therapists' CPD practice in HE settings it does, given the small participant size and homogenous sample, begin to explore current practice concerns. It also provides the impetus for a more detailed examination of the subject and generates, following Rønnestad and

Skovholt, (2013), interpersonal sources of knowledge that drive collective thinking and conversation, a necessary requisite of action.

The first stage of my research venture succeeded in contributing qualitative data to the sector. It took the form of a conference poster presentation (Turner, Goss & Caleb, 2017) at the Society for Psychotherapy Research (SPR) at the University of Oxford (Appendix 2), two HE practitioner network presentations (Kings College London & London School of Economics, 2017), and the establishment of the first research special interest group on the Executive Committee of the UC division of the BACP, aimed at raising awareness about the benefits of a research-orientated attitude and investing in therapists' continued development. This last aspect also included a quarterly journal article contribution (Appendix 3).

The PEP furthermore provided opportunities for my own continuing development and served to underwrite an improved, more generalisable research plan for the FP. The upcoming second stage of the two-stage exploratory sequential mixed methods design (Creswell, 2015) seeks to broaden the consideration of this complex area of practitioner development and use a method based on innovation to instigate action (Creswell & Plano-Clark, 2007). This method will provide a chance to explore the perceived impact of CPD on

therapists' actual practice with students, in addition to the felt consequences for practitioners who do not feel their developmental needs are being addressed. This may for instance include the potential for burnout and increased professional self-doubt leading to absenteeism, subjects the PEP did not cover.

Practitioners' attitudes and behaviours regarding CPD were thus touched upon only lightly in the pilot study, leaving the opportunity to undertake a fuller review of these factors in a future study. It would seem that further examination and practitioner feedback on the key challenges of CPD provision would be of value for those (such as the BACP UC division or the SCORE project) involved in developing, funding, and providing improved CPD products for student counselling practitioners.

2.3 From PEP to FP and Developments Along the Way

In previous sections I have attempted to show how the findings from the PEP (Turner, Goss & Caleb, 2017) produced valuable information on practitioners working in HE, who described a worrying lack of relevant student-focused knowledge and training in their experience of current CPD provision. I believe this shortfall in accessible, good quality, relevant knowledge will have consequences for the evolution of both practitioner and profession.

If the purpose of ongoing CPD is to ensure practitioners systematically maintain, improve, and broaden their competence, knowledge, and skills by keeping abreast of the latest developments and research (BACP, 2018), but at the same time there is limited knowledge on working with specific clinical populations and settings, there is a risk of practitioner disengagement and inadequate clinical practice evolvement. In order to adapt practice to meet evolving clinical expectations and guidelines, practitioners need to fully engage with learning frameworks, technology and clinical tools (Miller et al., 2015). The PEP's findings articulated the need for more relevant learning materials to make this happen effectively and enable practitioners to fulfil their professional duties in HEIs.

The capacity for practitioner engagement with new learning has been shown to depend upon knowledge that directly relates to practitioners' client groups and clinical context (Castonguay & Muran, 2015). This being the case, a proportion of CPD should ideally be delivered by specialists through targeted forums such as sector-specific practitioner networks and peer-led activities, with direct application to actual clinical dilemmas (Karas et al., 2020). It appears to me that the current shortage of such CPD actively positions student counselling practitioners and services at a disadvantage with regard to professional

advancement. It is this aspect that kept driving me to research the implications of practice development gaps and cultivate solutions.

The mental health of British students has become a public health issue (Brown, 2016; Sharp & Theiler, 2018), which has, in turn, led to well-funded research such as that undertaken by the Student Mental Health Research Network (SMaRteN), drawing interest from within academic circles and those with a keen interest in developing research on all matters related to the promotion of student wellbeing and the provision of mental health solutions in universities. This welcome attention exposes decades of underinvestment in university counselling services, many of which lack the expertise and funding to implement and collect a minimum counselling data set, a practice that is mandated by the National Health Service (NHS) as part of good practice and as previously mentioned, is an expected characteristic of mental health provision (Barden & Caleb, 2019; Barkham et al., 2019; Clarke, 2011).

Furthermore, the report *Challenges to addressing student mental health in embedded counselling services: a survey of UK higher and further education institutions* (Broglia et al., 2017) draws attention to the reality that, with an absence of data and transparency of effectiveness, confidence in current counselling interventions and practice will be questioned. This also highlights

the fact that without a research-led emphasis the innovation necessary to stay abreast of rapid and complex changes in the sector is compromised.

For student counselling services to maintain a perception of value to commissioners, particularly in a climate of increasing scrutiny, they are dependent upon producing evidence that attests to their service efficacy and best use of funding resources, as is the case for all healthcare services (Allan, 2019). Some services have already been outsourced, demonstrating the reality of the threat to the work of student counselling (Lightfoot, 2018). The professional and political context of my research both motivated my continued doctoral effort and my proposal to the BACP UC division to develop a research special interest group (SIG). This in turn led to the establishment of a HE practice-research network (PRN), namely Student Counselling Outcomes Research Evaluation (SCORE).

These propositions evolved from my own clinical and professional development experiences and the search of the literature on advancing practitioner development (Castonguay et al., 2011; Henton, 2012) I undertook as part of the feasibility study and FP. One of the final project's main objectives is to find ways to support the development of a sustainable research-orientated attitude and practice into CPD activity for university counselling personnel, to redress

potential threats. I was aware this would require more than just a single doctoral study provided by a novice researcher and thereby set out to collaborate with like-minded professionals.

I thus view both collaborative developments as consequential research products as each works to generate interest in the collective need to highlight the gaps in knowledge and training for student counselling practitioners, and the sector in general. I believe the present deficit in relevant up-to-date knowledge unintentionally undermines the professional development opportunities available to practitioners and, as a consequence, diminishes their value to the sector. Such a situation can render practitioners vulnerable to criticism and professional marginalisation.

The UC research SIG and the PRN both involve voluntary groups of professionals sharing their expertise and skills sets and therefore embodies multiple ways of knowing (Bruner, 1986). Both groups are a direct result of the growing confidence I gained carrying out the initial research (PEP) and the current final study (FP) and both feed into sector specific CPD, alongside advancing demands for transparency in HE-based clinical practice.

The link between these two groups and the current research project is the ability to develop and promote CPD in the form of various research activities. SCORE has provided opportunities for practitioners to participate in focus groups looking at developing a minimum data set – for instance looking at what is valuable data to collect – for the sector and receive training in data collation and exportation. The research SIG has provided a platform for the dissemination of relevant research activity and research-based events.

Learning to *know* the research territory, firstly by producing the research report and then by partaking in an ongoing research group and network, has compelled me to find my public voice. Chairing the research special interest group and being on the executive committee of the UC division has provided a viable platform from which to reach out to fellow therapists and exert influence over planned divisional events (such as research articles and conferences) and strategic proposals relating to the continued professional development of practitioners.

The orchestration of a one-day BACP UC research event at the University of Cambridge in 2019 is an example of my increasing confidence. The event focused on practitioner-led research into student counselling. Each presentation was given by a researcher who had explored an area of student-related

counselling work, for instance exploring the low presentation rates of Chinese international students seeking counselling (Appendix 4).

The research conference's objective was to raise awareness among university counselling practitioners of the importance of a research-led culture by showcasing recent practitioner-led projects relating to the clinical work. The evaluation feedback from conference participants was very encouraging and confirmed the findings of my small-scale study: there is demand for relevant sector-led activities in addition to other learning activity.

Similarly, the university and college counselling journal have a research-orientated column and articles in which I and others highlight relevant sector-orientated information, among other sector-related pieces. The journal readership has been increasing over the year, which indicates an appetite for reading research-based work on student counselling (BACP UC – internal report, 2020). Another example of my growing confidence was my approach to BACP's research bursary policy. The research bursaries were originally based on a successful PhD application at a named university. I felt I had to openly challenge these criteria as they served to exclude many practitioners who would not typically secure a PhD programme of study and, as a result, BACP now

consider funding practitioner doctorates such as the programme I am currently undertaking at Metanoia Institute.

The BACP UC conference forum, the research SIG and the UCC Journal articles have all provided a fruitful platform from which to disseminate the research outputs from the PRN – Student Counselling Outcome Research and Evaluation (SCORE). SCORE is a consortium of clinicians, academic researchers and professional staff established to share and utilise routine outcome data from university counselling services in order to improve knowledge on student mental health, inform service provision and develop training. The longer-term aim is to influence the development of sector-wide initiatives and form partnerships so as to develop CPD training that is informed by outcome data. As the findings from this study substantiate, there is a need for further development in this area of practice.

The steep learning curve associated with both the doctoral undertaking and the stipulated professional endeavours has placed a high demand on my resources (I proposed the formation of the research SIG and SCORE and currently chair both groups). The move into a more public-facing role involving speaking at conferences and workshops has been particularly challenging. The responsibility to present at national and international conferences and represent

the work of my fellow scholars has been a struggle at times, triggering old recurring feelings of “not being good enough”, and feeling out of my “competence” depth.

However, I have also experienced immense satisfaction and pride in the products that have come out of both forums (and which I will discuss in section 8) despite the discomfort I endured. I have a growing confidence in my ability to participate in and lead initiatives, and those I have undertaken have, so far, been met with interest and curiosity. But, importantly, I believe that, just as the outputs are raising awareness and opportunity in the sector, they also represent a meaningful contribution to my own development. The collaborative aspect of SCORE has served to break down my assumptions about research methods and my constructed perception of the exclusive nature of mainstream academic expertise. Indeed, it has provided a rich learning forum in which to exchange knowledge, improve skills and work together to bring about change in spite of our different positions and perspectives.

Most significantly, the SCORE experience has influenced my decision to take a sequential, mixed methods approach using the qualitative data from the PEP, in addition to designing an online survey questionnaire to collect quantitative and qualitative information. This was a purposeful attempt to capture a larger

sample of the therapist population and test the PEP themes, despite my lack of expertise in quantitative methodology or any affiliation with the philosophical premise of positivism. Below is a flow chart depicting the research design.

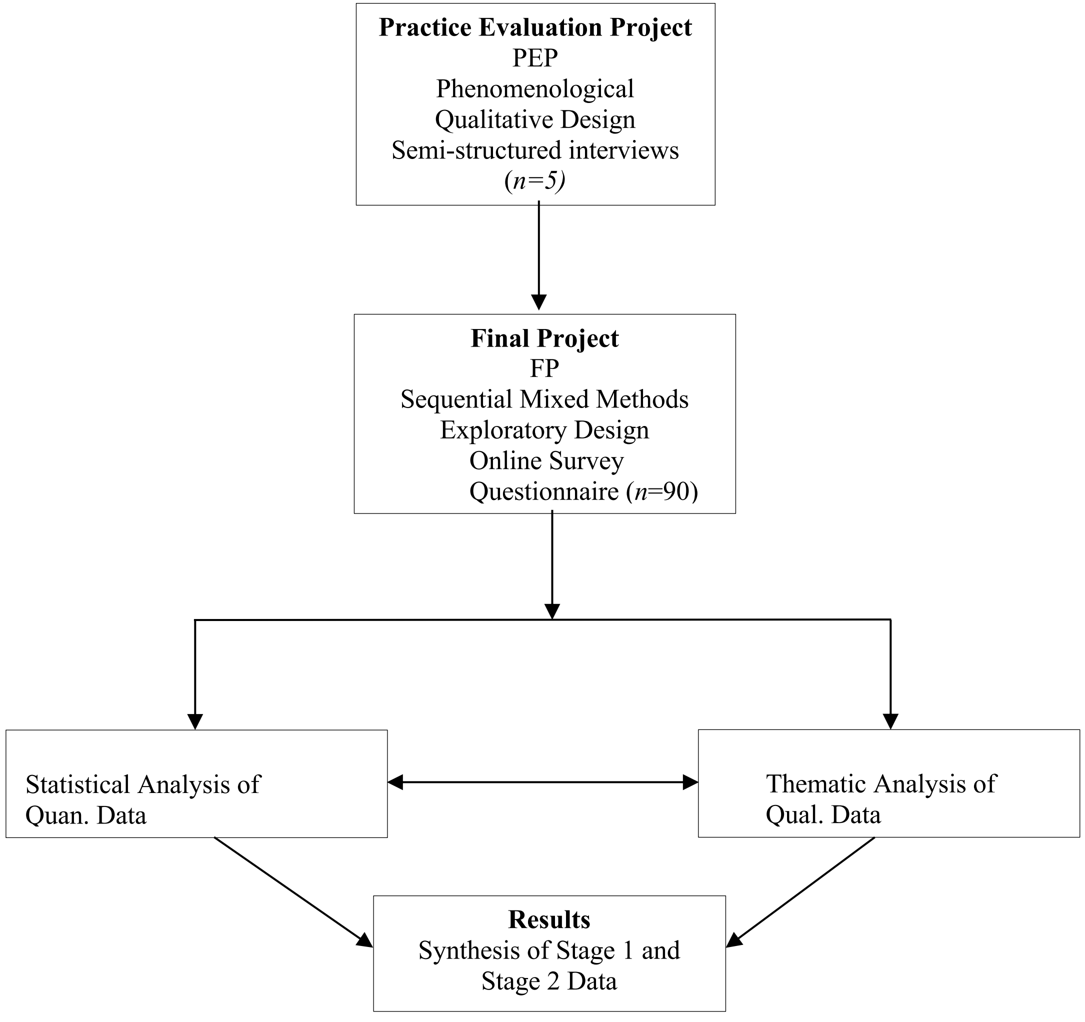


Figure 2.1.1: Flowchart of research progression: PEP to FP

2.4 Factors Shaping the Foundations of the FP

The personal, professional and political context within which the research is situated has influenced the FP design hugely. However, I feel the collective work undertaken by the SCORE project was most instrumental in bridging the gaps in my own learning and shaping my budding researcher lens. The experience of learning and working collaboratively, over a number of years within an active research framework, in pursuit of a shared outcome is different from the more common accumulation of knowledge from formalised educational pursuits.

PRNs originated within the field of medicine with the primary function of delivering on the health service effectiveness agenda by engaging clinicians and researchers in collaborative partnerships for improved clinical outcomes, provision, and training (DoH, 1996). The improvement of service provision and training is also a prime objective of both the FP and a longer-term goal of SCORE. Because research is grounded in the priorities of clinical services these networks provide a means through which research evidence can be utilised (Audin et al., 2001).

These frameworks serve to support reflective practice that has a direct impact upon the clinical work and allows clinicians to participate in the process of review and innovation that would otherwise be limited (Castonguay et al., 2010; Lucock et al., 2017). I feel very fortunate to have experienced the development of a forum

that fosters a means to establish an infrastructure for student counselling practitioners, in line with national healthcare strategies (NHS England, 2019). Such an approach works to ensure collaboration between clinical services and promote best practice, based on the interests of service users. I believe this is a necessary step in student mental health provision, given increases in student mental health demand and complexity and the limited resources of HEI counselling services (Barkham et al., 2019).

SCORE aims to use an empirically validated approach to demonstrate the yield of outcome data from HEI counselling services. Routine outcome measurement (ROM) in student counselling practice incorporates the use of clinical measures as tools to assess a student's current mental health status. An outcome measure provides a score, or an interpretation, of current psychological status. ROM is commonly used in student counselling practice to identify mental health risk factors and establish data prior to intervention as well as to track progress and evaluate the treatment outcome. Many student counselling practitioners use ROM, but often have little understanding of its implications for practice development (Broglia et al., 2018). SCORE provides an opportunity to demonstrate the efficacy of counselling as well as to upskill practitioners' knowledge in areas of clinical practice in need of review.

I realise this type of research is grounded in scientific philosophy, constructed on the assumption that an independent objective physical reality exists and can be measured and confirmed (McLeod, 2013). I am aware that this type of knowledge – traditionally based on quantitative measurement – has historically appealed little to student counsellors, myself included. However, it does present an opportunity and medium for practitioners to develop a broader understanding of the relevance of their work in the wider context of national healthcare strategies, with the aim of regulating healthcare practice and continued professional education (Karas et al., 2020).

It seems prudent neither to exclude nor to be excluded from the mainstream research that dominates the status quo and holds significant currency. My burgeoning view of research has been bound up with my involvement with the SCORE project, which has raised my awareness of the realities behind authority and influence. Engaging in action-centred research has not only created a shared language between academics and clinicians, it has brought the counselling work into closer contact with the core mission of universities within which they operate and that endorse the need to forge collaborative partnerships with NHS services (UUK, 2016). This reality has shaped my own research thinking and former professional mindset as, to impact the field of student counselling and promote

its value, my research findings need to incorporate multiple sources of knowledge so as to draw interest from a range of potential audiences.

For professional development purposes the ability to reach out to multiple audiences is evident. McLeod (2016) talks about five contrasting sources of knowledge: cultural, practical, personal, theoretical, and scientific. Each source offers value, and each possess its own strengths and weaknesses. Each is considered a necessary component of learning acquisition and is thereby integral to CPD. Adopting fluidity between different knowledge sources – by taking up a pluralistic stance – is one way to embrace the multiple cultures and multiple worldviews that make up social reality and inclusive learning practices.

In choosing a pluralistic perspective, I am recognising the diversity of meaning-making and availing myself of the range of existing psychological ideas and therapeutic models (McLeod, 2013, p. 13). This is the premise from which I hope to assist other practitioners to review their ongoing learning activity and the development of student counselling practice. By coming together and utilising multiple sources of knowledge, the work we do with our students and wider communities expands the cultural and clinical competence of everyone involved and, as a result, we are more likely to build the foundations of a representable research-informed practice of our own making.

One of the worrying consequences of a culture that lacks a visible research foundation, or an evidence-based practice is the emerging dominance of certain therapeutic practices over others. This not only limits one's choice of therapeutic interventions but also denigrates sources of knowledge and expertise that lack the dominant currency of effectiveness. Such a position leaves certain treatments, services, and staff vulnerable to marginalisation (Evans, 2012). This was emphasised in Dr Rost's previously-mentioned keynote address at the BACP UC research event (Appendix 4).

I illustrated this reality earlier when I highlighted how therapists from an established evidence-based culture (the NHS) are increasingly employed in student counselling services to satisfy the demand for the endorsed prevailing practices. One of the objectives of the SCORE project is to help student counselling services claim a national evidence-base in order to ensure transparency of service provision and practitioner development. From this vantage no single modality or knowledge source supersedes another, instead there are a range of context-dependent practices that work to support students in distress (Barkham et al., 2019).

In the US a similar initiative has successfully been developed. It has been achieved through the longstanding efforts of a multidisciplinary, member-driven,

PRN providing accurate, up-to-date information on the mental health of US college students. The Center for Collegiate Mental Health, or CCMH, actively connects practice, research, and technology within the US college sector to benefit students, mental health providers, administrators, researchers, and the general public (Castonguay et al., 2011). Key findings report that counselling is effective in reducing common mental health conditions in students (CCMH, 2018).

The collaborative efforts of CCMH's participating partners, colleges, and university counselling services and their supportive organisations have resulted in one of the largest databases on students' mental health. The data is used to develop and refine clinical tools, reports, research, and staff training provision, specific to the US student population. This information, collected from the CCMH database, enables a targeted approach to student problems and practitioner training development. This approach allows for a range of treatment options with flexible session frameworks for different student presentations, thereby providing a more sustainable and effective use of resources (CCMH report, 2018).

The founding members of the SCORE consortium were aware of, and inspired by, the US model. We all share the belief that the current paucity in data-led

knowledge on student mental health in the UK could be detrimental to progress in the sector, especially for counselling services (Barkham et al., 2019). At present, senior managers, service commissioners, and policy makers have begun taking a pragmatic approach to the annual increase in their staff and students' mental health (Hughes et al., 2018; IPPR, 2017; Morrish, 2019) with their focus leaning towards wellbeing ahead of mental health provision (UUK, 2016).

SCORE's objective of improving understanding of students' mental health needs grew out of a collective belief that, with enough hard work and commitment, a UK version of CCMH could be developed. The challenge, in the first instance, was to establish the feasibility of combining existing clinical data from current university counselling services that had been logged using different outcome measures on a range of different IT operating system, something that had never been trialled before (Broglia et al., 2021).

In contrast to national healthcare services, there is currently little standardisation in HE mental health practice or provision (Broglia et al., 2018). To meet national healthcare aspirations and expectations, student counselling practice needs to be informed by evidence so as to improve services and outcomes, as demonstrated by the Improving Access to Psychological Therapies (IAPT) services (NHS Digital, 2019). SCORE aspires to achieve something

similar through the development of a robust shared national student dataset (Broglia et al., 2021). The purpose of such a pooled dataset would enable services to:

- evaluate the effectiveness of student counselling services in UK universities and identify gaps in training and development.
- gain a clearer understanding of the mental health needs of students.
- identify mental ill health risk factors in minority groups, such as part-time students, students from Black Asian and Minority Ethnic groups, gender identity and trans-community groups and students disclosing disabilities, to improve therapeutic cultural competence and outcomes.

Looking back, it was the combination of recognising the knowledge gap among therapists working in university counselling services (which is common across the counselling and allied professions), reading the recommendations from the literature (Henton, 2012; Castonguay & Muran, 2015; Holmqvist et al, 2015), and comparing developments from overseas (Castonguay et al., 2011) and in different clinical settings (Lutomski et al., 2015; Palmer et al., 2013) during my literature review that impelled me to develop a student counselling focused, practice-based group whilst undertaking the FP research into the continuing professional development of HE-based therapists.

By contrast with most of the initiatives I encountered, which have a student-focused approach, my research is concerned with practitioners' experiences. I believe that the professional forums that have developed alongside my research will benefit both student and practitioner. This will be achieved firstly by highlighting the efficacy and value of the work, and secondly through the continued participation in multidisciplinary forums, which will establish a shared narrative of a whole-university approach to wellbeing. Staff development is an integral part of this core mission. Support for the funding and training of staff in student services is growing amongst both students and staff (Cage et al., 2021).

2.5 Overview of the Final Project

In introducing my final project work I have demonstrated how my personal and professional trajectory have connected with and incentivised my undertaking of further learning and skills development, beginning with the PEP study. I have outlined my views and participation in organised professional development activities and groups. I have also demonstrated several past and present initiatives to show the many influences involved in my construction of what I perceive to be relevant professional development, including participation in research activity.

As an insider-researcher (Lees, 2001) I feel well positioned to continue seeking a deeper understanding of university-based therapists' CPD practice, identifying any ongoing developmental needs and advocating for the "voiced" strengthening of good quality relevant CPD, given the situational constraints of the present professional and political climate. My attempts at maintaining transparency through documenting my motivations, interests, choices, and decisions at each stage of the research are in keeping with recommendations for quality assurance in mixed methods research (Creswell, 2008).

I am aware that all my personal and professional experiences outlined in this section impact the conception of my research, the questions I am interested in asking, the specific methods chosen, the recruitment processes, and the analysis and reporting of the data I collected. My involvement in various sector related initiatives, whilst also demonstrating commitment to addressing some of the sector-based challenges (Barkham et al., 2019), have shaped many of the assumptions I hold about both the context of HEIs and my construction (meaning-making) of what are the expectations for staff working within them. This in turn impacts the overall research enquiry, the research question, and my rationale for the study. For example, during the first stage of the research I draw attention to my concerns regarding student counselling practitioners' possible

lack of interest in my project. This fear-based perception stems from my own sense of reticence regarding formal research participation - as well as anecdotal observations of others over time - and illustrates how such experiences go on to shape some of my research decisions, which I attempt to make transparent throughout the study.

My intention in this final project is to consider how therapists working in university counselling services view their professional development activity. To evaluate whether participants feel current CPD prepares and supports them in their counselling work with students in the present climate. The following section reviews the research literature, paying attention to the historic development of student counselling practice and the impact of decades of change in order to develop an understanding of the implications of working with today's increased numbers of students, and the role of CPD in supporting healthcare professionals to challenge embedded cultural practices so they can stay abreast of change and carry out their clinical responsibilities safely and with confidence.

Section 3. Literature Review

To ground and contextualise my research in the current literature, I shall begin with an overview of the historical development and contemporary climate of student counselling in HEIs. This offers the reader a contextual understanding of the evolving nature of university counselling practice and current working conditions. Moreover, it sheds light on student counselling professionals' ongoing clinical development against a climate of context-specific tensions and the impact of wider cultural, political, and socioeconomic trends in the fields of education and health. Following this, I review the general literature on therapist professional development effectiveness studies. Attention is given to current recommended best-practice guidelines for continued learning from UK professional counselling and psychotherapy organisations and the evolving national strategic professional development agenda for health care professionals in the UK. Finally, I draw upon two studies exploring the professional development of counselling and that of allied health professionals to situate and justify the rationale behind my own continuing research enquiry.

Universities have undergone great change over the past two decades, spearheaded by both government initiatives and educational aspirations. Today, over 50% of young people enrol in HEIs (DoE, 2019) and meeting the needs of a larger, more diverse student population has generated certain challenges for

those studying and working within the sector (IPPR, 2017). As this review will demonstrate, the result of these structural changes and aspirational initiatives is the proliferation of an educational culture dominated by the principles of marketisation and cost effectiveness (Brown, 2015).

Research suggests that one consequence of these manufactured changes is an increase in the complexity of the needs of students presenting to university counselling services (Auerbach et al., 2016). As a result, the consequent demands on support services and the strain on academic and specialist support staff have more recently come to light (Advance HE, 2018; Hughes et al., 2018; Hughes & Spanner, 2019; Thorley, 2017). My examination of the changing function of university counselling services and the rising work-related demands associated with sectoral change will, as previously mentioned, be followed by a review of the dominant concepts of CPD in which I explore literature relating to the relationship between CPD activity and counselling and psychotherapy learning and practice in general.

The literature search is an indicative sampling of academic and grey literature available at the time of writing (spring 2020 - spring 2021). The preliminary literature search took a grounded approach, beginning with three general areas of examination: “professional development” and/or “continued learning” (and

related words), “university” and “higher education” (and related words such as “student”) and “therapist” and “counsellor” (or “psychotherapist” and “counselling” and related words such as “clinician” and “practitioner”).

The search identified over 30,000 national and international citations relating to “student” and “counselling/therapy” and “personal/professional development”. Ideally, I would have conducted a full-scope review of the literature (Rowland & Goss, 2000) but given the limited time and resources (characteristic of doctoral research projects), abstracts and titles were subject to strict screening for relevance. As a result, electronic and manual searches were limited to terms relating directly to the continuing professional development of university-based therapists in UK counselling services. The search encompassed the period from 1970 to 2019/20 so as to include early seminal texts on accounts of student counselling as an emerging practice. For example, “professional development” and “student counselling practitioners” were used or “&” to reduce all references to individual words and search terms.

The review of the existing literature was primarily conducted using Kings College London’s access to databases such as PsycINFO, Science Direct, PubMed, MEDLINE (Ovid), Google Scholar, Psychiatry Online, Dissertations and Thesis Online. Given the limited research specifically addressing the

experiences of UK therapists' continuing development (irrespective of setting) the search gradually expanded as the literature identified relevant additional areas of consideration. In addition, an informal literature search strategy was achieved using the reference lists or author citations from journal articles, texts or seminal books (Jaderberg, Goss & McBeath, 2019).

3.1 Background to Mental Health Provision in HE

The primary tasks of a university are teaching and research. Higher Education Institutions (HEIs) educate people to live and work effectively in an increasingly complex and technological world (Altbach, 2016). The competencies required for many of today's leading professions necessitates a sophisticated knowledge and skills base. As a result, these institutions fulfil a preeminent sociocultural and economic function in societies across the globe. There is growing international demand for organisations that can endow younger generations with the ability to think critically and perform work-based roles competently. Consequently, universities hold a large degree of economic, cultural, and social capital, affording them both power and privilege (Bentley, 2018).

The path of knowledge and skill procurement rarely runs smoothly, however. Higher learning is commonly set alongside the maturational transition from

adolescence to adulthood (Sawyer et al., 2018), a developmental milestone many university students must navigate or revisit alongside their higher learning. Many students face the task of adjusting and adapting to independent living, which, in turn, involves the emotional processes of separating oneself from parents or caregivers and individuating (Meyer, 2019). The recognition of the inherent complexities involved in this phase of development underpinned the inception of student counselling and health provision for students in HEIs more than half a century ago (Malleson, 1963; Swainson, 1977; Noonan, 1983).

Given that the nature and initial remit of counselling provision within HE is principally to support the emotional components of intellectual development the long history of the disparity in "cultural capital" between the two undertakings is not surprising. Whilst the primary task of HE is to generate economic capital through the provision of advanced learning and research that is objectively measurable (academic/ professional qualifications and research knowledge) and highly prized, counselling runs at a cost to its institutions and its output (emotional stability and maturation) is both subjective to every individual and personally and invisibly situated (Bentley, 2018).

History shows that student counselling practice has, from the outset, been a flexible and creative professional undertaking. Perhaps this is because it was

clear from the start that counselling, as a support for emotional development, has always been afforded a lower intrinsic worth – or cultural capital – than intellectual development (Swainson, 1977). Moreover, knowledge about how intellectual learning impacts emotional growth and vice versa was not well established and accepted at the time. However, despite these humble beginnings the profession has managed to survive for over 50 years and continues to adapt to the evolving demands of the educational environment in which it is situated (Bell, 1996; Barden & Caleb, 2019; Mair, 2016).

Bell pointed out over 25 years ago that student counselling has at its core "the need to be alert to the changing political and private context and to the opportunities within them; the need to collaborate with those who share a belief in the value of the work; the need to make work open and accessible. All of these are just as important as they were when the pioneers of student counselling first staked out the land and recognized the possibilities for growth" (Bell, 1996, p. 26). This continues to be the case today.

Examining the organisational and trans-cultural context within which university-based therapists operate is considered crucial to understanding both the implications for practice development and the ongoing situational and developmental demands of the work (McLeod & Machin, 1998). The

professionalisation of student counselling in the 1970s was a direct response to these situational demands, to legitimise the clinical work (ASC Archives, 1973).

Equally, today's longstanding wish to utilise clinical outcome data from counselling services to inform general trends in student mental health is a direct response to increases in reports of mental health conditions among students (OfS, 2019). This has resulted in a move towards an evidence-based practice (as modelled in the NHS), recommended by professional organisations in line with national guidelines and expectations (BACP, 2016; NHS Digital, 2019).

Awareness of – and action to meet – specific challenges at any given time, has long been the hallmark of the profession. A prime example of this has been the COVID-19 pandemic and subsequent lockdown measures, which prevented staff and students from meeting face-to-face. As a result, staff in many university counselling services were offering online support to their communities within 24 hours of the restrictions coming into effect (Anthony & Goss, 2020). This capacity to respond flexibly during turbulent times has presented opportunities as well as barriers for UCS staff (ASC Archives, 1973; Bentley, 2018). Existing socio-economic challenges of funding threats and the need to evidence efficacy and efficiency of services are like those experienced across the healthcare professions (Allan, 2019).

The current increase in student mental health issues has had a knock-on effect on the whole academic community (OfS, 2019; House of Commons Library, 2019; Thorley, 2017). Reports of increasingly low morale and poor mental health among staff (Hughes et al., 2018; Moorish, 2019; Watts & Robertson, 2011) has led to a concerted effort by senior managers in HEIs to prioritise the mental health of the whole university community. This positive approach towards the mental health and wellbeing of the whole university population (UUK, 2017) presents an opportunity for counselling services to share their long-standing "situated" expertise and re-position themselves at the forefront of the HE mental health agenda (Barden & Caleb, 2019; Mair, 2016).

3.2 An Overview of University Counselling Services

University counselling services are considered to have informally begun in the late 1940s, but the trajectory of the profession is far from homogenous (Bell, 1996; Lafollette, 2009). Some services grew out of careers and guidance models, some were independently formed, whilst others affiliated themselves with the introduction of student health services. Archive records reveal that the first official embedded student counselling service was at University College, Leicester, (now known as Leicester University), established in 1955 (Swainson, 1977).

In her book *The Spirit of Counsel: The Story of a Pioneer in Student Counselling*, Swainson (1977) reflects on how, at her time of writing, the majority of university staff were either indifferent or overtly hostile to the establishment of a counselling service within a university context. She records challenging working conditions and a long battle to establish the service. Eventually, in 1955 she won the fight, and acknowledges the support of university-based medical practitioners. This win heralded a new dawn of collaborative service provision between counselling and medical services, current in many universities today.

Dr Nicholas Malleson, a psychiatrist working in one of the first university student health services, provides an early account of mental health provision in a university setting. He writes about the influence of emotional factors on achievement, stating that "…large numbers come to a student health service for help with psychological problems… and for them to maintain the high expectations of intellectual efficiency… their treatment is important." (1963, pg. 43). Malleson is recognised for correlating and documenting student drop-out rates (15%) from universities and his accounts are among the first to associate the role of counselling with student retention.

Student retention remains a key justification for the continued funding of embedded counselling and mental health and wellbeing services (Caleb, 2014; Wallace, 2012). Indeed, the British Student Health Officers' Association (BSHA, 1951-1965) was founded in order to "… relieve sickness and promote the highest possible level of health for the individual and collectively for all who study and work in Universities and Institutions of Higher Education". The association was re-named the student health association in 2011 and it continues to highlight the impact of psychological factors on student non-adherence to academic commitments.

These innovations led to the development of a framework for student mental health. Such accounts may be responsible for the misconception that student counselling originated as a response to non-medical demands in student health provision, which erroneously suggests a unified initial purpose in the development of university counselling services (Malleson, 1972; Bell, 1996).

According to some accounts, Newsome, Thorne, and Wyld (1973) returned to the UK to pioneer counselling support at Keele University, with the aim of educating trainee counsellors in resolving difficulties arising from young people's developmental milestones. Their account documents how student counselling services, such as the one at Keele, were principally intended to

support students “who are experiencing normal developmental difficulties” rather than “clinical illness”, (Newsome et al., 1973, p.10-31). Many of the cited pioneers went on to influence the professionalisation of the sector and played a key role in establishing the Association for Student Counselling in 1970 (Thorne, 1985).

Historical accounts of student counselling service developments reveal a professional path that evolved from a number of traditions to form the occupational practice and provision as it is more commonly understood today. For example, the service that Swainson founded at Leicester evolved alongside her own psychoanalytic training and was based on a psychodynamic perspective of emotional development. Other student counselling service developments however – such as those evolving from careers guidance models or influenced by the US model of guidance and counselling (Thorne, 1985) – adopted a more person-centred approach to practice and provision (Bell, 2010).

Differences in theoretical orientation and application were set aside as the pioneers of student counselling came together to work towards the gradual formation of a recognised professional framework, namely the Association for Student Counselling (ASC), in 1970. At the time the main priority for the association was the formal establishment of counselling practice criteria that

could be offered by suitably qualified training professionals. This was to validate and, in turn, raise awareness about the complex interconnection between intellectual and emotional development (ASC Archives, cited in AUCC Journal, 2010). The ASC formed the foundations of the professionalisation of counselling and psychotherapy in the UK. In 1977 the organisation became the British Association for Counselling (BAC), which later expanded to include psychotherapists, becoming the British Association for Counselling and Psychotherapy (BACP), with specialist areas such as the University and Colleges division (UC) and it has gone on to become the leading professional body for counsellors and psychotherapists in the UK, with over 50,000 members (BACP, 2020).

Situating the work of counselling within an organisational context to define, bring attention to and better understand the challenges of the work has long been adopted and continues today in the divisional work of BACP's University and Colleges division (BACP, 2018a), which is dedicated to championing counselling work within further and higher education.

The early pioneers of student counselling (Newsome et al., 1973; Milner, 1974; Swainson, 1977) defined their work in relation to the impact of the nuanced institutional setting and wider social milieu. The consideration of the impact of

inherent structural matters such as timetabling, subjects, exam and assessments, policies and procedures on the work of therapists is evidenced throughout the literature regardless of the specific challenges being examined at any given time (Noonan, 1983; Thorne, 1985; Bell, 1996; Rana, 2000; Stanley & Manthorpe, 2002; Caleb, 2014, 2015, 2016; Mair, 2016; Percy, 2016; Barden & Caleb, 2019). Similarly, the wide engagement with the sector journal, *Universities and College Counselling* (UCC, published quarterly by BACP) has, over the last 50 years, produced numerous member-based and non-member-based articles that document evidence of the institutional impact of counselling young people in education and examine wider sociocultural and political issues affecting the setting.

In all the literature I reviewed, there was the common theme of explaining the challenges of counselling by addressing the evolving organisational factors of the setting in which the work takes place, as well as salient changes in society at large. This extends to present day recommendations that practitioners and services strategically (re-)align the therapeutic endeavour with the updated goals and mission of each institution, the sector generally and wider social context (Platt, 2017).

It is argued that, in doing so, services can utilise the specialist knowledge they possess and convey the nature and importance of the therapeutic work within the learning context. Thus, information is presented within a shared framework that is more comprehensible to the senior managers responsible for commissioning services (Mair, 2016). However, resources are finite, and there is a fine balance to be found between the proactive strategic work essential to align with each institution's everchanging objectives and national trends, and the reality of managing day-to-day services and delivering fit-for-purpose mental health provision (Clarke, 2009).

HEIs are contexts in which attributes of the wider societal framework, such as a hierarchy of knowledge, are replicated and shaped and it is therefore important to consider social trends and dominant discourses when examining the impact these forces have on the conditions, expectations and practice of staff working within such institutions (Drier, 2008). For example, the timeframe of recent changes in the sector such as expanding participation, the introduction and rise of tuition fees, the imposition of a Teaching and Excellence Framework, and the creation of a regulatory Office for Students, parallel significant changes in attitudes towards the nation's psychological health in general and expectations of well-being in society at large.

Improving Access to Psychological Therapies (IAPT) services and documents relating to the mental health of children and young people in England (NHS Digital, 2018) have contributed to a shift in the cultural, socio-political, and economic climate in which universities and their departments and services operate today about mental health guidance and provision (Barden & Caleb, 2019; Barkham et al., 2019). Most HEIs provide confidential mental health support services as part of their student support or health remit (RCP, 2011) and all HEIs are required to act in accordance with the UK Quality Code for Higher Education, although, as autonomous organisations, they can make their own decisions about the nature of support they provide (European Commission, 2017).

Consequently, the type of service structure and support provision offered to students and staff varies across the sector (Ruckert, 2015). Each service has evolved its modality of practice, employment contracts, policies and procedures etc., in response to its own institutional context and each is now tasked with adapting to a much changed and challenging environment (Barden & Caleb, 2019). The shift to short-term, brief counselling in the sector is an example of economically driven trends that have gone on to shape counselling service provision and practices offered in higher education institutions (Hallett, 2012).

The impact of widening participation and the internationalisation of HE is believed to be a key factor in driving changes in practice, along with the expansion of multi-disciplinary support within universities (MWBHE, 2015). Such trends have a knock-on effect on the staff and students inhabiting these environments and the "often-overlooked" challenges they carry (Platt, 2017). After two decades of growing reports of disturbance among university students and the resultant impact on and implication for staff and service provision (Rana et al., 1999; RCP, 2003, updated 2011) senior managers are now actively aware of the underrepresented realities of young people's mental health and their outstretched resources have become a national concern for the DoE, NHS, and society at large (MHF, 2017).

The dissemination of mental health strategies, policies and procedures in HEIs was once deemed the territory of embedded university counselling or mental health support services. The justification for embedded support was originally based on the benefits of a range of easy-access, student-focused interventions and preventative measures, and clear communication pathways within institutions regarding sensitive (or confidential) internal policies and procedures (BACP, UC Resource 003, 2017).

The BACP UC *Good Practice in Action* Sector Resource provides clarification and promotes the value of embedded university counselling services:

> An embedded service is one provided on the premises and staffed by counsellors who are directly employed by the college or university and managed by a senior figure within it. The counsellors know the institution's culture and act as a resource for the wider institution, such as engaging in preventative work with students who may not have accessed the counselling service and providing training for academic/support staff on identifying signs of mental distress and how to respond to students or colleagues exhibiting these.
> (BACP, UC resource 003, 2017:7)

In the last few years, universities have been under considerable pressure to respond and demonstrate the effectiveness of their mental health policies and resources (Randall & Bewick, 2016). The move towards a more standardised provision of support has generated books, journals, and research articles (Barkham et al., 2019; Barden & Caleb, 2019; Broglia et al., 2017, 2018; Mair, 2016) that share ideas and knowledge on the topic whilst guidance and strategy papers propose strategic recommendations for the "whole university community" and sector with regard to mental health provision (RCP, 2011; UUK, 2017; UMHC, 2019).

Whilst there is growing evidence of the cost-effectiveness of counselling interventions on student retention and attainment and duty of care and reputation (Auerbach et al., 2018; Simpson, 2013; Wallace, 2012, 2014), the current climate remains challenging for embedded counselling services (Dufour, 2020). At least in part this continues to be because of the lack of robust data capturing the conditions and outcomes of the mental health of the student population and the efficacy of the treatment they currently receive. As I mentioned earlier, the traditional culture of many embedded counselling services evolved from relational models of support rather than health service standardised protocol-driven therapies (Coren, 2014).

Equally, pooling and analysing collected routine outcome data within embedded counselling services remains a challenge. The original service development structure predates the demand for evidence-based information typically found in NHS-funded psychological services, endorsed by the National Institute of Clinical Excellence (NICE, 2011) and there are limited funds to re-structure counselling services to emulate the health system. Similarly, there are limited resources available to train staff for data usage and quality assurance (Barden & Caleb, 2019; Barkham et al., 2019; Broglia et al., 2017).

Embedded counselling services have long suffered from funding that is insufficient for 21st-century service development and staff training, despite redesigned service pathways prioritising efficiency (Randall & Bewick, 2016). The relative resources that services do receive tend to be ringfenced for managing year-on-year increases in demand and developing alternative interventions (Dufour, 2020). At the same time services must also continue to argue for more support to professionally and structurally develop according to updated guidance and policy (Caleb, 2015; RCP, 2011).

The argument for resources to increase in line with workloads (Caleb, 2016) has largely been met with strategic recommendations and creative suggestions of ways to manage finite resources in the face of growing demand (HEFCE, 2015; Lewis, 2016). It could be argued that these relative decreases in funding are partially responsible for the inability of embedded services to meet the concurrent expectation to demonstrate efficacy through transparent practice and innovation. Decades of structural underinvestment has produced a vicious cycle that renders services and their traditional practices vulnerable to scrutiny and criticism (Barkham et al., 2019; Brown, 2018).

In addition, the current climate of high-profile mental health strategies somewhat obscures the fact that university counselling services championed the

need for institution-wide mental health policies, procedures, and student-focused practices (Rana et al., 1999; RCP, 2011; Caleb, 2015; MWBHE, 2015; HEFCE, 2015) long before the launch of the "Step Change" framework (UUK, 2017). This framework is designed to encourage all UK universities to become places that foster mental health and wellbeing and enable all students and staff to flourish and succeed. The growing national and international attention on the mental health and well-being of students has been welcomed by those campaigning and working for decades at the forefront of mental health in HEIs. The hope is that the expertise of those managing and working in embedded university counselling services will be considered valuable and, more importantly, utilised (Barkham et al., 2019).

Ideally, the newfound attention on rising student demand and reported complexity in those presenting to counselling and mental health services in the sector would be addressed as part of the wider crisis in children's and young people's mental health and resourced appropriately (NHS, Digital, 2018). The establishment of closer partnerships between external NHS mental health services and HEIs has been suggested to respond appropriately to the current need and to further protect the mental health of those studying and working in HE settings (Hughes & Spanner, 2019).

One consequence of proposing a more integrated and coordinated approach to student mental health, for instance re-defining the parameters of each institution's "duty of care", is that such discussions serve to highlight the current provision offered by university counselling and mental health services (UMHC, 2019). Unhelpful comparisons have been drawn between NHS clinical services and university mental health provision, disregarding the historical development of the latter, which were not originally designed for treating young people with serious and complex mental health issues (Byrom, 2015; Taylor, 2020). Decades of under-resourcing is clearly a barrier to the re-purposing of services to realistically meet the current demand for mental health support and training in line with the standards mandated in the NHS (Priestley, Broglia, Hughes & Spanner, 2021).

Nevertheless, despite these challenges there is a continuing and growing evidence base demonstrating the effectiveness of embedded university counselling services in the UK. They have established a successful role in helping students continue their studies whilst managing the developmental challenges that can adversely impact their academic work and personal sense of wellbeing (Broglia et al., 2021; Connell et al., 2008; Murray et al., 2015). In spite of this, a key criticism continues to be the lack of robust published outcome data or any subsequent innovation. This makes it difficult to evidence

successful outcomes in line with national best practice expectations, which are vital for continued commissioning and support (Dufour, 2020).

It could be argued that this situation once again comes down to insufficient funding and research expertise because the national gold standard for outcome research studies remains randomised control trials (RCTs). These expensive clinical trials require specific, inflexible conditions and are largely conducted within established and funded research departments. McCrea (2016) points out that this means research into student counselling tends to be limited to small scale studies, but she goes on to advocate for gathering practice-based evidence (PBE). There is growing support for PBE in the university sector, given the need to establish a research-orientated culture and to meet the ongoing pressures to contribute knowledge to and about the sector that have now become a priority for commissioning purposes (Dufour, 2020).

Embedded university counselling staff, as stated earlier, are uniquely positioned to inform (by sharing data and practice) and deliver student-specific interventions within their settings (BACP, 2018). But all too often staff struggle to be viewed as such by the wider institution and sector within which they operate (Bentley, 2018; Mair, 2016). One report "… highlights the need for practitioners in student counselling services to be experienced in the student

context. In effect, student counselling services need to be **viewed** [my emphasis] as a specialist service embedded within university settings" (Broglia et al., 2017, pg. 10).

History tends to repeat itself and, to achieve the much-needed "capital" to be appreciated as having the expertise to shape future provision, university based-therapists once again find themselves having to adapt and develop a research informed practice (Barden & Caleb, 2019; Broglia et al., 2021; Hughes & Spanner, 2019), in line with clinical services in other health care settings. Warnings about the dangers of not evaluating the work are not new and can be traced back over decades (Breakwell, 1987; Woolfe, 1996; Connell et al., 2006, 2008).

It is for this reason that the continued development of higher education-based therapists forms the foundations of this final project. There is considerable pressure on staff working with today's students (who are self-reporting with more complexity, diversity, and risk than ever before) within an environment increasingly characterised by the commodification of higher learning, teaching and research. Most significant perhaps is the shift from training and providing a confidential service that was largely unseen to being visibly accountable, known, and transparent. Such expectations can enhance work-related anxieties

and lead to higher levels of burnout (Gulliver et al., 2018; McAllister, Oprescu & Jones, 2014; Moorish, 2019) particularly if continued learning lacks a cohesive strategy.

The focus on mental health and a call for change, whilst reasonable and appreciated, is also exposing, and potentially threatening for staff, many of whom trained decades ago and who lack confidence in some of the knowledge areas required today (Bager-Charleson et al., 2018). Greater expectations from stakeholders regarding "duty of care" and an accountability to evidence practice requires a greater level of research-informed awareness and responsiveness. The latter perhaps produces an additional pressure on an already over-utilised staff group, responsible for years of quietly adapting practice and client provision with relatively little commendation (Bentley, 2018). Practitioners' expressed feeling undervalued and undermined professionally was a theme found in a recent study exploring counsellors' experiences of providing counselling to students in university-level institutions (Harrison & Gordon, 2021). The study highlights the growing complexity of the role and suggests the importance of role recognition. The newfound mental health agenda and its prominence in HE exposes the clinical and training implications for HE-based therapists (Dufour, 2020, p. 4).

The core skills and knowledge of many therapists (HE-based or otherwise) are drawn from an eclectic, diverse range of traditions, often shaped by context-dependent variables (socio-cultural, linguistic, gender-related, theoretical, etc.). The provision of counselling and mental health support in universities is well-established in the literature and demonstrates how specialist knowledge offers a valuable safety net for students experiencing past, reoccurring, or present difficulties (Barden & Caleb, 2019). Yet, set against the current tide of the restrictive NICE guidelines and evidence-based rhetoric, such expertise can become overshadowed and undermined (Bager-Charleson et al., 2019).

The complex nature of student support "typically entail[s] the provision of a breadth of support options, including bespoke, time-limited, individual and group student counselling both in person and online; prevention and outreach; consultation to faculty and staff; and risk assessment and management" (Priestley et al., 2021, p. 1). University counselling services have adapted to address the multiple concerns of students who come forward with study-related issues – such as exam anxiety, procrastination, and perfectionism – in combination with the developmental challenges of late adolescence (identity formation or managing separation and loss) or emerging or historic mental health conditions (anxiety and depression). Because the work invariably involves interacting with a wide range of expertise in student services (such as

disability, advice, and finance specialists) to support multiple student needs, the skill set is nuanced and thereby specialised (see competencies for working in further and higher education guide, BACP, 2017).

Services supporting student metal health and wellbeing offer a range of interventions delivered by a spectrum of professionals such as counsellors, psychotherapists, group analysts, psychologists, cognitive behaviour therapy practitioners, mental health advisors, and well-being advisors (Holm-Hadulla & Koutsoukou-Argyraki, 2015). Inevitably, the support they deliver varies, ranging from welfare advice to wellbeing support to psychological interventions, and, similarly, the roles, training, professional body affiliations and qualifications of the staff delivering these services vary too (Dufour, 2020).

The proliferation of embedded multidisciplinary services in many universities today could be argued as a direct response to the changing demands of the student population over the last decade, as well as national expectations for educational institutions to provide a "duty of care" through mental health service provision (Barden & Caleb, 2019). Interestingly, I have found very little research addressing the training needs of these multi skilled professionals from their actual lived perspective.

Recent literature on the challenges facing university counselling, mental health support and wellbeing services tend to focus on the tensions regarding a lack of matched funding (funding allocated based on rising costs of service delivery) despite responsibility for student mental health, within a context of limited evidence informing service provision and strategy (Barkham et al., 2019; Broglia et al., 2017; Caleb, 2014; Dufour, 2020; Mair, 2016; OfS, 2019). The absence of relevant up-to-date systems and analytical knowledge is important and problematic as without data difficulties in identifying what therapists do, do well, and need to do better or differently to develop in line with national guidelines and expectations will unfortunately persist. In turn, it will become harder to confidently argue for the continued commissioning of these services as "fit for purpose and value for money" (House of Commons Education Committee, 2018).

The benefits of a more coordinated approach to collecting and sharing data across university support services to yield large, high-quality datasets has been well articulated (Barkham et al., 2019), and the feasibility demonstrated (Broglia et al., 2021). The advantage of pooling data to improve services has long been established by Improving Access to Psychological Therapies (IAPT) services, which have been collecting general population patient data for over a decade, now seen as best practice (NHS Digital, 2019). A similar initiative

exists in the US for college counselling provision, which informs staff development training (CCMH report, 2018). Such an approach enables the profiling of students' presenting concerns and the documenting of any changes that result from counselling. This also provides services with the ability to gauge which problems counselling interventions can effectively address with which students. This in turn shapes progressive training and development opportunities for counselling staff (Broglia et al., 2021).

To summarise, practitioners across the counselling professions are expected to engage in therapeutic interventions supported by a robust evidence base to ensure they are safe and effective (DoH, 2017). However, time and cost seem to continue to be real-life barriers preventing therapists across clinical settings from gaining the confidence to engage at a deeper level with research-led practice, despite the expectations of different stakeholders (Castonguay et al., 2010; McDonnel et al., 2012). One of the key challenges highlighted is limited resources (primarily time and cost) available to assist therapists with quickly accessing and engaging in new data-driven knowledge, training, and development (Broglia et al., 2021).

This concern was reinforced in the findings from stage one of my research, a qualitative study (Appendix 1) that shed light on a sub-sample (n = 5) of practitioners' views of current development opportunities for clinicians working

in HEIs, and laid the groundwork for further investigation. Therapists echoed concerns raised in the literature about the lack of accessible, relevant CPD activity and time to support clinical practice in the current climate (Turner et al., 2017). In addition, there appears to be limited evidence that the accumulation of hours of annual CPD reliably improves clinical practice (Bullock et al., 2020; Castonguay & Muran, 2015) and, as cited previously, a growing concern that a widening gap between research and practice persists across the counselling professions (Bager-Charleson et al., 2018; Henton, 2012; McLeod, 2016).

The concern regarding evolving best practice, largely shaped by the "institutional epistemology" of healthcare settings (Drier, 2008), contrasts with the literature on healthcare professionals' actual practice (Morrow et al.,1986). Practitioners have commonly been found to prefer learning from clinical experience, partly due to perceptions about inadequate resources and training for the adoption of "new" empirically -supported interventions (Stewart et al., 2012). Furthermore, mainstream research has tended to minimise the impact of organisational and social contexts on the actual clinical practice within which counselling activity takes place (McLeod & Machin, 1998), despite evidence that practitioners can view research informed CPD activity as non-generalisable to clinical settings (Nelson et al., 2006).

I began my literature search with an overview of the social and institutional processes inherent within the development and clinical practices of counselling services in UK HEIs (Bell, 1996; LaFollette, 2009) before going on to examine the literature on therapist effect and evolving clinical practice development, because of the importance of cultural and organisational factors in shaping service provision and training. I believe the history of student counselling explains the disparities found in current clinical practice and development in HEIs with those stipulated in recommendations for healthcare professionals' continued education activity (Karas, 2020; NHS, 2019).

Few UK studies have examined counselling professionals' experiences and perspectives regarding the demands of present-day working conditions. This has led to a deficit in research addressing some of the challenges and ethical dilemmas associated with multiple health determinants (Harrison & Gordon, 2021). Similarly, there exists no published material on practitioners' experience of present-day continued education programmes, despite calls for more research in the area of student counselling (Randall & Bewick, 2016) given CPD programmes are ideally developed to support learning and management of occupational challenges (Platt, 2017; Dufour, 2020). The absence of knowledge on practitioners' general work-based experiences influenced my decision to develop a broad research question. I considered exploring practitioners' overall

experience of CPD practice and provision to be of greater value to knowledge accruement, than the narrower focus of practitioners' confidence and compliance with integrating research knowledge into practice. Moreover, I surmised that a question regarding research within the context of general CPD activity would gauge practitioners' engagement with a research-informed practice, as recommended for best practice development (NHS, 2019).

3.3 An Overview of Continuing Professional Development (CPD)

Therapist development and learning is a vast topic of interest to many researchers and practitioners (Castonguay et al., 2011; Ericsson, 2004; Jennings & Skovholt, 1999; Miller et al., 2008; Norcross, 2005; Orlinsky & Rønnestad, 2005; Rønnestad & Skovholt, 2001, 2005, 2013; Wampold & Brown, 2005). The subject area has produced a plethora of literature, drawn from a variety of sources including theoretical literature, survey data, empirical research, and autobiographical materials. At the beginning of this section, I described the literature search I undertook for the terms "professional" and "development" and related words, which generated thousands of references. I therefore propose for the purposes of the current study to focus only on the key findings related to what therapists report as significant to their practice and that which is presented as reliably impacting their development in outcome studies.

The quest to determine the factors involved in "becoming a good therapist" underpins much of the literature on therapists' continued development and learning. Large studies have shown that the individual practitioner and the therapeutic relationship contribute more significantly to outcomes than any treatment intervention (Saxon & Barkham, 2012; Wampold & Brown, 2005). The term "therapist effects" accounts for therapeutic qualities such as collaboration, empathy, and the therapeutic alliance to name a few, and, as stated above, these terms are believed to rival outcomes attributable to any single treatment method (Norcross & Lambert, 2018; Wampold & Imel, 2015).

The findings from five decades of empirical research seeking to identify the dominant helpful phenomenon of psychotherapy appear to keep returning to "… a general trend across studies, the largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent therapeutic relationship between patient and therapist, regardless of technique or school of therapy" (Henry, 1998, p. 128). Clients generally attribute the effectiveness of their treatment to the relationship with their therapist (Levitt et al., 2016) and therapists themselves highlight the impact of learning acquired during their own personal therapy has on their practice with clients (Norcross et al., 1992).

Similarly, therapist self-report studies show the positive benefits of supervision, but there remains a paucity of research demonstrating a significant positive link between supervision and client outcomes (McMahon, 2012; Watkins, 2011). The same inconsistencies are found in studies looking at the significant value of personal therapy and client outcomes (Orlinsky et al., 2005; Norcross & VandenBos, 2018).

Human process research seeking to examine the meaning of being a therapist, the impact of training and ongoing development across time have identified different therapist development phases (Rønnestad & Skovholt, 2003, 2012; Skovholt & Rønnestad, 1995). There are six phases starting with the lay helper phase, then advancing through the beginning student, advanced student, novice professional, experienced professional and, finally, senior professional phase (McLeod, 2013, p. 71).

Similarly, studies seeking to identify the characteristics of “master therapists” (Jennings & Skovholt, 1999) and establish specific effective attributes of therapists reveal a set of common qualities. These qualities include being a voracious learner, having a sensitivity toward and valuation of the complexity of the human condition, a high level of emotional sensitivity and self-awareness, an ability to accept feedback, taking an active role in personal

mental well-being and being aware of the implications for clients if the therapist is not mentally or physically well. “Master therapists” possess strong interpersonal skills, believe in the therapeutic alliance as a foundation for effective therapy and regularly draw on their own personal and professional experience in their work with clients (McLeod, 2013, p. 72).

Several follow-up studies have further examined the theme of exemplar therapist attitudes and strategies and found the key qualities included an avid desire to keep learning from “interaction with clients”, “supervision”, “therapy”, and “personal life”. It seems that therapists across the globe are keen learners and committed to activities that support the development of emotional receptivity and/or growth in awareness (Jennings & Skovholt, 2005). A core theme related to the “developing practitioner” is therapists’ life-long participation in learning, which is believed to “propel the development process” (Rønnestad & Skovholt, 2013).

Ericsson, Krampe, and Tesch-Römer’s (1993) article on “The Role of Deliberate Practice in the Acquisition of Expert Performance” advocated the theory that professional expertise is learned based upon continuous engagement in deliberate practice, utilising the classic action learning cycle proposed by Kolb in 1984, (see Figure 3.3.1 below).

Figure 3.3.1: Example of Kolb's active learning cycle (1984) – BACP (2016)

Miller, Hubble, and Duncan (2008) went on to adapt learning theory to the counselling and psychotherapy profession. The authors identified a baseline of efficacy by engaging in deliberate practice and reflecting on feedback (from in-vivo session videos and supervisor feedback) for improvement in future client interventions. Related research demonstrates that therapists can improve client outcomes over time through deliberate practice by focusing on specific identified behaviours using continuous self-reflexive and supervisory examination (Rousmaniere, 2017).

In the absence of conclusive evidence determining which professional activity distinctively impacts therapist effectiveness it can be assumed that a multitude of factors contribute to client progress (many, such as life events and socio-economic factors, being external to the therapeutic process) including the continued training, personal therapy, and supervision of practitioners' (Rønnestad & Ladany, 2006). This commitment to learning and diversity of professional activities undertaken by therapists working in HEIs may explain how practitioners manage the clinical challenges pertinent to working with the student population so resourcefully and continue to "fit what is available to the needs of the client" (Heyno, 2007, p. 10), despite limited evidence of the impact of any single activity.

The aim of this research is to explore how therapists working in HE view the utility of their professional development activity and identify what may (or may not) be viewed as impactful to practice. One objective was to find out more about the range of activities that therapists in HE can access. This will help me to establish whether current CPD guidance, provision, and products meet therapists' current learning needs by supporting them to feel capable in their work with students. Such knowledge could prove useful in formulating potential guidance strategies for promoting the equitable access to essential and precious relevant continued learning resources. The involvement of practitioners in

developing a comprehensive understanding of student mental health and counselling support for the wider sector would serve to simultaneously decipher where gaps in knowledge and training exist and to develop ideas about useful partnerships for product development based on practitioners' feedback.

3.4 CPD and Professional Associations' guidelines

The term CPD aspires to bring together a diverse range of educational and context-specific (practice-based) learning activities relevant to a given profession. The intention is to give professionals recognition and praise for continuous learning in specialised areas of their work; it can also be called up-skilling. CPD is also a basis for continuing accreditation by professional bodies and is generally defined as "… any process or activity that provides added value to the capability of the professional through the increase in knowledge, skill, and personal qualities necessary for the appropriate execution of professional and technical duties, often termed competence" (Professional Association Research Network, (www.parn.org.uk)).

Most professions view CPD as important and even necessary to ensure best practice. Some professional associations have moved towards compulsory CPD schemes in which attendance is monitored and sanctions for non-compliance are

implemented in the belief that this improves the image of the profession and individual professional organisations. CPD is thus seen as promoting up-to-date best practice that meets the standards of a third party, such as an indemnity company, often for legal purposes (Professional Associations Research Network, 2011).

Professional associations operationalise the formal route for a profession's qualifications, covering examinations, assessments, competencies, and experience levels. They also set standards for professional ethics and practice. It could be argued that such organisations have a large investment in the CPD "industry" and that, likewise, therapists regulated by these organisations also have a vested interest in staying abreast of new developments in order to demonstrate good practice and feel confident and protected in their work with the general public. This has the potential to be a self-serving cycle but is it effective for learning outcomes?

In the UK, the practice of counselling and psychotherapy is not compulsorily registered or statutorily regulated like, for example, in the field of medicine. This can lead to a lack of general clarity for those within and external to the profession regarding the term's "counsellor" and "psychotherapist". Confusion complicates the process of identifying training and professional competencies

(Ryan et al., 2018). There is currently an ongoing standardisation project – Scope of Practice and Education (SCoPEd) – between several leading professional organisations, namely the British Association for Counselling and Psychotherapy (BACP), the United Kingdom of Counselling and Psychotherapy (UKCP), and the British Psychoanalytic Council (BPC). SCoPEd is attempting a systematic mapping of existing competencies, standards and training and practice requirements for the profession (BACP, 2020), to develop a framework for counselling and psychotherapy practice.

In the absence of any such framework there is general agreement between the leading professional associations, which for this research purpose are BACP, BABCP, and UKCP for continued education criteria, to maintain safe and ethical practice. Whilst I acknowledge other professional bodies exist, such as HCPC, I have focused on these three organisations because they represent the largest UK professional organisations for counselling and psychotherapy professionals, respectively. The range of CPD learning activities specified by each is broad and covers formal and informal activities, favouring a formal system of planning and recording.

The BACP recommends the use of an active learning cycle that requires a minimum of 30 hours and focuses on what members gain from their planned

CPD activity. Like most professional organisations, BACP provide a template for the purposes of planning and reflection, which may be required for submission in the case of a random audit. In the BACP guide to CPD, members are asked to show clearly how they have reflected, planned, actioned, and evaluated their development needs and they are required to demonstrate how this will have an impact on their practice (BACP, 2016).

CPD measurement systems adopted by professional bodies generally fall into two distinct camps. Input measurements are based on objective measurable variables, such as number of hours of CPD activity undertaken across a set time period, and output measurements include professionals' ratings of the impact of the CPD activity on their practice. The former measures activity that has been undertaken and assumes the value is in participation. The latter attempts to measure impact; however, critics of the system purport it can be manipulated as audited participants can describe how they completed the four learning cycles in their annual CPD (often retrospectively) and it is therefore subject to confirmation bias.

Most CPD frameworks advocate for a variation of the learning cycle (Kolb, 1984) (as shown above in Figure 3.3.1): evaluation, reflection, planning, and action. BACP, as outlined earlier, recommends such an approach, as does the

BABCP. Both membership organisations randomly audit their members, and failure to meet the standards can result in being removed from the register. These terms are not dissimilar from those of allied healthcare professions such as the General Medical Council (GMC), where greater attention is paid to "legal" responsibilities.

UKCP's CPD policy differs as it takes an input measurement approach, but with a caveat of a "five-year peer-review" that requires a more planned, reflective appraisal of CPD. The evidence suggests that deliberate practice is effective for improving therapists' skills and the professional organisations cited above recommend a variation of this mode of CPD planning, through appraisal and evaluation. However, studies continue to find such recommendations among counselling professionals to be largely absent in actual practice (Fender, 2017; Miller et al., 2015).

3.5 CPD Trends and Implications for HE-based Therapists

Alongside clinical supervision, CPD is the means by which all practitioners in the counselling and allied healthcare professions commonly engage in learning support. Funded CPD is a precious resource and is considered a vital component of mental health safeguarding for both the practice of therapists (their own

wellbeing as well as the wellbeing of their clients) and their institution as a whole. However, as cited previously, research demonstrates that therapists, who are clearly committed to continuous learning and generally oversubscribe to CPD (Fender, 2017), tend to overlook the suggested best practice of CPD planning and keeping abreast of advances in relevant research-informed activity than other types of learning activity (Castonguay et al., 2010; Turner et al., 2017; Dufour, 2020).

It is for this reason that the continued development of professional skills and competencies has been encouraged across the counselling and allied professions. Because of the current challenges and complexity of the work of student counselling the BACP UC division recently revised the document *The Competencies Required to Deliver Effective Counselling in Further and Higher Education* (BACP, 2016). This document, compiled by experienced senior HE-based practitioners, provides guidance on the practice and development of meta-skills of counselling in education. It delivers clear generic therapeutic competences and sector-specific knowledge required for student counselling as well as identifying meta-competencies associated with the specific organisational context.

The utility of these guidelines, beyond simply endorsing specialist skills sets for therapists working in further and higher education and the expectation to adapt practice to setting, has been questioned (Platt, 2017). The issue of adapting these guidelines into relevant sector specific CPD training is an aspiration for my final project. The hope is the research data will clarify what training gaps exist, given there appears to be a chasm between what CPD is being offered, what is deemed impactful by research informed experts and supervisors, and what is currently undertaken by therapists for integration into practice.

Research highlights therapists are "… dedicated to self-development as a means of engaging ongoing support …with life experiences, learning from clients and acceptance in the professional community being valued above more traditional concepts of CPD" (Fender, 2015, p. 3). Thus, personal experiences and milestone events, practice with clients, supervision, and the professional community take precedence in perceived value over the more formal modes of learning and development, such as evolving evidenced based interventions (Fender, 2017; Rønnestad & Skovholt, 2013).

Research continues to demonstrate that it remains a challenge to effectively engage therapists across the counselling and allied professions in research-led activity endorsed by national policy, professional organisations, outcome

studies, and researchers in the field (McLeod, 2016). Explanations exist to explain this disinclination (Castonguay et al., 2011; Castonguay & Muran, 2015), but change in behaviour does not appear imminent when one considers the findings of a recent study in which 25 clinicians disclosed they rarely used research evidence in either assessment or treatment (Stewart et al., 2018).

Similarly, the utilisation of PBE remains limited as therapists reportedly lack the confidence and experience in conducting and disseminating practice-based research (Evans et al., 2003), or feel there is limited interest and support from colleagues or institutions (Bager-Charleson et al., 2019). My research serves to explore whether opportunities exist for providers of CPD to educate professionals in evolving “best practice”, as the literature implies therapists are not currently being encouraged, supported, or given access to information on individual therapist treatment outcome data – to identify gaps – as recommended (Karas et al., 2020; Saxon & Barkham, 2012). Furthermore, there may be ethical considerations for client, institution, practitioner, and sector if these circumstances remain unattended (Nezu, 2020).

Practitioners working in highly emotive and demanding settings, such as HEIs with year-on-year increases in high-risk client presentations, may feel obliged to continue working in their professional roles regardless of their competencies

given the amplified pressure. This could lead to increases in work related tensions, vulnerability, and fear of professional criticism (Scupham & Goss, 2020), with therapists' losing confidence. In turn, poor clinical judgement, or burnout, with negative consequences for both clients and practitioners (Delgadillo et al., 2018) are likely to increase in such circumstances.

Therapist confidence contributes to the effective practice of therapy and to successful client outcomes (McMahon & Errity, 2014; Norcross & Lambert, 2018), with some practitioners consistently able to deliver better outcomes than others (Saxon & Barkham, 2012). Therapist effect accounts for between 5-10% of variance in clinical outcomes and the characteristics associated with this effect are empathy, alliance, deliberate practice, and professional self-doubt, as stated earlier (Firth et al., 2019). Therapist feelings of self-doubt are commonly reported, indicating a propensity for practitioners to feel inadequate and therefore in need of good quality and relevant ongoing professional development guidance and training (Mehta, 2006; Nissen-Lie et al., 2015).

Different professions and different clinical settings have their own distinct culturally embedded practices and unique learning challenges and needs. Firth et al. investigated treatment setting on clinical outcomes for patients receiving psychological therapy and found substantial variation in clinical outcomes

between therapy providers, such as NHS, voluntary organisations, universities, and private practice. The "clinic effect" reflects the structured differences in clinical population characteristics, recruitment, and therapist practices (therapist effect), institutional resources, and training programmes and between clinical providers and sectors (Firth et al., 2019). This study hopes to highlight the importance of considering the broader institutional, socioeconomic, and geographic context in which therapy is offered, as a way of further understanding the specific needs of practitioners in a particular setting.

3.6 Developing My Research Rationale

An important objective of my study is to shed light on the effect of culturally embedded CPD practices, given the existence of an evolving agenda of standardisation of continued education for healthcare professionals (NHS, 2019). Researching university counselling practitioners' learning experiences serves to highlight any distinct challenges and development needs specific to this group of professionals, their client group, and clinical setting (Firth et al., 2019). Corrie and Callanan note "different professions may require different levels of managerial support embracing the new research-orientated culture" (2001, p. 148), an approach considered fundamental to "best clinical practice" if expected standards in quality-of-care are to be acknowledged and integrated into practice by practitioners (Leach & Tucker, 2017). The lack of such

information presents a barrier towards developing and providing relevant professional education to maintain and improve existing care standards.

Given there is limited literature specifically addressing the effectiveness and relevance of CPD for UK student counselling practitioners' ongoing professional development, I chose to look at two contemporary studies that I considered closest to my own research enquiry. Both examine healthcare professionals' perceptions of the effectiveness of existing CPD models on clinical practice, and the influence of broader sociocultural and economic factors; although each study differs in terms of clinical context and sample population.

The first study, carried out into the effectiveness of CPD on behalf of the General Medical Council (GMC), was conducted by a team of medical clinicians and educators. The study by Schostak and colleagues recruited non-training doctors from varying staff grades including senior consultants and institutional officials from a range of specialities. The aim of the research was to determine participants' understanding of their own and colleagues' learning, and to see how this related to conceptions of CPD, its provision, uptake, and efficacy (Schostak et al., 2010).

To identify what promotes and what inhibits medical practitioners' learning, the researchers examined participants' experiences of a range of CPD models used across medical specialities, exploring perceptions of effectiveness. A mixed methods research design was adopted, where data was collected through a self-designed questionnaire, letter correspondence with clinical leads, semi-structured interviews, and the use of shadowing. The study was anchored in the literature that considered CPD to be "beyond what doctors do" with "no single, singular or correct way of doing CPD" (Schostak et al., 2010, p. 6).

Key insights from the literature informed the questionnaire, interview, and letter questions. It was noted, for instance, that flexibility is considered key in the design and provision of CPD, alongside the principles of justification and transparency. Active learning modes that link CPD with evaluated learning needs were found to be more effective in facilitating the integration of knowledge into routine practice. Issues related to assessing, accrediting, and the quality assurance of CPD - given the extensive range of CPD activities and providers - were noted as grey areas from the literature search and thus incorporated into the researcher's design tools.

This study, whilst sharing similarities in its aim to explore practitioners experience of CPD, differs from mine in that the population is restricted to

medical professionals in medical settings. A further difference was the specific intention to assess medics' engagement with reflective practice, identifies as a core activity for medical professionals' best practice development (Schostak et al. 2010, p. 18). Another difference was the evaluation of current practice needs and barriers using "shadowing". Shadowing clinicians in routine practice provided the researchers with the opportunity to assess practitioners' integration of their learning, as it was applied in day-to-day clinical duties. Shadowing is not possible in the current study due to the confidential nature of counselling, although it may be possible in future research to investigate integration of learning through permitted audio or video recordings used for supervisory purposes.

Medical professionals' CPD differ from counselling professionals' as there exists the requirement for personal development plans (PDP) to be "informed by objective practice data and evaluated by an appraiser" (Karas et al., 2020, p. 7). CPD is evaluated by independent regulatory bodies situated within medical colleges and deaneries (Karas et al., 2020). Medicine, alongside dentistry, is one of the few health care professions that has evolved in line with national health strategy documents (DoH, 2017; NHS England, 2019). Given that the Department of Health is currently reviewing the system of professional development regulation for all health care professionals (DoH, 2017), it seems

important to determine to what degree my research participants' actual practice complies with the literature on best CPD practice, and provides a rationale for undertaking the research.

The second study of interest is Fender's (2017) practitioner-led qualitative research exploring "*The experience of continuing professional development and its impact on clinical practice".* This research adopted a pluralistic approach using Interpretative Phenomenological Analysis (IPA) and analysed five purposefully recruited humanistic private-practice participants interview transcripts, exploring their experiences of professional learning. The key findings from the qualitative data were then used to develop a quantitative survey, in which 41 of the humanistically orientated therapists participated. My interest in Fender's study was the focus on the relevance of current CPD models to the work of psychotherapy, given that "neither modality or techniques have significant impact on the efficacy of psychotherapy, but the person of the therapist and the relationship do" (2017, p. 3).

Fender' (2017) findings confirmed the theme, commonly-found in the general literature, that therapists are committed to self-development. However, his novel data showed that the nature of their development is emergent rather than planned, highlighting how national directives – for a planned approached to

CPD (Karas, et al., 2020) – had not been adhered to by the study's participants, despite their dedication to continued learning. As indicated one of my research aims is to assess whether this is the case for counselling professionals working in HE, bearing in mind the evolution of UCS, as detailed earlier.

Fender's data further suggests his respondents prefer learning from life events (births, deaths, group interaction) and believe experience from clinical practice impacts their development more profoundly than formal learning activities. This is again a consistent finding among psychotherapists generally, as previously reported in studies (McLeod, 2016; Rønnestad & Skovholt, 2013). Fender's participants allegedly struggled to identify examples of "impact to practice from learning activities such as conferences and journals" which wasn't the case with their informal learning experiences (2017, p. 9). By contrast, knowledge acquisition through conference attendance and evidence-based information from networking and reading journals elicited the highest scores from medics, who cited such learning as essential to effective clinical practice (Schostak, et al. 2010). My own research is interested in ascertaining which CPD forums student counselling professionals engage with and why.

A key distinction between my research and Fender's is that his participant sample is exclusively drawn from psychotherapists in private practice who self-

reported as humanistic in orientation. In addition, his sample strategy "was purposefully biased towards those therapists who were positive about self-development" (Fender, 2017, p. 5). The commitment to generating research on UK therapists' experiences of current CPD models is a strength of the study given the paucity in data relating to therapist's development. However, the therapist sample is small, and the recruitment strategy limits the applicability of the study's findings to therapists employed in organisational settings.

By contrast, my study set out to explore the CPD experiences of counselling professionals employed within university counselling services. These participants are drawn from different training backgrounds, experience levels, organisational responsibilities (clinicians, clinical leads, and supervisors), each with their own personal development lens. Furthermore, my research aimed to capture the extent to which the participants viewed effective CPD practice as that which addresses the distinctive needs of clinicians, clinical leads and supervisors, their clients, and the organisations within which they work, as well as evolving national policies disseminated by professional organisations (Karas et al., 2020).

All counselling professionals are obligated to undertake professional development (PARN, 2011), and Fender's (2017) study notes the influence of

the dominant discourse on conceptions of CPD, as evidenced by participants taking and recording certified CPD activity mainly for professional body reaccreditation purposes. Fender suggests this reported activity demonstrates participants' awareness that formal CPD tends to carry more currency than informal, despite the conflict with therapist's general view of CPD efficacy. This supports suggestions of the influence of a tacit hierarchy of knowledge among counselling professionals (McLeod, 2016).

The lack of organisational support for participants' development was highlighted by Fender to explain the small percentage (5%) of therapists who adhered to CPD guidance, in addition to having an expressed preference for informal learning. By contrast, my study is situated within the context of organisations of higher learning, where CPD budgets often do exist, although they may vary in resource and service strategy (Mair, 2016). Consequently, I am interested to see if institutionally embedded frameworks shape practitioners' conceptions of their ongoing learning needs. I have examined this by asking questions relating to practitioners' professional body membership, and attitudes and behaviours regarding CPD. And, similarly, by identifying whether differences exist between participants' levels of experience and/or position and their CPD choice and perceptions of its impact.

With these multiple factors in mind, as I mentioned earlier, I decided to keep my research enquiry broad and ask practitioners working in university counselling services about their continued learning in the current climate. I was apprehensive that a question specifically relating to practitioners' adherence to research informed CPD activities, despite compliance concerns in the general literature, could be construed as supporting the dominant EBP discourse. I am aware of the range of counselling backgrounds employed in the sector, and of the distinct evolutionary development of student counselling and therefore did not want to unintentionally reproduce wider sociocultural power relations (Parker, 1992), and risk excluding members of the student counselling community (Dufour, 2020; Finlay, 2019).

I wanted to find out what CPD practitioners engage with and whether they feel supported in their practice and to offer a considered interactive conversation about professional development. My intention was that this would serve to identify learning gaps (reported in the literature), as well as meet the call for more research on practitioners' experiences of counselling that considers the context of practice (Randall & Bewick, 2016). As a member of this professional community, I am acutely aware of the lack of research investigating staff perceptions of the work in UCS (Moorish, 2019; Platt, 2017).

In short, I wanted my data to highlight the CPD that student counselling professionals commonly engage with, the barriers they experience, and their views on any impact that setting and population have on training requirements. I hoped that gaining updated information on practitioners' routine learning would provide a chance to assess actual practice against current best practice expectations. Such an approach supports sustainable change by attending to and working with how things stand whilst presenting motivation to change from within (McMahon, 2012).

As an "insider-researcher" (Lees, 2001) I have the advantage of access to the setting and population, but I am cognisant of the potential disadvantage my "insider" assumptions and view can have on the research design and interpretation of data. Confirmation bias denotes how insider researchers can seek evidence to validate existing beliefs (Nickerson, 1998) and this is an obvious concern given my commitment to generating new knowledge that advocates for the inclusion of individuals' experience through participatory research (Hughes & Spanner, 2019). I hope to reassure readers of the steps taken in the interests of quality assurance (discussed in the methodology and discussion sections), and that by continuing to review the literature examining the effectiveness of therapist practice development in the context of current UK national guidance for health care professionals my research will be sufficiently

informed to justify and situate the enquiry and design in relation to existing research studies.

3.7 Literature Review Summary

I have reviewed the literature on several areas of practitioners' ongoing professional development in the counselling and allied healthcare professions, including general conceptions of the nature of CPD. To anchor and contextualise this final project, I first described the profession of student counselling in university settings, its practice, and the political backdrop over the last 50 years, highlighting the impact of established cultural and institutional traditions in student counselling practice.

My intention was not to add to the outcome literature on what contributes to the efficacy of counselling professionals working in HEIs, instead my modest goal was to explore what these professionals felt was necessary to practise safely and competently during times of challenge and change. A combination of current-day situational constraints, increased accountability regarding a research-informed clinical practice, and a dearth of up-to-date knowledge on the experiences of practitioners working in HEIs (Moorish, 2019; Randall &

Bewick, 2016) justified my ongoing research. CPD that is perceived to enhance therapists' confidence, competence, and overarching understanding of professional responsibility, whilst also supporting students' higher learning, seem to me to require a wider research question than simply focusing on practitioners' research related competence and needs.

My evolving research view, grounded in the literature and taken alongside personal and professional observations, was that my research question and the data generated would profit from a broader, more generalised approach to practitioners' experiences of continued development. The intention to identify common CPD practice and specific learning forums to support confidence and competence building in clinical practice with students seemed useful given the paucity of knowledge in the area. I believed that by addressing all practitioners' CPD experiences, participants may be more interested in the study than if I simply focused on research-orientated CPD practice. The latter, I feared might limit interest to those therapists with a research orientated background and an awareness of the role of research in best clinical practice. This position set the foundations for the rationale and objectives of the final project, which will be discussed in the following section.

Section 4. Design & Methodology

4.1 Introduction

I open this section by explaining the rationale behind the design and research methodology adopted for the final project, including an outline of the epistemological and methodological thinking, with reference to the quality control criteria that informed my research decisions. This detailed account is followed by an in-depth description of each stage of the method, including survey design, materials, recruitment and sampling procedures, and data collection. Ethical considerations, and my analysis of the findings, follow in separate sections.

4.2 Design and methodology rationale

Research that evolves from "a real-life issue that needs to be addressed, a problem that needs to be resolved, a question that needs to be answered" (Crotty, 1998, pg. 13) is the premise upon which my research journey was built.

The stimulus for the research came from the literature on therapist's development, my earlier research findings (PEP), dialogue with other counselling professionals, and my own personal and professional experiences. The literature endorsed the importance of therapists' ongoing development, whilst simultaneously raising concerns about a common and growing practice-

research gap across the healthcare professions (Boisvert & Faust, 2006; Finlay & Evans, 2009; Henton, 2012; McLeod, 2016). This documented concern legitimised my own professional observations and interest in the efficacy of CPD activity on therapists' practice. Moreover, I was impelled to pursue research specifically relating to therapists' continued learning practice in HEIs, of which little existed, during a challenging time for professionals working in the support services in this sector (IPPR, 2017).

The wider debate around counselling professionals' limited interest in evidence-based CPD practice (Bager-Charleson et al., 2019; Dufour, 2020), despite evolving research on improved learning outcomes (Lingard & Truths, 2016; Rousmaniere, 2017) shaping statutory CPD recommendations (NHS, 2019), intrigued me. From the literature there appeared to be a common assumption among counselling and allied professionals that simply engaging with a range of CPD activity is sufficient to maintain and improve clinical practice (Karas et al, 2020). I was curious to find out about my professional community's general awareness of national expectations and whether their experience of CPD supported them in meeting their professional obligations (Karas et al., 2020; Fender, 2017).

These factors shaped my decision to develop a broader research question, asking practitioners about their general experience of CPD in order to gain updated information on common learning practices, attitudes, and behaviours as well as perceived developmental needs relating to specific work with students in HEIs. The question I developed was:

How do practitioners working in HEIs experience their professional development and perceive its impact on clinical practice with students?

The related domains of interest that I wanted to explore included the ways in which therapists:

- conceived the role of CPD in their clinical practice
- experienced the learning they undertook
- perceived the benefits and challenges of practice development
- conceptualised improvements in CPD guidance and education

To investigate the complex internal worlds of research participants, in this case therapists, researchers are encouraged to consider the application of methodological integrity - the methodological basis of trustworthiness - to strengthen the quality of their research methods and findings (Levitt et al., 2019). The trustworthiness of a study is believed to be achieved when research is designed to support the articulated aims of the researcher, their

epistemological approach, and the characteristics of the studied phenomenon and participants (ibid, p. 2). Levitt et al. (2019) stipulate that methodological integrity supports researchers to make and defend their research decisions and findings. Assessment of methodological integrity involves demonstrating *fidelity* (adequate data sources, demonstration of reflexivity in data collection and analysis, and the degree to which findings are anchored in the data), as well as *utility* (influence of context, degree to which data demonstrates insight, and coherence of findings in relation to research objectives).

My aim was to continue to research a relatively unexamined topic in order to enrich understanding of how to guide clinicians to best improve their clinical practice through continued education and to inform the systems in which therapy and CPD are delivered. Using the framework of methodological integrity, I required research methods that would support my unique objective to assess the extent to which my earlier detailed qualitative results, collected from a small number of participants, could be developed to provide useful information that can improve practice and shape policy in the wider professional population of counselling professionals based in HEIs (Creswell & Plano Clark, 2011).

I felt a mixed methods exploratory sequential design was the best method to achieve my research objective (Creswell & Plano Clark, 2011 p. 187). The model enabled use of the collected qualitative data (PEP) to develop a follow-up quantitative method of data collection and analysis, the quantitative strand building on the qualitative. My aim, to capture a greater response from the practitioner population in stage two, was in part, an attempt to mitigate against my own assumptions that might have influenced the results and test the findings from the first phase of the research, given my insider-researcher status (Lees, 2001). I also wanted to be able to manoeuvre myself into a better position from which to influence sector-led knowledge, practice, and policy so I inevitably directed the research design to the most appropriate methods for this task (Creswell, 2007).

Reflexivity is a core part of an audit trail, which provides a clear rationale for a researcher's theoretical and methodological choices and decisions. Researchers' self-critical accounts of their study's process gives others a clear path to follow. Keeping records of raw data with notes and ideas, detailing coding procedures, accounts from meetings with independent researchers or critical friends, pilot testing, and reflexive journaling (Creswell, 2007; Etherington, 2004) all evidenced the integrity of my research. The challenges of being both the researcher and researched are well documented (Creswell, 2007; Etherington,

2004; Finlay, 2011; McLeod, 2011; Stiles, 2003), and I was aware from the outset that the research process was fully informed by my own personal experiences and professional observations and context, as well as historic and prevailing sociocultural and political trends. My experiences as a HE-based therapist/supervisor and my involvement in past and present sector-related CPD activities have all, notwithstanding my immersion in the research enquiry itself, informed the processes and outcomes of this study.

The goal of my final study was to explore practice-based development concerns and the needs of therapists working in HE by gathering information on their CPD attitudes and behaviours. I wanted to look at how practitioners perceive their CPD activity, and the benefits and challenges associated with learning, their views on the role of professional regulatory processes and their experience of institutional factors, all of which I was familiar with. The FP study was designed to use mixed data, collected through an online questionnaire, to feedback practitioners' experiences of CPD and shape future learning provision and practice, guided by quality control criteria adopted by counselling and psychotherapy researchers.

4.3 Clarifying My Philosophical Position and Quality Assurance Criteria

Taking my research aims into account, I needed to clarify my developing epistemological position. My background is one in which the prevailing beliefs and values of the status quo were often challenged (by parental figures) and my own professional development is, in many ways, not dissimilar. I trained and currently practice with a therapeutic lens shaped by two theoretical orientations. I believe both practices offer different but complementary ways of understanding oneself, others, and the world. The decision to develop my clinical skills through additional training evolved directly from practice needs. That is, listening to feedback from students who, given situational constraints associated with higher learning, reportedly wanted a more pragmatic and guided approach to counselling support (Wallace, 2012). My own research interest has similarly evolved from practitioner context-based concerns.

My own sociocultural influences mean that I have postmodern, feminist and pluralist beliefs. I lean towards a constructivist worldview, grounded in the idea that the lived reality of human existence is "organized around an active process of co-construction that involves attributing meaning to experience, and continually revising these meanings through collaboration and conflict between individuals and groups" (McLeod, 2013, p. 52). Originally, hermeneutics and phenomenology – the search for understanding through interpretative enquiry

and co-constructed meaning making (Finlay, 2008) – influenced my research intention.

I wanted to uphold the relational aspect in my research inquiry, and qualitative research uses a range of methods and interpretative procedures to shed light on the world whilst also recognising that, in doing so, it inevitably causes change (Denzin & Lincoln, 2008). Interpretative Phenomenological Analysis (IPA – Smith et al., 2009) seemed a good method given it is well established among UK psychologists (Langridge, 2007), and offers a solid literature basis and clear methodological framework for inquiry into complex human processes. Although the approach was congruent with many aspects of my research, the in-depth analysis of a limited number of participants' lived experiences did not fit my aim to generate a generalised and multi-view report that could validate my earlier research findings.

Grounded theory, developed by Glaser and Strauss (1967), held a similar appeal during my original considerations. Like IPA it has a thorough literature base, rigorous guidelines, and a focus on the publishing of pragmatic findings. It is also grounded in realist assumptions that matched my own; however, the explicit emphasis on theory generation or explanatory frameworks was not an objective of my current study (Charmaz, 2014). I wanted to continue to explore

and validate therapists' experiences through establishing common trends, rather than developing a theoretical framework. General trends in CPD would serve to update knowledge of CPD practice and shape policy, a priority of the research. As shown, my research objectives and philosophy influenced my final decision to choose a mixed methods design (Creswell et al., 2003). The exploratory sequential model gives greater weight to the qualitative stage of the research, currently underrepresented in the literature on counselling in HEIs (Connell, 2006), and reflects the primacy of the first stage (PEP), justifying the weighting decision or priority of approach. Furthermore, as an experienced practitioner who had undertaken a small-scale phenomenological study, I was more familiar and skilled in qualitative than quantitative methodology (Morgan, 1998). Figure 4.2.3 below shows the chosen two-stage sequential mixed methods exploratory model.

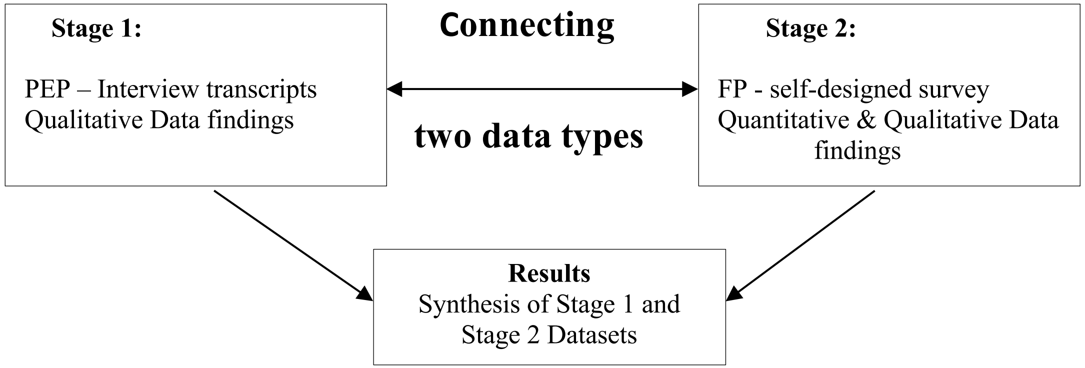


Figure 4.2.3 Sequential Mixed Methods Research Design: Exploratory Model with Priority of Approach Given to the Qualitative Component (Creswell et al. 2003)

As mentioned, the sequential element in Figure 4.2.3 denotes two distinct stages to the research. The first stage comprised the collection and reflexive analysis of qualitative thematic data from participant interviews undertaken in the preliminary study (Appendix 1). Stage two builds on the first stage and is designed to test and explain the qualitative findings by developing a nationwide self-designed online survey to collect both quantitative and qualitative data. Stage two serves to broaden the range and depth of information generated on student mental health practitioners' learning practice. The measurement of common elements of CPD practice in HEIs provides utility, as currently there is limited research on participants attitudes and behaviours to CPD, so new information fulfils this gap.

Throughout my career I have observed the utility involved in quantitative measurement, used in counselling service reports to demonstrate benefit. University counselling services have long campaigned for more resources on the back of such reports by demonstrating student usage, emphasising the role of services in student retention (Caleb, 2014). Similarly, the exploratory model provided the means to generate distinct, compatible data on various features involved in participants continued education. Furthermore, the model evolved from educational research that similarly sought to shed light and obtain discrete

but complementary data on a particular topic, considered to enhance the quality of the research design (Creswell et al., 2003).

Conducting methodical and sound research is essential for research findings to be accepted. Tashakkori and Teddlie (2003) developed a framework for assessing quality in mixed methods research, encompassing the concepts of validity from quantitative methods and trustworthiness from qualitative ones. They introduced the concept of "inference quality", combining the element of validity of methodological design with the trustworthiness of interpretative rigor (Bryman, 2014). Establishing a project's internal validity, i.e., testing a survey's face validity to assess the extent it measures what it claims to measure (see 4.9: Survey Design), and credibility, demonstrating rigor through a data analysis audit trail (see 4.12: Online Survey Data Collection and Analysis) are two examples of recommended quality criteria used in my FP two-stage exploratory sequential mixed methods design (Creswell & Plano-Clark, 2007).

To address and assess quality in mixed methods research, core criteria for each phase of the study has been developed and refined (Bryman, 2014). At the planning stage a clear rationale for the use of a mixed methods design is required to address the research purpose and question (see Sections 1-4). The study needs to be situated in the existing literature (see Section 3) and the

researcher's philosophical assumptions must be transparent, as stipulated below in 4.4 (see also Section 1, 2, 4, 7). The decision to use a particular mixed method model must also be transparent, as stated above (Creswell & Plano-Clark, 2011).

At the operational stage, the implementation of quantitative and qualitative methods needs to follow quality assessment criteria established for each tradition, as well as demonstrate the effective integration of both components with priority of weighting decision clarified (see above - Figure 4.2.3). The procedures for sampling (see 4.11), data collection, and analysis (see 4.12) need to be linked to the research purpose and question. When interpreting the results, any inferences drawn need to be consistent with the research aims (mentioned above) and findings (see Section 6). And, finally, the dissemination of findings should transparently report the research process, including the utility of mixed methods research, with an explanation of the value and implications of the study for practice and policy (see 7.9). Quality assessment of mixed methods research is considered an ongoing process of evaluation through each of the research stages, enabling findings that generate "credible, trustworthy, dependable, transferable, and/or confirmable" inferences (Onwuegbuzie & Johnson, 2006, p. 52).

4.4 Research Assumptions

For the purposes of transparency, I held a few assumptions about the research data I was likely to collect given my practitioner training, clinical observations, the review of the extant literature, and the qualitative findings from my feasibility study (PEP). My first assumption was therapists working in the HE sector would be committed to and undertake a diverse spectrum of CPD activity and, overall, be supported by their employer to meet their professional body's annual CPD hours. However, I also held the assumption that therapists would not choose their CPD activities based on a planned approach that identified their learning needs in relation to their development, and in the context of the setting and service requirements. These assumptions came from observations that were accrued over time: some practitioners seemed to relish participating in a range of new learning ventures to maintain their knowledge and skills to benefit the client group and service provided, others seemed less motivated yet still engaged, while a few practitioners clearly resisted change and learning innovation. The process of individual and collective practitioner development is complex and based on many economic, sociocultural, and political, historic, personal, and professional factors, some of which I hoped would become clearer through the research findings.

Furthermore, I assumed I would find that professional association recommendations – to be guided by research-led CPD to continue to develop a research-informed practice (as the BACP recommended in 2018) – would not be wholly understood, embedded in development practice, or adhered to. In addition, I presumed that the findings would probably endorse the principal themes of the PEP and show practitioner interest to be the key motivator for most self-directed CPD activity undertaken in the HE context, given this is common across the profession (Bartholomew, Perez-Rojas, Lockard & Locke, 2017; Castonguay et al., 2011). This practice, common though it is among counselling and allied health care professionals, is not generally advocated given ethical considerations (Nezu, 2020).

4.5 Background to the Research Design and Methodology

As recommended, I have clarified my epistemological position, research assumptions, and outlined the reasons for my decision to follow a specific research design and methodology shaped by my wish to meet the research objectives and question (Creswell & Plano Clark, 2011). Other factors influenced my decision to select a mixed method design for my FP, such as my own ongoing professional development and involvement in the PRN (SCORE), shifting my preference for designing a purely qualitative study to a mixed method, challenging beliefs that I lacked the skills to take such an approach.

I had never considered the concept of "multiple ways of knowing" in the context of knowledge production until commencing doctoral learning. This perception was further reinforced when I collaborated with academic researchers to design a large-scale quantitative study with the purpose of yielding new, generalisable knowledge to evidence a call towards a national agenda in support of student mental health provision and training as part of the SCORE project (Barkham et al., 2019).

The quantitative methodology adopted by SCORE served to capture the conditions and outcomes of students using counselling services to inform the sector of student mental health trends nationwide. The utility of this information derives from its ability to shed light on the general provision and efficacy of psychological support as well as to ascertain training needs. Moreover, data-generated knowledge is a persuasive form of information that can lend support to the continued existence of embedded university support services' expertise (Dufour, 2020), and as mentioned above these factors influenced my research decisions.

The dominance of knowledge based on large quantitative datasets is the feature of validity and generalisability (Sills & Song, 2002) and this aspect also ensures the appropriate representation of student minority groups, who are at risk of

identification in smaller sample studies. It was with these considerations in mind that the SCORE project's first peer-reviewed published article (Appendix 5) appealed for an organised approach to HEI counselling service data collection, analysis, and reporting (Barkham et al., 2019). This approach appealed to me when considering the value and utility of quantitative data, in addition to qualitative for my own research study.

Over the course of my research development, it became clear that my earlier small-scale qualitative research, influenced by my own phenomenological and socio-culturally constructed biases and valuing of experiential, embodied, meaning-making knowledge, lacked some of the necessary components for impact in the wider academic community, whose support I hoped to engage. Furthermore, a scoping review conducted by Connell (2006) proposed adopting quantitative research methods linked to EBP and PBE knowledge paradigms to strengthen counselling provision in the sector, an objective I endorsed and thus wanted to model.

Connell's (2006) proposal for more practitioner research, in addition to recent debate on the lack of good quality research and robust data to adequately inform the sector (Barkham, et al., 2019; Randall & Bewick, 2016), reinforced my sense that certain members of my target audience, such as academics and

service commissioners would be more likely to consider my findings with the inclusion of normative data (Barkham et al, 2019; Broglia et al., 2017). Such data would also serve to check any tacit bias in my analysis of stage one data, as mixed methods data findings are considered in terms of their coherence with each other and the overall research question and objectives (Creswell & Plano Clarke, 2007).

With these motives in mind, I put quality control measures in place to ensure I remained aware of the impact of my research intentions and discourse on the design and interpretation of data. As a sole researcher, collaboration with colleagues - two practitioner-researchers, an external clinical psychologist with experience of TA and a psychiatric researcher working with quantitative data - guided the quality and integrity of the project's process, particularly during the analysis stage (see Section 7: Reflective Methodological Discussion).

The principle of "multiple ways of knowing" remains at the heart of my research process and I adopted a mixed methods research model to utilise the rich thematic qualitative data derived from the PEP themes and to shape the open response survey questions, staying true to the voice of participants (Levitt, et al., 2019). I designed a survey that would generate a mix of quantitative and qualitative information. The open response survey questions were designed to

enable practitioners to express themselves and give a more in-depth experiential quality to the questionnaire, given one of the criticisms of survey-based research is the degrading, reductive nature of the approach (Rubin & Rubin, 2005).

The survey design hinged upon the premise that the open text comments would continue to generate an experiential and emotive knowledge base whilst the quantitative closed questions delivered broad sweep nomothetic knowledge commonly relied upon in traditional academic and managerial contexts. I am also aware that a core component of this research has been my own continuing professional development, and modelling CPD to my audience of student counselling practitioners. I have already raised the issue of counselling and psychotherapy practitioners' propensity to minimise the value of broad-sweep quantitative knowledge and its relevance to clinical practice (Bager-Charleson et al., 2019) and my hope was that my research narrative may encourage others to similarly embrace unfamiliar knowledge forms.

I believe the growing numbers of published, peer-reviewed mixed methods studies demonstrate to readers the value and complementary nature of using different types of data, providing the potential to broaden practitioners' understanding of a subject from different perspectives, helping to break down

historic barriers and biases on certain knowledge sources (Jäderberg et al., 2019; McBeath, 2019; Scupham & Goss, 2019).

4.6 Adopting a Pluralist, Critical Realist Perspective

I previously mentioned my own clinical training background, which incorporates two distinctive schools of epistemic and therapeutic practice: cognitive behaviour therapy and psychodynamic psychotherapy practice. These two therapeutic modalities are often seen as polarised in their epistemological trajectories, not dissimilar from criticisms of mixed methodology wherein problems associated with combining two distinct skills sets are viewed with caution (Bryman, 2014).

Measurement and the practical application of quantifying patterns is a longstanding human tradition and forms the basis of the natural sciences, facilitating huge developments in knowledge and understanding across many disciplines, with ground-breaking progressive outputs. Positivism and constructivism have traditionally come to represent two distinct, opposing perspectives and each has customarily been associated with either quantitative or qualitative research methodologies in isolation (McLeod, 2013, p. 59).

Goss and Mearns (1997) were early advocates of the representativeness of both paradigm data sources, recommending researchers take a pluralist approach when evaluating the complexity of human processes. A pluralist position embraces the validity of multiple sources of knowledge when examining the complexity of existence and human nature. Pluralism considers that, as opposed to a single set of answers or truths, reality is mediated through each person's culturally, personally, politically, and socially situated experience (McLeod, 2016). This is a position I aspire to hold in both clinical practice and research production.

Critical realism offers a similar space for combining both methods and sources of knowledge to understand and change reality (Alvesson & Skoldberg, 2009). It is from this vantage point that I am drawn to mixing quantitative and qualitative research. I am also attracted by the range of strategies that exist, particularly the strategy that involves building an understanding of a phenomenon such as student counselling practitioners' experience of ongoing professional development, when using qualitative inquiry and then testing the data themes with a quantitative tool to establish commonalities (Mruk, 2010).

My growing awareness about and interest in the applicability of both data types, offering a fuller representation and thereby utility, is a consequence of the

emphasis on seeking to better *understand* and to *search*, rather than to *fact find* and *research* in the more traditional sense (Mair, 2010, p. 27). Adopting a methodological position that values a variety of sources of knowledge seems particularly pertinent to the underlying principle of my study, where a significant gap between research and practice has been identified in my working context (Barkham et al., 2019; Broglia, et al., 2018), and a key objective is to bridge such gaps.

As a practice-based researcher, working in a context governed by the traditional (positivist) hierarchy of knowledge, I felt it was important to adopt a methodology and epistemological position that considers the value of many forms of knowledge, including those that govern mainstream research. The aspect of combining knowledge forms was important to me, as therapists' commonly used knowledge base (experiential/qualitative) is often overshadowed in mainstream research by the hierarchy of quantitative-based knowledge within HEIs (McLeod, 2016).

My research decisions have inevitably been influenced by my practitioner-researcher position. My own construction of academic institutions, their historic structural inequalities, and the relationship these institutions have with the work of counselling (as discussed in previous sections) shaped my research objective

to generate and update knowledge to "advocate" on behalf of practitioners' occupational experiences and development, given so little exists (Connell et al., 2006). In turn, my construction of what is important in clinical practice is highlighted in my discourse, and it thereby impacts the research process in terms of the questions I asked and - perhaps more importantly - did not ask across both research stages.

I felt it was important to use this study as a platform to advocate for the counselling profession's ethical commitment to promote diversity, equality, and consideration of context, in addition to knowledge generation (Barker & Pistrang, 2005). Human process research is complex and contextually positioned. The ongoing development of therapists is similarly a complex area and therefore such an approach is well suited to the task of addressing intrinsic - invisible - complexities such as structural inequalities and individual histories and personal factors (Campbell et al., 2012).

From the literature, adopting a mixed methods framework appeared to favourably position the findings for dissemination to a broad audience, regardless of epistemic leanings and biases (Creswell & Plano Clarke, 2007). It also served to shed light on any inequalities that might exist in practitioners' ongoing development. I believe awareness of and conversations about

difference and inequality (regarding CPD) need to be widened in order to make change and transformation more viable and research is a tool with which to begin such a process. Moreover, mixed methods hold the researcher to account, as there are clear steps in developing a good research tool to validate collected data and reduce researcher biases (see DeVellis, 1991, as cited in Creswell & Plano Clark, 2011).

Proponents of mixed methods research (Creswell & Plano Clark, 2007; Feilzer, 2010) report critical realism and pragmatism as the most used approaches in mixed methods studies and I will outline below my reasoning for following this tradition. In taking a mixed methods approach, and facing the challenge of using two distinct methodologies, I became aware that the critical realist philosophy provided me with the rationale for doing so. "Critical realism" seeks to vindicate the integration of a positivist view, that the world exists independently of our constructions of it, with the constructivist view that our understanding of the world is created by our own subjective lived experiences (Bhaskar, 1998).

The double recognition of the existence of an independent reality and the subjective interpretation of this reality is what distinguishes critical realism from singular empiricist (positivist) and social constructionist (interpretative) paradigms (Finlay & Ballinger, 2006; Willig, 2008). The aim of understanding

reality as well as potentially transforming it made adopting the critical realist position very attractive to me and my research intention (Alvesson & Skoldberg, 2009).

In terms of participant representation there are advantages and disadvantages to using both qualitative and quantitative methods. Whilst the online survey used in the FP offers respondents the anonymity to honestly articulate their views without fear of reprisal, and potentially captures multiple perspectives, it lacks a personal and individualistic dimension (Silverman, 2000). By contrast, the transcribed semi-structured interviews carried out in the PEP offered an intimate space to gather specific personal information. That said, interviews have more potential for insider-researcher influence, resulting in less credible findings (Creswell, 2007).

Each method is traditionally seen as a separate skill set but this is changing, as outlined above. My own trepidation at being neither a scientist-researcher nor trained in quantitative methods supported my initial reluctance to consider this approach and enhanced my desire to take up a research design more attuned to my skill base. However, pragmatists and critical realists challenge this stance and emphasise a research question and purpose as the primary motive behind

methodological choice, over and above expertise or epistemological leanings (Howe, 1998).

With this perspective I felt encouraged to reconsider my original methodological intention and challenge my learning. The justification of the research question and purpose provided the necessary impetus for me to take up the unfamiliar method and combine research strategies despite my inexperience. In doing so I believed I was actively modelling continued professional development, by attempting to bridge a gap in my own knowledge base.

My aim to enhance the research data for different audiences and expose the influence of culture, organisation, and limited resources on therapists' access to relevant continued learning activities shaped this final decision. This decision served to further endorse "insider research" (Trowler, 2011), to better understand therapists' attitudes towards and practice of CPD and to produce research that is co-developed from information that is practical and context-based, not simply founded on objective generalisations or subjective supposition, thereby allowing various types of products to be created for different purposes.

4.7 Review of Pluralist Mixed Method Design

The literature on mixed research methods, to produce knowledge that will aid further understanding of an unattended area of experience and practice, complements a pluralist pragmatic and critical realist perspective. After considering alternative approaches, I decided to use a framework that permitted the analysis of mixed data sets, resulting in a broader examination of the area.

Therapist responses inevitably incorporate multiple domains of action, events, and lived experiences, so combining quantitative and qualitative methods enriched the findings by facilitating a more distinct picture of the researched area. In addition, the ability to capture nuanced aspects of the complex interaction of multiple domains (pluralism) and offer different perspectives on various aspects of the research question (Creswell & Clark, 2011) provided a wider platform for the eventual communication of findings. This was a priority if I was to achieve my doctoral objective of ensuring my research demonstrated "impact".

As Shaw and Frost astutely highlight "Pluralistic approaches seek out multiple perspectives to engage with difference. By considering how each method works alone and with other methods, pluralistic approaches set up dialogue across

methods rather than putting up barriers between them" (2015, p. 643). This, again, articulates a principle at the heart of my research. Moreover, mixed methods research has increasingly been championed in the counselling and psychotherapy profession because it "… can enhance the validity and reliability of findings as well as allow for the exploration of contradictions found between the quantitative and qualitative results." (Hesse-Biber, 2010, p. 456).

With the aim of putting the findings into practice, establishing the trustworthiness of the research data to "parallel the conventional quantitative assessment criteria of validity and reliability" (Nowell et al., 2017. p. 3), was vital, influencing my decision to continue to use reflexive thematic analysis (TA). Professor John McLeod's words of caution "to adopt safe methods whilst undertaking doctoral research", especially given the situational constraints of novice researchers (PK Seminar, Metanoia Institute, 2017), echoed in my decision to stay with reflexive TA rather than adopt a new qualitative data analysis approach. I felt I had established some ground for the continued use of the six-phase TA framework (Braun & Clarke, 2006) shown in Table 4.7.1 below.

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 4.7.1 The Six Phases of Thematic Analysis (Braun & Clarke, 2006)

My understanding of the value of reflexive TA is that the driving force of the analysis is the raw data not simply the research question or the researcher's epistemological position, as befits the foundations of other approaches (Fereday & Muir-Cochrane, 2006). This provides built-in flexibility, increasing its appeal to me as a novice researcher, given data can be analysed from both a theoretical vantage point (deductive) and a data focused position (inductive). The use of both deductive and inductive approaches has been established and promoted, enabling users to see data with their theoretical bias whilst availing themselves of new and unknown views, adding more texture to the findings in the process (Joffe, 2012).

The six-phased method shown in the above table (4.7.1) is an iterative and reflective process that develops over time and involves moving between phases rather than a linear progression as can easily be assumed from the TA diagram (Braun & Clarke, 2013). Peer debriefing during data analysis ensures sole researchers are exposed to "aspects of the research that might otherwise remain unspoken" (Nowell et al., 2017 p. 10), and journaling provides an audit trail for the generated ideas and codes that go on to form the data driven themes. I used both throughout the coding process to assist in examining how my thoughts and ideas evolved, as was necessary for the findings to be credible (see 4.12).

In outlining my decision to anchor the final project in the mixed methods approach, I have demonstrated the relevance of economic, socio-cultural, and political factors to the research enquiry. Contextual and epistemological considerations shaped the need for a specific research design and methodology capable of reflecting the impact of said situational factors. I believe a pluralist, critical realist, and pragmatic epistemological approach offered greater congruence with my research needs than the methodologies originally considered. I now describe the methodological stages, with quality criteria undertaken to enable evaluation of trustworthiness, before moving onto research-related ethical issues addressed in Section 5.

4.8 Method

The table below depicts the cumulative stages of the research process (which took longer than anticipated in the Learning Agreement (LA) stage), followed by an account of the methods used to carry out the research project.

Project stage and timing	Task	Timeframe taken to accomplish stage	Additional task/s
Stage 1: Following submission of LA (November 2018) and feedback from Metanoia Institute and Middlesex University Programme Planning Panel on proposal in March 2019, start FP preliminary survey design	• Research, design and test survey • Test survey's usability • Amend LA following feedback and re-submit	January 2019 – March/April 2019	• Reflexive Journaling • Refine questionnaire for pilot • Agreement from AA and AC
Stage 2: Following ethical approval from Metanoia Institute and Middlesex University Programme Planning Panel in May 2019, finalise survey design	• Finalise survey and pilot survey to colleagues • Act on feedback • Seek agreement to proceed from AA and AC	May 2019 – June/July 2019	• Continue to attend PK seminars and peer group activities • Test pilot data and statistical package

Stage 3: Following agreement survey is fit for purpose and agreement gained from AA & AC to proceed in July 2019, activate survey and familiarise myself with data collected	• Activate CPD in HE survey on onlinesurveys.ac.uk • Email HE professional networks • Place survey on BACP research notice board	July 2019 – September 2019	• Journal the experience • Familiarise data from responses • Plan second invite • Check any correspondence
Stage 4: Close survey and begin the process of data collection, analysis and results Meet with AA to agree a plan going forward Request study leave to write up FP Proof FP **Submit FP**	• Collect and analyse quantitative data and collaborate with statistician • Collate qualitative data • Check analysis for triangulation • Peer Present FP • Write up and proof FP • **Email four copies**	September 2019 – December 2019 February 2020 March 2020 Submit PK paper **Autumn 2020/Spring 2021**	• Reflexive journaling of data analysis process • Attend FP module • Email Metanoia of proposed submission date • Prepare conference papers

Table 4.8.1 Stages of the Research Project (DPY360)

4.9 Survey Development and Inclusion Criteria

The Metanoia Institute and Middlesex University Programme Planning Panel granted my final research project ethical approval in late May 2019 (Appendix 6). Whilst waiting for this announcement I began the FP by finding an ethical,

data-secure, and user-friendly online survey platform (see Stage 1 in table 4.8.1). The website onlinesurvey.ac.uk was chosen after researching several options such as SurveyMonkey (www.SurveyMonkey.com) and Qualtrics (www.Qualtrics.com). It appeared to be a well-established website (formerly BOS, 2007) developed for the education sector and frequently used by researchers in academic institutions.

This online platform came at a cost, unlike the other sites, but I speculated that the custom-made academic URL (uniform resource locator) (https://cpd.onlinesurveys.ac.uk/cpd-in-he-survey-copy) would foster credibility with the target audience, who would be invited to participate through several HEI professional networks. One of the limitations of online survey data collection is the detection of junk mail by organisational firewalls and servers (Evans & Mathur, 2005). The onlinesurveys.ac.uk platform was less likely to end up as spam or junk mail as it shared an academic URL. I hoped this would also moderate against low response rates, which is another weakness of survey-based research.

The added benefit of free in-house customer IT support, various survey templates to peruse and a statistical package was particularly appealing as a novice survey designer, inexperienced in statistical analysis. I did not anticipate

the steepness of the learning curve involved in designing the closed and open survey questions and, with hindsight, I can see the consequences and areas for improvement, which I discuss in Section 7. I did not expect the level of in-depth response that the participants gave to some of the open questions, and I fear I missed opportunities to collect additional information because of my inexperience in question development, also discussed in Section 7.

Another important feature I considered during the survey design was ensuring secure data protection. The platform protected data with strict security standards in line with ISO27001, whereby all data is processed in compliance with GDPR; an essential requirement of researchers' ethical commitment to and duty as members of the Information Commissioner's Office (ICO). The impersonal nature of online surveys and fears about data protection can be deterrents to participation in surveys but these aspects did not appear to impact engagement. Confidence in my ability to reassure participants and institutions of their anonymity was a high priority and swayed my final decision to use this survey website.

Online surveys are viewed as a cost-effective way to reach a large sample of the target population and gather information about beliefs and knowledge relatively quickly. They are perceived as a useful tool for assessing respondents' needs,

providing quantifiable data, and identifying opportunities for change (Denscombe, 2007). This strategy offers a greater data yield, which fitted my objective to identify the new training needs of therapists working clinically within educational settings. Dahlberg and McCaig (2010) recommend that well-designed surveys generate the right data when they are brief, clear, user friendly, and custom-made. Figure 4.9.1 (Evans & Mathur, 2005, p. 250) guided the survey design and development in the attempt to maximise participation.

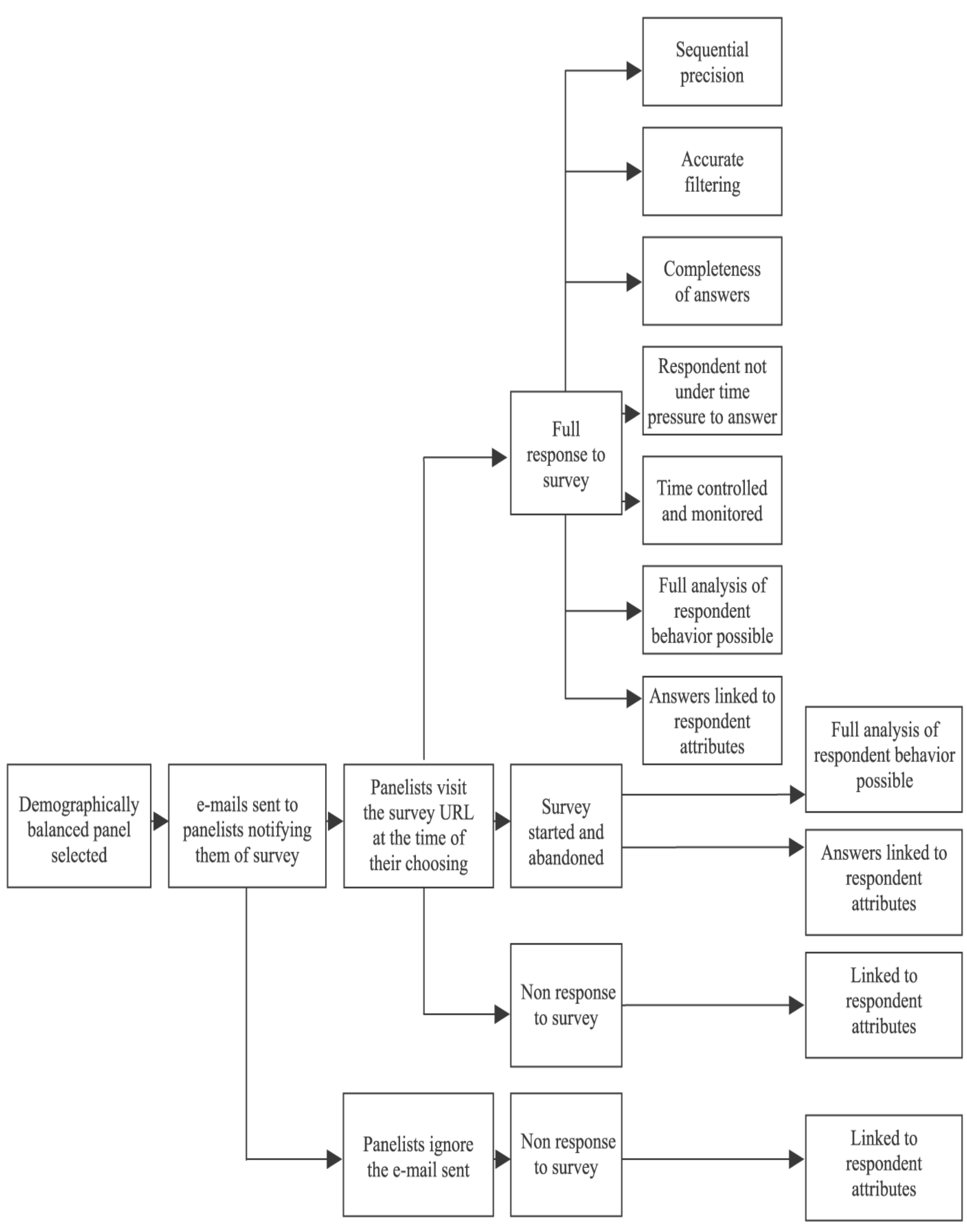


Figure 4.9.1 A Guide to Respondent Methodology for Surveys

The development of the self-designed survey questionnaire (Appendix 8) took place over several months (January-March 2019), following an initial review of the literature and alongside the design of a research recruitment advert (Appendix 9) that preceded the survey questionnaire. It also included a preliminary information statement detailing the need for participants' consent and providing clarification that by continuing to the main survey body consensual agreement was given (Appendix 10 & 11). Withdrawal from the study was permitted at any point and duly highlighted in the information.

The survey method was chosen and developed for the purposes of this research, as there was no standard measure available to collect the required data. I reviewed published studies focusing on health professionals' attitudes and behaviours towards CPD (Golding, 2003; Schostak et al., 2010; Fender, 2017) to locate established tools, and for the purposes of construct-validity (Creswell & Plano Clarke, 2011). Whilst some of my survey questions are adapted from those I reviewed, ensuring a degree of face validity, others differ as they were designed with my own research objective in mind.

I included 25 items on the final questionnaire, which consisted of closed, single, and multiple-choice quantitative questions, as well as 6 open-ended qualitative items. Themes from the qualitative phase were developed to cover a range of

issues related to CPD activity over a 12-month timeframe, and some questions were used to collect demographic information. As mentioned, I engaged four independent colleagues with qualitative and quantitative research experience from varying training backgrounds to provide independent consultation and peer debriefing, in addition to my allocated Academic Advisor and Consultant. All survey feedback was incorporated in the final version and endorsed by each member to validate data sources (Robson, 2011).

The research objective was exploratory rather than confirmatory so the use of both closed and open-ended questions provided a level of data standardisation. Quantitative questions were intended to generate descriptive and inferential statistics related to therapists' CPD attitudes and behaviours whilst the qualitative responses were designed to engender a more experiential response of their learning experiences and their impact to clinical practice in their HE setting, seeking to know more about what was perceived to be useful and impactful to practice and what was missing, in order to inform the development of future training products, if viable.

To contextualise (maintain research utility) and ensure data adequacy (fidelity), the preliminary survey questions centred on demographic information such as professional accrediting body, gender, years of experience, theoretical

orientation, and position held, ensuring sufficient variation among the participants to generate information that would be relevant and useful to the research question and purpose. Active professional membership, two years post-qualification experience and ongoing clinical supervision formed the inclusion criteria. Table 4.9.1 below shows survey's inclusion criteria.

Post qualifying experience	2+ years in HE
Professional Membership	BACP, BABCP, UKCP…
Supervision (clinical)	Current

Table 4.9.1 Research Inclusion Criteria

Inclusion criteria was set to preserve the representativeness of the sample and data. All research participants required the standard post-qualification experience for paid employment in HEIs (2 years or more post-qualification), active membership with one of the leading professional associations such as BABCP, BACP, HCPC, or UKCP and ongoing engagement with a clinical supervisor. This criterion ensured responses were from suitably qualified student counselling professionals, interchangeably termed clinicians,

practitioners, psychologists, psychotherapists, student counsellors, and therapists known to be currently practicing in UK university counselling services, and required to undertake annual CPD.

These differing professional backgrounds represent current employment in the sector and denote the range of influencing discourses informing the work of student counselling. To usefully answer the research question participants need to have a level of assimilation in the sector and familiarity with the work of student counselling (hence 2 years or more working in a UCS) and the profession more generally (active professional membership and supervision). This offered a degree of homogeneity within the variant professional participant sample.

Learning activity preference, funding level, geographical position, and its impact on access to CPD and similar questions were all set to establish the underlying processes involved in participants' CPD decision-making. Depending on answers to the questions, the survey platform used skip logic to guide participants to the next relevant section. The remaining open-ended questions invited participants to reflect on their experience of any CPD they had undertaken in the past 12 months and consider the impact it had on their

practice in an open text format. The online tool recorded a number of responses to each question and participants were free to skip questions as desired.

The purpose of the question development stage was two-fold. In addition to gathering information on therapists' experience of CPD regardless of professional training background and their perceptions of its impact on practice to fill knowledge gaps, I hoped to develop products that would begin to address any identified gaps in knowledge and skills from a strategic premise and fulfil my doctoral obligation to demonstrate impact to the field. The strategy would be in the form of new and refined research-informed activities to develop training reflecting the present-day practice demands and trends of HE. Moreover, these activities would ideally be designed according to the raised concerns or areas of need expressed by practitioners doing the work.

To illustrate the point, there is an existing BACP UC competencies guide developed specifically for student counselling practitioners by practitioners working in further education, sixth form colleges and HEIs which remains underutilised (BACP, 2017). Very few CPD products seem to be designed with these competencies in mind, despite their being developed to target or refine specific aptitudes and specialist skills for practitioners working in the educational sector (Platt, 2017).

The rationale for the development of targeted CPD trainings incorporating specific sector-based competencies would highlight certain skills required in relation to practice-based dilemmas with complex students. This has the potential to breathe life into the existing competencies framework and give therapists training in line with voiced practice concerns, which may differ depending on their position and experience. The purposefully designed questionnaire is intended to capture the perspectives of therapists, managers, and supervisors to assess any attitudinal or behavioural differences. Any differences found between position in service or years of experience for example could indicate whether independent training opportunities for the different positions or experience levels are warranted.

4.10 Survey Implementation and Participant Recruitment

I first sent the completed survey, including the recruitment flyer and participant information (Appendix 11), to both my Academic Advisor (Dr Ruth Caleb) and Academic Consultant (Dr David Mair) as well as my clinical supervisor (Dr Roger Smith) for feedback. I then made amendments where suggested, such as shortening a question. The questionnaire test stage followed, to trial the overall accessibility and clarity of survey and to measure completion times. Amendments were made to several of the fields for completion ease prior to

piloting the survey with additional colleagues working in the sector who did not go on to participate in the final research survey.

The pilot stage checked the survey's face validity, ensuring questions measured what they set out to measure, and involved the same respected colleagues who were aware of my philosophical perspectives and whom I trusted to shed light on my "blind spots" (Bager-Charleson, 2014). Online survey response rates are commonly low, but researchers can improve response rates by employing certain strategies, such as a pilot test giving importance to factors such as completion times (Fink, 2013).

Surveys that are straightforward and engaging rely on the question format being concise and easy to navigate and complete (Wansink, Cheney & Chan, 2003). It was therefore important that aspects of the questionnaire completion process, such as the standard time estimated to complete the survey (10-12 minutes) were correct. Given the constraints on therapists' time and their possible ambivalence towards research-led activity (Bager-Charleson et al., 2018), the estimation of survey completion time had to be accurate and clearly articulated, which the pilot stage ensured was the case with my survey.

The final survey product used wording to promote participating in research as a valid CPD activity, endorsed by professional organisations when research projects are directly linked to therapists' practice and involve therapists reflecting on their work (BACP, 2020; HCPC, 2020). Participation in research studies encourages practitioners to use their voice to raise awareness of personal views on professional development with the reassurance of anonymity. The pre-survey phase enabled me to also familiarise myself with the statistical package and "quality control" measures.

4.11 Recruitment Strategy and Sampling Approach

My recruitment strategy began with contacting professional networks to which I had access. I began recruiting participants by contacting a group of university support service managers or clinical leads, known as Heads of University Counselling Services (HUCS), a professional network based on service position, as opposed to modality, training background, or professional membership. I sent information about the study (Appendix 9) to HUCS with a request to forward it to all counselling practitioners currently working in their university counselling, mental health, or wellbeing services. This was in addition to the networks I had direct links with through my professional training and accreditation status, as well as voluntary positions, such as BABCP, BACP UC and the CBT in HE network. The latter is a network for practitioners trained

in CBT interventions and is largely made up of chartered clinical and counselling psychologists, with accredited CBT psychotherapists.

A request to pass the survey link to student counselling colleagues was included in the study information as I was aware that both these organisations are represented by accredited members belonging to HUCS and the CBT in HE groups. There are many counselling professionals, like me, who are accredited with more than one professional body through multiple trainings. I felt that by contacting these networks (HUCS and CBT in HE) I would increase the likelihood that my sample would reach colleagues accredited with HCPC and UKCP and other professional bodies that I did not have direct access too. This was my attempt to reach and represent the range of student counselling professionals employed in UK HEIs, to address my research purpose and question.

Over 500 therapists working in HEIs would have received two information notifications between June and September 2019 inviting them to participate in the research project (Appendix 9). I used a purposive sampling method known as homogenous sampling (Barglowski, 2018). This is a sampling technique based on the shared characteristics of a group, such as occupation and work setting. It is used when the research question is specific to the characteristics of

a specific group of interest, such as student counselling professionals' continued learning. Creswell states that sampling is purposive as participants are sought because they can "purposefully inform an understanding of the research problem and central phenomenon in the study" (2007, p. 125).

This is particularly valid if the motive behind the survey is to capture new information, as was the case here, given the paucity of existing literature on the subject. Morrow similarly suggests that "… sampling is always purposeful – that is, participants are deliberately selected to provide the most information rich data possible" (2005, p. 255). A homogenous purposive sample does suffer an in-built confirmation bias, but, as stated above, the value of the extractable information about the population and investigated phenomenon mitigates concerns about the risks (Creswell, 2007).

Concerns focus on the fact that survey respondents are usually those interested in the survey subject matter and are more familiar and comfortable with internet use (Haase et al., 2012), leaving an unknown percentage of the sample population unrepresented. Whilst this is true for many sample populations the HE-based practitioner population works in a setting in which access to a computer is ubiquitous and a basic level of IT skills and knowledge is necessary to undertake employment. There remains the issue that those who respond may

share the rhetoric of the research intention and are not representing members who do not participate in the survey.

During the construction of the survey, I considered the limitation of population bias and, in consultation with critical friends, used deliberately neutral phrasing when writing the survey information and questions to address this issue. I employed various strategies to ensure the survey had a successful response rate. For example, the research participation information (Appendix 10) explained the relevance of the research for the promotion of practice-based knowledge and innovation. I highlighted participation in the study as an opportunity to have one's voice heard and demonstrate practitioner expertise, recommended by professional organisations (HCPC, 2018).

The survey was also distributed several times across the timeframe to help increase participation and reduce respondent bias; however, it is acknowledged that selection bias is an inevitable limitation of this research method. In addition, due to the nature of survey anonymity there is no way to record respondents who did not complete or who may have actively withdrawn from completing the questionnaire, increasing the likelihood of the data becoming skewed.

The survey was open during the summer academic recess months, (June-September 2019, and a total of 90 therapists completed the survey). The timeframe could have been an additional barrier to collecting a larger representative sample as term-time-only therapists may have been absent during this period. However, this timeframe was deliberately chosen because, for the majority of HE based therapists (both year-round and term-time only), this is a time when there is less clinical activity and more availability in the academic calendar for administrative tasks and CPD related activity.

I used a variety of platforms to analyse the survey data. In the first instance, I used the in-house online survey statistical analysis function and then I exported the survey data using Excel to a research colleague (Larisa Dinu) familiar with statistical packages (IBM SPSS, Amos 23) who had agreed to assist me with analysing the quantitative data. Qualitative data collected from the free response items on the questionnaire was imported from Excel into Word to enable thematic analysis of data (Braun & Clarke, 2006). Two critical colleagues and my clinical supervisor provided an independent validity check of my interpretation of the qualitative data by reviewing the data corpus and noting their own ideas. This process allowed new themes to emerge that were independent of my own CPD lens. Data extracts for reporting themes and sub-themes in the results section were also discussed in these peer briefings.

The statistical significance of a population sample is determined by calculating what is deemed to be a sufficient sample size for valid inferences to be drawn from the outcome data. To successfully determine whether CPD activity is correlated with therapist practice or any other variable I used the Pearson Product Moment correlation analysis (Benesty et al., 2009; Cohen, 1992) to calculate the response rate figure required. I made a liberal calculation based on there being a total population size of 600 HE-based therapists in the sector. It is not currently possible to accurately determine how many practitioners work in university support services given there is no statutory registration. However, the calculation suggested I would need a minimum of 85 respondents for a sufficient sample size and the response rate of 90 was therefore deemed to be adequate.

Having given due consideration to some of the inherent limitations of small-scale survey-based research I am convinced that the qualitative information deriving from both the PEP and free text response survey questions improves the integrity of my data (Braun & Clarke, 2013). Bringing together themes from the PEP sub-sample and the qualitative data generated from the open response comments to the FP questionnaire provided a fuller picture of therapists' current attitudes towards and experience of CPD in practice in HE settings. The receipt

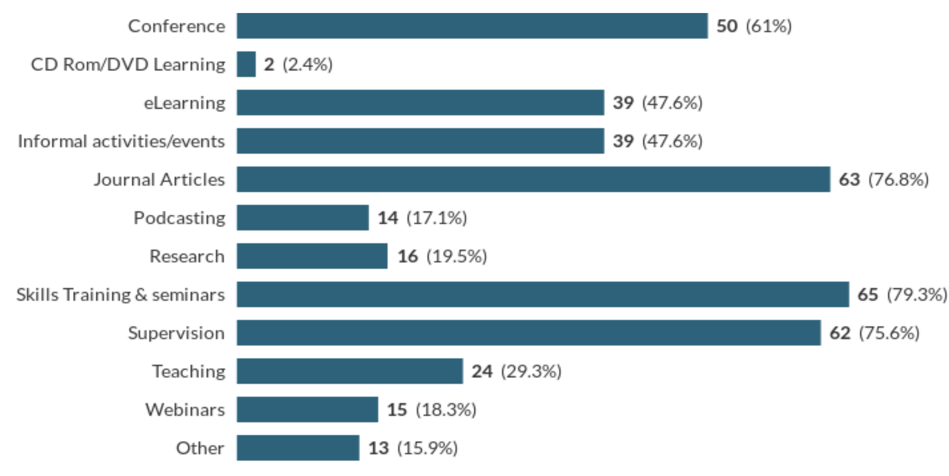
of the completed questionnaires was manageable within a limited timeframe and adhered to a small-scale study using participant generated data (ibid, 2013).

4.12 Online Survey Data Collection and Analysis

In taking a pluralist mixed methods approach, I analysed the quantitative and qualitative survey data using tools to generate descriptive statistics (for the quantitative data set) and reflexive thematic coding analysis (for the qualitative data set). Integration of the mixed datasets at the final analysis stage focused on finding connections between ideas, theories, and experiences (Goss & Mearns, 1997). In assuming that the collected survey data would generate low statistical validity the results were intended to be most useful in terms of whether themes identified in the PEP were common and thereby endorsed. The latter could then be used to inform and impact the sector through CPD product development, knowledge, and strategic recommendations.

The online survey platform included tools to generate descriptive and inferential statistical information from the closed questions in the form of graphed information. An example of the descriptive information generated from question 10 is shown in figure 4.12.1. The question was adapted from a survey in a report into *The Effectiveness of Continuing Professional Development*

commissioned by the General Medical Council (Schostak et al., 2010). The question asked respondents to indicate the type of CPD undertaken in the last 12 months. The category 'Other' included books, email groups, membership to professional network groups, peer-supervision, reading, and running groups.



Multi Answer: Percentage of Respondents Who Selected Each Answer Option (e.g. 100% would represent that all this question's respondents chose that option)

Figure 4.12.1 *Example of Survey Results in Bar Chart Form to Question Asking Respondents to Indicate the Types of CPD Taken Over the Last 12 Months*

The descriptive statistics generated from the online tool were available to view after each respondent had completed the survey. It provided the opportunity to further familiarise myself with the data set as it developed throughout the three months that the survey was open. It also kept a count of participant figures so reminders could be sent out to maximise participation.

The in-depth data analysis took place following the closure of the survey in the autumn of 2019 and continued thereafter. The in-house online survey statistical analysis function was initially used, and thereafter the quantitative data was imported into two further data analysis platforms: Excel and a Statistical Package for the Social Sciences (IBM Corp, SPSS Amos 23, 2015). SPSS was used to analyse single and multiple-choice closed questions to produce descriptive reports. A one-way ANOVA (analysis of variance) was completed with CPD ratings as the dependent variable and years of experience as the independent variables. A Bonferroni post-hoc test was then run to test significant differences between the groups.

Qualitative data was imported into Excel and then transferred into a single document to enable thematic data analysis. This began the process of data familiarisation – the reading and re-reading of all the participants' responses to gain a general perspective of the data, alongside note-taking for ideas of tentative themes. I also used a Word document containing the raw free text responses to cascade familiar thematic coding for the purposes of triangulation to the pilot-test colleagues, as reported earlier. Respondents were informed of the consultation process during the data analysis in the participant information sheet (Appendix 9).

Thematic analysis was conducted on all the data collected in response to five of the six open survey questions (Appendix 8) to identify, analyse, and record recurrent themes across the data set. I carried out thematic coding analysis according to the recommended stages to create a rich, detailed, and complex account of the collected data (Braun & Clarke, 2006, 2013). I chose not to use a software package to analyse the data as the process is deemed “flexible, straightforward, and accessible” (McLeod, 2011, p. 146) without its use and I was somewhat familiar with the technique from the PEP.

The six open text questions generated nearly 10,000 words from participants suggesting an interest in the subject area. I had not anticipated the degree of in-depth comments and started the analysis by using an inductive approach with each question data set, so the codes and themes came directly from words in the survey data. I felt it was important to see therapists’ actual responses and to try to report the data as it was given, regardless of my assumptions and biases. This was an attempt to examine the data by adopting what Braun and Clarke refer to as a semantic rather than a latent lens so that the data can initially be considered at an explicit or overt level rather than “anything beyond what a participant has said or written” (2006, p. 84). This safeguards the data and ensures it stays as close as possible to respondents’ descriptions, limiting the risk of themes fitting the researcher’s preconceived ideas.

I carried out an exploratory process of developing the analytic codes by repetitious reading, note taking (adding sticky notes ideas to the documents) and highlighting (colour-coding) words and sentences to refine the raw data. This process served to identify and then classify emergent subthemes (codes) and eventual main themes across the datasets. I added new codes at different sittings and some subthemes and main themes were amalgamated where there was obvious crossover. I decided not to calculate and record word frequency to form codes on the grounds that Braun and Clark (2006) recommend a balanced view of the data rather than a focus on specific words or sections, which may support preconceived ideas.

I balanced my attempt to stay true to the emergent themes from participants' responses with my own deductive meaning-making of them for reporting purposes. The final thematic framework consisting of four meta-themes derived from nine sub-themes seemed to suitably fit the responses to the research question and go some way to ratifying the earlier findings of the small-scale PEP. All the themes can be traced back to the participants' responses in the original raw text document (Appendix 13) and are illustrated in the findings section with participant quotes selected after consultation with co-researchers, as recommended for quality purposes (Levitt et al., 2019). A reflective

methodological discussion focusing on the research strengths and areas for further development is provided at the end of the discussion section (7).

4.13 Summary

In this section I have outlined the philosophical foundations underpinning my decision to develop a two-stage sequential mixed methods research design, using an exploratory model (Creswell et al. 2003). The two stages of the research included qualitative data from five separate hour-long, semi-structured interviews (PEP) and a nationwide online survey to generate additional quantitative and qualitative data. This sequential mixed methods study progressed from qualitative to quantitative, with additional open text survey questions designed to elicit supplementary in-depth data for additional qualitative analysis. This served to connect the mixed datasets and further contextualise the normative statistical data.

Throughout both stages of the research, I endeavoured to attend to quality assurance and be mindful of the ethical issues associated with undertaking human process research as an "insider" researcher, ensuring that respect and safety of participants was at the heart of every stage of the research. In the next

section I provide a general review of the ethical issues, and outline those that apply specifically to survey-based practitioner-led research.

Section 5. Ethical Considerations

In this section I outline the ethical considerations informing my decision-making throughout the research project. I begin with an overview of general ethical principles relating to research and then address specific ethical considerations for participants involved in online survey-based research. I conclude the section by considering the ethical implications related to practice-based research and the position of “insider researcher”.

5.1 Overview of Ethical Practice

Danchev and Ross (2014) usefully remind “novice” researchers from the caring professions to begin the research journey by first reflecting on themselves in relation to the research process. This is done to develop a sound ethical basis on which to build one’s research question, rationale, and design. The authors refer to this process as ethical sensitivity (ibid). They state that it is from this premise, operating alongside professional organisational codes of conduct and statutory ethical frameworks, that one ideally commits to self-awareness in relation to others with the understanding that “in order to care for others it is necessary to be proactive in maintaining self-care” (2014, p. 7). This message applies to therapists and researchers alike.

Kvale and Brinkman (2009) observe that, while the term *ethics* linguistically stems from notions of character, contemporary understandings of ethics tend to be linked to formal guidelines, such as the BACP Ethical Framework for the Counselling Professions (BACP, 2018). Ethics is key when considering any research project, especially when the area of examination is considered sensitive and vulnerable to exposure or publicity. I considered this and the wisdom of "ethical sensitivity" throughout the various stages of the project, given my intention to publicly disseminate my findings.

Kitchener and Kitchener (2009) propose a five-level model of ethical reasoning based on ethical theory. Researchers are encouraged to interweave different levels of ethical reasoning throughout the research endeavour. The first level relates to the "intuitive or immediate" gut response to gathering information on a situation or subject and it is followed by a consideration of existing laws and ethical frameworks and the theories behind them. These are principally developed in order to influence behaviour, confining it to a set code of conduct that adheres to a set of shared universal values such as the common principles of beneficence, non-maleficence, autonomy and justice. The authors suggest the final level of ethical reason should take into consideration the meaning of any particular ethical position and evaluate the interaction of the philosophical underpinnings of ethical theories in context.

I made use of this reasoning when I selected a research topic that seeks to make a positive contribution to a professional community's knowledge base. I also employed it to ensure participants were fully briefed on the research objectives, thereby minimising exploitation. I was also aware that both gender bias and an ethnocentric perspective would influence the design, collection and analysis of the research data, given that I am a Caucasian, female, heterosexual, middle-aged, university-based therapist and supervisor and thus an "insider-researcher" (Lees, 2001; Trowler, 2011).

To mitigate (as far as is possible) my gender bias and ethnocentric perspective I actively recruited critical colleagues who identified as male and LGBTQ+ and who belonged to an ethnic minority group, underrepresented in the sector. I made the decision to seek the critical lens of colleagues with minority-based experience to check and discuss the impact of ethical dilemmas in relation to my specific research criteria, such as ensuring anonymity and other areas that may make up my blind spots.

Their feedback led to amendments to the inclusion criteria. This specifically related to the inclusion of ethnicity in the demographic criteria. In light of the small number of ethnic minority practitioners employed in HE-based counselling services, I needed to take steps to protect their anonymity. Collegial

input reinforced my awareness of how little the diversity of student counselling practitioners has changed over my professional lifetime. Sadly, this has resulted in the scant representation of minority practitioners' experiences of CPD in my research and is a recommended area of continued examination.

There are certain common principles that underpin ethical research with human participants (McLeod, 2003):

- Beneficence, or else the promotion of wellbeing
- Nonmaleficence, or the prevention of harm
- Autonomy, or respect for others' self-autonomy
- Fidelity, or the fair and equitable treatment of participants

To ensure I adhered to these principles, I followed the process of continual reflection throughout my research journey (Munhall, 1989).

Guidance from professional frameworks and my own personal and professional moral code of conduct as a therapist and supervisor further safeguarded research participants and served to minimise the risk of harm through involvement in the study. Kvale and Brinkman (2009) point to four areas of ethical concern, which overlap with therapeutic codes of conduct. These are: informed consent,

confidentiality, inherent consequences, and the researcher's role. It is suggested that these areas be continually addressed throughout the research process, and I observed this advice, as I would when working with a client in clinical practice.

I also took steps to help participants consider the benefits of research participation in the design. This was to increase the likelihood that participants would profit from the experience, such as by highlighting the survey's status as an anonymous forum for practitioners to express a "lived" professional view and contribute their expertise to the co-production of knowledge and a felt sense of empowerment – to be heard.

My belief is that participating in practice-based research provides a positive platform from which participants can freely convey their experiences and feelings and make a valuable contribution to the limited literature on the professional community to which they belong. My own experience has shown that the act of participating in research encourages and inspires a review of previously unconsidered aspects of the work. It was with this in mind that I highlighted the fact that participation in research studies counts as CPD activity for accreditation purposes, hoping to foster a sense of collaborative research-orientated learning among the professional community.

Finally, I ensured there was opportunity for interested parties to contact me before, during and after their participation in the study to raise any participatory matters or concerns. This included issues of access, such as when a particular disability may prevent participation, or when a participant had limited or no online capability. I also signposted the support that was available in the event that any participant experienced any distress or discomfort at any point in the research survey.

5.2 The Ethics of Online Survey-based Research

My research used an internet platform to conduct an electronic survey using a mixed data questionnaire format to reach a wide audience. Having previously utilised a face-to-face semi-structured interview format for the qualitative study, I imagined there would be fewer ethical challenges with an online questionnaire-based study, given the anonymity afforded to participants in the context of an online survey that does not require participant pre-selection and operates a unique respondent coding system.

Research ethics are imperative when participants are drawn from relatively small professional communities and when organisational factors may come to light and reveal identifiable information (Danchev & Ross, 2014, p. 71).

Survey-based studies are generally considered to carry fewer ethical dilemmas than other research methods in terms of participant anonymity and informed consent, but I took the view that no research is considered ethically neutral (Lindow, 2001). With this in mind, I ensured confidentiality and data collection, processing, and storage was made secure, in line the Data Protection Act (1998), BACP (2018) and General Data Protection Regulations (2018).

I considered the ethical concerns Kvale and Brinkman (2009) raise regarding participant consent, confidentiality and consequence and the researcher's position to key factors. Informed consent is required whenever personal or identifiable information is collected. In this study I disseminated clear information about the research project in the pre-survey research recruitment announcement (Appendix 10), which was sent to the professional networks of HE based therapists. This ensured that participants were clear about my ideas, my position as an "insider researcher" and any aspects relating to their participation such as data protection, confidentiality. and anonymity. I provided this information again in the introductory email inviting therapists to participate in the research study, before they clicked to proceed to the survey link (Appendix 11).

Participation was completely voluntary, and no incentive was offered. Each participant was directed to clear information links regarding the safe keeping and cessation of data, in addition to a complaint's procedure link. A declaration that I had received no external funding, with no conflict of interest from a third party was included in the research information. The participant consent form was embedded within the introductory email preceding the survey link and it contained information on data protection protocols and full contact details of the governing organisations, which could be reached if participants had concerns at any point during the survey.

As the research was designed to utilise data from a self-designed online survey questionnaire, I ensured the online platform gathered information anonymously by generating a personal code for each respondent that did not store any email or other identifying details from participants accessing the survey link. This meant participants could not retrieve their data unless they kept a record of their unique code. In addition, participants were informed they were free to withdraw from completing the questionnaire at any point in the process and reassured that their data would be destroyed following the completion of the research. None of the participants took up the offer of further correspondence following the survey completion despite the offer of a follow-up on request.

Caution is advised when using survey-based information due to the "disinhibitory factor" associated with online mediated research, as respondents may be more likely to self-disclose inappropriately or act-out online than in a face-to-face context (Suler, 2004). Equally, the anonymous, online format could enable participants to speak more openly about difficult experiences or concerns. This was particularly true when participants revealed experiences of institutional pressure in response to context-based tensions (Oppenheim, 2000).

My commitment to rigour is demonstrated in terms of the accrued experience and skills I possess. As both a practitioner (of over 20 years in the university counselling service sector) and a novice researcher undertaking a small-scale qualitative study (Appendix 1), I have gained research skills and knowledge to continue on to a deeper, more challenging, research project. The current project provides a clear argument for adopting a mixed methods methodology and the results section (especially the qualitative data) has been checked by critical friends and an external researcher for the purposes of triangulation. The participants' accounts were in line with the many of the earlier themes generated from the sub-sample (n=5) of HE-based therapists' transcripts as well as areas highlighted in the general literature, with a minimal degree of variance. The continuity across two datasets (qualitative interviews and survey data) and the extant literature possibly reflects the rigour and transparency of the FP.

In the remainder of this section, I will examine some of the ethical implications of practice-led research. Practice-led research is primarily concerned with the nature of a specific area of practice, in this case the continued efforts of therapists in HEIs to develop and maintain good practice, and the production of knowledge to impact under-researched areas. The ethical nature of "insider-research" means it is up to the researcher to honour fellow their fellow practitioners' generous personal contributions in as accurate and considerate way as possible. One of the challenges of being an insider researcher is the impact of holding such a position, particularly when the researcher is part of the researched group. There is a fine balance between self-knowledge, reflexivity, and the potential to bias the research (Berger, 2015). The issue of being in dual roles and the respective power dynamics associated require due consideration.

5.3 Ethics Considered in Practice-led Research

As an accredited member of two UK counselling and psychotherapy professional organisations, the BACP and the BABCP, I endeavour to abide by and keep in mind the principles of each organisation's ethical framework in my professional conduct as both a practitioner and a researcher. BACP's Ethical Framework for the Counselling Professions (2018) highlights the values of autonomy, beneficence, non-maleficence, justice, trustworthiness, and self-respect.

Practice-based research relies on all these principles but particularly on "authenticity and trustworthiness" (Finlay, 2016). The integrity of the researcher and research design is key and underpins practice-based knowledge generated from individual participant's personal lived-experience. Similarly, throughout the research project I have read and observed the BACP's Ethical Guidelines for Research in Counselling and Psychotherapy, which states that "researchers who are BACP members are required to be guided by the BACP Ethical Guidelines for Research in the Counselling Professions, which are based on the values, principles, duties and responsibilities which are relevant to, and accepted by, the counselling professions" (2018; GP87).

I took particular care to safeguard participants against any potential harm by acknowledging that research involving personal experience can be emotive and cause distress. Due diligence was taken in managing the risks of inducing emotional distress. I developed and utilised a stakeholder analysis (Appendix 9) and fostered a sense of trustworthiness by choosing a quality survey platform with robust data protection and security. Clear information about the project was available, with a full consent process that ensured research veracity. I was transparent about the process of data collection and analysis, the additional involvement of researchers and the intent to disseminate findings publicly and highlighted the benefits as well as the pitfalls of taking part in a research study.

In addition to the professional organisation mentioned above, my FP research was informed by the principles set out in Metanoia Institute's Ethical Framework for Research. I was particularly mindful of taking every precaution to protect the anonymity of the research participants and associated organisations, as therapists working in HEIs are part of a relatively small professional community. As a result, I safeguarded, collected, analysed, and stored data in accordance with the information provided by the Data Protection Act (1998), General Data Protection Regulations (GDPR, 2018) and the Information Commissioner's Office (ICO).

In committing to undertake practice-based research that is relevant, rigorous, resonant, and demonstrative of reflexivity (Findlay, 2011), my research-practitioner status required transparency from the outset of the research process. This was achieved by being visible as an "insider-researcher" from the recruitment stage through to the dissemination of the findings. I clarified the various employed and voluntary positions I held – researcher, practitioner, professional association executive committee member – from the outset. I sent out the research recruitment advert and invitation through sector-based networks, exposing my interest in the research and my role as chair of research SIG and member of the profession. I updated the membership of the BACP UC practitioner network in the sector journal and presented stage one research

findings at conferences and workshops. I recruited colleagues to critically appraise the research materials, kept a reflexive diary and, over the years, consulted with my Academic Advisor, Consultant, and supervisor to keep a check on my assumptions and biases.

My professional roles within BACP UC served to publicly signal my insider status and my identity as a university-based therapist and supervisor. This may have functioned to level out some of the power dynamics associated with practice-based research. According to Marshall and Batten (2004) the power issues pose less of a challenge when the researcher belongs to the population, but this does not mitigate against the risks associated with such a position (Creswell, 2013). My position was likely to skew the survey sample, as those who agree with my professional perspective would be more likely to participate, possibly reducing the involvement of other informed but opposing perspectives. This combination left me acutely aware of my responsibility as an insider-researcher to ensure ethical sensitivity during data analysis and the critical reporting of the research findings.

On the one hand I have understood my deliberate status as insider-researcher as one “who influences, if not actively constructs, the collection, selection and interpretation of data” (Finlay, 2002, p. 212). On the other, I felt concerned

about the consequences of my beliefs, particularly those leaning towards a more transparent developmental practice, driven by identified gaps in knowledge and in line with service provision, which may be unpopular among practitioners in the sector. Similarly, I felt uneasy about the lack of relevant good quality CPD being advocated for and provided by professional bodies, despite my direct professional relations and an established commitment to such organisations.

My insider-researcher status contributed to the anxieties I experienced around the outcome of the research. This, perhaps, is part of the reason I found the data analysis stage so disconcerting. I am aware that working within one's competency level is central to the trustworthiness of the research product yet the old feeling of being out of my depth returned, leaving me doubting my research abilities. The diversity of the survey data, particularly the connecting of quantitative results with two sets of qualitative data, left me questioning my decision to adopt a mixed methods design.

Elevated levels of stress pose ethical issues in terms of one's own wellbeing, selfcare, and competence. Competence and reflexivity in research (Etherington, 2004) are connected and, because of the experience, I requested a period of unpaid leave in order to take the necessary time to write up the FP and manage family life during the ongoing challenges presented by the COVID-19 climate

and restrictions. Fortunately, I was aware that it is not uncommon for doctoral students to experience anxiety and fear whilst undertaking research, particularly during the data analysis and reporting stages, even in more usual social circumstances (Bager-Charleson et al., 2018).

The added climate of personal and professional uncertainty triggered by the pandemic lockdown (which continues as I write this report), influenced how I became acutely aware of my ethical duty to reporting participants' accounts of their ongoing practice development. The responsibility to accurately portray participants' experiences and shared views weighed heavily. Therapists' knowledge (or lack thereof) and the impact on practice had been brought sharply into focus with the move to rapid remote working, despite limited training, to support members of the HE community through COVID-19.

The rapid response to remote working, achieved in 24 hours at the service where I work, was an example *par excellence* of therapists' ability to manage and adapt their practice because of situational constraints (Turner, 2020). Like many, I was involved in this real-life practice change and presented with the ethical imperative to offer a form of remote support without the recommended training, because the benefits of offering support outweighed the risks (Goss & Anthony, 2020). The benefits of remote working (online, email, and telephone)

felt like a positive response to an unprecedented situation, regardless of the challenges. The implications for both practitioner and client, as the practice continues over the longer term, remain to be seen (McBeath, du Plock & Bager-Charleson, 2020).

It seems appropriate in a practice-based research context to include the present "lived" events of COVID-19 and comment on the impact these have had in the section considering the ethical implications of practice-based research. The emotional cost of enduring difficult times within the research process, and the impact upon family and professional life, feel important to also highlight, given the ethical implications raised at the beginning of this section in relation to researcher self-care and its impact upon the research process.

In this section I have attempted to show the ethical considerations and pragmatic steps I took to ensure this practice-led research demonstrated rigour, sensitivity and transparency. The methods used to promote "reflexivity" (Finlay, 2011) and "trustworthiness" (Josselson, 2013), were based on aspirations for change. My central belief is that different sources of knowledge have their own validity and transformative qualities, particularly when providing a platform for participants' unvoiced experiences to be heard in order to potentially affect change (McLeod, 2017). In the end it is ultimately up to the

reader to judge whether I have demonstrated that my understanding and use of ethical frameworks has provided a robust-enough structure for the FP.

Section 6. Final Project Results

6.1 Introduction

The aim of this research is to better understand the impact of CPD on higher education-based therapists' clinical practice. My intention was to collect and analyse a range of data sources, resulting from the two stages of research. The objective was to contribute personalised and generalised information specific to this unexamined area of practice and practitioner population. Primacy was placed on the qualitative approach in which understanding is generated by participants' perspectives (shaped by their respective social interactions and personal histories) with normative data usefully depicting some corresponding common trends (Creswell et al., 2003).

I decided to conduct a pluralist, sequential, mixed-method exploratory design so I could test the qualitative findings generated from a small sample of the HE-based therapist population in the first phase and collect a larger sample in the second phase. The connected mixed-data results are derived from participants' practice-based accounts. They provide a context-dependent description of CPD practices intended to update knowledge and inform future professional development training products. For clarity, the results will be presented as recommended (Creswell & Plano Clark, 2011) in three main parts, as outlined below:

- **Quantitative analysis of statistical data from CPD in HE survey (6.2)**

  In the first part, I provide the summarised quantitative results generated from participants who took part in the survey using labelled figures and tables. A combination of statements and brief explanations are used to highlight points of interest and relevance. I will provide an analysis of data collected from closed survey questions relate to practitioner information and then answer questions related to therapists' attitudes and behaviours with regards to CPD activity.

- **Qualitative analysis of open-text data from CPD in HE survey (6.3)**

  The second part offers an interpretive narrative of thematic accounts generated from the qualitative analysis of responses to open-text survey items. This aims to deepen insight into therapists' experiences, thoughts and suggestions regarding current CPD practice. Thematic maps and tables are used to present the different themes generated from participants' responses to different questions with in-vivo examples provided to evidence superordinate and subordinate themes.

- **Summary of the findings from the FP (6.4)**

  In the final part of the results section, I offer an overview of the key findings from both qualitative and quantitative perspectives and demonstrate how the datasets are connected. That is, I show how the quantitative results build on,

and connect with, the qualitative findings from both stages of the project, giving a richer overview and understanding of therapists' CPD experiences and their perceived impact upon clinical practice.

Initially I used the online survey's in-house statistical analysis function to produce quantitative data results. The data was later imported into an Excel spreadsheet and then transferred again into the Statistical Package for Social Sciences (SPSS 23, IBM Corp, 2015) to run a statistical analysis. American Psychological Association (APA) style tables (Appendix 12) were produced alongside figures following statistical conventions to show quantitative data in bar chart form. Qualitative data (full text) was imported into Microsoft Office Word (Appendix 13) to enable thematic analysis (coding) to be conducted and shared with fellow researchers for the purpose of data triangulation and rigour.

6.2. Quantitative Analysis – Descriptive and Inferential Statistical Data

Here, I present the quantitative results using descriptive statistics in order to display and describe the data, ensuring that any informing trends are clear. The use of inferential statistics to deduce different factors' significance to how the HE therapist population views and behaves in relation to CPD practice, was restricted due to the type of data collected, but useful, nonetheless.

Assuming statistical independence, i.e. that variables are independent of each other, meant that only descriptive analysis could be used with the required degree of confidence (Nimon, Zientek & Henson, 2012).

6.2.1 Response Rate

90 university-based practitioners completed the online survey, between the months of June and September, in the academic year 2018/2019. The survey response rate was 18%, based on a conservative estimate of the student counselling population. This meets the lower end of the response rate criterion for reliability of representation, but rates are highly variable, with multiple factors producing an average response rate of around 25% (Menon & Muraleedharan, 2020). However, given the objective of this study is to better understand under-researched phenomena of a small practitioner population and generate up-to-date knowledge for the benefit of that particular population, rather than make generalisations, the figure gives a degree of confidence to the dissemination of findings to the wider university practitioner population. The response rate to a professional therapist organisation survey – the SCoPED membership questionnaire – elicited a similar response of 14% (BACP, 2020).

The nature of a purposive sampling strategy means it is open (however unintentionally) to selection bias and any consideration of its representativeness

must therefore be viewed in the light of the role of rhetoric and other influential factors (Creswell, 2007). However, in circumstances where there is a paucity of up-to-date knowledge the higher purpose of knowledge production is taken to outweigh risks associated with bias and non-representativeness (Menon & Muraleedharan, 2020).

According to the latest BACP UC professional membership figures, there are 449 individual and 65 organisational members of the division (BACP UC internal report, 2019). Therefore, a generous assumption of a total population size of 600 university-based therapist participants (given the other network numbers surveyed) means a sample size of 90 allows for a margin of error of 9.53% at the 95% confidence level and 12.53% at the 99% confidence level. This calculation means there is sufficient confidence to report findings to the HE therapist population and interested parties, bearing in mind the cited limitations.

Following McBeath (2019) and using gender breakdown data to determine a demographic comparison to further depict how representative the survey sample might be the following gender-based information was generated. The majority of respondents identified as female (74.4%, n=67), with a minority reporting as male (23.3%, n=21), one identifying as non-binary (1.1%, n=1), and one

preferring not to say (1.1%, n=1). These figures are consistent with professional counselling and psychotherapy organisations statistics with large therapist populations (74% female, 24% male, 2% “preferred not to say”) (UKCP, 2016).

6.2.2 Demographic Information

Questions relating to demographic information such as employment position, experience, modality of practice and professional body membership were included to explore whether these characteristics determine differences in responses and to identify any common trends in relation to the research questions. For instance, I asked about years of experience to establish whether there was a relationship between this and practitioners’ rating of CPD activity. This type of information is useful to update knowledge and to assess whether a targeted CPD approach based on the learning needs of practitioners at different experience levels is worth considering to maximise learning outcomes.

I identified three main positions of employment in university counselling services: Clinician, Head of Service/Clinical Lead, and Supervisor and these are displayed in Figure 6.2.2 below.

Position	N	%
Clinician	63	67%
Head of Service	18	19%
Supervisor	12	13%

NB: N>90 because of dual roles for some respondents.

Figure 6.2.2 Current Position Held in University Counselling Service.

The largest group of respondents were clinicians (68%, n=63), followed by heads of service/clinical leads (19%, n=18) and supervisors (13%, n=12). The proportional response rate of heads of service/clinical leads is significant, given there are fewer managerial positions in HE counselling services and the role often consists, in part, of managing CPD budgets across a team. The results could thereby provide useful information and recommendations for this group in particular.

It is notable that some respondents indicated more than one service position (hence 93 responses) demonstrating that a few practitioners hold dual roles, for instance being both clinician and clinical supervisor. It should be noted that numbers presented in some figures and tables reflect the number of responses as opposed to the number of respondents participating in the survey.

The demographic information collected for years of experience, modality of practice and professional accrediting body are presented in the following figures below. Figure 6.2.3. shows how many years of experience therapists had been practising for post-qualification.

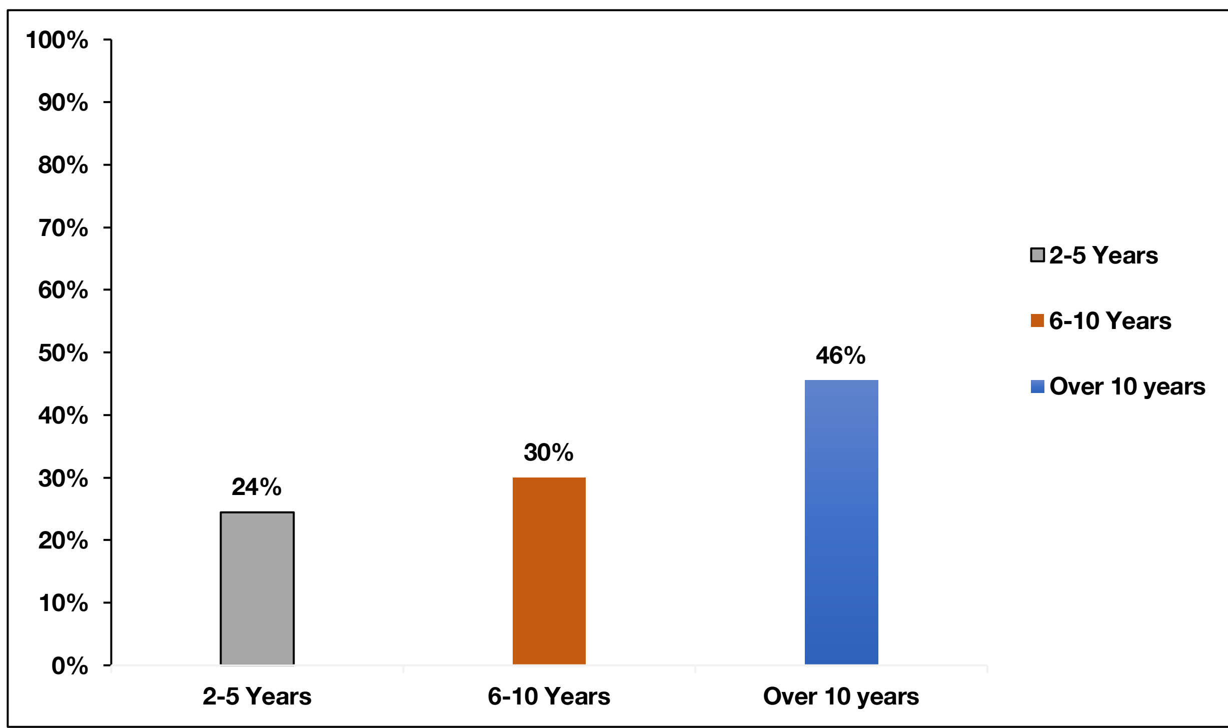


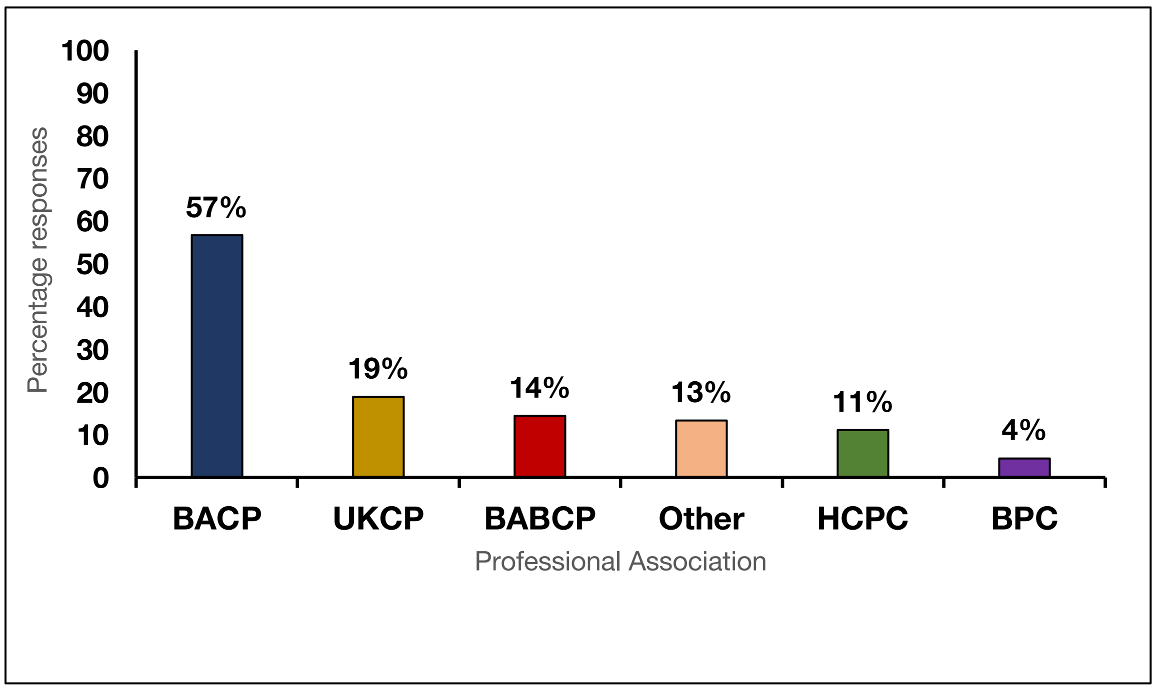
Figure 6.2.3: Experience as a HE Therapist in Years

The largest group of survey respondents were practitioners who had 10 years or more experience (46%, n= 41) and, again, the figures are similarly proportionate to those collected from the recent BACP member questionnaire in which practitioners with ten years' experience or more (36%, n=2,981) were the largest group of respondents (BACP, 2020). This suggests this sample is representative of the wider professional therapist population.

In this study, I made years of experience post-qualification an inclusion criterion, along with being a member of a professional body and currently engaged with clinical supervision, in order to avoid confusion with practitioners who are still in training or waiting for accreditation with a professional body. All of the respondents (100%, n=90) indicated they undertook regular supervision for their clinical caseload, were registered with a counselling and psychotherapy professional organisation and completed the minimum annual CPD. This is not a surprising result given the nature of survey self-selection relates to interest in the research subject (Sills & Song, 2002). It was also a main finding in the first stage of the research, that therapists demonstrated a high commitment to CPD above the minimum professional requirement (Turner et al., 2017).

The survey was designed so any practitioner could participate in the study, irrespective of the inclusion criteria. This was done in order to mitigate against the limitations of self-selection and to explore contrasting views. It was for this reason the questionnaire was circulated among several professional networks. Given I hold a public position within the BACP professional network, it could be argued that the greater representation of BACP members is due to my public profile. However, current membership in the three leading professional bodies (BACP, UKCP and BABCP) is around 50,000, 10,000 and 13,000 respectively,

and this is proportionate to the figures in the sample. Figure 6.2.4 below shows the breakdown of memberships.



British Association for Counselling and Psychotherapy (BACP); British Association for Behavioural and Cognitive Psychotherapies (BABCP); Health and Care Professions Council (HCPC); United Kingdom Council for Psychotherapy (UKCP); British Psychoanalytic Council (BPC) – (Some respondents belong to more than one professional body).

Figure 6.2.4 Sample of Professional Memberships.

The results unsurprisingly show the largest self-reported professional membership group was the BACP (57%, n=51). BACP is the largest UK counselling and psychotherapy organisation, with over 50,000 members drawn from across the therapeutic modalities and a range of clinical settings. It also has a longstanding dedicated university and college counselling division (BACP UC) that evolved from the Association of Student Counselling (Bell, 1996). It is therefore not surprising that so many therapists working in HEI are BACP

members. The United Kingdom Council for Psychotherapy (UKCP), originally formed to represent psychotherapists in the UK, was the next largest professional organisation cited (19%, n=17). The British Association for Behavioural and Cognitive Psychotherapies (BABCP), which has recently notified members that it has launched a special interest group for HE based CBT practitioners (BABCP, 2020), was the third organisation (14%, n=13). This suggests an awareness of and interest in the professional development needs of CBT practitioners in the sector.

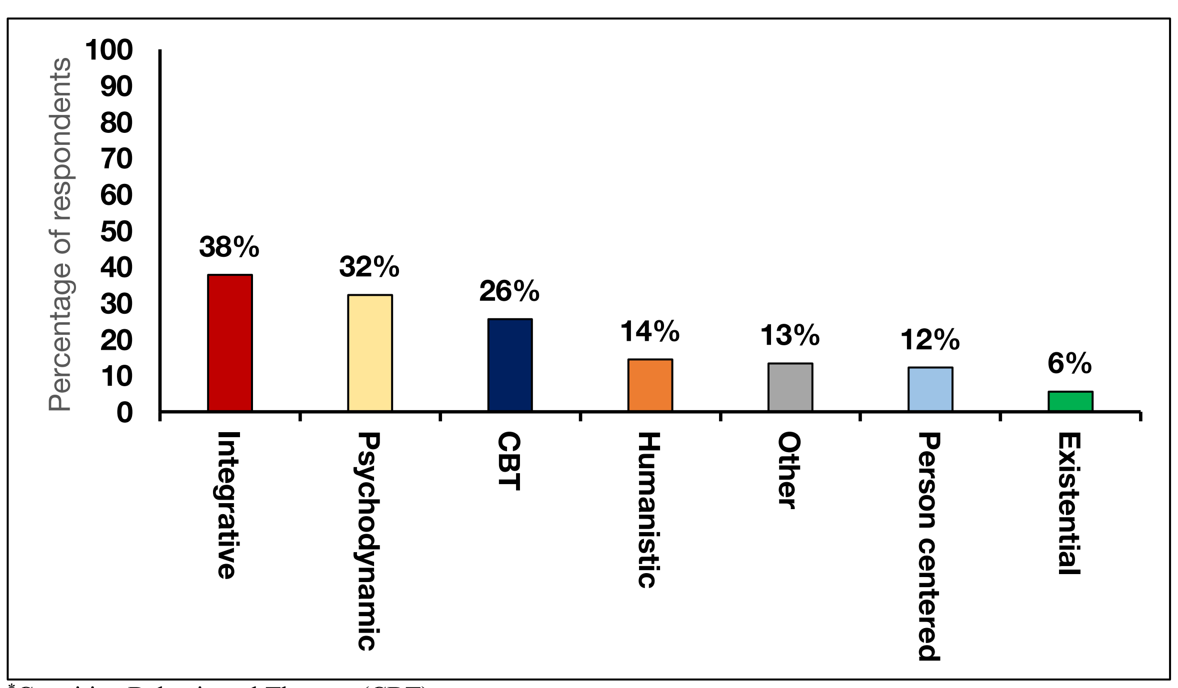
The Health and Care Professions Council (HCPC) (11%, n=10) traditionally represents chartered psychologists as well as other recognised health professions such as social workers and occupational therapists more commonly associated with NHS healthcare settings. This illustrates that there is an emerging cross section of practitioners working in the sector. In addition, 13% of respondents indicated they had a professional body membership in the "other" category. These are shown in figure 6.2.5.

Organisation	N	%
British Psychoanalytic Council	4	4%
British Psychological Society	6	7%
Community for Cont. Psychotherapy	2	2%
EMDR Association UK & Ireland	1	1%
Human Givens Institute	1	1%
National Counselling Society	2	2%

Figure 6.2.5 Additional Professional Memberships Reported

The professional membership data in Figure 6.2.4 and Figure 6.2.5 shows that there is a more diverse practitioner population in the university counselling service setting than has historically been reported (Bell, 1996). An explanation for this demographic change could be the relatively favourable and secure employment conditions and opportunities secured in HEIs over the last 20 years or so.

Respondents were asked which therapeutic modality of practice they felt best reflected their training and clinical work (they were able to select as many as applied). This question was intended to gauge which factors were most influential on theoretical approach and CPD practice. Figure 6.2.6. shows how therapists identified their theoretical training.



*Cognitive Behavioural Therapy (CBT).

Figure 6.2.6 Self-declared Theoretical Orientation In Which Therapists Were Trained

127 responses were elicited about participants' modality of practice, as shown in Figure 6.2.6. This indicates that more than one modality was specified by some of the respondents participating in the survey. The most common theoretical orientation among participants was Integrative (38%), followed by Psychodynamic (32%), Cognitive Behaviour Therapy (26%), Humanistic (14%), Person Centred (12%) and Existential (6%).

Figure 6.2.7 below shows 13% of responses identified additional models in the "other" category and this further confirms the diversity of practitioners in

contemporary HE counselling services as well as how important modality is to practitioners, as the information was purposefully included in the free text box.

Therapeutic Model	N	%
Group Analytic	2	2%
Compassion Focused Therapy	1	1%
Gestalt	3	3%
ACT and 3rd Wave Behavioural Therapies	1	1%
Human Givens	1	1%
Psychosynthesis, Transpersonal.	1	1%
Psychoanalytic	2	2%
Psychiatrist	1	1%

Figure 6.2.7 Self-reported Theoretical Orientation/s Of Models In which Therapists Were Trained.

6.2.3 CPD Activity-Related Questions

Following the collection of practitioners' information, the survey asked about participants' engagement with and attitudes towards CPD. This helped me to better understand practitioner preferences about professional development activity and specific learning forums. The vague nature of the term CPD and wide variation in the criteria of CPD schemes makes comparisons problematic,

but I wanted to get a better sense of practitioners' experience and understanding of CPD practice (given it is a professional requirement of best practice) and explore differences and similarities between responses.

Question 8 – Have you completed any CPD in the last 12 months?

All respondents reported that they had engaged in multiple forms of CPD activity, regardless of their position, years of experience, modality, and professional membership. The follow up question (Q9) provided space for practitioners to explain if they had been unable to undertake sufficient CPD to fulfil their professional organisation's recommendation or to outline any other factors relating to their CPD practice. There were no responses to this question, indicating that all respondents had fulfilled their professional CPD requirements.

Questions 10 – What type of CPD have you done in the last 12 months?

I asked participants to select the type of CPD activity they had completed over the previous year from a list of 11 standard learning forums. This question was intended to explore CPD preference and establish common trends in CPD provision. The was designed as a multiple-choice question and thereby offered the standard "other" category to give respondents the opportunity to specify an

unlisted activity. The breakdown of activities is represented in Figure 6.2.8. below and is followed by Figure 6.2.9, where additional activities are listed in the free text box.

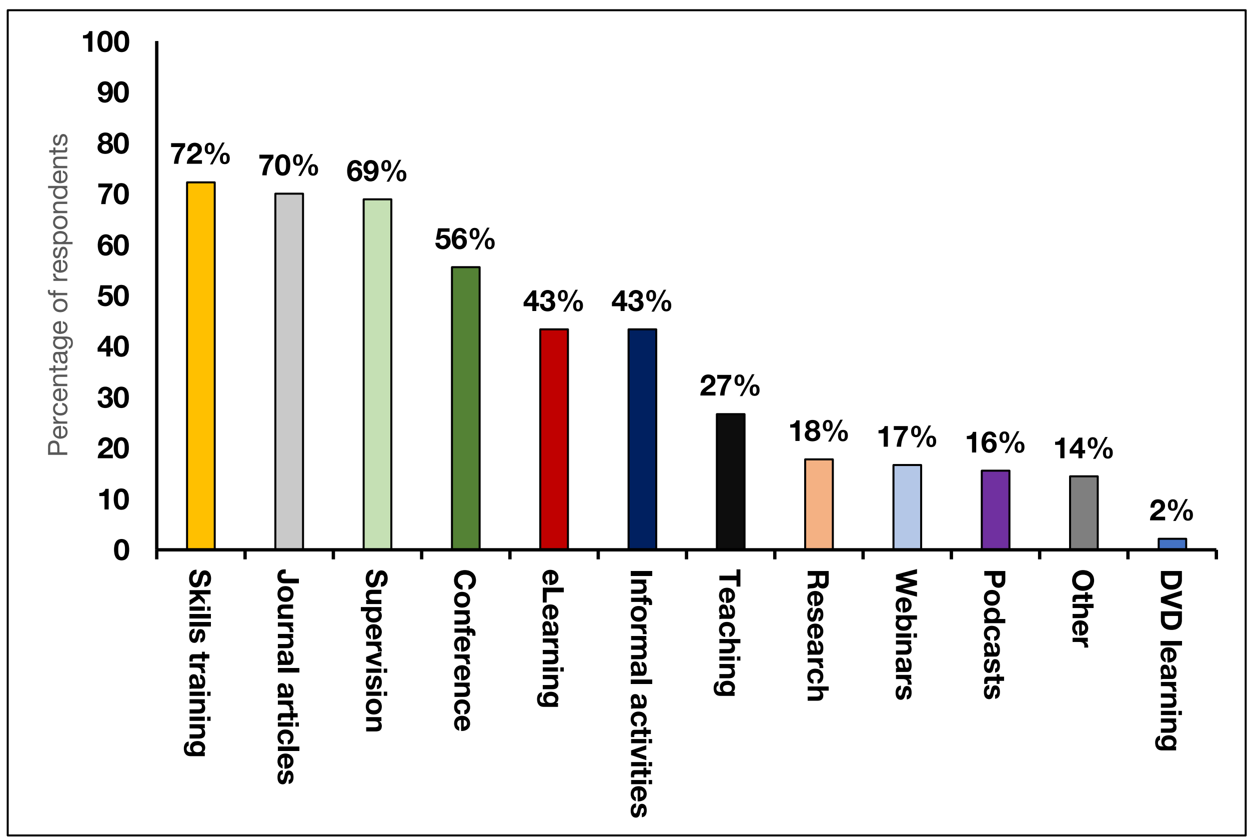


Figure 6.2.8: CPD Activities In The Last 12 Months Indicated By Respondents

As can be seen above, the three most cited CPD activities were skills training, journal articles, and supervision. Skills training refers to the dissemination of knowledge and teaching of skills that relate to specific clinical competencies with the purpose of improving and maintaining a professional's capability and confidence. That this is the most common form of training is not surprising,

given therapeutic skills and knowledge development has been reported to contribute to therapists' confidence (McMahon, 2012).

Therapist development is ongoing. In order to maintain and update skills, meet best practice guidelines and manage a demanding work context, there are a wide range of skills training courses available, from general therapeutic techniques used with particular presenting problems to specific training practices such as single session therapy (SST). It is common across the counselling and allied profession for practitioners to self-select certified CPD activity when asked to record CPD (Fender, 2017).

14% of participants described additional CPD activities undertaken over the timeframe in addition to those listed in Figure 6.2.8 above. These are displayed below, in Figure 6.2.9. The list of activities suggests the value of multiple forms of learning and an awareness of the benefits of different development forums. It also reinforces the wide scope of activities deemed to be "CPD". It is worth noting that learning through group and peer-led work, indicated by respondents in Figure 6.2.9, is deemed to be effective on influencing practitioner behaviour (Forsetlund et al., 2009).

CPD activity	N	%
Books	4	4%
Workshops	3	3%
Peer supervision & attending group therapy	1	1%
Training in attachments issues	1	1%
Running staff & student workshops	1	1%
Discussion groups	1	1%
Special Interest Group work	1	1%
Personal development group	1	1%

Figure 6.2.9. Therapists' "Other" CPD Activities.

70% of respondents read journal articles and this figure increased to 74% when including books for professional development (4%) from the free-text responses. HE has a rich history of sector-related peer led publications, as shown in the literature review. Many of the respondents receive a quarterly journal dedicated to issues in university and college counselling (BACP UC Journal), and all of the leading professional organisations cited above offer members in-house therapy related journals advocating the usefulness of reading.

Moreover, reading professional literature has long been a core component of professional therapeutic trainings and ongoing development (Womack &

Chandler, 1992). Therapists report reading to be a key area of development and it is likely to be associated with the use of therapeutic tools such as bibliotherapy and psychoeducation, used in clinical practice. As a supervisor, a key role with supervisees is sharing information from research informed articles and books related to both client presentations and practice.

It is important to note that my results may, for a variety of reasons, differ from other studies. I am aware for instance, that the list of CPD activities was derived from standard CPD activity lists and this may well have influenced respondents' answers. Questionnaire design implicitly directs participants' answers and is a limitation of survey-based research, as discussed in the methodology section. However, the "other" category provides respondents with some agency and opportunity to comment on learning activities that were not mentioned, and the variety of response indicate engagement with the question paints an encouraging picture of a balanced approach to practitioner development activity.

As previously stated, I was interested in exploring whether demographic data such as years of experience had any correlation with CPD activity preference so I could gauge differences in developmental need. This was done with a view to targeting and refining practitioner learning products. The descriptive data in

Figure 6.2.10. below provides more information about some of the patterned differences within the subgroups from the total response data from Figure. 6.2.8. above.

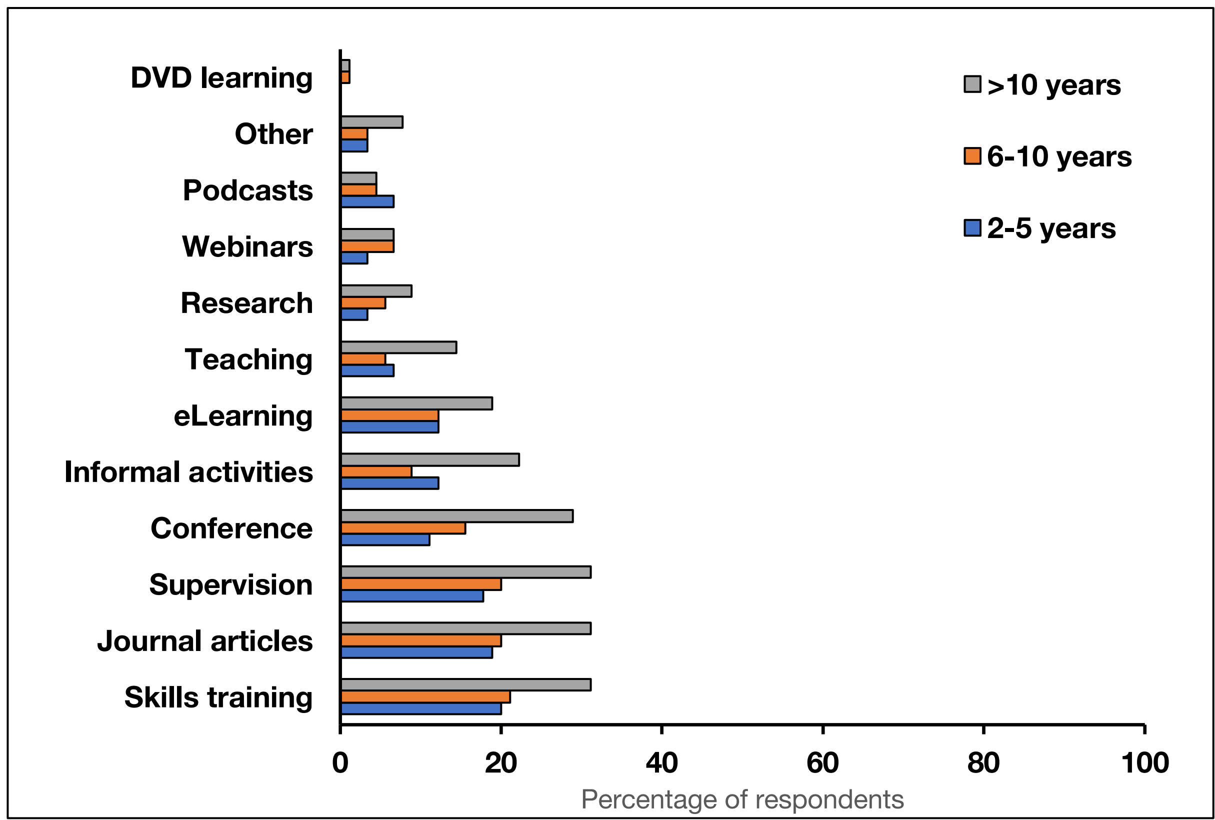


Figure 6.2.10. Years of Experience and Type of CPD Activities (Multiple Choice)

With a response rate of 72%, skills training and seminars were the most regularly attended CPD activity, signifying therapists prioritise formal over informal CPD. However, in Figure 6.2.10., above, we can see that the most experienced therapists – who also make up the largest percentage of survey respondents (46%) – reported undertaking a blend of formal and informal CPD activity across learning activities domains. This trend is consistent within each

of the experience groups. So, regardless of how long a practitioner has been working, the top three CPD activities reported are the same, but in slightly different orders, and there is always a blend of formal and informal activity. This breakdown gives a fuller description of the data and shows that a blend of formal and informal learning activity is commonly undertaken, as recommended by professional bodies (BACP, 2018). Given research into the efficacy of learning modes is still developing and the onus to ensure that CPD activity is of adequate quality and relevance remains on the individual, a blend of learning activities and forums bodes well for practitioner development.

I wanted to see if the different modalities reported by participants yielded different CPD activity preferences. Figure 6.2.11 below shows the breakdown of descriptive data by CPD type and modality. The largest self-reported theoretical orientation was Integrative (38%), and the three largest modality-based groups all reported supervision as their first choice of CPD. The perceived benefits of clinical supervision for professional development are well established (Watkins, 2011). Provision is generally funded for practitioners in HE so, although this result was not unexpected, it was nonetheless encouraging given the importance of clinical support, particularly in high demand contexts.

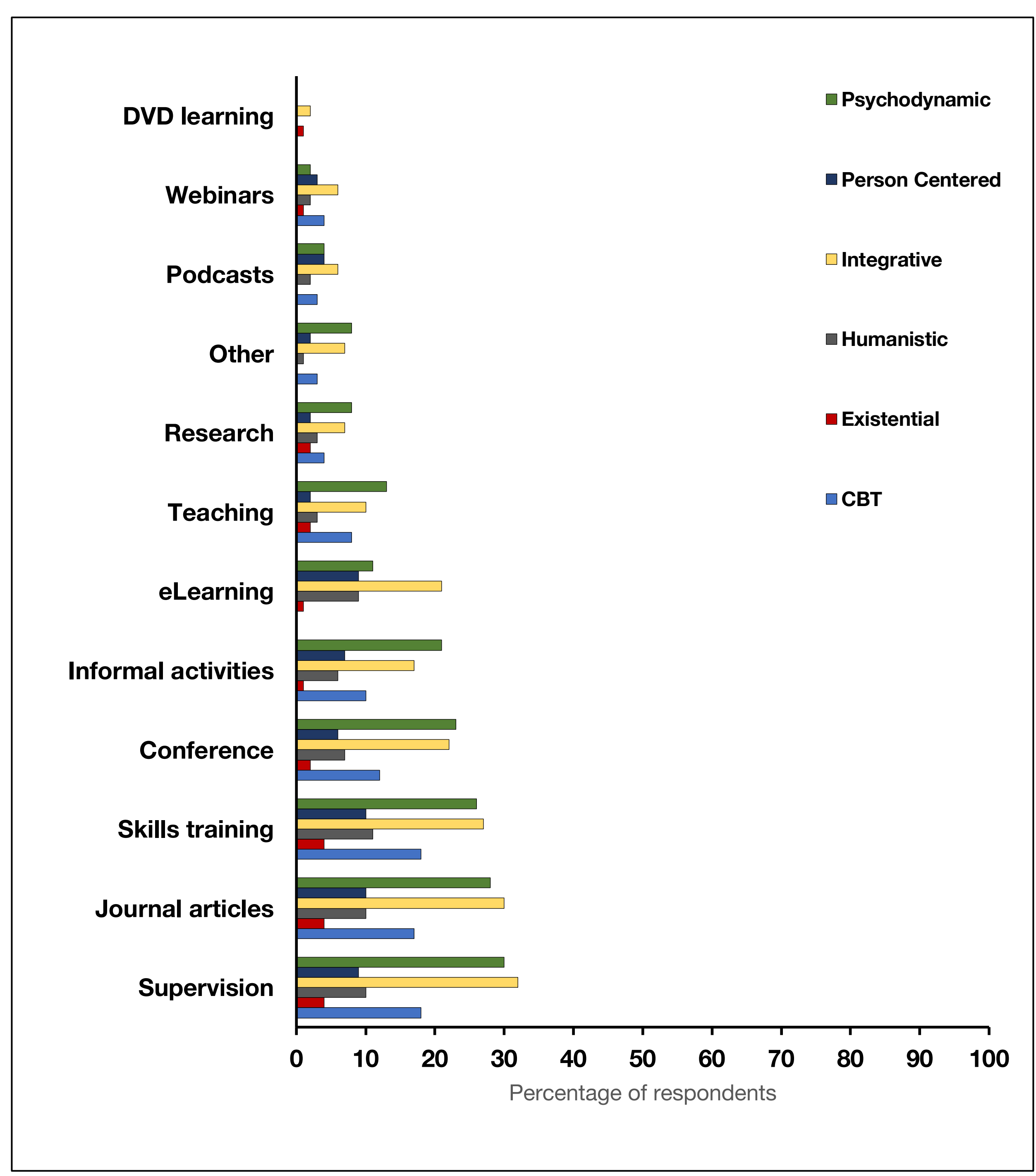


Figure 6.2.11. Modality and Type of CPD Activities

The findings from Figure 6.2.11 offer a contemporary view of changes in counselling practitioners' CPD behaviours. Practitioners' learning needs are set against various obstacles. These include the rising costs of CPD delivery, accommodation and travel rates, time away from work, and the limited funding and constraints of the academic framework. However, regardless of modality, the top three CPD activities reported are the same, albeit in slightly different orders.

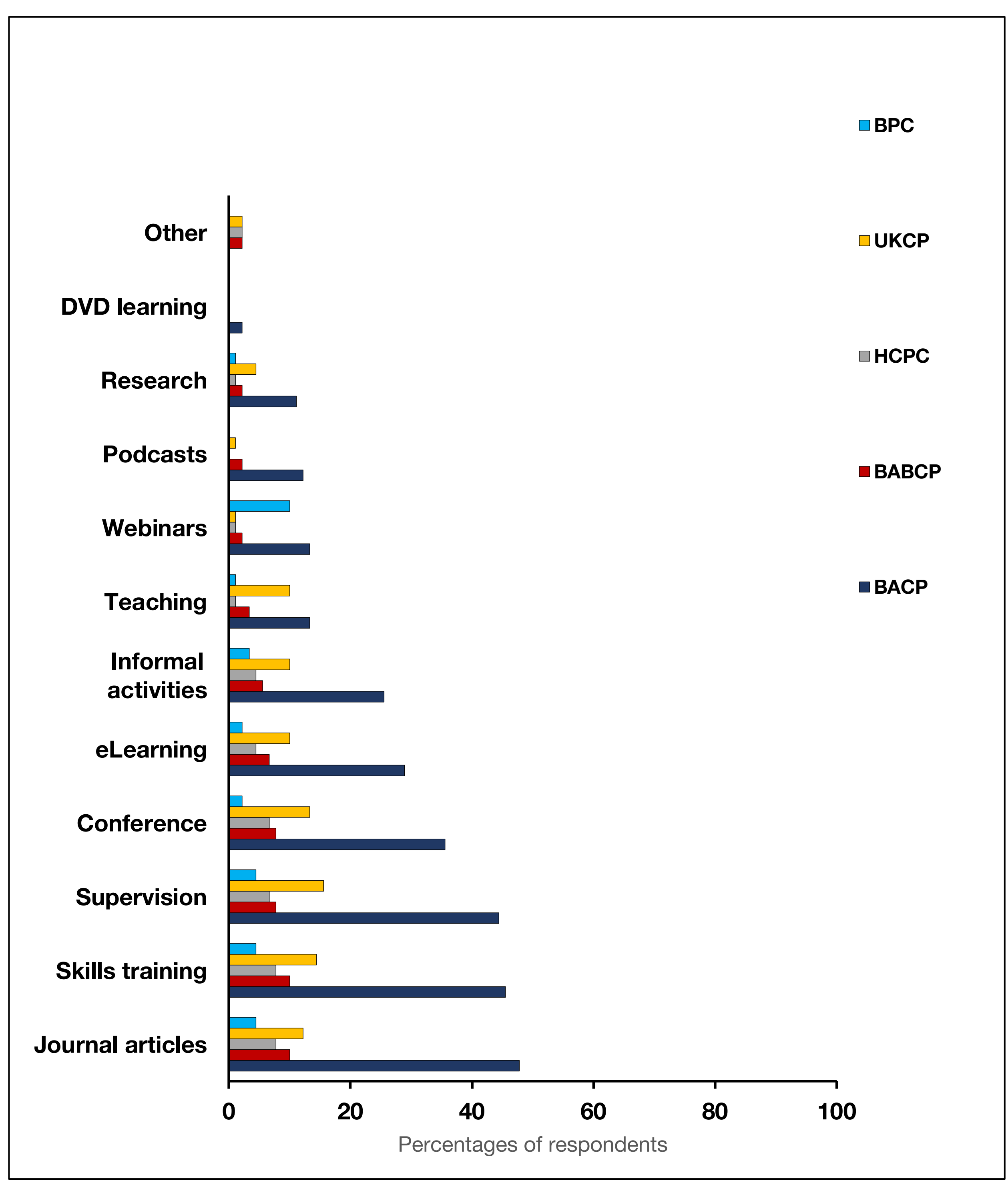
The results show practitioners attend fewer conference events. These CPD forums provide developmental opportunities such as networking, peer-led discussion forums, and involvement in sector-led initiatives, all of which are elements that formed the backdrop to my own and many of my fellow practitioners' ongoing sector-specific development in the past (AUCC, 2010).

By contrast, these results show that practitioners do engage in forms of electronic learning, with webinars featuring across all therapeutic modalities. This augurs well for developing the accessible, relevant CPD that practitioners require to keep abreast of developments in a climate of fast-changing ideas, expectations, and technologies. The impact of the global pandemic on clinical practice and the ongoing development opportunities provided by virtual

working platforms means that engagement with web based CPD is likely to increase.

I continued by examining the relationship between CPD type and a therapist's professional organisational membership because of the primary role professional organisations play in setting criteria and regulating standards for ongoing development and learning. Although all the leading professional bodies (BACP, UKCP, BABCP, HCPC) require members to plan, review, and reflect on their CPD, they only *suggest* acceptable modes of learning.

However, I wanted to establish if the CPD frameworks of independent professional bodies influence practitioners' choices of CPD and identify whether differences exist. No obvious differences were found between professional membership and CPD activity type but, interestingly, the descriptive information shows that certain recommended learning activities featured little or not at all among memberships. Figure 6.2.12 below displays the results.



Behavioural and Cognitive Psychotherapies; HCPC, Health & Care Professions Council; UKCP, United Kingdom Council for Psychotherapy; The British Psychoanalytic Council.

Figure 6.2.12. Professional Membership and Type of CPD Activity

57% of respondents were members of the BACP and these individuals cited the same top three categories: journal articles, skills training and seminars and supervision. This trend was consistent across the leading professional bodies with the exception of the British Psychoanalytical Council. Members of that organisation reported webinars as their most frequent form of CPD.

The future of virtual learning environments is an expanding area and, since the pandemic, they have become a primary forum for CPD, suggesting there is further opportunity for the ongoing development and promotion of this mode of learning. The results suggest some professional organisations are ahead of others in terms of virtual CPD provision. This study therefore recommends the development of various digital platforms as a potential point of interest for developers of CPD.

A study mapping the literature of CPD requirements for UK health professionals reported that professional organisations face the challenge of providing regulated CPD (Karas et al., 2020). In addition, there is a growing evidence base about effective learning methods such as interprofessional education and peer-to-peer learning (Wallace & May, 2016). Current research has identified gaps in future virtual-learning environments, which are likely to become more widespread in the future. In the context of increasingly

technology-delivered professional education and skills development, services, this gap will need to be addressed (Karas et al., 2020).

Question 11 – How did you choose this CPD?

In this question I asked how respondents choose their method of CPD in order to assess whether they follow recommendations for best practice based on evidence of effective learning methods. Participants were given a list of criteria from which to indicate the decision-making process associated with their annual CPD programme and, once again, the category "other" gave respondents the opportunity to comment. The list is presented in Figure 6.2.13 below. Respondents could choose multiple answers. I have included the five respondents who chose to comment in the "Other, please specify".

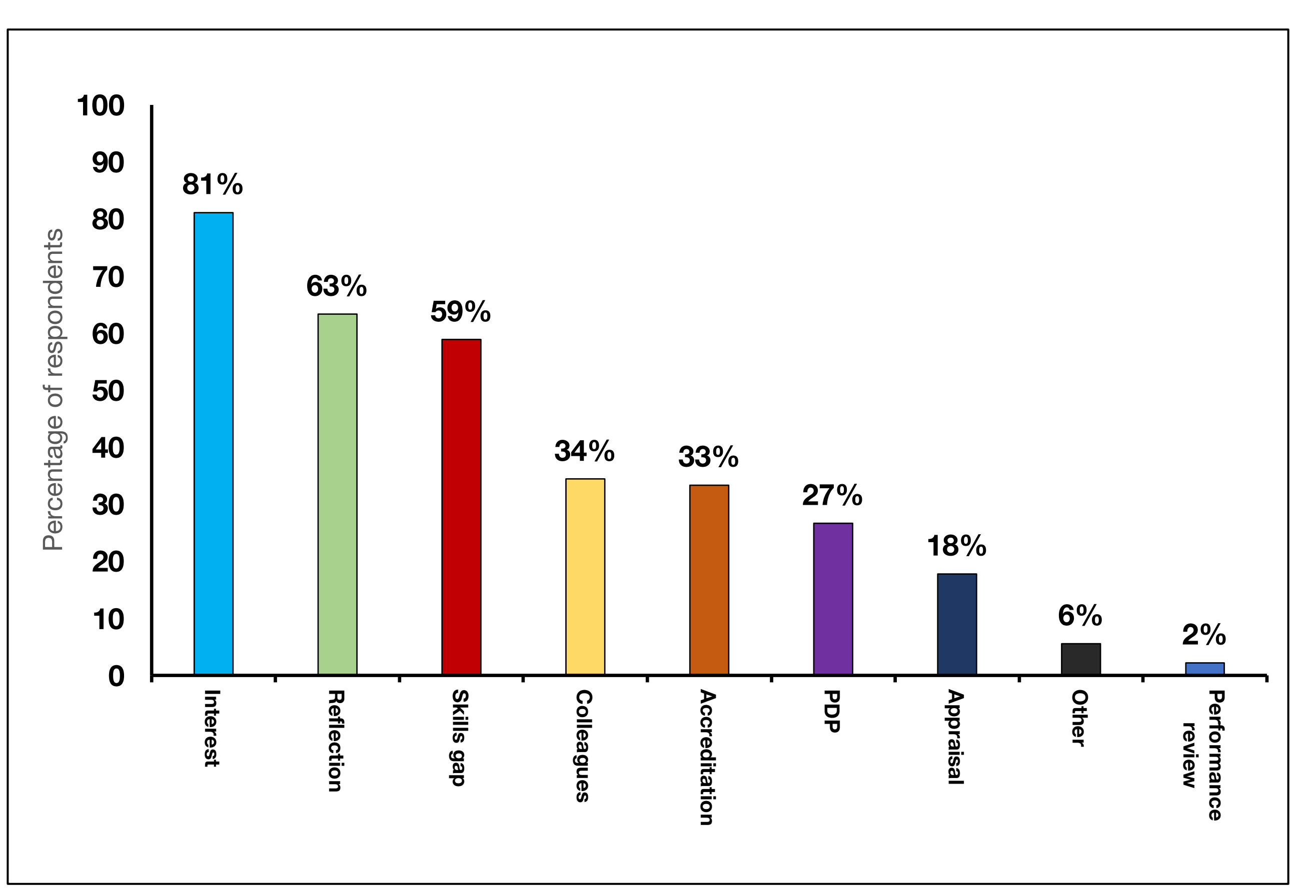


Figure 6.2.13: Motivating Factors in Choosing CPD in the Last 12 Months

I was not surprised that the data revealed that, for most respondents, the greatest motivating factor was interest (81%, n=73). The literature (Castonguay et al., 2010; Fender, 2017) and thematic data from the first stage of the research both identified this as a common practice among therapists. My own anecdotal experience, as both practitioner and supervisor, further supports the findings that choice of CPD is largely based on practitioner interest in either subject area, content or workshop presenter.

Reflection on practice (63%, n= 57) and knowledge/skills gap (59%, n=53) were the next most common selections. Best practice recommendations from professional organisations suggest CPD practice should be characterised by a learning cycle of reflecting, planning, learning, and evaluating (BACP, 2018; BABCP, 2012; UKCP, 2013). Ideally, this should be conducted collaboratively by taking a planned approach based on identified learning and developmental needs, prior to the CPD activity (Karas et al., 2020).

The results from this study highlight that CPD activities planned through a personal development plan (27%, n= 24), appraisal (18%, n=16) or performance review (2%, n=2) were least influential on the self-directed CPD decision making process, despite professional body recommendations. This information shows there is scope for improving practitioners' knowledge of effective CPD

practice, particularly given moves towards the statutory regulation of continued education across the health-related professions in lieu of promoting professionalism (DoH, 2017).

The value of advanced CPD planning, based on identified learning need informed by the wider context of an individual's clinical practice, is endorsed by professional bodies but it is not, at present, a requirement. This is in spite of evidence showing improved benefits to outcomes when learning is undertaken in conjunction with input from a supervisor (Beausaert, Segers & Gijselaers, 2011). This is relevant for both professional body guidance and those responsible for CPD provision and practitioners' supervision arrangements.

Table 6.2.1 below presents the free text comments of 5 of the 90 respondents and illustrate some other influential factors associated with choice of CPD activity. These range from what could be learnt from active engagement in discussion forums to the constraints of wider institutional and global factors.

Table 6.2.1 Free Text Comments to Question 11 on How CPD was Chosen

Participant	Free Text Response to Q11 – *How did you chose CPD?*
1.Female, CBT clinician with 2-5 years of experience.	"presented in a team meeting"
2. Female, CBT clinician with 10+ experience	"Discussion with Supervisor"
3. Female integrative, clinical lead, with 6-10 years of experience	"Our service no longer has a budget for individual CPD. Our head decided to use the budget for group sessions on CBT as deemed most relevant across the whole team (which includes counsellors and mental health practitioners)"
4. Female, integrative clinician with 10+ years of experience	"I chose activities because I am aware of global instability due to climate chaos and potential societal collapse. My employer does not consider this relevant but I believe it underlies a lot of the anxiety we see in students today"
5. Female, psychodynamic clinician/supervisor with 10+ years of experience	"A bi-product from special interest group membership"

The third response from the experienced clinical lead that her service no longer has a budget for CPD demonstrates a concerning lack of organisational understanding of the importance of ongoing learning in therapist competence and confidence building. It also suggests a lack of awareness of the ethical

implications of a lack of CPD provision given complexity and volume of student counselling work.

The lack of organisational understanding with regard to clinical practice expectations cited in the free text response above may explain the findings in Figure 6.2.14 below. Descriptive information regarding motivational factors in choosing CPD activity and position held in service, shows that head of service did not elicit any response to the role of a performance review in directing managers' own CPD decision-making. Appraisals, performance reviews, and personal development plans (PDP) are commonly used interchangeably but both the appraisal and PDP elicited low responses. This finding exposes a systemic "blind spot" in organisational support for recommended continued learning practices. This is an ethical requirement, and would clearly benefit from further investigation (Nezu, 2020).

National best practice recommendations (DoE, 2019) advise that learning objectives are set at the beginning of a year, alongside a performance review to pave the way for necessary training and to ensure objectives are achievable. These results imply there is a significant research-informed gap among those in positions of governance in HEIs. CPD education targeted at heads of service/clinical leads could, given these individuals' responsibility for the

continuing education of all multi-disciplinary team members, improve CPD practice overall.

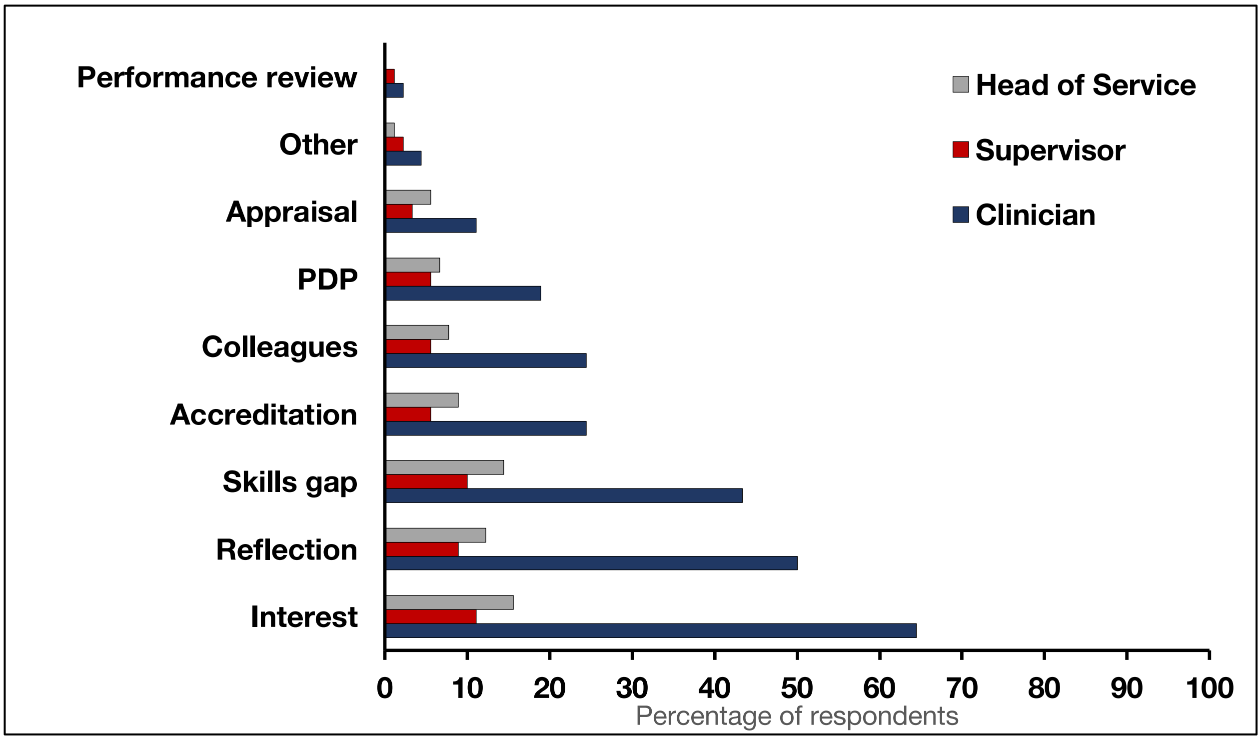


Figure 6.2.14. Current Professional Position and Factors Involved in Choosing CPD

Figure 6.2.15, below, shows CPD choices mapped against years of experience in the profession. This presents a similar pattern to that of “current position”, with interest, reflection, and knowledge and skills gap being main motivational factors in CPD decision making. The group that stood out in this dataset was the least experienced practitioners (2-5 years), who indicated that CPD decision making did not involve a performance review and rarely an appraisal or PDP despite the prevailing pressures on HE staff and research indicating that increases in pressure heighten occupational stress (Hughes & Spanner, 2019;

Moorish, 2019). The training gap in provision of CPD best practice and a lack of guidance to plan and reflect on CPD choices for less experienced practitioners is highlighted and warrants attention.

Findings from a recent scoping review of defined CPD requirements show that use of a PDP or other form of planned CPD evaluation (Karas et al., 2020) is rare across counselling and allied professions, with the exception of medical practitioners. Healthcare professionals tend to lean towards self-directed and self-evaluated CPD, as shown in the current study.

For CPD provision to deliver its potential it appears there is a need for the establishment of a more coherent framework including appraisal, identification of developmental needs, research into learning opportunities, active learning and integration into clinical practice and evaluation of clinical practice (Greene, 2006).

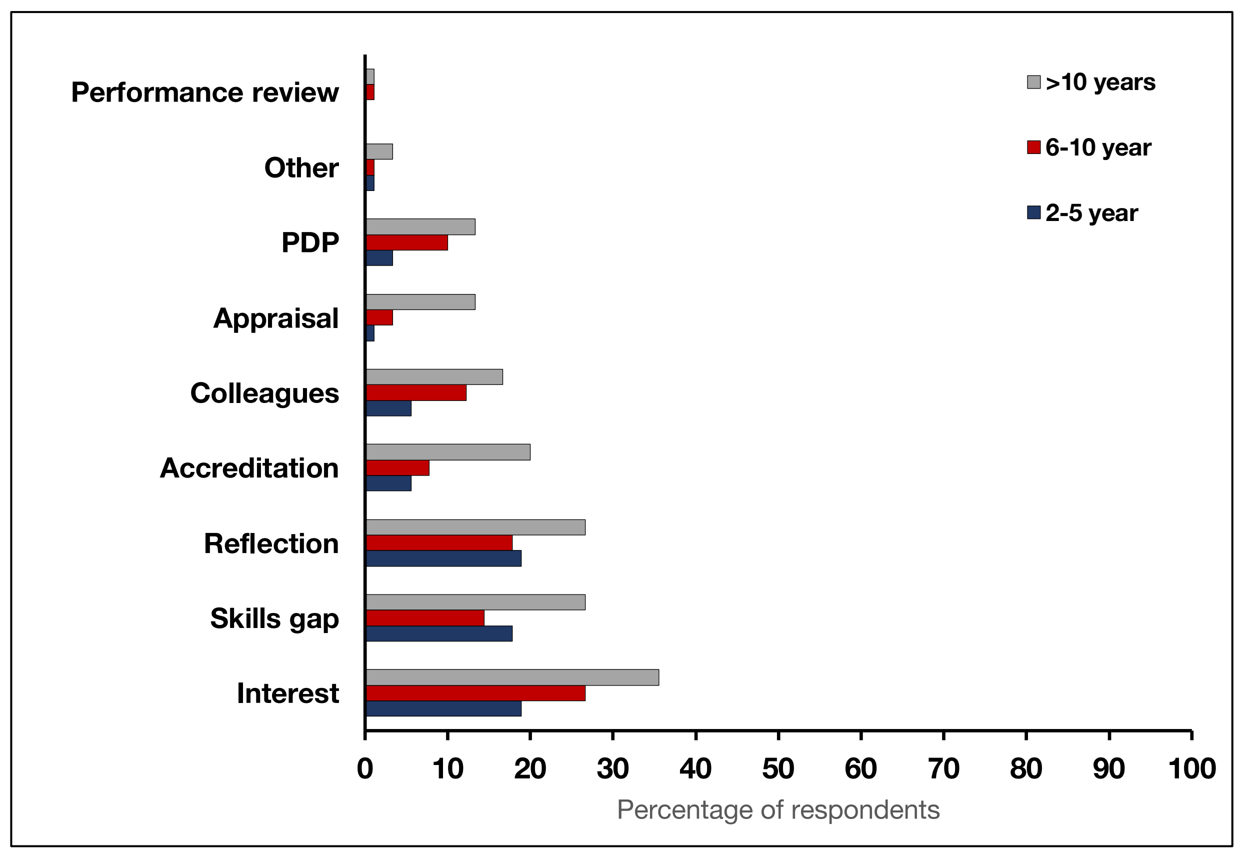
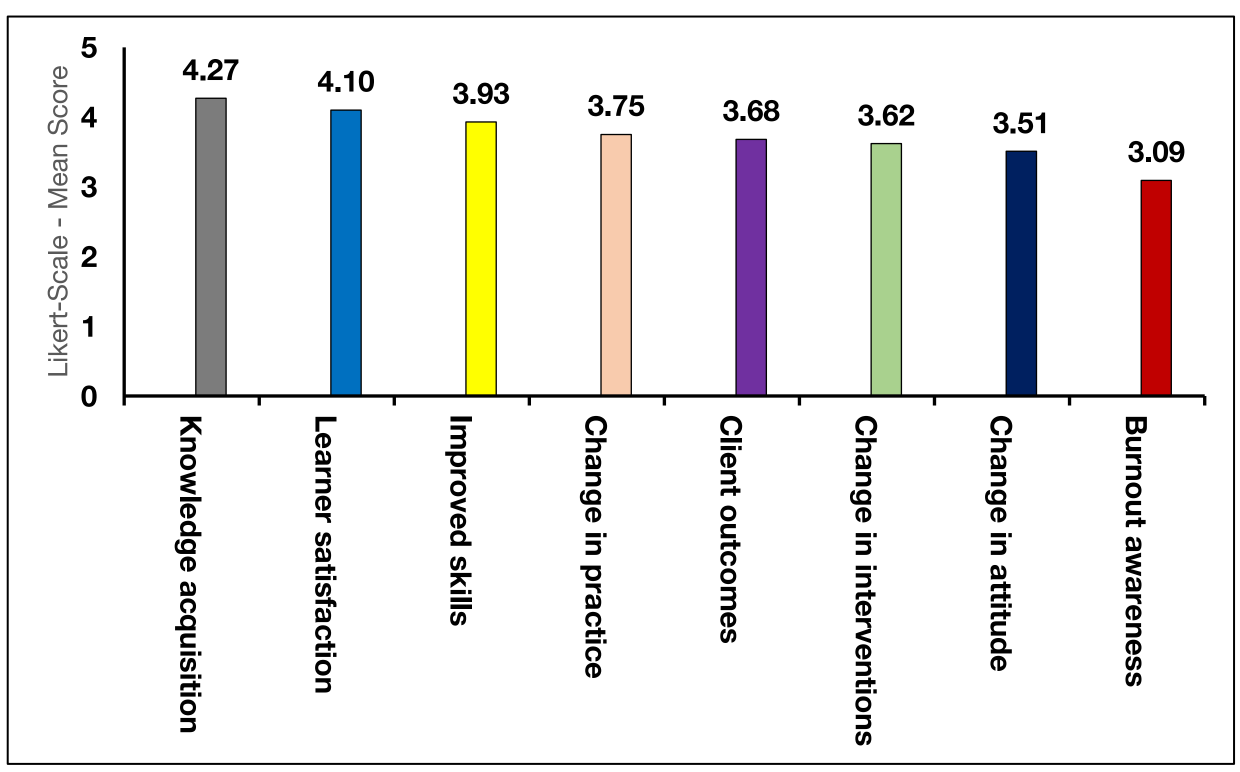


Figure 6.2.15. Years of Experience and Factors Involved in Choosing CPD Activity

Question 13 – In what ways was the CPD activity directly relevant to your practice as a HE-based therapist?

Participants were given a list of eight learning outcomes – from burnout awareness to client outcomes – and the option of a free text box "other" from which they could indicate their perceived learning outcomes using a five-point Likert-scale.



Relevance of CPD activities was measured using a 5-point Likert-scale, where 1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree.

Figure 6.2.16. Mean scores of Reported Relevance of CPD Activities in Response to Q13

The mean scores in Figure 6.2.16 show knowledge acquisition was the highest learning outcome reported by respondents. 94% of respondents specified gaining new knowledge (mean=4.27) as most relevant to clinical practice, with 38% saying "strongly agree" and 56% "agree". Similarly, respondents cited learner satisfaction (mean=4.10) as a strong factor associated with CPD outcomes. 83% agreed, with 31% stating they "strongly agree" and 52% that they "agree". 78% of respondents associated CPD favourably with skills improvement (mean=3.93; 20% "strongly agree"; and 58% "agree").

These results suggest that, overall, respondents believe that satisfaction with up-to-date knowledge acquired though attendance at CPD programmes actively improves their clinical skills and practice. This finding explains the earlier result showing that respondents have a preference for skills training and seminars. However, the perception of relevance and the effect of learning on clinical practice is questionable, given research emphasising practitioners' propensity towards unreliable self-assessment skills (Greene, 2006).

Research examining the accuracy of clinicians' self-assessment indicates there is a tendency for practitioners to over-estimate their clinical achievements and competence (Alicke et al., 1995). By the same token, practitioners' self-appraisal of their training needs and competencies are likely to be over-inflated and lack accuracy regarding actual training needs, which incidentally, are reported to increase alongside career progression (Green, 2006). So, the more experienced a practitioner, the less accurate they are at assessing their actual learning gaps. This is cause for concern given the present lack of CPD education and guidance in HEIs.

With this information in mind, the finding that 78% of respondents felt their CPD activity resulted in improved practice indicates that a degree of scepticism would be prudent. Caution is needed given the lack of self-assessment accuracy

among practitioners, particularly those most experienced (and of which this study is largely composed).

62% of respondents agreed that client outcomes were relevant to clinical practice development. This is despite there being no indication from respondents of client outcome data featuring in CPD decisions and the limited amounts of planning or evaluation available to target ongoing development based on identified developmental need. The use of client outcome data in identifying gaps in practice efficacy is not a requirement of professional CPD practice, yet these results suggest it has potential value for identifying learning gaps.

58% of the respondents reported that CPD did not inform them about "burnout" (32% "neither agreed nor disagreed and 26% "disagreed" or "strongly disagreed"). I found this result worrying, given occupational burnout is characterised by therapist disengagement (Maslach, 1982). Research shows effective client outcomes are based on engagement and the formation of a good empathic therapeutic alliance (Wampold, 2015). The pitfalls regarding unattended clinical practice development and provision present to practitioner, client, and institution are stressed in the literature and emphasised by these figures (Delgadillo et al., 2018).

These results suggest that practitioners unaware of the vagaries of work-related stress are likely to go unnoticed and unsupported in existing CPD arrangements. Opportunities to access information and interventions designed to enhance coping and resilience when working in demanding mental health settings are thus more likely to be missed. Inevitably, this increases the propensity towards occupational stress (Delgadillo et al., 2018). I believe this information offers the chance for those responsible for advising, developing and delivering CPD to prioritise practitioners' knowledge on such self-care topics in advance of their experiencing poor health, which, incidentally, forms part of the ethical framework for the counselling professions (BACP, 2018).

Question 14 – I consider CPD to be…?

I designed this question to use a rating scale to explore participants' attitudes towards their completed CPD activities. Respondents rated a standard list of 11 criteria – bureaucratic, enjoyable, engaging, essential practice, ethical, informative, professional, progressive, rewarding, threatening and unnecessary – using a five-point Likert-scale, where 1=strongly disagree, 2=disagree,

3=neither agree nor disagree, 4=agree, 5=strongly agree.

*p-value significant at $p<.05$.

CPD ratings	*Mean (SD)*			*F*	*df*	*p*-value
	Clinician	**Supervisor**	**Head of Service**			
Bureaucratic	3.81 (1.03)	3.36 (0.80)	4.06 (1.06)	1.56	2, 75	.216
Enjoyable	1.69 (0.64)	1.83 (0.57)	1.94 (0.55)	1.12	2, 80	.329
Engaging	1.65 (0.62)	2.08 (0.51)	1.94 (0.55)	3.35	2, 80	.040
Essential	1.32 (0.51)	1.50 (0.79)	1.64 (0.86)	1.69	2, 80	.191
Ethical	1.34 (0.59)	1.66 (0.77)	1.52 (0.62)	1.53	2, 80	.222
Informative	1.50 (0.57)	1.91 (0.51)	1.76 (0.56)	3.37	2, 80	.039
Professional	1.34 (0.51)	1.66 (0.65)	1.58 (0.71)	2.12	2, 80	.126
Progressive	1.65 (0.78)	2.27 (0.64)	1.88 (0.60)	3.38	2, 79	.039
Rewarding	1.59 (0.66)	2.27 (0.64)	2.00 (0.61)	6.18	2, 79	.003
Threatening	4.31 (0.76)	3.83 (0.83)	4.25 (0.68)	1.96	2, 78	.148
Unnecessary	4.76 (0.51)	4.45 (0.68)	4.62 (0.61)	1.44	2, 76	.242

Table 6.2.2 Relationship Between Current Position and CPD Ratings

63% (n=56) of respondents strongly agreed that CPD was professional, 61% (n=54) thought it was essential and 58% (n=52) considered it an ethical part of clinical practice. These findings corresponded to a theme that emerged from the PEP showing practitioners perceive CPD to be an integral part of their professional identity and clinical autonomy. It would have been interesting to investigate significant differences between practitioner position and CPD rating but, because the ratings were not independent of each other, it was only possible

to cross tabulate the data in order to describe the interaction between variables, as shown in Table 6.2.2 above.

A small difference was found between the mean scores of CPD rating "rewarding" and position. Therapists with the role of supervisor (M=2.27, SD=0.64) found CPD to be more "rewarding" than clinicians (M=1.59, SD=0.66) and clinical leads (M=2.00, SD= 0.61). This finding reflects the role of clinical supervisors, who are responsible for overseeing practitioners' clinical practice and professional development.

As a supervisor myself, I see the distribution and application of relevant research knowledge and ideas as a core component of supporting supervisees' professional work and providing good case management. I make my own personal and professional development agenda transparent and encourage supervisees to do the same. This enables a shared understanding of CPD interests, theoretical outlook, learning style, and methods that inform the work and research of both supervisor and supervisee. The general trend from the data shows that, irrespective of position, the scores were similar. With these descriptive statistics we can conclude that attitudes to CPD are not significantly affected by one's professional position. This is useful information in considering developments of CPD activity in the future.

A one-way ANOVA was used to analyse CPD ratings and years of experience. This statistical procedure was possible because there were three independent groups based on years of experience, which was not the case for the previous data due to some practitioners holding more than one position (for example, clinician and supervisor). Below is the table showing the relationship between years of experience and CPD ratings.

CPD ratings	*Mean (SD)*			*F*	*df*	*p*-value
	2-5 years	6-10 years	over 10			
Bureaucratic	3.85 (1.01)	3.58 (1.13)	3.93 (0.93)	0.87	2, 77	.420
Enjoyable	1.66 (0.57)	1.83 (0.63)	1.75 (0.64)	0.39	2, 81	.672
Engaging	1.66 (0.48)	1.79 (0.65)	1.81 (0.65)	0.38	2, 81	.680
Essential	1.31 (0.89)	1.70 (0.86)	1.72 (1.06)	1.40	2, 88	.250
Ethical	1.13 (0.35)	1.59 (0.69)	1.62 (0.70)	4.69	2, 88	.012
Informative	1.36 (0.49)	1.70 (0.54)	1.80 (0.68)	3.82	2, 88	.026
Professional	1.27 (0.45)	1.51 (0.64)	1.42 (0.59)	1.10	2, 88	.338
Progressive	1.50 (0.59)	1.77 (0.84)	1.87 (0.76)	1.72	2, 87	.184
Rewarding	1.54 (0.59)	1.70 (0.66)	1.94 (0.72)	2.69	2, 87	.073
Threatening	4.13 (1.16)	3.96 (1.12)	3.97 (0.99)	0.19	2, 86	.822
Unnecessary	4.71 (0.90)	4.37 (1.04)	4.40 (0.86)	0.96	2, 84	.387

**p*-value significant at $p<.05$.

Table 6.2.3: Relationship Between Years of Experience and CPD Ratings

Looking at the mean scores within groups (Table 6.2.3 above) it seems that more experienced therapists (10+ years) rated their CPD activity as marginally

more “engaging”, “essential”, “informative”, “progressive”, and “rewarding” than their less experienced (2-10 years) colleagues. However, the range of difference between the groups was not found to be statistically significant, following a Bonferroni post-hoc test. It can therefore be argued that the findings presented in Table 6.2.3 show that attitudes to CPD are not affected by length of service. Again, this is potentially a very useful result for future research into CPD. Different samples might have different CPD needs, but their attitudes to CPD seem fairly uniform, irrespective of years of practice and position held.

Respondents with more experience in the sector are likely to hold positions of responsibility (clinical lead or supervisor) or have held positions with management-type duties in the past. The free text responses in the Table 6.2.4 below all come from experienced practitioners with management responsibilities. These practitioners indicate greater familiarity with CPD practice and experience of the actual impact on clinical work and have lower expectations of their ongoing learning. All four respondents articulate that the impact of learning depends on the relevance and quality of the CPD.

Participant	Free Text Response to Question 14: *"I consider CPD to be…?"*
Female, Psychodynamic practitioner/supervisor with 10+ years' experience.	"I've answered for good CPD but this isn't always the case, sometimes the subject is interesting but not very relevant to our area of practice"
Female, Person-Centred clinician/supervisor with 10+ years' experience	"all above answers depend on the CPD!!"
Male, CBT head of service, with 10 + years' experience	"It will depend on the subject, format of the training, the facilitator, etc."
Female, integrative clinical lead with 10+ years' experience	"Depends on the quality of the CPD."

Table 6.2.4: Free Text responses to Rating of CPD Activity

Question 15 – How do you learn best? (tick top 3 learning forums)

I developed this question to evaluate participants' preferred learning forums and explore whether differences between groups existed, particularly given advancements in technology and learning. Respondents were asked to indicate

their top three learning styles from the 10-item list shown below in Figure 6.2.17.

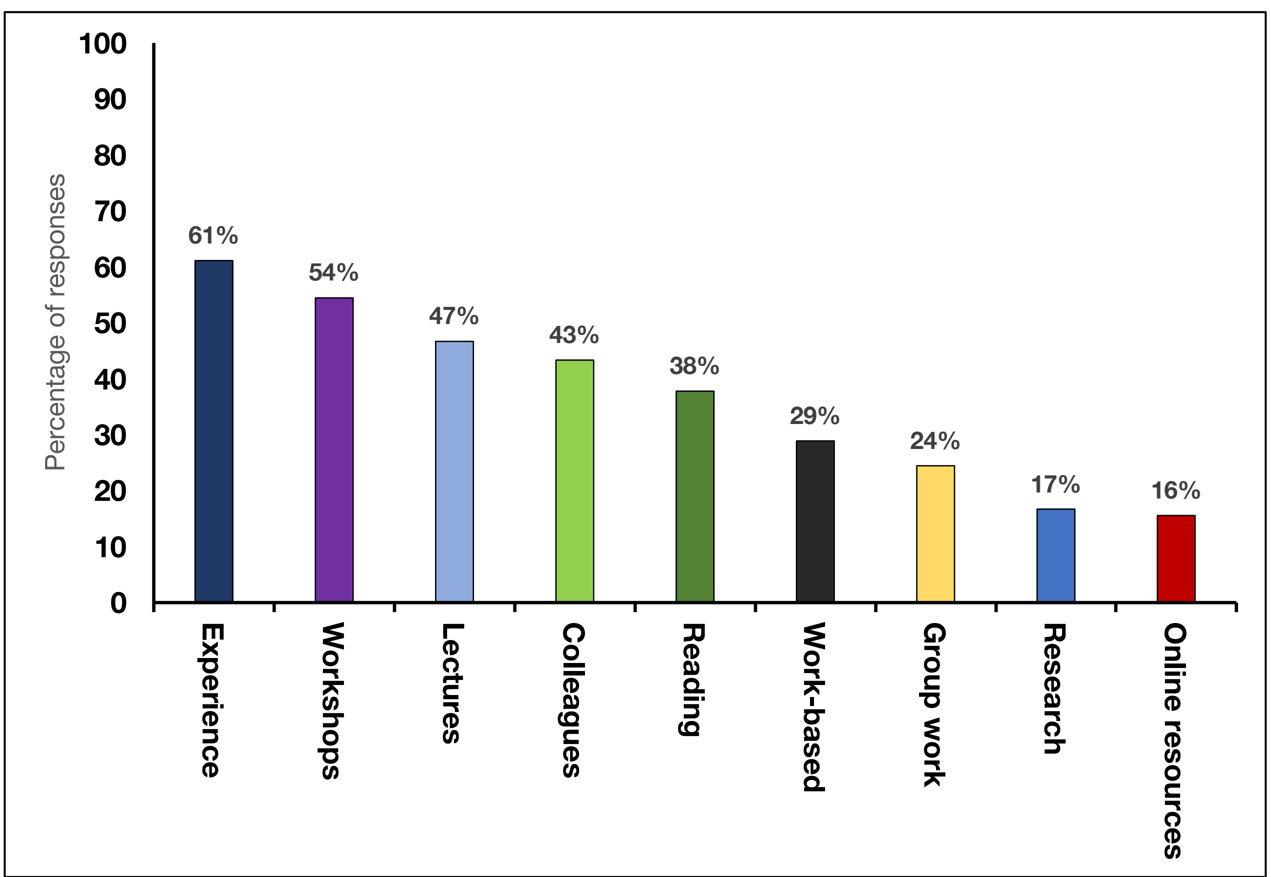


Figure 6.2.17. Therapists' Self-reported Best Learning Style

61% of respondents selected experience as their principal learning style with 54% citing workshops and 47% lecture/seminars. This finding complements those from Rønnestad and Skovholt's (2001) review of senior psychotherapists' development, which identified "learning arenas" for professional development. Participants saw experience as a primary "learning arena". A separate study also verified the importance of experiences in professional development, with

therapists rating interaction with clients and supervision as being most impactful to their professional development (Rønnestad & Skovholt, 2013). Only 17% of survey respondents specified that research activities were a valuable continued learning forum. I was interested by this finding as it resembles wider research findings across the counselling and psychotherapy profession (Morrow-Bradley & Elliott, 1986; McLeod, 2016; Bager-Charleson, McBeath, du Plock, 2018) that highlight a persistent and tenuous relationship between research and clinical practice.

Clearly there are ongoing challenges to therapist engagement in research activities, which has been a consistent concern across the profession. Research has sought to explain why clinical practice is not sufficiently influenced by research (Castonguay et al., 2010; Castonguay & Muran, 2015; Henton, 2012) and recommendations are made for developing a research informed practice (Barkham & Mellor-Clark, 2003; Goodheart, 2006). The results of this study suggest the existence of a research-practice gap among HE-based practitioners of CPD that would benefit from further education and innovation.

I designed the remaining five survey questions to ascertain therapists' perceptions of the barriers to CPD provision, given current national health strategies to regulate CPD in the health-related professions (NHS, 2019).

Question 16 – Who is involved in planning your CPD provision?

Given there are recommendations to organise a planned and collaborative approach to CPD (BACP, 2018; Kolb, 1984), I asked participants to indicate who is involved in the planning of their ongoing development. The majority of responses showed that this was self-directed 52% (n = 69). The involvement of a manager was indicated by 25% (n = 33) and 12% (n= 16), while 6% said they had input from their employer or professional body 6% (n=8).

3% of respondents selected "other" and specified the involvement of a supervisor. These results advocate for greater collaboration in CPD planning, given the emphasis from professional bodies and national strategy briefings on a multidisciplinary approach to improve both individual and collective practice-based performance (Lingard & Truths, 2016).

Question 17 – Is your CPD funded by your employer?

I asked participants about institutional funding for CPD in light of national plans about the statutory role of CPD in non-medical healthcare professions (NHS England, 2019). 62% of participants said their CPD was funded and 38% said no. This finding indicates there is room for improvement in organisational behaviour when clinical services are offered in non-healthcare settings, given national healthcare expectations of professionals' CPD practice.

Question 18 – Does your funding allocation impact your access to CPD?

I asked participants to consider the impact of funding on access to significant CPD to gauge whether respondents perceive their CPD needs are adequately met with the institutional funding. 65% of respondents perceived that it did impact their access to CPD and 35% said it did not. This finding suggests that the current variation in funding allocated to practitioners' ongoing learning is not seen as sufficient to meet the professional development needs to maintain and improve clinical practice.

Question 19 – If your funding allocation impacts your access to CPD, please state how?

I included this question to give participants an opportunity to expand on their perceptions of barriers to CPD and I received a surprisingly high number of responses. A total of 47 responses were collected and these are thematically analysed and briefly explained in Section 6.3.

Question 20 – Do you perceive your university's geographical location impacts your access to CPD?

67% of participants said no and 33% said yes, their location did affect their access to relevant, good quality CPD. Respondents were given the opportunity to expand and these findings are also presented in Section 6.3.

The quantitative results show there are significant gaps in CPD provision and practice, despite a wealth of information and recommendations from professional bodies and evolving national guidelines on CPD's role in promoting professionalism in health care (DoH, 2017).

6.3 Qualitative Data Analysis of Free-text Questions

In this part of the results section, I will share the thematic data generated from participants' free-text responses. I invited respondents to share their thoughts, feelings, and experiences of CPD activity and its assumed impact on clinical practice. Six open response questions were designed to relate specifically to practitioner attitudes towards practice development and its perceived relevance to working with students in HEIs. I had not anticipated the sincerity and volume with which practitioners responded and wonder if this level of engagement was a result of both the anonymity offered by the survey format and the importance of the subject matter to those who took part in the study (Oppenheim, 2000). The data suggests that participants care deeply about their ongoing development.

I am aware that the qualitative themes on which I now focus are based on responses from self-selected participants who were stimulated to respond either

by interest or concerns about professional development, or both. I should re-emphasise a condition of survey-based research, which characteristically captures small samples of motivated respondents, is that the data does not necessarily represent the wider practitioner population (Sills & Song, 2002). However, I present my findings, analysis and final conclusions as potentially useful observations, albeit subject to the inbuilt limitations of the research strategy.

The main (superordinate) themes and subthemes (subordinate) arising from the thematic analysis of the five of the six survey questions generated nearly 10,000 words. In order to minimise participant frustration and encourage survey completion answering these questions was non-compulsory and as a result, the number of responses to any survey question varied. I have reported response rates and percentage calculations alongside each question for clarity, as shown in Table 6.3.1 below.

Open survey question	Response rate (N=90)
Question 12 – Can you describe your CPD activity and briefly comment on whether you found it beneficial to your practice as a therapist working in higher education?	N=68 (76%)
Question 19 – If your funding allocation impacts your access to CPD, please state how.	N=47 (52%)
Question 21 – If your university's geographical location impacts your access to CPD please state why.	N=23 (26%)
Question 22 – Describe how CPD impacts your practice with university students.	N=86 (96%)
Question 23 – Was the CPD relevant to working within the current HE climate?	N=84 (93%)
Question 24 – Briefly state what changes could be made to improve CPD activity for therapist's working with the student population.	N=80 (89%)
Question 25 – Do you have any further comments related to CPD activity?	N=33 (37%)

Table 6.3.1: Qualitative Open Text Questions and Number of Respondents (N) and Percentage (%) Calculation of Respondents

I began the examination of the qualitative data by following the same reflexive thematic analysis method used in the PEP (Braun & Clark, 2006) as outlined in the Methodology section (Section 4);

- data familiarisation reached through reading and re-reading texts (1)
- generation of initial ideas, codes or emergent subthemes (2)
- searching for main themes (3)
- reviewing key themes (4)
- defining and naming these themes (5)
- reporting the thematic findings (6)

My coding of the emerging themes evolved directly from the participants' comments. I read and re-read the text, highlighting descriptive words and colour-coding and scribbling points of interest beside the text. Stages 1-3 were repeated on each question's raw text. This ensured I explored therapists' accounts, noting any cited value, limitations, articulated concerns, or identified challenges and suggested improvements while remaining aware of my own beliefs and biases on the issues, given my insider-researcher status (Etherington, 2004; Finlay, 2008). Stages 4-6 of the thematic analysis process are presented chronologically with each question exhibiting a thematic map to reflect the overall meaning of each question's data set. The inclusion of in-vivo examples

highlights thematic characteristics, and these are accompanied by a brief interpretive narrative of what I believe to have been communicated by participants (Braun & Clarke, 2006, p. 92).

I chose to present the qualitative data in a question-based thematic map format with an interpretive narrative to ensure transparency of analysis. The full highlighted and coded thematic text generated from each question can be found in the appendices (Appendix 13). Themes that recur across the whole data set were later collapsed and merged to form the overarching main themes and subthemes presented in a table at the end of the section (Table 6.3.2).

Independent colleagues who assisted in the pilot stages of the survey design checked my codes and themes for accuracy of account (Creswell & Plano-Clark, 2011), as well as offered their own interpretations. I have presented a final summary of the connected mixed data results to illustrate how they link up and I will discuss this in relation to the earlier findings from the PEP in order to bring both phases of the research together.

I devised the first open question on the survey to follow on from a closed multiple choice question inviting participants to indicate how they picked their

CPD activity. This follow-on question was intended to elicit more about the perceived relevance of the learning activity to the work setting as well as to develop practice. All research questions are engineered to entice participants to provide information on areas of significance to the research inquiry. The validity of survey data, results, and interpretations are central research concerns.

Content and construct validity are procedures researchers employ to ensure their questions and data yield are legitimate and to mitigate threats to internal and external validity (Creswell & Plano-Clark, 2011, p. 210). The use of pre-exiting questionnaire items, survey pilot testing, and triangulation of data involving independent checks are measures I employed for quality control (Stiles, 2003). However, I acknowledge that the research data is vulnerable to the role of rhetoric in participant accounts. Taking account of the inherent weaknesses in the research design, the open text boxes do provide a range of commentary relating to a CPD activity and views of its effects upon clinical practice.

Question 12 – Can you describe your CPD activity and briefly comment on whether you found it beneficial to your practice as a therapist working in higher education?

The main theme that emerged from question 12 was the perceived “usefulness” of CPD. The words useful, beneficial, essential, helpful, and supportive were used frequently with reference to CPD, regardless of its perceived impact on actual work with students in HEIs or any associated challenges. The superordinate theme was therefore named to convey the **Utility of CPD** implied by the participants’ broad descriptions. The majority of participants had an agreeable perspective on CPD, conveying the sense that they appreciate and are committed to all forms of knowledge acquisition and learning forums, regardless of whether the benefits translate to a change in attitude or an intervention specific to their clinical setting.

Figure 6.3.1 below shows the thematic map created for this question. Whilst the overall impression was of the benefits practitioners derive from formal and informal CPD activities, the subthemes expose the complexity of the area and reveal both differences and obstacles.

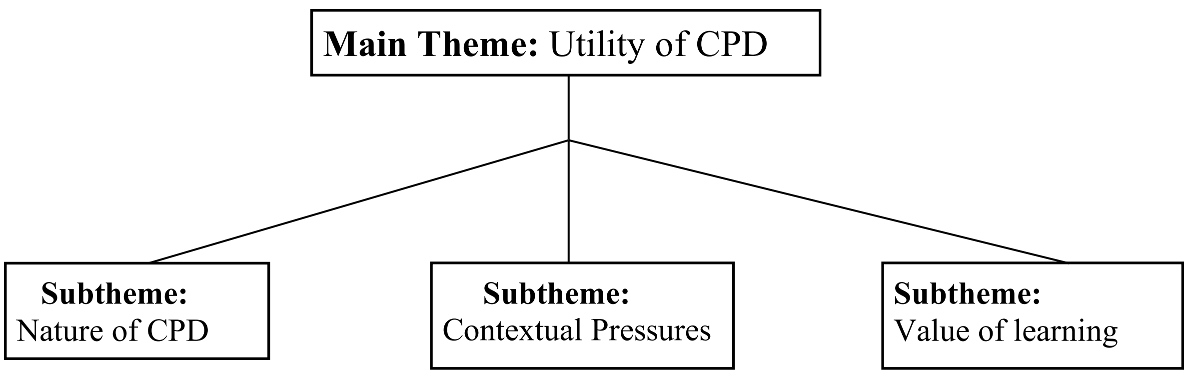


Figure 6.3.1: Thematic Map for Question 12: Factors Associated with Ongoing Development and Impact on Practice

- **Nature of CPD**

Responses associated with the subtheme **nature of CPD** stressed the variation in CPD provision with regard to its felt relevance and perceived effect on practice development. Unsurprisingly this articulated variation in CPD experience seems to influence participants' engagement level and their evaluation of the potential benefits of the encountered activity. Furthermore, comments suggest the utility of CPD is dependent upon responsibilities associated with a practitioners' role, as well as the relevance of the learning activity to that role and the sense of learning requirement. The first text example illustrates how the therapist's position as a supervisor benefits from CPD because of its direct relevance to the supervisory role.

> Supervisor Training – very beneficial as I currently supervise trainees and Mental Health Advisers…

(Female, Head of Service/Clinical Lead, CBT, 10+ years – participant 89; code 4992907)

The second illustration similarly shows that the value ascribed to CPD is related to the application of the knowledge acquired by the designated tasks. But here the practitioner cites the relevance of the teacher training role to both delivering a specialised student course and improving general clinical practice.

> Mindfulness teacher training – am currently running 8-week MBSR groups for students and embedding values/philosophy in my clinical practice-been incredibly helpful for things such as emotional regulation, grounding techniques, observing thoughts…
>
> (Female, Head of Service/Clinical Lead, Integrative, 6-10 years – participant 57; code 4806575)

In another example, a less experienced practitioner conveys the utility of CPD for enhancing knowledge specific to the clinical population.

> 1 year (120 hour) working with children and young people; it was enormously helpful, particularly in understanding developmental needs of clients…
>
> (Male, Clinician, CBT/Integrative, 2-5 years – participant 40; code 4796969)

A practitioner's modality or theoretical orientation is also a significant factor in perceptions of CPD's utility. The text below demonstrates a practitioner's developmental needs in specific practice requirements. This makes sense given some professional bodies endorse maintaining and improving clinical competencies through modality focused CPD (BABCP, 2012). The brief nature of the work is also mentioned in relation to the conflict between practitioners' primary training and the constraints of the clinical setting.

> Seminar on adapting CBT for people on the autistic spectrum – useful to a degree working with students on AS, could ask questions.
> OCD online training, part way through, helpful for thinking about formulations, HE work is brief and training not geared towards this.
> Some articles focus on students, not often on CBT.
> webinar/workshop on neuroscience, (part way through set of 4); beneficial for psychoeducation.
> (Female, Head of Service/Clinical Lead, CBT, 6-10 years – participant 13; code 4786970)

The final extract conveys how a therapist's theoretical modality, their chosen CPD activity and the applicability of new knowledge to their clinical practice result in the perception of good, effective CPD.

> I attended a two day training workshop on neuro-
> psychoanalysis both last week and a year ago… Since attending the

> workshop, I have been able to actively bring a neuro-psychoanalytic perspective to my work with clients in a very direct way, by being conscious of helping my clients to focus on immediate feelings and their emotional experience in relation to unmet emotional needs. This has helped to usefully contextualise events in their past or present lives and give them new meaning, which we have used to understand and work through their problems in a more focussed, often practical way.
>
> (Male, Clinician, Psychodynamic, 2-5 years – participant 14; code 4787902)

One unsurprising interpretation arising from participant comments is that the type of CPD activity and its perceived impact on practice development is influenced by a practitioner's clinical training, theoretical orientation and appraisal of their situated personal and professional needs. It could also be assumed that these therapists chose their CPD activity based on self-identified need. The recommended approach to CPD emphasises ongoing education based on clinicians' identified knowledge and skills gaps as well as wider institutional factors (DoH, 2017). It is likely that in these cases, and given the costs attached to the training, the recommended co-appraisal of CPD was implemented.

The literature implies there are added benefits to taking a planned and coordinated approach to continued learning (Kolb, 1984; Ericsson et al., 1993).

Indeed, this strategy is adopted nationally (DoH, 2017) and endorsed by professional bodies (e.g. BACP, 2018). Research shows that planning CPD to meet needs identified by the directed evaluation of knowledge and skill gaps is most likely to impact clinical practice (Miller et al., 2015; Rousmaniere, 2017). Respondents' accounts provide evidence of this. Recommendations that will help organisations develop CPD practice protocols to ensure these elements coalesce to impact practice, are an intended product of the FP.

- **Contextual pressures**

The second sub-theme, **contextual pressures**, emerged in response to therapists' perceptions of CPD activity's impact on situated work-based factors. This subtheme encapsulates the sense that context-driven tensions exist between professional (institution-based) obligation and responsibility, and the individual practitioner or team's development needs. Ideally, wider institutional learning should take place in addition to the practice development of individual and multi-disciplinary team members (NHS, 2019). The response below indicates that institutional expectations and demands (an integral part of CPD) can tacitly direct CPD decision making. There is an implication that the value of CPD for maintaining and improving individual competences specific to the clinical work is minimised.

Various – GDPR; safeguarding; “customer service”; It was helpful for my role in a university but not directly helpful at all in terms of my work as a therapist.

(Female, Clinician, Gestalt/Integrative, 10+ experience – participant 62; code 4807944)

These factors clearly shape therapists’ perception of CPD. The perceived developmental benefits (or lack thereof) for practice may even serve to reinforce the sense of an institutional lack of understanding of and value associated with the work. This is the case in spite of an overall sense of understanding of the profit associated with such learning activity. In a similar response, a participant describes training in a particular model of support: One At A Time (OATT) therapy. The comment conveys the sense that the training was based on the developmental needs of a possible service strategy objective, leaving the practitioner frustrated with what actually constitutes learning and development of improved knowledge and skills.

I recently attended some training within the university that I work for on OATT model... I’m afraid it was awful and I took very little from the experience.

(Female, Clinician, Person-Centred, 6-10 years – participant 65; code 4809558)

In another example, the respondent describes a broader issue related to context-based pressures. The quote illustrates the increasing complexity of working with specific clinical presentations and the knowledge required to do so. It also highlights that learning and skills attainment does not easily translate to the work setting.

> Understanding and working with people with personality disorder… All very beneficial but the challenges of working in the now four session model persists especially in the light of more demand and more complex presentations.
>
> (Female, Clinician, Psychodynamic, 6-10 years – participant 79; code 4822845)

The final extract shows the value of CPD activity but again stresses the challenges associated with training aimed at practitioners from different clinical settings and contrasting therapeutic infrastructures.

> Very helpful but obviously not aimed at the HE environment which seems to be the way with 99% of the training.
>
> (Female, Clinician, Integrative, 10+ years – participant 23; code 478853)

- **Value of learning**

The third subtheme, **value of learning**, was derived from responses to question 12. Here therapists report on specific CPD activities they attended over the year. This theme conveyed therapists' motivations and level of commitment to their continued learning and development, regardless of specific content or perceived "practice" benefit, and is conveyed below.

> I attended a conference on neuroscience for therapists and found one talk very interesting but it was not relevant to my work with students.
>
> (Female, Clinician, CBT, 10+ - participant 24; code 4788591)

The function of CPD is complex and multi-dimensional, making the "benefits" difficult to singularly determine. One conclusion is that there are benefits to attending CPD activity (no matter how vague the CPD) regardless of its direct relevance to clinical practice or client population and setting. The value derived from implicit learning, such as informal knowledge accrued through sharing practice, networking, refreshing knowledge, and updating skills at such events makes all forms of learning activity feel useful, as evidenced in this quote from an early-career therapist.

> …ability to talk to others and share best practice.
>
> (Female, Clinician, Psychodynamic, 2-5 years – participant 81; code 4807585)

This aspect may be why most activities related to the profession constitute CPD and can be set against the minimum hours proscribed by professional organisations. However, the findings suggest that future recommendations for professional organisations' development of CPD guidance and education should be based on a number of required learning objectives established in consultation with a manager or supervisor. This may help practitioners engage with a variety of activities that benefit professional development in multiple ways.

At present there seems to be a general assumption that simply fulfilling the minimum requirement to undertake a range of listed activities is evidence of good CPD practice and culminates in progress. A coherent and strategic approach to CPD may lessen the current challenges and constraints practitioners face in finding activity that is transferable to their own practice. As one of the participants said:

> I found it stimulating and helpful but it is always a struggle to integrate new learning into practice as there is so little time to reflect and process the learning.
>
> (Female, Clinician, Integrative/Psychodynamic, 10+ years – participant 43; code 4806473)

If CPD practice were a structured clinical activity in which therapists received encouragement in training, and the support to plan and reflect on their learning in discussions with a manager or supervisor, the current practice of choosing activity based on interest or unrealisable expectations (as is suggested by both the quantitative and qualitative datasets) might be lessened. A response to the question about CPD's relevance to practitioners' work settings shows learning is felt to be undermined by its non-transferability to practice.

> The majority of workshops were relevant to my practice in HE. In terms of the CPD being beneficial they were particularly useful in terms of developing my clinical knowledge. However, may not be applied to the HE setting due to short term nature of the therapy provided in HE settings.
>
> (Female, Clinician, CBT, 2-5 years – participant 81; code 4830656)

It is notable that many of the subthemes overlap with regard to the purpose of the activity and its perceived benefits to client work in HE. The representability of each subtheme illustrates the myriad of communicated challenges and differences involved in the process of learning. Respondents highlighted the range and variety of activities they undertook but expressed a general sense of usefulness in development activity. This formed the main theme **utility of CPD**.

Question 19 – If your funding allocation impacts your access to CPD, please state how.

Question 19 followed a closed question asking about support and funding for access to CPD. The closed question, (Q18), asked therapists to indicate if their funding allocation impacted their access to CPD and 65% (n= 50) replied that it did. Question 19 was therefore intended to provide participants with the opportunity to comment on their experience of CPD funding, or the lack thereof, and describe how they felt this impacted their access to CPD opportunities. The thematic map below encapsulates the main theme and subthemes generated from 52% of the responses to this open text question.

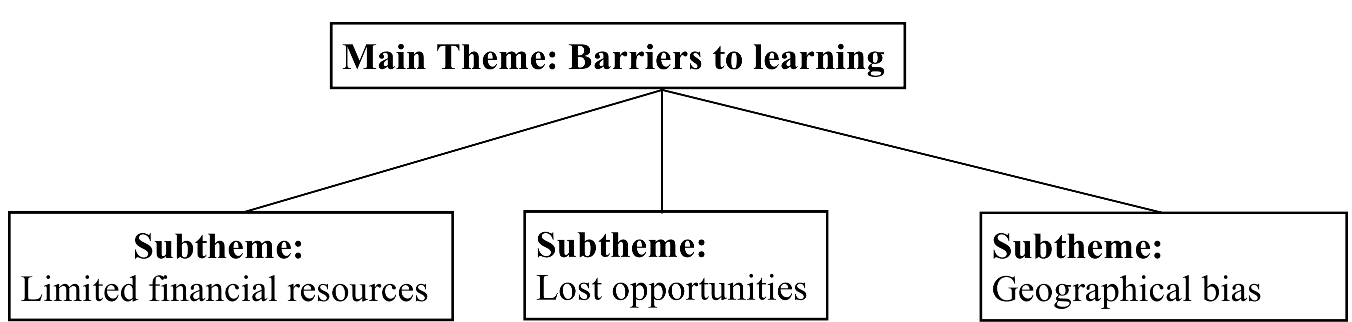


Figure 6.3.2: Thematic Map for Q19: Challenges Accessing CPD

The second main theme, **barriers to learning,** incorporates three emerging subthemes frequently cited in the text responses (Q19 & Q21). All subthemes interrelate and there were several comments about constrained provision and a

sense of year-on-year funding decreases. The result is that therapists self-finance their CPD in order to maintain their professional integrity and comply with best practice recommendations.

- **Limited financial resources**

The first subtheme, **limited financial resources**, highlights therapists' experience of restricted institutional resources for CPD-linked pursuits. This led to tensions related to a practitioner's actual "felt" learning need. Some therapists reported feeling that, despite full or partial funding, some CPD needs were not met because of the lack of financial support. Financial costs are the most commonly cited barriers to learning activity. The following response clearly articulates the issue.

> The funding will dictate what and how much I can access due to limited financial funds.
>
> (Female, Clinician, Integrative, 2-5 years – participant 75; code 4816737)

Participants frequently reported that the costs (time taken out from work and monetary expenditure) were considered too high by HEI funding providers, especially given competing service operational factors. The comment below illustrates this point and indicates the lack of organisational awareness and

understanding of recommended healthcare provision (DoH, 2017; NHS England, 2019).

> At the moment I can only go on "in-house" CPD as the University is not able to fund anything external.
>
> (Female, Clinician, Gestalt/Integrative, 10+ years- participant 62; code 48079440)

Another participant described how her annual CPD has been withdrawn completely and this again demonstrates organisational failure to allocate sufficient resources for health provision and professionals' practice.

> Previously had a small CPD budget but this has been withdrawn.
>
> (Female, Clinician, Humanistic, 10+ years – participant 59; code 4807154)

Similarly, the below comment shows how practitioners feel implicitly responsible for their ongoing development and undermined by the impact of limited resources.

> I can't afford to do much and the Uni won't pay for much and its getting less.
>
> (Female, Clinician, Psychodynamic, 10+ years – participant 61; code 4807585)

This issue is timely given the move towards statutory regulation of health professionals' continuing education (NHS England, 2019). There is also the new whole-university approach to promoting community well-being (Hughes & Spanner, 2019). My data suggests that the practice and wellbeing of practitioners are not at present being adequately considered and supported by university senior managers, despite the pledge to promote healthy working and learning environments (UUK, 2019). This comment from a university service manager that "funding is capped, and so more expensive courses are only possible with self-contribution." (Female, Head of Service/Clinical Lead, CBT, 10+ years – participant 89; code 4992907) highlights the challenges of managing limited resources for both ongoing professional development and service provision. It seems to me that there is a real opportunity to raise awareness of these critical issues. This is emphasised in the responses to the survey and I intend to make recommendations to professional organisations, through my position on the BACP UC executive, about the need to protect and promote CPD as an integral part of clinical practice.

- **Lost opportunities**

The second subtheme, **lost opportunities**, relates to the sense of missing out on relevant CPD and a feeling of resignation that one's institution does not sufficiently attend to, or value, practitioners' continued development. It seemed

that (as with the first theme) participants felt the responsibility for ongoing development resided predominantly with the practitioner, not in collaboration with the employer where it could be managed by professionals such as managers and supervisors. The question of who carries ultimate responsibility for practitioners' ability to meet professional accredited status is a moot point, particularly given it is an essential requirement for the position of university mental health practitioner. This quote from a Head of Service illustrates this point.

> My employer will only fund some CPD. They do not hold any responsibility for ensuring I fulfil my BACP professional requirements. The amount of CPD per annum (provided and paid for) appears to be decreasing year on year.
>
> (Female, Head of Service/Clinical Lead, Integrative, 6-10 years – participant 77; code 4822513)

I found the participants' accounts of the lack of CPD funding from HEIs alarming. It is hard, when looking at the respondents' comments, not to imagine that institutions ascribe little value to mental health professionals working in the sector. Such a widespread shortfall in funding for those supporting the most vulnerable members of the community is troubling and has a negative impact on

all staff, especially in light of recent reports of increases in ill health in the sector (Moorish, 2019).

This is a very different environment from the one in which I matured. CPD seemed better supported and financed, as evidenced in my own earlier accounts of managers encouraging team members to regularly commit to professional body initiatives and, at the very least, attend the now-defunct three-day university and colleges annual counselling conference (AUCC, 2010). The quote below indicates that this environment is very different today.

> Most of my CPD (as defined by UKCP) depends on my own self-motivated initiatives.
>
> (Male, Head of Service/Clinical Lead, Psychodynamic, 10+ years -participant 67; code 4809769)

The sense respondents conveyed of feeling that relevant CPD opportunities were being missed due to funding constraints is evidenced in the final extract. The piece also conveys the sense that CPD is vulnerable to becoming a tick box exercise rather than being based on actual learning needs as is intended.

> Some of my CPD is funded but I feel some years opportunities come to do more relevant training and this won’t be funded or time away granted

and therefore I have to miss out.

(Female, Clinician, Integrative, 6-10 years -participant 31; code 4786970)

Question 21 – If your university's geographical location impacts your access to CPD please state why?

I designed this question as a follow-up to the (closed) question, 20, which invited participants to indicate whether or not they sensed that geographical location affected their access to CPD. This reflects one of the research objectives – namely, to consider the accessibility (equity) of good relevant CPD products for development purposes.

Whilst 67% of respondents (n=84) did not feel location had an effect on access to CPD (n= 58), 33% did (n = 28). Of the 28 participants who responded, 23 provided comments in response to question 21 suggesting that good, relevant CPD is perceived as primarily London-based. The quote below conveys the perception that this reality excludes practitioners based elsewhere in the UK from undertaking or delivering relevant CPD, given the increased costs of travel and accommodation in the capital, in addition to the learning event.

> There is far more going on in London than in other areas of the UK. I have to travel and pay for accommodation to access that.
>
> (Female, Clinician, Integrative, 6-10 years – participant 31; code 4790795)

A second extract highlights how these restrictions have a particular effect on those living in the more remote parts of the country. In the past, hosting conferences on bygone universities' campuses during academic recess ensured a country-wide representation of geographical access to relevant sector-led CPD.

> We're based in Scotland and a lot of training does not come North of the border and I can't afford the expense of travelling to London.
>
> (Female, Clinician, Person-centred, 6-10 years – participant 65; code 4809558)

There was substantial overlap between the themes generated from this question and those in response to question 19; this related to the main theme of **barriers to learning.** I therefore decided to merge the two datasets (see figure 6.3.2 above). These thematic findings are consistent with feedback the BACP received from its members on the benefits of and barriers to membership and that resulted in the establishment of strategic objectives to better represent and serve the four nations equally (BACP, 2020).

Question 22 – Describe how CPD impacts your practice with university students?

Question 22 invited participants to consider and briefly describe how CPD affects their clinical work with students. 96% of participants (N=86) responded to this open question, the highest response rate to any single open question. I felt heartened by this as the question appeared towards the end of the survey and this signalled continued engagement with the survey.

Comments indicate a general theme of CPD provision "assisting practitioners" to feel clinically capable and connected to their clinical setting and population. Indeed, **keeping abreast** of one's overall professional remit and integrity is important for professional constitution. Figure 6.3.3 below shows the thematic mapping of text responses and all of the original thematic content can be found in Appendix 13.

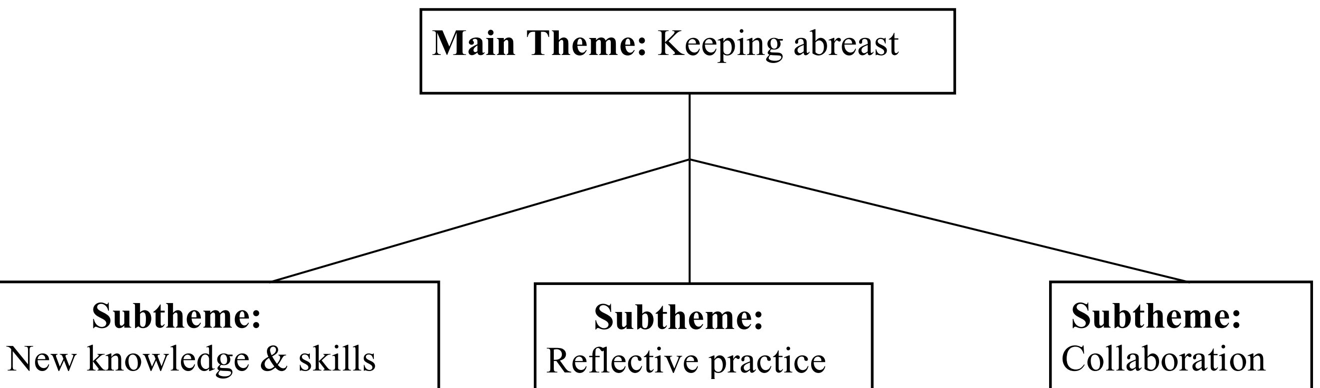


Figure 6.3.3: Thematic Map for Q22: Keeping Abreast (up to date learning & maintaining good practice)

- **New knowledge and skills**

Comments relating to the subtheme **new knowledge and skills** stress the importance of relevant learning provision to enhancing therapists' clinical work and simultaneously supporting their need for a "felt-sense" of professional capability, responsibility, and integrity in their work with students. There were numerous examples given to illustrate the impact of the CPD activity undertaken and to highlight its perceived benefit to practice, reinforcing the high value placed on CPD, a consistent theme in both qualitative and quantitative datasets as well as the literature in general. The first comment exemplifies the association between CPD and updating knowledge, fulfilling best practice recommendations and increasing a practitioner's confidence.

> Fills knowledge gap (including best practice) and increases confidence in my work.
>
> (Female, Clinician, Psychodynamic, 6-10 years of experience – participant 84; code 4863715)

The next extract demonstrates the utility of new knowledge for both practitioner and client in the context of shared learning and therapeutic engagement.

> I try to use new learning as soon as possible. Students are particularly keen to learn and understand theory and evidence base, so keeping up to

date is vital.

(Male, Clinician, Human Givens, 6-10 years – participant 39; code 4795697)

94% of practitioners reported CPD as being “essential” to clinical practice in the quantitative data and the following extract similarly conveys the sense that CPD is an integral component of practice development, fostering increased practitioner confidence and therefore directly benefitting clients.

> … feel it is essential to both my professional and personal development as a practitioner. I also feel it is beneficial to the students if I gain expertise in areas.
>
> (Female, Clinician, Integrative, 2-5 years – participant 41; code 4800162)

The benefits of CPD in enhancing practitioners’ knowledge of working with a specific client group – in this case, the student population – featured frequently in the data and is highlighted in the quote below.

> Hugely, its allowed me to modify my practice to suit this age group.
>
> (Male, Clinician, CBT, 2-5 years – participant 40; code 4796969)

The relevance of new knowledge and skills specific to the clinical setting is stressed in the next extract, which was one of many similar comments.

I have done CPD specifically related to the HE sectors which can help with best practice e.g. suicide prevention.

(Male, Clinician, Psychodynamic, 10+ years – participant 82; code 48144416).

The link between new knowledge/skills and improved outcomes was reinforced in the next extract.

It allows me to be more skilled in different presentations and to update to have good outcomes.

(Male, Clinician/Supervisor, Integrative, 6-10 years – participant 4; code 4428310)

The final quote is thought-provoking as it draws attention to CPD in the context of both skills development and learning about different experiences, which may relate to other therapists' clinical experience or clients, or both. Cultural competence is a huge area of development and is necessary for practitioners working with multi-cultural populations.

I'm continuing to develop my skills as a clinician and to learn about different life experiences in order to work with a diverse client population.

(Female, Clinician, Integrative, 6-10 years – participant 31; code 4790795)

- **Reflective practice**

Therapists consider the ability to reflect on their actions and integrate practice-based experience to be a prerequisite for optimal learning and professional development, regardless of their years of experience, theoretical orientation, or position held (Rønnestad & Skovholt, 2013). Reflective practice was frequently inferred in participants' accounts of CPD and, as a result, it formed the second subtheme emerging from the data to this question. Reference is made in the subsequent extract to how helpful, as well as how challenging, it can be to think about clinical knowledge and developments that can feel irrelevant to the client group and setting.

> CPD provides a space to look at one's practice and in relation to others and set standards or benchmarks. Sometimes it feels constructive to the setting and others frustrating as we are very time limited and have a unique population which isn't necessarily addressed in CPD.
>
> (Female, Clinician/Supervisor, Integrative, 10+ years – participant 6; code 4444264)

The following quote also stresses this theme of the practice-based realities and tensions encountered by HE-based practitioners, who value CPD's role in providing a space to discuss and share situational factors and their effects on clinical work.

> CPD ideally raises therapists' awareness of the salient themes of the work e.g. we currently have more demand than resource which puts therapists under pressure but also reduces the time we have with clients and they can feel their needs are not being met. All this makes the environment challenging and CPD is an opportunity to reflect, innovate and discuss.
>
> (Female, Clinician, CBT, 10+ years – participant 10; code 4786970).

The more general theme of CPD incorporating and encouraging reflective practice, is highlighted by the comment that acknowledges the principal role reflective practice has in practitioner development.

> The self-awareness that I gain from a lot of the CPD that I attend also develops me as a practitioner.
>
> (Female, Clinician, CBT, 6-10 years – participant 56; code 4806585).

The nature of working in a higher learning context with the needs of a client group who are themselves engaged and challenged by the learning endeavour, may demand a more active "reflective" practice than that found in other clinical settings or contexts. Moreover, if therapists are regularly adapting their knowledge and skills to meet context-specific demands and still provide support, they require a level of alertness and reflexivity.

- **Collaboration**

The third subtheme that I found emerging from the text was **collaboration**. Participants conveyed the necessity of sharing professional experiences and work-based realities in order to stay abreast and maintain good practice, and they felt CPD provided this. Networking, participating in peer-groups, the dissemination of knowledge and such, whether delivered internally or externally, all recurred when practitioners described how CPD affected their practice. The implication is that collaborative (informal) learning is perceived to be of benefit to practitioner growth and development. The responses implied that the collaborative aspect is often integral to formal CPD activities, such as conference events. This concurs with my own experience of CPD, as described in earlier parts of this document, and is expressed in the following extract.

> Keeping abreast of current discussions and issues through the UC Journal is crucial. At my previous university (before budget cuts) I used to attend the BACP UC conference which I found massively beneficial. Sharing good practice with colleagues, networking, and attending seminars all with direct relevance to university students – it was great.
>
> (Female, Head of Service/Clinical Lead, Integrative, 6-10 years – participant 77; code 4822513)

Learning and knowledge acquisition through teamwork is effective in influencing practitioner behaviour (Forsetlund et al., 2009). Respondents demonstrate awareness of the merits of collaboration in both datasets, and this is illustrated by one participant who stated that the impact of CPD:

> Stimulates thinking (and therefore practice) through hearing how other clinicians and/or professionals deal with and think about issues affecting young adults, as well as issues emerging from the HE context (bullying, diversity, etc.).
>
> (Female, Clinician, Psychodynamic/Group Analytic, 10+ years – participant 22; code 4788269)

One early-career practitioner spoke of CPD's impact in relation to being kept informed of new HE specific research and how this knowledge opens up discussions and shared practices.

> … keeps me informed of new research in HE, can discuss issues facing students and hear cases from other clinicians.
>
> (Female, Clinician, CBT, 2-5 years – participant 12; code 4787489)

A university counselling service manager describes CPD in the context of collaboration as an:

Opportunity to engage with colleagues and share best practice.

(Female, Head of Service/Clinical Lead, 10+ years – participant 49; code 4806543)

Question 23 – Was the CPD relevant to working within the current HE climate and did it address identified student concerns such as BAME, LGBTQ+?

I asked this question to gauge participants' experience of CPD's relevance to their clinical population and setting in the current climate of growing demand and increasingly complex and risky student presentations. Although this question received a high response rate, most participants responded with one-word answers. Following consultation, I made the decision to report the findings quantitatively and the implication of this decision is reflexively discussed in Section 7. There were 84 responses and, of these, 35% (n = 29) responded yes, 21% (n = 17) no, and 44% (n= 37) were more ambivalent, stating for example, "yes and no", "somewhat" and "it varies". The higher proportion of participants stating that CPD's relevance to client, context, and climate varied or was not relevant indicates there is a gap in the relevant sector-specific CPD.

Question 24 – Briefly state what changes could be made to improve CPD activity for therapists working with the student population.

I then invited participants to suggest ideas and thoughts from a practice-based position on improvements to learning and development provision. There were 80 responses given and from these I developed a thematic map to reflect the overall meaning of the data set. Comments invariably included the words, "higher education", "students", "university", "specialist training", and "practitioner-led" when highlighting the perceived lack of accessible and applicable CPD or significant aspects that practitioners believed would help improve their continued learning. The main theme was therefore defined as **HE sector-specific CPD**. Figure 6.3.4 shows the main theme and respective subthemes.

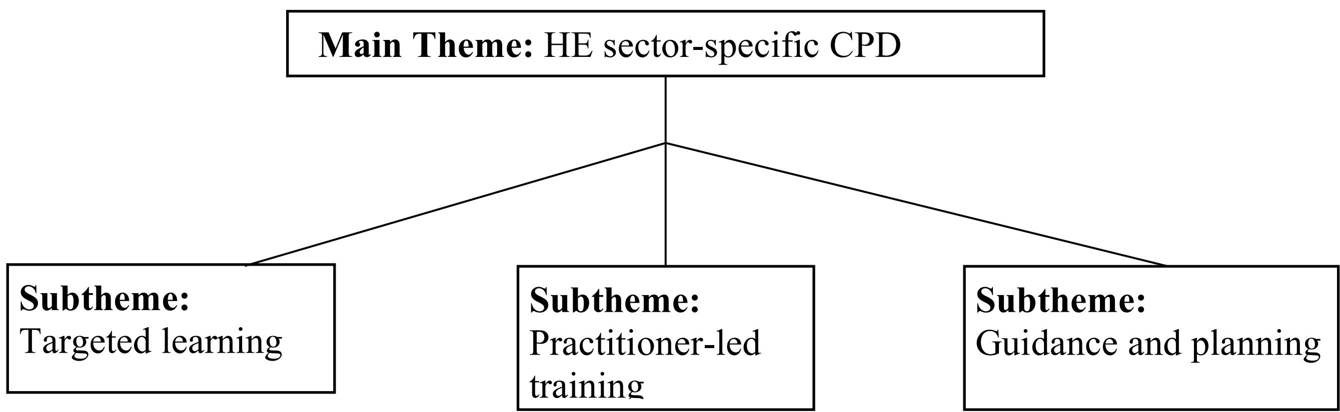


Figure 6.3.4: Thematic Map for Q24: HE Sector-specific Training

- **Targeted learning**

Targeted learning captures participants' concerns at receiving CPD that directly relates to the nuances of their particular clinical setting and client group. The setting (HE) and client group (university students) shape the work, so CPD should ideally reflect the work. However, this data shows therapists clearly feel that this is not happening in the context of their ongoing learning and development. Their concern is understandable given therapists' moral obligation and ethical responsibility to manage their work professionally in relation to wider institutional and socio-economic, political and cultural forces.

The practice of therapy in educational institutions is not without its conundrums, for example therapeutic support has to flexibly accommodate timetabling changes. There is also an awareness that academic-related presenting concerns are common among presenting students (Broglia at al., 2021) and support is therefore needed whilst concerns are current, making waiting times a challenge for services striving to meet student needs as near to the point of contact as possible. These inherent challenges are further exacerbated in the current climate of increased demand and against a backdrop of a growing awareness of and scrutiny into all matters pertaining to mental health. In the absence of a systemic foundation for context-based mental health-related knowledge it seems reasonable and understandable that practitioners feel

the need for CPD that incorporates practice-based learning. CPD that is sensitive to these environmental demands and related pitfalls is astutely reiterated in the comment below:

> CPD activity needs to be focused on what therapists in the sector are coming up against – risk, limited sessions, lack of realistic pathways, etc.
>
> (Female, Clinician, Integrative, 10+ years – participant 9; code 4492454)

Given that practitioners work with a diverse multi-cultural population, knowledge and training needs to address the impact of these differences, which is a reasonable expectation of students seeking support today. The Black Lives Matter (BLM) movement has exposed widespread minority-group incompetency and CPD provision is an arena that could redress this situation. Practitioners raise this point in the data, as exemplified in the following extract.

> Specific training towards specific student populations; from grads, internationals, men, BAME, transitions…
>
> (Male, Clinician, CBT, 2-5 years – participant 27; code 4787814)

As student demand for counselling has increased over the years, services have adapted by limiting the number of sessions offered (Barden & Caleb, 2019; Mair, 2016). Working to a short-term model requires teaching and skills

practice, given most modalities are based on longer term therapeutic frameworks. Participants cited the challenges associated with short-term working, especially given increasingly complex and at-risk student presentations, and suggest how CPD could be improved to support this common practice.

> CPD specifically related to working short-term with students who may be risky or have complex presentations.
>
> (Female, Clinician, CBT, 10+ years – participant 24; code 4788591)

The final extract highlights the point that CPD providers and the knowledge they develop could incorporate more clinical vignettes that reflect different situational issues, in addition to client presentations and interventions.

> Training institutes need to recognise the daily reality of clinical practice in HE and ensure that student mental health, suicide awareness and brief term models are incorporated into training programmes.
>
> (Female, Head of service/Clinical Lead, Integrative, 10+ years – participant 52; code 4806592).

- **Practitioner-led training**

The following subtheme characterises the main theme of HE sector-specific training and follows on from the former targeted learning subtheme. Therapists emphasised the perception that **practitioner-led training** would improve learning and development. Suggestions that CPD activity should ideally be

developed and delivered by therapists who have acquired a wealth of experience and knowledge about the realities of working with students and HEIs reflects the sense that these practitioners do not feel their particular context or work challenges are understood by some CPD providers.

> It would be good to have more access to CPD delivered by experienced HE therapists/managers who are responsible for the practice and delivery of brief support with students presenting with often very critical problems in an environment that is very competitive and threatening…
>
> (Female, Clinician/Supervisor, Integrative, 10+ years – participant 6; code 4444264)

Two more quotes made reference to "practitioner-led training"

> Current practitioners to deliver workshops.
>
> (Male, Clinician, Person-centred, 10+ years – participant 3; code 4423682)

> A selection of courses that address specific issues relevant to the student population facilitated by counsellors working in the sector.
>
> (Female, Clinician, Integrative, 10+ years – participant 50; code 4806576)

BACP has long supported membership training events and specialist networks through the work undertaken by its universities and colleges division. But listening to reoccurring themes in this data suggests that not enough is being delivered at a local, means-costed level to address need. Indeed, the BABCP, the professional body that represents CBT practitioners, has recently announced

the launch of a new HE SIG (Chelms, 2020), further indicating the existence of a gap in CPD provision for therapists working in the sector. The final comment, below, confirms that need.

> More national shared training networking with other counsellors.
>
> (Male, Head of Service/Clinical Lead, Integrative, 10+ years – participant 53; code 4806528)

- **Guidance and planning**

The final subtheme was defined as **guidance and planning**. This subtheme resulted from therapists' comments about the current lack of coherence in structure, guidance, and support about CPD. This theme directly relates to findings from across the counselling professions that there is a general lack of CPD planning (Fender, 2017). However, participants in this study seem to advocate for a regulated CPD approach, as an early career practitioner articulates below.

> Formal planning of CPD with wider team or line manager based on knowledge gaps, typical students presenting concerns, cultural and diversity issues. It would be helpful if some CPD topics were mandatory, such as equality and diversity training, diagnostic features of common mental health problems, evidence-based therapies and NICE guidelines. This would ensure that students are being assessed and advised appropriately about their problems which would enable appropriate

> referrals/signposting, thus ensuring that the resources offered by university services are meeting the needs of all its students.
> (Female, Clinician, Integrative, 2-5 years – participant 7; code 4445546)

Professional associations (see Section 3) all endorse a CPD framework, with a planned approach based on identified learning needs (gaps in knowledge and skills) to ensure safe, "ethical" clinical practice. Investment in good quality relevant CPD training, based on identified need, is key to determining its enduring impact upon clinical practice (Anthony & Goss, 2020).

The following comment from a mid-career practitioner endorses the view that CPD should be integrated into service policy and based on client concerns, possibly as a way to protect funded CPD.

> CPD activities to be part of service strategies and to ensure adequate funding and time is given for this activity and to ensure that funded CPD is directly related to concerns or issues affecting HE student population.
> (Female, Clinician, Psychodynamic, 6-10 years – participant 8; code 4449500).

Question 25 – Do you have any further comments related to CPD activity?

This was the final question of the survey. I collated thirty-three responses and the themes identified from these accounts correlated and overlapped with the two main themes of **barriers to learning** (Q22) and **HE sector-specific training** (Q24) and were therefore merged. To illustrate the overlap, I have included three participants' accounts. The first expresses the feeling conveyed by participants that there is a lack of good quality relevant CPD for therapists working in HE.

> I strongly feel there is a lack of a real programme of professional development for therapists in HE, many of whom stay in the sector for a long time (I've been on and off for 18 years) and it would be great to have a properly recognised post qualification ongoing menu of relevant CPD for therapists in the field.
>
> (Female, Clinician, Integrative, 10+ years – participant 23; code 4787853)

This is supported by a comment expressing the sense that practitioners with experience and qualification should play more of a role in CPD provision.

> I think it should be directed more by supervisors, clinical leads and line managers in order to avoid the fact that practitioners seem to default to what seems interesting rather than CPD that improves a skill or helps them to obtain a new technique/training.

(Female, Head of Service/Clinical Lead, CBT, 10+ years – participant 89; code 4992907)

The final example illustrates the view that a coherent and safe CPD framework is required for ethical clinical practice and provision, in a manner like those adopted by healthcare professionals in the allied professions.

> Having worked in the sector for a few years there doesn't appear to be a coherent and safe way to practice. Risk protocols and service provision is not what it should be. Further HE CPD and engagement in specific populations is needed to create a safe environment to work and an ethical necessity for students.
>
> (Male, Clinician, CBT, 2-5 years – participant 15; code 4787814)

Participants' responses convey an overriding sense of a group of practitioners who are committed to their clinical role with students in HEIs but who, at times, find the work challenging on a number of levels for a variety of reasons. As professional therapists they express the capability to manage these pressures with sensitivity and forbearance, whilst continuing, on the whole, to adhere to organisational (both external and internal) policies and procedures, despite the finite resources, lack of systemic support and overall limited relevant CPD.

This perception of CPD does not seem to devalue the experience of learning perhaps because these practitioners, as has been found across the profession in general, share the belief that commitment to learning activity drives professional development (Rønnestad & Skovholt, 2013). After all, the majority of participants stated that CPD was an essential, ethical, and professional part of good clinical practice and they had all undertaken the required statutory CPD.

Therapists said that continuous development provided them with a feeling of competence and confidence in their work, regardless of the challenges it posed and irrespective of its tangible impact upon practice. Recommendations for improvements in training and delivery of CPD across the sector were generously shared and seemed to be eagerly awaited by respondents.

These thematic results were extracted from an unexpectedly generous 10,000-word response, elicited from the 90 HE-based therapists who participated in the online survey. With the participants' consent I have analysed and reported, in collaboration with others, their thoughts, experiences, ideas, and suggestions for public dissemination, in order to update knowledge on practice development and contribute practice-based knowledge to the shaping of future policy. The four main themes and nine subthemes are represented in diagrammatic form in Table 6.3.2 below.

Main Theme	Subtheme	Example Text
Theme 1: **Utility of CPD**	1.1: Nature of CPD 1.2: Contextual pressures 1.3: Value of learning	"Attended eating disorders workshop and found it useful" "HE work is brief and training not geared towards this" "Very helpful generally but obviously not aimed at the HE environment which seems to be the way with 99% of training"
Theme 2: **Barriers to learning**	2.1: Limited resources 2.2: Lost opportunities 2.3: Geographical bias	"Cost is always questioned when requesting training" "I would attend many more formal CPD events if I had access to more funding" "I'm far away from the London-centric therapy training provision"
Theme 3: **Keeping abreast**	3.1: New knowledge & skills 3.2: Reflective practice/s 3.3: Collaboration	"I become more aware of general ethical issues; update my practice, and become more specifically aware of current issues pertinent to students" "The self-awareness that I gain from CPD that I attend develops me as a practitioner" "Opportunity to engage with colleagues and share best practice"
Theme 4: **HE sector-specific CPD**	4.1: Targeted learning 4.2: Practitioner-led training 4.3: Guidance & planning	"More research in student mental health and the development of specialist CPD activities" "Those of us working in HE conducting research and evaluation presenting to others" "CPD could benefit from proper planning "

Table 6.3.2: Themes and Subthemes from the Qualitative Data Set

6.4 Summary of the Findings from the FP

In this section I have reported on the findings from the online questionnaire, outlining both quantitative and qualitative perspectives. The findings offer useful insights into common CPD practices, motivational factors, and trends in therapists' attitudes and behaviours towards CPD activities and learning styles.

These findings will be discussed in the next section and despite the differences in the nature of the information presented, the two datasets complement each other and provide a broader picture of how therapists working in HEIs experience CPD provision. Furthermore, the data sets were consistent with the qualitative themes from the earlier PEP findings. The PEP found therapists to be committed to CPD and recognised continued learning as a self-directed, emergent activity rather than a planned and collaborative integral part of clinical practice. It was also found that choice of CPD were grounded in interest as opposed to being based on evaluated needs, as recommended (Lingard & Truths, 2016).

Practitioners expressed concerns at the lack of guidance and support in finding good quality CPD that was relevant for working with students in HEIs. Changes to student counselling services and practice such as the introduction of larger,

multi-modality and multi-professional teams, increased student demand and complexity and brief interventions, were some of the area's practitioners mentioned as being challenging but rarely addressed in CPD.

I believe the consistency of the themes across both phases of the research, supported by studies cited in the literature, contribute valuable knowledge about therapists' professional learning practices and learning gaps. The mixed data results combine the generalisable quantitative with the more personalised qualitative datasets, to contextualise and offer important insights into student counselling practitioners CPD experiences and needs. The implications of these synthesised findings will be discussed in Section 7.

Section 7. Discussion

7.1 Introduction

The FP findings exploring how practitioners working in HEIs experience their professional development and perceive its impact on clinical work with students were notably consistent across both stages of this mixed methods study. Analysis and synthesis of both qualitative and quantitative data sets provided useful information (Creswell et al., 2003) that can improve our understanding of said professionals' CPD practice and offer suggested areas for improvement. This section will discuss the key results in more detail and demonstrate how the synthesised mixed data corpus connects with, and contributes to, the relevant literature fulfilling the research purpose. Following that, I will evaluate the research strengths and future considerations in relation to the quality criteria established in the methodology section before concluding with a reflexive account of my learning and implications for this project and potential studies in this area.

7.2 Overview of Key Findings

Five key elements for student counselling practitioners' ongoing development were elicited from the mixed data results. Participants' responses collectively communicated that CPD is **required**, it needs to be **relevant** to practice, existing **restrictions** and **resources** need to be reviewed, making CPD the shared **responsibility** of all stakeholders in order to ensure best professional

development practice. Each element connects with specific findings as outlined below.

CPD is ***required*** conveys the key finding of the value and commitment placed on continued learning, with 94% of participants reporting knowledge acquisition as the highest learning outcome. CPD is viewed as fundamental to maintaining and improving clinical practice. Thematically analysed qualitative data across both stages of the research complement the above finding, *Theme 1*: *Commitment to ongoing development of skills and competency* from stage one and the open-text survey responses – *Theme 1: Utility of CPD* – illustrate the importance of learning to practitioners' professional development.

Quantitative results show that 63% of participants viewed CPD as professional, 61% saw it as essential, and 58% deemed it ethical. Similarly, qualitative data from the first stage interviews identified a main theme relating to *practitioner autonomy and consolidation of professional identity*. In line with past research on therapists' commitment to "lifelong learning" (Castonguay et al., 2013; Rønnestad & Skovholt, 2013; McLeod, 2016), every survey participant reportedly fulfilled annual CPD requirements (100%, n=90), and demonstrated a dedication to continued development beyond professional body recommendations.

On further examination of the qualitative data, the second main survey theme – *Theme 2: Barriers to learning* – highlights the perceived constraints associated with CPD provision, despite the importance placed on learning for best practice development by participants and professional development criteria. The identification of barriers such as limited CPD resources and access led to feelings of *lost opportunities,* a subtheme within the main theme. Whilst 62% of participants reported they received institutional funding for CPD, 65% implied that their funding did not fully meet the costs of their learning, with a further 38% reporting no funding at all for CPD activity. Therapists' commitment to CPD appears to come at a personal cost for many, regardless of the benefits. Unsurprisingly, the findings show that for those participants with less choice in CPD activity, little or no institutional funding, and coming from non-centralised regions, current CPD provision is viewed less favourably than those with more ***resources*** and less geographical ***restriction***.

Motivators for CPD activity indicate that 81% of participants based their CPD choice on *interest*, 63% cited *reflection on practice* and 59% stated a *knowledge and skills gap*. Similarly, the qualitative survey data – *Theme 3: keeping abreast* and *Theme 4: HE sector-specific CPD* – provide a fuller picture of this issue, with new knowledge and skills relating to client group and setting seen as important by many clinicians who participated in the study. This finding was

confirmed by the quantitative results showing 94% of practitioners chose *new knowledge* as their learning objective, 83% reported *learner satisfaction* and 78% cited *skills improvement*. The key findings thus demonstrate that most practitioners value the utility of all learning activity but may place higher value on CPD which is perceived to be ***relevant*** to their practice with students and fulfils their professional responsibility to update their knowledge and skills to the benefit of the service user (BACP, 2018; HCPC, 2018).

Many participants reported experiencing challenges to accessing good quality ***relevant*** CPD. This was conveyed across the two research stages. The thematically analysed interview data produced *Theme 3*: *Tensions over time, cost, and lack of sector-specific CPD* and open text comments elicited the theme, *HE sector-specific CPD,* relating to challenges with the transferability of new knowledge to the participants' specific client group and setting. The challenges associated with securing ***relevant*** CPD raised the issue of a lack of guidance and support in CPD planning. This led to communications for sharing the ***responsibility*** for professional development with other stakeholders such as managers, supervisors, and institutions. There was significant overlap of these reoccurring elements in the qualitative data main themes.

Interestingly, less than half of respondents engaged in a formal CPD evaluation process such as a *personal development plan* (27%), *appraisal* (18%), or a *performance review* (2%), despite national recommendations for a planned approach to healthcare professionals' continued education (DoH, 2017). Some practitioners expressed concerns that this unplanned approach to CPD was unsustainable and in need of review. The importance of a structured approach to CPD, commonly seen in the allied professions may explain why only 17% of participants specified research as a valuable activity for professional development despite a national directive for "research and innovation to drive future outcomes improvements". A research-led practice is a fundamental part of the long-term plan for the professional development of healthcare professionals (NHS, 2019, p. 75). The suggestion of a shared ***responsibility*** for student counsellors CPD may serve to change existing culturally embedded attitudes that have tended to minimise research activity.

In short, my research participants described the role of continued learning activity and evaluated its effects on practice in various ways, as shown in the findings above. CPD's significance to personal and professional development was plainly apparent, as was participants' awareness that CPD is an essential and ethical part of routine clinical practice that ensures clients' safety, as well as their own. Key themes to emerge from the participants' collective responses

across the two research stages was the importance of having an accessible, relevant programme of learning activity, in addition to clinical supervision.

The literature on the continued development of counselling professionals provides general frameworks for understanding how CPD is defined and characterised. And existing CPD frameworks offer evolving standards of recommended general CPD practice, informed by research (Karas et al., 2020), however my findings show that a lack of detail and pragmatic guidance impairs compliance with national health profession strategies (DoH, 2017). Moreover, I assert that my findings suggest that the current unattended state of CPD practice in HE, reinforces an implicit and costly assumption that undertaking learning *per se* is sufficient to maintain and improve clinical practice.

Participant accounts express the difficulties in maintaining and improving practice because of limited funding, insufficient support to aid access and engage in relevant CPD, academic-related situational constraints and insufficient time allocated to integrate new learning. The drive to attend learning activities relating to student presentations or perceived relevant interventions for the student population, through training and skills seminars favoured by this research group, is considered a challenge for many. Participants reiterated many of the identified challenges documented in research

conducted in UK HEIs with counselling professionals (Harrison & Gordon, 2021; Randall & Bewick, 2016).

CPD practice driven by self-interest and based on self-assessment, shown to be the majority case in this research, appears to lack a coherent evaluation of individual learning gaps that is balanced against service need and wider sector and national developments. By contrast, many in the allied health professions have engaged in protected CPD that is regulated and forms part of a clear, multi-professional, evolving national framework, committed to maintaining and improving clinical competence for over a decade (Golding & Gray, 2006).

A key research objective of mine was to contribute up-to-date information on the unexamined areas of learning experience, practice, and provision for HE-based practitioners. The focus was to ascertain what practitioners feel is missing yet necessary to support their growth and development to be fit to practice. Practitioners participating in this research have helped to generate information to contribute towards raising awareness of what is **required** for them to meet current best practice criteria, timely given evolving national directives for the healthcare profession's continuing education agenda (NHS, 2019).

7.3 Practitioners' understanding of the role of CPD

A considered look at my key findings to see how they connect with, and add to, existing literature begins with the participating practitioners' understanding of the central role of CPD in practice development. In line with a vast body of literature (Castonguay et al., 2013; Fender, 2015; 2017; Karas et al., 2020; McLeod, 2016; Rønnestad & Skovholt, 2013) my research participants' dedication to CPD supported claims that therapists are generally avid life-long learners.

Participants demonstrated a high level of pragmatic engagement with a diverse range of learning activities to support their clinical development. The quantitative results showed a tendency towards specific learning arenas, with 72% choosing *skills training and seminars,* 70% *journal articles,* and 69%, *supervision,* regardless of position, experience, modality, or professional body membership. This preference for formal activity to "*keep up to date"* and to use *"discussions with colleagues"* to verify clinical practice corresponds with the findings from Schostak and colleagues' (2010) study exploring *The effectiveness of Continuing Professional Development* with medical professionals.

The common finding of a preference for formal CPD forums may in part be due to organisational perspectives shaping practitioners' conceptions of CPD. Organisations seek to record and quantify activity to evidence accountability and transparency, leading to the legitimisation of certain CPD activity over others. Academic institutions are in the business of qualification and certification of learning, so it is likely that practitioners have a tacit understanding of this "hierarchy of knowledge" (McLeod, 2016), evidenced by their engagement with formal CPD.

Moreover, formal knowledge ratified by professional organisations forms the foundation of a lucrative CPD industry. Therapists are inundated with promotional CPD materials promising essential skills and knowledge, reinforcing the benefits of these activities. Whilst these activities may be of value, they may not be as beneficial as promoted, nor any better than low-cost or free alternatives (Fender, 2017). Participants in this study did demonstrate engagement with a wide range of learning, despite the cited majority preference.

CPD in all its forms is seen to inspire new ideas, facilitate shared practice, enhance professional confidence, revitalise clinical work, and, just as importantly, assure stakeholders that practitioners continue to develop and perform ethically and effectively in their clients' best interests (BACP, 2018).

Professional development clearly matters to practitioners, as emphasised in the qualitative data providing a deeper sense of the significance attributed to it, as evidenced in the extracts below from both the FP and PEP, respectively.

> The range of CPD I have undertaken is very varied and ranges from attending BACP or in-house training days to watching TV programmes or reading articles with a mental health theme, or discussions with colleagues. How I benefit depends – it might be developing new ways of working with clients, or gaining insight, knowledge and understanding of a certain issue…
>
> (P60; Female, Clinician, Humanistic, 10+ years)

The following comment from an experienced female psychodynamic practitioner, during the interview stage in phase one of the research similarly conveys an awareness of CPD's multi-purpose role.

> Outside of it being an ethical requirement of good practice and continuing accreditation, I think it's an opportunity for me to think about my personal and professional needs to continue to work competently and effectively… to identify areas I need to continue developing or areas that are perhaps new to me… keeping myself up to date with client needs…
>
> (P01; 02.25)

7.4 Common CPD Practice

Participants' dedication to ongoing development was somewhat expected given counselling practitioners are required by professional organisations to evidence their obligation to work safely, effectively, and legally within their developing scope of practice by attending annual CPD and regular clinical supervision (Williams, Hannington & Hanson, 2011).

Interestingly, following the most frequently cited learning objective in this study, to gain *new knowledge* (94%), 83% cited *learner satisfaction*. This result was again found in the earlier study by Schostak, et al., 2010, and possibly confirms the common but somewhat misleading view that mere engagement with CPD activity builds practitioners' skills-base and competence. Extensive research on therapists' professional development found practitioners tend to communicate the feeling that "if I was better trained, I wouldn't feel so lost and so incompetent" (Skovholt & Rønnestad, 2003, p. 52), implying that better quality training is a vital component in capability building.

By the same token, research shows therapists' link knowledge acquisition with levels of confidence (McMahon, 2012). This may explain why such a high proportion of practitioners chose skills training and seminars, journal

articles/books, and supervision, as all of these activities disseminate up-to-date knowledge, theories, and new interventions. Comments from the qualitative data, which generated the main theme *keeping abreast* and subtheme *new knowledge and skills,* illustrates this point, as does the below comment from an experienced female psychodynamic practitioner.

> Fills knowledge gap (including best practice) and increases confidence in my work.
>
> (P84)

However, when I asked therapists about their preferred learning style 61% reported *experience.* This finding appears to contradict the numeric data highlighting *skills training and seminars* as the most useful learning forum, further evidenced by the first main survey theme *Utility of CPD.* The latter conveyed participants' perceptions of the effectiveness of training and skills activities for practice development. Although these contrasting results may signal external influences such as the need to show evidence to receive funding or the influence of organisationally embedded frameworks, they may equally indicate practitioners' understanding of the importance of multiple sources of *knowledge* (McLeod, 2016).

Practitioners' experience of insight gained from a variety of knowledge sources would explain the blend of formal and informal activity found to be generally

undertaken by therapists participating in this study. Studies showing that learning through experience, such as working with clients, and experience gained through personal life milestone events, has been cited in the literature as a fundamental learning arenas for therapists (Fender, 2017; Rønnestad & Skovholt, 2001). A later study by Rønnestad and Skovholt (2013) in which *interaction with clients* was deemed to have the greatest impact on development, followed by *supervision*, confirms the importance of learning from experience. In general, therapists rate supervision as a key contributor to career development (Orlinsky & Rønnestad, 2005), alongside client work and personal therapy. The datasets collected here similarly highlight the value participants attach to learning through experience, whether through supervision, peer-led forums, networking opportunities or formal CPD arenas.

Effective supervision operates to bridge case management between therapeutic practice and developmental requirements (Norcross & VandenBos, 2018). According to this data, supervision seems to provide an operational role in supporting both professional conduct (ethical and clinical dilemmas) and professional development (reflexivity and identifying learning gaps). Supervision thus clearly provides a context-specific mentoring role, in addition to sharing clinical caseload management and practice development. This is

highlighted in the extract below, which articulates the importance of relevant clinical setting knowledge in the supervisory forum:

> Supervision has been the most beneficial in terms of focusing specifically on the demands of the HE context in as much as it provides an opportunity to focus quite specifically on the clinical work. My other CPD activities (training, conferences etc.) were not orientated specifically to HE therefore any benefit was more to my general practice as a therapist.
>
> (Male, Psychodynamic Clinician, 2-5 years – P20)

Participants in this study conveyed the importance of supervision in both quantitative and qualitative data. 69%, regardless of position, experience, modality, or professional membership, indicated a preference for learning through *supervision*. This finding is, again, not surprising given clinical supervision is required for professional accreditation. The quality and strength of the supervisory relationship is central to what establishes supervision as constructive to practice development (Watkins, 2011), and this was articulated frequently in participant accounts.

The clear appreciation of regular clinical supervision and its central role in professional development is conveyed by participants throughout the data. An

influential factor in this finding may be because many experienced HE practitioners offer supervision in addition to their clinical work. This nuanced knowledge base appears in respondent accounts, highlighting the value associated with the supervisory process. It is important to note that some supervisory relationships are not experienced positively. The views here come from practitioners who participated in this study and therefore do not reflect the supervisory experience of all practitioners working in HEIs or elsewhere. Nevertheless, it demonstrates the value for practitioners of regular support, to reflect on clinical work and professional development, with an experienced clinician in the sector. This feature corresponds with the national directive endorsing peer orientated CPD for health care professionals (Karas et al., 2020).

Another common area of professional development frequently attended by participants in this research was learning through group discussion, which is reportedly highly effective in influencing practitioner behaviour (Forsetlund et al., 2009). The third main survey theme of *keeping abreast* included the subtheme *collaboration* because of reoccurring comments relating to this essential learning mode. This was also a particularly important learning mode for respondents who expressed a lack of CPD opportunity. Collaborative learning is highlighted as a targeted area for ongoing development in strategy

papers (Karas et al., 2020). An experienced, female psychodynamic clinician conveyed the value of shared practice to her development by stating that:

> … attendance at clinical discussion groups with peers has benefitted my practice in terms of sharing different perspectives which enrich clinical thinking (P22).

My personal ongoing development through the research undertaking has influenced my learning attitudes and behaviour greatly, as evidenced in my commitment to developing the BACP UC research sig and the SCORE consortium. The disappointing finding that only 17% of practitioners perceived *research* as a valuable learning mode contradicts my own developing experience, but complements the qualitative data collected in stage one and reflects wider reports across the counselling professions regarding a lack of research uptake (Castonguay et al., 2010; Henton, 2012; McLeod, 2016). Counselling and psychotherapy trainings have traditionally lacked an epistemological research base and this may explain the “patchy” interest in and uptake of research-orientated activities (Bager-Charleson et al., 2018, p. 5), as depicted in my findings.

Therapists tend to be critical of the clinical relevance of research and can struggle with the traditional presentation of published research (Bager-Charleson et al., 2019). Nevertheless, a research informed practice is a requirement for best practice (BABCP, 2012; BACP, 2018; HCPC, 2020) and participants in this study were unequivocal in their perceived efforts to practice *ethically and professionally,* despite exposing aspects of their CPD practice to the contrary.

Research draws attention to the challenges experienced by therapists integrating research knowledge and skills into clinical practice, citing a persistent lack of support from colleagues and institutions in addition to limited education (Bager-Charleson et al., 2018; Castonguay et al., 2010; Dufour, 2020; McBeath, et al., 2019). Fear, lack of confidence and time limited resources further restrict opportunities for practitioners to participate in research, as they look to prioritise learning for more immediate practice demands (McBeath et al., 2019). More information of this unexamined area of practice seems necessary given that it brings clinicians into direct contact with the nuanced work of their client population and setting.

Respondents' limited uptake of research (17%) is an area worthy of further examination given research engagement would bring practitioners into contact

with academic colleagues and the core mission of their institutions (Broglia et al., 2021; Dufour, 2020). There is also the CPD requirement of inter-professional development for health care professionals, highlighted in national strategic reports promoting professionalism for the healthcare professions (DoH, 2017).

The aspiration among student counselling professionals for promoting professionalism in the counselling and allied professions is evidenced in support for the SCORE project. The recently published outcomes paper demonstrating the effectiveness of university counselling interventions with students (Broglia et al., 2021) is a direct result of interprofessional collaboration. The outcomes paper found that counselling benefitted students specifically in the domains of academic related anxiety and student wellbeing, indicating that practitioners' nuanced practice is effective in meeting student needs and overcoming structural issues.

Harrison and Gordon's recent study on counsellors' experiences of providing counselling to university-level students sheds light on practitioners' flexible approach to counselling. It also highlighted the counsellors' experience of a lack of national recognition for the work undertaken in HEIs, similarly articulated in my research participant accounts. The complexity and nuanced nature of the

work was felt to be undervalued despite the reality that such services constitute main providers of counselling in the UK (Harrison & Gordon, 2021). Further research into how counselling professionals adapt their interventions would be useful knowledge for CPD.

7.5 Gaps in CPD Practice and Provision

The literature review shed light on broad trends as well as concerns regarding general professional development in the counselling and allied professions (Bager-Charleson et al., 2019; Castonguay & Muran, 2015; Karas, et al., 2020; McLeod, 2016; Stewart, et al., 2018) and exposed a dearth of research specifically relating to student counselling practice (Barkham et al., 2019; Connell et al., 2006; Randall & Bewick, 2016). My research objective was to fill this deficit and update knowledge on student counselling professionals' CPD practice, and whilst this was achieved it could be argued that much of the mixed data findings are consistent with existing literature relating to the professional development of all therapists, not just those working in HEIs.

However, Firth and colleagues (2019) justify researching different clinical settings to explore the impact of structured differences on clinical practice, resources, training programmes, and the like, as discussed above. My research

data highlights specific institutional factors perceived by practitioners to benefit - as well as prohibit - continued learning, particularly with regards to meeting best clinical practice recommendations. Academic structures within HEIs have historically dictated time allocated for CPD and the cessation of previously held annual sector-led events (designed in accordance with the academic calendar) has impacted access to some relevant forums. A perceived lack of organisational guidance and governance in CPD practice, as reported by some participants, is due in part to relative annual cuts in UCS budgets. 38% received no financial support for professional development and this notable lack of support for continued learning corresponds with over half of respondents (52%) reporting a self-directed and unregulated CPD practice.

Neglect of national guidance for CPD to be conducted in conjunction with a line manager (25%), employer (12%), or supervisor (5%), may explain why CPD is largely driven by interest, as reported by 81% of survey participants as opposed to evaluated learning gaps. Interestingly, the qualitative data conveyed mixed feelings relating to the self-directed nature of CPD practice in HEIs among participants. Whilst some expressed frustration with the lack of a coherent CPD strategy in the sector, others favoured the autonomy of CPD practice.

These divergent perspectives are likely associated with funding and or support. Those who are funded, or partially so, are free to choose their CPD activity, whilst those who receive no funding are likely to want a structured approach to ensure resources are allocated to this area of practice. Similarly, practitioners whose accrediting body requires evidence of specific learning forums are likely to positively receive a structured approach to CPD to ensure they fulfil expected CPD criteria. CPD practice in the allied professions is a formalised part of clinical practice within employing organisations and is both protected and regulated as a result (Golding & Gray, 2006; Karas et al., 2020; Schostak et al., 2010).

It should be noted that despite *interest* being the main motivator in CPD activity, participant comments show that practitioners frequently search for relevant training, to better position themselves to meet the needs of their clients. Whilst many respondents reported encountering challenges accessing pertinent CPD when asked about its relevance to client population and setting, this was not the case for all respondents. An experienced female integrative practitioner noted that:

> Nowadays, students and non-students populations and their problems are becoming increasingly similar. CPD need not be specifically for the student population to be relevant (P29).

Although this comment diverges from most participant accounts on the relevance of CPD, the comment again raises the earlier question as to whether some practitioners may look to blame external factors such as CPD or structural issues for their own limitations in managing the increasingly complex therapeutic work in their setting (McMahon, 2012).

The characteristic determination shown by practitioners to rise to professional challenges, whilst striving to maintain standards expected by clients, institutions, and regulatory bodies is, however, apparent across most participant accounts. All four main themes and nine subthemes document practitioners' recognition of work-based pressures and include creative ways they overcame structural obstacles and continued to provide quality care to students, a featured main theme in Harrison and Gordon's (2021) recent study. This is consistent with earlier studies showing the student counselling role has become more complex and in-demand over the last decade or so, leaving practitioners navigating a tension between the condition to meet the institutional discourse of promoting student productivity with their professional discourse that emphasises therapeutic wellbeing (Platt, 2017; Randall & Bewick, 2016).

All thematic findings, particularly *HE sector-specific CPD,* convey practitioners' concerns about how to continue to meet evolving work-based

demands and maintain professional integrity, notwithstanding clinical practice improvement. The difficulty in engaging education and training that is perceived as transferable to the setting was highlighted by a female head of service with 10 years of experience:

> … provide a recommendation framework to universities to offer a budget and allow time for clinicians to attend. More stuff specifically around working with students in very brief ways as a lot of skills based CPD events are run by people working in more opened ended ways and end up not being as relevant (P56).

This account highlights the view that generic CPD may be responsible for learning and practice challenges rather than acknowledging the struggle to manage the increasing complexity of the therapeutic work, disadvantaged by limited time constraints to consolidate learning material. The literature review shed light on the struggle HEI counselling services have long experienced in balancing innovation and good therapeutic provision with institutional requirements and wider socio-economic and political demands (Bell, 1996). However, judging from participants in this study there appears to be a widening gap in sector-wide innovation akin to that established by the pioneers of student counselling, successful in establishing the profession and a legacy left for continuing development of the sector (Bell et al., 1992).

Maintaining high professional standards is a constantly evolving challenge for all therapy providers (Allan, 2019), which seems greater today given the fast-changing nature of mental health provision, related technology, and increasing trends in mental health demand. Variation in the systems and resources allocated for the maintenance of practitioners' professional competencies in UCS makes this all the more challenging. Knowing what constitutes effective CPD thereby becomes anyone's guess. However, participants in this study - referenced through the main theme *HE sector-specific CPD* and subthemes *targeted learning, practitioner-led training* and *guidance and planning* - communicated the "felt" need for more sector-led knowledge and support. The need for sector-specific clinical practice and development was expressed by practitioners regardless of their modality, position held, years of experience, or professional membership.

The clear value associated with peer-led training, professional networks, supervision, group discussions, and clinical meetings found in this study and others (Karas et al., 2020) converges into what Johnson et al. (2013) called competence constellations. This communal approach to clinical practice moves the responsibility for clinical competence from the individual practitioner to the collective practice of teams, which is more akin to the past era of student counselling events and network activities. Such forums serve as a "form of

professional triangulation, that is, a process of comparing experience about similar activities across a range of perspectives in order to find out what is common, what is different, and what is contrasting." (Schostak et al., 2010, p. 32), in line with the national agenda for continued education.

The high level of CPD commitment found in studies looking at therapists' professional development may inadvertently obscure the reality that few counselling professionals follow advice to plan and structure their CPD as recommended for maximum benefit (Fender, 2015). This raises the issue of whether this frequent finding serves to minimise low engagement with evolving research evidence on effective development processes, such as deliberate learning practice (Miller et al., 2015; Rousmaniere, 2017). Deliberate practice is based on "Kolb's Learning Cycle" (Kolb, 1984), advocated by professional organisations. A core component is the assessment of clinical practice to determine and identify learning gaps in specific areas in need of attention and improvement. Interestingly, deliberate practice did not feature as a CPD activity in this study, yet it is recommended in reports for best CPD practice in the counselling and allied professions (Karas et al., 2020).

Participants responded differently to the evolving demands of their counselling role and associated training needs, which were founded upon a tradition of

unassessed self-directed growth. My results are not dissimilar to Fender's 2017 study in which participants were mostly found to have an emergent unplanned approach to CPD. In less challenging contexts and in better-resourced times this may be sustainable. But in the present HE climate some practitioners, particularly those in positions of responsibility, called for a review. An experienced cognitive behaviour therapist and head of service said:

> I think this should be directed more by supervisors, clinical leads and line managers in order to avoid the fact that practitioners seem to default to what seems interesting rather than CPD that improves a skill or helps them obtain a new technique/training. (P89).

Some counselling practitioners however do not agree with a regulated continued education agenda, feeling that autonomy over clinical development is a vital part of CPD. An experienced female integrative clinician said: "It feels as if there is a lack of trust in professionals deciding what would be helpful to them, and… presupposes that planned CPD is somehow of greater value" (P51). Although the quantitative data did not show any statistical differences between position, experience, or modality and CPD experience, the qualitative free text comments, displayed alongside numeric data, clearly reveal divergence between practitioners' views and positions, making for a richer narrative on a complex area of counselling practice.

When commenting on what changes could be made to improve CPD activity for therapists working with students, organisational support was highlighted. Interestingly, professional bodies and universities were cited as agents of change. One account from a female respondent with over 10 years of experience, said:

> Professional bodies such as BABCP, BACP recognising the needs of professional clinicians working in HE – universities and those of us working in HE conducting research and evaluation of our work and presenting to others… funding from universities should be offered. (P36).

Continuing with the theme of what could improve therapist's development, an experienced male psychodynamic clinician and supervisor said "BACP could run conferences and webinars on the UC competencies that were put out some years ago but haven't been discussed since." (P4).

Regardless of where participant concerns are directed, the appeal for more assistance in targeted learning for effective management of increasingly complex caseloads is apparent. Whilst there are practitioners who feel satisfied with the organisational support they receive, particularly those with added experience in the work and allocated resources within the setting, many said they felt more was necessary. Participants seemed acutely aware of the changes in complexity of their client work and the limited resources in their service for

further training in this type of work. The experience of a lack of organisational understanding and resource allocation for relevant training and development has an important influence on perceived case-load management ability, model adopted, and consequent confidence and competence in clinical practice (McMahon & Errity, 2014). These concerns are not limited to student counselling professionals working in educational institutions but beg the question of who decides the appropriate model and treatment plan for a given setting and client work and based on what evidence?

I believe these research findings provide useful information for those of us responsible for promoting good practice, such as myself and colleagues in executive roles on professional body committees. The role description states that our purpose is to promote ethical, effective, and professional counselling provision across the sector, and that we are responsible to the board of governors and members. Building an up-to-date knowledge base on common practices for therapists working in HEIs is a starting point. I have already presented my findings to an executive committee and, as a result, the findings have been used to make the case for targeted action in practitioner-led sector-specific training and education, at no or minimal cost to members.

7.6 Further factors related to professional development

The increasing pressure of work environments in the education and health sectors may account for some of the demographic shifts identified in my study. The literature suggests that student counselling historically developed from two distinct modalities: psychodynamic and person-centred counselling (Bell, 1996; Thorne, 1985). The results of the present study show today the largest self-reported modality in university mental health and well-being support services is integrative, with 38% of participants self-reporting as such. However, with 76% of the participants reporting six or more years of post-qualification experience, I wonder if this result points to a group of practitioners who may have integrated a range of post-qualification training and skills into their practice over time, thus identifying as integrative therapists?

Integrative therapy is a term commonly applied to preparative counselling and psychotherapeutic trainings that combine different therapeutic tools and approaches to fit the needs of the individual client. An integrative therapist can, however, be trained in one or more schools of counselling and therapy, not just formal preparative integrative training. I am a practitioner with two distinct therapy qualifications that I developed over a 20-year period in order to flexibly adapt my skills to the demands of my students and HEI.

Over the years I have gained a broad understanding of human development, with skill sets drawn from a variety of CPD activities delivered by different schools of counselling and psychotherapy, as well as my own research. An integrative approach describes a flexible and pluralistic therapeutic practice that differs from traditional, singular forms of talking treatments. The need to flexibly adapt clinical skills to context demands as identified in recent studies (Harrison & Gordon, 2021; Platt, 2017; Randall & Bewick, 2016) may be why more therapists working in HEIs self-report as integrative practitioners.

I raise this finding because it further illustrates the changing nature of student counselling practice, which requires an increasingly context-dependent approach to clinical practice, as voiced by participants. The changing nature of the counselling work is also reflected in a specific competencies guide for the sector in which the following competencies and meta-competencies are described: a core therapeutic model, context-based knowledge (FE/HE), assessment skills, the ability to tailor therapy to client need, a developed understanding of mental health, familiarity with client referral pathways, and organisational understanding (BACP, 2016).

This document also highlights practice-based strategic interventions, such as brief work due to time constraints resulting from the academic structure

(semesters/terms, breaks and exams) and the impact of a deadline-driven culture (creating periods of increased demand) that requires the “ability to plan and provide interventions that are cognisant of the needs of students but also reflect the resources available…” (BACP, 2016b, pg.51). The document should ideally be accompanied by training provision that is purposefully designed to facilitate the building and refinement of said competencies for counselling professionals working in the education sectors (Platt, 2017).

My research data highlighted practitioners’ concerns about the lack of guidance and planning and gave suggestions for a HE CPD framework, to ensure any required meta-competencies associated with working in HEIs is accessible through continued training. A view validated by the words of an experienced, integrative clinician: “I would like CPD to be better structured in our context, by this I mean there be a BACP framework which there is for UC competencies but how to seek CPD to change practice.” (P9). Frequent reference was found across all data sets to a need for ongoing education, knowledge, and skills, to better equip counsellors to deal with the fast-changing developments in HEIs. Cultural competence, managing complex caseloads, referral pathways, short-term work and risk, evidencing practice, keeping abreast of institutional, and wider student-related directives were all cited by practitioners and should form the foundations of any CPD provision.

Comments from an early-career, male psychodynamic therapist clarify what is felt to be needed:

> specific training towards specific student populations – from grads, international students, men, BME, trans and I think work on short-term therapy would be beneficial as an underestimated impact is time. The time constraints regarding starting or ending a semester is important as is training for navigation of NHS systems as students to access support at home or uni is still not addressed (P15).

This practice-based information has since been used to inform potential training collaborations in order to produce events grounded in these practitioner suggestions and clinical training requirements (see Section 8).

7.7 Listening to Practitioners in Order to Inform Practitioner Self-care

Literature on stress-related environments has found that a perceived lack of support in clinical settings is the main predictor of work-based stress (Delgadillo et al., 2018; Orlinsky & Rønnestad, 2005). As mentioned, UK universities are increasingly perceived as high stress environments (Auerbach et al., 2017; IPPR, 2017; Royal College of Psychiatrists, 2011), which, unsurprisingly, has led to an increased strain on both academic and support staff (Hughes & Byrom, 2018; Hughes & Spanner, 2019). My research rationale was to engage student counselling practitioners' in sharing their experiences of

working in HEIs and to provide a platform to increase the general understanding of their work, including the opportunities to continue to develop their clinical expertise for the benefit of their clinical community.

My research participants voiced anxieties about managing increasingly complex and heavy caseloads within a limited-session framework impacted by academic systems. Some areas of CPD were perceived as neglecting to adequately address practice-based realities, leaving practitioners frustrated at finding ways to adapt and integrate the learning into their context. Given this finding, a worrying 58% of the respondents indicated that *burnout awareness* was not evident in the CPD activities they had undertaken over the 12-month period. This whole area of practitioner concern was well articulated by a female CBT practitioner with 6-10 years of experience: “More concentration on delivering short-term therapy – how to manage difficult presentations and what can be done in brief work and continuing to think about the consequence of the potential for burnout in managing a large caseload” (P16). It seems that this deserves more research.

Burnout and compassion fatigue is on the rise in the “caring professions” and there exists an established deficit in self-care practice and training to minimise the impact of the work (McCormack et al., 2018). Given common work-based conditions across the health care professions, alongside the data generated from

my study, there appears an increasing need, if not an ethical duty, for CPD provision to actively support learning in how to sustainably maintain a positive work-life balance, whilst simultaneously ensuring client safety and practice efficacy (Sabagh et al., 2018). Figures of an increase in both students and staff reporting mental health issues in universities has yet to shape strategy in CPD practice and provision for counselling professionals, but in the light of published concerns about the implications of burnout among health professionals (Scott, 2018), it may be prudent to heed the warnings.

Issues relating to staff wellbeing have been exacerbated by the global pandemic, which has resulted in many therapists in the university community rapidly adapting their working practices to online working with little or no training, as in many healthcare settings. Anthony and Goss acknowledge the rapid response to the crisis that practitioners in the sector took and state "…the imperative for a quick fix that will allow services to continue operating at all, recedes as the time needed to upskill ourselves, and to adapt our services to something that resembles a 'new normal' way of working, increases" (2020, p. 20).

There does seem to be growing awareness in the form of campaigns, largely driven by active practitioner members within professional bodies and organisations, to tackle "practice-based" issues. The BABCP has just launched

the CBT Practitioners in Higher Education Special Interest Group (BABCP, 2020). This group was founded with the aim of improving communication between BABCP practitioners working in HE, and to encourage research relating to CBT in HE.

The action to form a special interest group further validates my research findings. The formation of such a group suggests an escalating priority for psychological professionals working in specific settings with specific issues to collaborate, share best practice, and work to increase knowledge specific to this client group and setting, a requirement of their re-accreditation (Chelms, 2020). Once again, although most counselling professionals share similar professional development needs, this suggests there are some clear differences defined by clinical setting and client group. Such differences justify some sector-related ongoing training.

Similarly, BACP have supported the development of the research special interest group within the UC division, given members' longstanding wish to utilise service outcome data and evidence student counselling practice to improve knowledge, service provision, and training. The independent practice research network, SCORE, has begun this task (Barkham et al., 2019) with endorsement from the BABCP, BACP, and UKCP, and an article disseminating the findings of the feasibility project has been published (Broglia et al., 2021).

Organisational backing demonstrates there exists a real need for updated evidence-based knowledge on clinical setting practice. Moreover, it endorses professional development stemming from interprofessional forums and is evidence of an increasing trend for professional bodies to unite to tackle the complex structural issues involved in improving evolving healthcare provision.

These are welcome signs. Support, in the many ways it manifests, is clearly needed by the highly committed professionals who dedicate themselves to helping others learn how best to approach their lives to reduce stress and mental ill-health. The findings from my study demonstrate that practitioners do need help to learn how to continue to grow professionally. And, given professional bodies for the counselling professions state that practitioners have an ethical duty to look after themselves so they are fit to provide care and support for others (BACP, 2018; HCPC, 2018; UKCP, 2016), it seems there is a shared responsibility in ensuring this is actualised.

The responsibility for selfcare is not easy to put into practice if attention and effort tend to be externally directed towards the needs of clients and demands of commissioners and institutions - a problematic feature across the health professions (Allan, 2019). The responsibility to provide good quality mental health provision should not lie solely with the practitioners, as my data suggests

it is currently perceived to be in HE and, possibly, other settings. Ideally, it should be the responsibility of all interested parties. Commissioners, regulators, trainers, service providers, and users, in addition to therapists, need to share the burden of responsibility and, in so doing, improvements in CPD provision may follow.

7.8 Sharing the Responsibility of Ongoing Education

I became incentivised to explore the impact of CPD on HE-based practitioners' practice development against a backdrop of continuing change. My observations that student counselling, an occupation originally implemented to deliver educational therapeutic support (Bell, 1996; Mair, 2016), resembles more often an NHS psychological service with all of the costs and none of the benefits (Taylor, 2020).

The pressure to meet the wider "target-driven" changes in the education sector has evolved without expertise and the structural means to do so effectively (Barden & Caleb, 2019; Brown, 2016; Rustin, 2013). And, as this study confirms, the resources for developing and maintaining good clinical practice for staff working at the coalface of a mental health epidemic have not tallied with resources for other student mental health initiatives, nor those in wider national healthcare settings. In fact, due to general rising costs, they have

diminished in comparison to what (quality and relevance) was on offer in the past (Caleb, 2015).

An overarching theme of this research has been university practitioners' ongoing clinical practice requirements, invariably perceived as not being sufficiently met at present. Suggestions comprise targeting CPD around the work undertaken in university counselling services: principally by ensuring that the post-qualification learning content should be directed towards practice-based issues (student and setting) with experienced trainers and supervisors developing and delivering accessible (regionally-inclusive CPD and low-cost) CPD. Notably, there were calls for more governance from professional organisations providing CPD advice and targeted training, and the strategic development of CPD policy for employing institutions delivering clinical services.

A shared approach, mitigating the impact of escalating work pressures on practitioners through a well-resourced personal and professional selfcare plan and development agenda, would clearly benefit all parties and has finally become a strategic mission in the sector (UUK, 2018). After all, the generic therapeutic competencies – emotional attunement, emphatic responsiveness, and knowledge of theory and method – are the foundations of clinical practice. The

degree to which a practitioner can enhance these competencies is somewhat dependent upon continued support and development (McLeod & McLeod, 2014).

7.9 Reflections on the Quality of this Research and Areas for Development

I will now critically evaluate my research in relation to the quality criteria established in the methodology section (**S**ection 4), focusing on some of the research**'s** strengths as well as factors that may limit the validity and trustworthiness of my findings.

Participation in the survey (18%), based on a conservative estimate of counselling professionals working in HEIs, is a feature of the research's validity. The response rate matches that of response rates reported by professional membership organisations for counselling professionals (BACP, 2020; UKCP, 2016). In addition, **by** contacting multiple networks, this survey took measures to include practitioners from a greater variety of training backgrounds **in order** to reflect the variance in the student counselling population today **and avoid** being limited to one professional network**,** as is commonly the case. Surprisingly, a sizeable, rich mix of free text information was shared by survey respondents**,** in addition to earlier interview data, leaving

me with **a** degree of confidence in the credibility of the research and findings (Patton, 1990).

Similarly, the demographics of survey participants closely matched wider demographics for counselling and psychotherapy professionals (UKCP, 2016). The survey part of the study further lends acceptability in terms of its familiarity to mainstream researchers and service commissioners in HEIs, which provides a degree of political leverage through which to advocate for change. Equally, the inclusion of qualitative data brings a deeper, more personalised element to the quantitative data, providing the opportunity to hear real accounts from counselling professionals and use that to shape change. Furthermore, I believe that, by utilising a two-stage mixed methods exploratory design (Creswell & Plano Clark, 2007), my research advocates for an underutilised research method in my professional community, which is itself another strong quality of this research.

Moreover, the mixed methods design matched my overarching research purpose and desire to explore the experiences and identify the needs of an understudied professional group. The consistency in findings across both stages of the research provide a coherent and synthesised narrative that adds credibility to the data. For instance, insights gathered from the numeric data on student

counselling professionals' common attitudes and behaviours complements the closed-question free-text comments, earlier experiential themes from interviews, and open question accounts regarding participants' perceptions of the specificity and transferability of training and skills to setting and client group.

The mixed data findings reflect the whole data corpus, with convergent and divergent data enriching the overall narrative and demonstrating the complexity of the researched phenomenon. The complementary nature of the data sets reinforces the integrity of the data as a whole, so one can surmise that the findings are not unique to the small research sample.

However, the reliance on my participants' own judgements of their professional development from CPD could arguably be seen as a limitation of the study. I did not examine areas of actual change in participants' clinical practice as a result of CPD, nor differences in the activities undertaken in different circumstances and at different times. Clearly these factors have an active role in participants' experiences, as demonstrated in responses to questions on the relevance of CPD activity to clinical practice. One participant noted "it varies", whilst others stated "it usually feels like a box-ticking exercise..." and "I usually enjoy it and benefit from it".

Divergence in the data is again apparent in the responses to a multi-item closed question asking what CPD is considered to be, which also offered the opportunity to comment. Whilst the more experienced therapists rated CPD as more engaging, essential, informative, and rewarding than those with less post-qualification experience, all the free text responses (from experienced practitioners) stipulated that this utility was dependent upon the particular CPD and factors such as the quality of subject content or the presenter. Participant responses thus indicate that impact of learning activity on clinical practice varies between different learning instances and is a more layered and complex phenomenon than a single item measure conveys.

This leads to questions about the term CPD, itself an ideologically shaped construct determined by multiple factors including participants' personal, economic, sociocultural, political, and geographic circumstances (McLeod, 2016). It could be argued that face validity of the construct of CPD is questionable, as evidenced by the spectrum of experiential accounts given by the respondents. The nuanced complexity of CPD, again illustrated by the range of experiences that the participants voiced, is an integral component of learning, not necessarily evidence of it having a greater or lesser impact. It may be that a myriad of learning sources and experiences integrated over time determines effective professional development (McLeod, 2016).

The extent to which my preconceptions, biases, and wish to advocate for the profession impacted the research findings is another significant factor regarding the study's credibility. Bias in research is always present and is believed to be exacerbated by "insider" researchers (Trowler, 2011). Despite my attempts at transparency regarding my research assumptions and the quality controls that were employed, my novel "insider" researcher status led to some obvious bias. Bias is identifiable, as evidenced in my survey question design. Three of the five open-ended questions expose my assumptions relating to existing CPD barriers for HE based therapists. My views were unintentionally integrated into the questions, possibly leading respondents away from thinking about their own experienced barriers to continued professional development.

In retrospect I can see how my inexperience in formulating open-ended questions directed participants to either confirm or disconfirm the barriers to CPD that I had identified. I thereby unknowingly at the time missed opportunities to gather information on a range of significant barriers to CPD besides the ones I was suggesting, such as family life or unexpected milestone life events. This also led to an overlap in the data yield. Similar responses were given to two separate questions and this resulted in the decision to collapse the repetitious text from two questions into one (Braun & Clarke, 2013).

In addition, one open-ended question (Q23) generated more one-word responses – yes, no, maybe – than anticipated. On reflection this was due to the unintended closed nature of the question. At the analysis stage, following consultation, the decision was made to present the data in percentages in keeping with data analysis of closed questions. In order to give due consideration to some of the text data generated I included one participant account (see p. 319) that clearly diverged from a main qualitative theme (*HE Specific CPD*). This comment served to reinforce variance in therapist perspectives as well as demonstrate the complexity of the studied phenomena. The decision to include the divergent comment was therefore justified on the basis that it made a valuable contribution to the research narrative that otherwise would have been lost in the chosen data presentation (McLeod et al., 2010).

In hindsight, a non-directive question format may have led to a deeper exploration of participants' learning experiences. In doing this, more data on other factors related to practitioners' growth may have generated different themes and subthemes. Nevertheless, the main themes and subthemes I analysed were considered in the context of the whole research narrative, in relation to the research questions, within the limits of my research experience. Theme headings, vetted in peer meetings for coherence and credibility (Nowell et al., 2017), reflected the research questions and came directly from the body of text

(Braun & Clarke, 2006), establishing a degree of trustworthiness. It is likely, however, that the main qualitative themes I identified may well differ from those found by another researcher holding contrasting views with different research objectives.

Both my interview schedule and survey questionnaire were constructed on the basis of my overarching research intention to highlight the work of student counselling professionals and advocate for change. My preconceptions about the different value afforded to academic departments and professional services in HEIs exposes my own social construction of reality within my working context. I believe that as a result of the hidden nature of counselling work in HEIs – to ensure confidentiality through anonymity – therapists' work can, at times, go unnoticed and thereby appear less valid to the institution, a feeling similarly conveyed in recent qualitative research exploring the experiences of Irish counsellors working with university students (Harrison & Gordon, 2021). I am also aware of the currency bestowed on generating mainstream knowledge through research in HEIs. So, although I originally planned a purely qualitative study, I changed to a mixed methods design in the belief that mixed data findings offer more political leverage among academics and commissioners of services, given the familiarity of data presentation. Inevitably, my discourse shaped the research plan and design to be more visible to multiple audiences.

Furthermore, the implementation, analysis, and reporting of data focused on areas of interest to me and my research purpose to be 'heard' and advocate for change. While participants across both research stages were free to express any issues related to their professional development, it could be argued that they would be more likely to share a similar motivation. The inclusion of divergent data does, however, give some indication of different practitioner perspectives relating to CPD practice, as do the quality controls employed to maintain the rigour and integrity of the data findings (Stiles, 2003).

The investment associated with my "insider-researcher" status is thus a strength and a limitation. Useful information emerged in relation to my mixed data, particularly the influence of the context of student counselling (academic related barriers, historic cultural CPD customs) on participants and the phenomena in question (Levitt, et al., 2019). But the significance of my political interest in promoting awareness of practitioners' challenging circumstances probably took attention away from considering other salient therapist development factors. I believe my research did profit from my "insider" position, given participant engagement is an underutilised area of activity (research) in my sector. The level of engagement in my area of study provides an awareness-raising platform about evolving CPD practice, that can lead to conversations that build

momentum, attract investment, and validate a shared conceptual framework (Rubin & Rubin, 2005).

Human process research looks to explore and acquire greater understanding of complex issues. The importance of updated knowledge relating to therapist development is necessary to ensure up to date clinical practice (Cooper & Wieckowski, 2017; Rønnestad & Skovholt, 2013). The limited attention given to research led practice in my sector is an example of how my research and related initiatives have begun to assist a culture shift. Of equal importance is having the opportunity to share experiences about practice development and, at times, the solitary nature of student counselling work, given there is relatively little literature about this area of clinical practice (Connell, 2006). I believe these aspects of my research constitute a gain as they serve as catalysts for insight. My findings have supported, diverged from, and added to the literature on practitioner development, particularly for student counselling professionals.

If I were to do the research again however, I would use follow-up interviews to ask questions that move beyond participants' superficial descriptions of their learning, to capture novel formulations of their experience (Levitt et al., 2019). This would strengthen my current data and lend more currency to the specificity of counselling professionals' CPD needs for effective practice in HEIs.

Counselling professionals working in HEIs are a diverse group with converging and diverging narratives about clinical practices, such as supporting academic related anxiety, in addition to growth and development. Understanding the contribution of these, that is, the language and meaning associated with different and similar ways of being and doing (Willig, 2015), would further enrich our understanding and allow for a deeper consideration of the relationship between different discourses and the implications of these for individual institutions.

My overriding feeling from my area of inquiry is that confidence and clinical competence evolves and improves as a result of a combination of up-to-date specialist and tacit lived-experiential knowledge elicited from and with others. Neither of these things are possible in isolation nor without a shared conceptual framework. Guidelines and policies for education and training are useful tools in safeguarding the quality of learning content and continued provision but do not guarantee integration of learning, confidence, or competence (Curado et al., 2015). This is likely to be dependent on a number of context-specific support processes and structures. For decades, student counselling has been at the forefront of championing the emotional health and wellbeing of students, perhaps it is now time to devote some of that attention to the personal and professional needs of its practitioners.

7.10 Brief Summary

In this section, I have considered the mixed data findings from researching practitioners' professional development. My research highlighted some differences in practitioners' learning needs and levels of support they receive. As demand from institutions and student cohorts vary and fluctuate, so does the areas of practitioners' practice development. However, there was a clear sense from participating counselling professionals that certain areas of student counselling work would benefit from specific knowledge forums directed towards the context and population, in line with research demonstrating practitioners are more likely to engage with CPD related to their clinical setting (Castonguay & Muran, 2015).

The challenges that participants raised about having access to relevant, good quality CPD may be common across therapists and clinical settings. Nevertheless, my research raised additional concerns specific to the therapist population being examined here. These included work patterns shaped by the academic calendar impacting practice development and/or academic related presentations. Likewise, participants' anxieties and fears about not being sufficiently supported to meet their professional responsibilities in a setting currently lacking a coherent post-qualification training and development agenda are specific to HEIs as NHS clinical settings have a developed CPD framework

(Golding & Gray, 2006). Moreover, research shows that improvements in general therapist competence and confidence are likely to lead to better client outcome data when resources account for structural differences pertinent to the clinic setting (Firth et al., 2019).

This research served to emphasise the central role and importance of learning for practitioners, in the myriad of forms that learning takes. It also shed light on evolving national expectations of continued education for healthcare professionals not yet fully recognised by practitioners working in HEIs (DoH, 2017; NHS, 2019). The data has thereby added to the current body of knowledge on professional development, shedding light specifically on the nuanced needs of counselling professionals working in HEIs. The findings call for employers, practitioners, professional organisations, supervisors, and CPD training providers to come together to continue to maintain and improve standards of care for those offering counselling support in non-clinical settings. Such an approach would assist practitioners working with rising demand and increasing complexity and risk to navigate current and future challenges arising from the counselling work in HE.

The next section is devoted to products generated and recommendations proposed to further raise awareness on the researched topic and bring about change.

Section 8. Research Impact, Implications, and Recommendations

8.1 Introduction

In this section I consider the impact of my research and demonstrate its usefulness and outcomes for professional practice. I begin by looking at how my research has added to the literature on psychotherapy practice (specifically for practitioners who work or intend to work in HE settings) through public platforms such as conference presentations and workshops. I then discuss the various initiatives that I have either developed or co-developed and continue to lead to influence policy on learning support and provision. Finally, I outline the recommendations I intend to propose to key stakeholders, with some reflections and proposals for future directions that could build on the findings.

8.2 Research Objectives and Yield

In earlier sections of this document, I outlined my wish to know how therapists working in HEIs experience their CPD and perceive its impact on clinical practice, with the purpose of generating awareness of this unattended area of practice by contributing to the existing literature. I also intended to utilise up-to-date practitioner-based accounts of CPD for the purpose of instigating relevant CPD training development and knowledge.

I anticipated that, between these objectives, I would make a valuable contribution to student counselling practice, which would provide relevant training and skills to help practitioners working with complex student cases, as well as provide insight into a small but under-represented clinical specialism and improve practice. In advocating awareness of practitioners' needs for education and knowledge specific to their client population and clinical setting, the research may also usefully transfer to other professionals, who would benefit from ongoing training specific to their own particular clinical settings and client group.

8.3 Conference Presentations and Workshop Forums

My objective to circulate my research findings at relevant conferences and workshops as and when results became clear throughout the research process has been fruitful.

8.3.1 Society for Psychotherapy Research (SPR), Oxford, 2017

My first opportunity to present my research was at the international conference of the Society for Psychotherapy Research, (SPR), held at the University of Oxford, UK, in 2017. A poster presentation of my qualitative small-scale PEP findings, phase one of the research, was accepted and can be found in Appendix

2. The poster presentation area was well-attended, and my research attracted the attention of many of the research authors I had encountered in my literature review and cited in my doctoral work. It was the first time I felt a welcome sense of belonging to the research community not just as an observer, but as a participant.

8.3.2 University Forum Presentations, 2017

In the same year I presented my findings at two respective university staff development forums. One at Kings College London (KCL), to a mixed group of thirty practitioners attending a CPD event and the second at the CBT in HE termly network meeting, held at the London School of Economics (LSE). The presentation was well received by both groups and led to lively discussions about the paucity of student focused CPD and the need for more relevant training and guidance in ongoing education, further corroborating my findings.

8.3.3 BACP University & Colleges Research Event, 2019

As part of my role as chair of the research special interest group, I proposed and developed, with the support of the BACP events team, a sector-specific research event with fellow UC Executive committee colleagues. "Working with research in practice – universities and colleges conference" was opened by Dr Felicitas Rost (Appendix 4), the then-President of the SPR UK Chapter, and her keynote

address was on the importance of developing a psychotherapy research evidence-base to contribute knowledge to counter the dominance of current research hierarchies and promote all psychotherapeutic practices and client choices. The remaining presenters were all chosen on the basis of their practice-based research projects, which were specific to the FE and HE settings. The feedback from attending members was encouraging and confirmed there is practitioner interest in research that has direct application to the setting and client group.

8.3.4 BACP Annual Research Conference Presentation and Online Webcast, Belfast, 2019

In addition to a 30-minute co-presentation on the research work of the SCORE project – "Gathering outcome measures for the sector: a feasibility study" – at the annual research conference "Shaping counselling practice and policy: the next 25 years", a colleague from SCORE and I were invited to participate in a live webcast on our research activities. This additional event was offered to four respective research studies in order to encourage participation from delegates unable to physically join the conference as well as provide a platform for researchers to disseminate their work to a wider audience. The discussion, hosted by Dr Alistair Ross, was on the work of university counselling services, developing an evidence-base and innovation of service training and provision.

Link to the webcast: Day-1-studio-discussion-with-geraldine-Dufour-and-Afra-Turner.mp4 – VLC media player

8.3.5 SPR EU & UK Conference Krakow, Poland, September 2019

The same colleague and I gave a brief paper presentation on Universities and Colleges: A feasibility study on gathering outcome measures for the sector to improve knowledge and service development and training four months later at the SPR conference.

8.3.6 BACP Annual Research Conference, Bristol, 2020

I successfully submitted an abstract to the annual BACP conference for a brief presentation (10-15 minutes). I was later asked to consider a longer presentation slot of 30 minutes, given the panel's interest in my timely research topic and findings. However, the face-to-face presentations were unfortunately cancelled due to the COVID-19 pandemic and I instead submitted a poster presentation to the alternative online event. A showcase of the research projects from the BACP Research Conference 2020 is still available online at:

https://bacp.co.uk/events-and-resources/research-archive/poster-exhibition-2020/

8.3.7 Society for Psychotherapy Research, Amherst, USA, 2020

My FP research abstract (178767) “Bridging the Gap & Continuing to Develop Professionally: A Study Exploring the Impact of Continuing Professional Development (CPD) Activity on the Practice of Therapists in Higher Education (HE) Settings” was accepted for the SPR Annual Conference 2020 at Amherst, USA (Appendix 14). This conference was also cancelled but was not replaced by an alternative online event.

8.3.8 SMaRteN Early Researchers Virtual Lab Presentation, 2020

SMaRteN is part of a larger research network, funded by UK Research Innovation (https://www.ukri.org) to develop research around mental health. One of SMaRteN’s research initiatives is a virtual lab group for early career researchers and PhD students. I was invited to present my research in October 2020. This was a remote presentation for 25 participants, followed by a lively discussion. I was the only presenter who brought both an academic and clinical perspective on the experiences and needs of staff working in the current climate in HE (Appendix 15).

8.3.9 BACP Annual Research Conference, Manchester 2021

My research abstract from the 2020 cancelled conference “Promoting Collaboration in Research, Policy and Practice” was rolled over to this year’s

event. I am also taking part in a panel discussion with two fellow SCORE members; Dr Emma Broglia and Geraldine Dufour on the topic “Is Evidenced-Based Research Enough to Help Protect Embedded HEI Counselling Services? How Can We Strengthen the Learning From Research to Impact Strategy and Make the Case to Commissioners That Our Services Are Worth Investing In?” (Appendix 16).

8.4 BACP UC Executive Committee work

8.4.1 Proposal and Development of BACP UC Research SIG, 2017

In 2017 I was re-elected to the BACP UC Executive Committee to establish a research special interest group. The mission of the executive is to promote and support “the professional status of counsellors, psychotherapists, psychologists and CBT therapists working in counselling” in colleges, sixth forms and university settings by providing up-to-date information and advice, coordinating networking and training events and undertaking and publishing research (https://bacp.co.uk/bacp-divisions/bacpuc/about)

8.4.1.1 Research SIG OUTPUTS

Publication list

- Turner, A. (2021). Notes from the Chair of research SIG. *University & College Counselling,* 9 (1), p. 07.

- Turner, A. (2020). Notes from the Chair of research SIG. *University & College Counselling,* 8 (4), p. 07.
- Turner, A. (2020). Notes from the Chair of research SIG. *University & College Counselling,* 8 (3), pg. 07.
- Turner, A. (2020). Notes from the Chair of research SIG. *University & College Counselling,*8 (2), p. 07.
- Turner, A. (2020). Notes from the Chair of research SIG. *University & College Counselling,*8 (1), p.07.
- Turner, A. (2019). Notes from the Chair of research SIG. *University & College Counselling,* 7 (4), p. 06.
- Turner, A. (2019). Notes from the Chair of research SIG. *University & College Counselling,* 7 (3), p. 06.
- Turner, A. (2018). The BACP UC Executive Launch of Research Special Interest Group. *University & College Counselling, 6,* (4), pp. 29-30. (see Appendix 3).

Conference list

- BACP UC event - Working With Research In Practice – Universities and Colleges Conference – June 2019, University of Cambridge.

8.4.2 Proposal and Co-founding of a Practice Research Network

In 2017, following my re-election to the BACP UC Executive Committee, and upon completing the first phase of my research (PEP) I set about coordinating a practice research network (PRN) for the sector. The aim was to bridge the practice-research gap (a finding from the PEP) and begin utilising the data collected by counselling services.

This initiative led to the establishment of Student Counselling Outcome Research Evaluation (SCORE), an independent consortium of clinicians, clinical leads, academic researchers, and professional staff committed to realising the longstanding wish in further and higher education to develop a shared routine outcomes database to provide evidence for the sector and improve service provision and training.

SCORE is supported by two professional bodies: the British Association for Counselling and Psychotherapy (BACP) and United Kingdom Council for Psychotherapy (UKCP) through financial and in-kind involvement of researchers' time. Six founding universities support the project with in-kind contributions from clinicians and clinical leads. I chair the group with Dr Emma Broglia as project manager and Louise Knowles as deputy chair.

UKCP donated a fund specifically for the training workshops. BACP support the research project and see the collaboration as a strategic priority (see https://www.bacp.co.uk/about-us/advancing-the-profession/research/score/).

A series of workshops have been offered since summer 2020 and continue to provide training for practitioners working in the sector to support best practice in using outcome measures in student counselling (see www.scoreconsortium.group.shef.ac.uk/training-and-resources)

8.4.2.1 SCORE OUTPUTS

In addition to the training workshops, SCORE have held a number of recorded research focus groups with practitioners from FE and HE to begin developing a minimum dataset for the sector. The focus group discussions will be transcribed and thematically analysed as part of a wider research study. The following products have resulted from SCORE collaborations.

Publication list

- Barkham, M., Broglia, E., Dufour, G., Fudge., Knowles, L., Percy, A., Turner, A., Williams, C. & SCORE Consortium (2019). Towards an evidence base for student wellbeing and mental health: Definitions, developmental transitions and data sets. *Counselling and Psychotherapy Research,* 19(4), 351-357. Doi: 10.1002/capr.12227.

- Broglia, E., Ryan, G., Williams, C., Fudge, M., Knowles, L., Turner, A., Dufour, G., Percy, A. & Barkham, M. (2021). Profiling student mental

health and counselling effectiveness: Lessons from four UK services using complete data and different outcome measures. *British Journal of Guidance and Counselling.* Doi: 10.1080/03069885.2020.1860191

Conference list

- BACP Annual Research Conference – May 2019 (Afra Turner & Geraldine Dufour) and (Dr Emma Broglia)
- UCC Division Event – June 2019 (Dr Emma Broglia)
- SPR EU & UK Conference, Krakow - September 2019 (Geraldine Dufour & Afra Turner) and (Dr Emma Broglia)
- SMaRteN Conference, Cambridge – December 2019 (Dr Emma Broglia)
- SPR Annual Conference, Amherst – September 2020 (Cancelled due to COVID-19) (Dr Emma Broglia, Afra Turner, Louise Knowles)
- SMaRteN ECR Presentation – December 2020 (Afra Turner)
- BACP Annual Research Conference – May 2021 (Geraldine Dufour, Afra Turner, Dr Emma Broglia)
- SPR Annual Conference, Germany – September 2021 (Abstract submitted)

8.5 Training Partnership With Charlie Waller Trust (CWT)

As a result of my research findings, I contacted Dr Andrew Reeves in his current role as Colleges and Universities Programme Director at the Charlie Waller Trust, with the idea of forging a training partnership between BACP UC and CWT. Following a meeting in December 2020 between Dr Reeves, two additional CWT colleagues (all specialists in FE and HE), myself and the Chair of UC, Mark Fudge, we made an agreement to roll out a training package in the new year. The following six online training sessions are currently being developed and have been proposed to BACP:

- Compassion Fatigue
- Change/uncertainty
- Gambling
- Isolation/loneliness
- Practitioner self-care
- Working online with risk

8.6 SPR, UK Ordinary Committee Member

I was invited to apply for the vacant position of student member of SPR, UK, by Professor Naomi Møller and Professor Jochem Willemsen in November 2020. My application indicated my Doctorate in Psychotherapy submission date, and on receiving my application I was invited to join as an ordinary member of the committee from January 2021 instead, and I accepted.

8.7 Post-doctoral Products

8.7.1 Publications

One of my doctoral objectives was to contribute to the limited body of research on practitioners' experiences of professional development activity. At the close of my FP Peer Presentation at the Metanoia Institute in January 2021, there was enthusiasm and interest in my idea to publish a book containing practitioners' accounts of their research projects and their experiences of professional development as a result of undertaking the research journey. A suggestion to co-edit such a book with a Metanoia staff member was mooted, which I received with appreciation and felt confirmed the value of my research. I will endeavour to pursue this once the FP is submitted and I have exchanged emails with the relevant parties. I will do this in addition to submitting articles from my research findings to a peer review journal such as *Counselling and Psychotherapy Research* or *British Journal of Guidance and Counselling.*

8.7.2 Recommendations for the Profession

My research findings have revealed the need for further development in CPD provision to promote practitioners' fruitful growth. I am therefore intending to make the following recommendations to key stakeholders in the student counselling and wider professional community:

- **Recommendation one:** I recommend that HEIs allocate sufficient resources for the provision of CPD and see this as an integral part of routine clinical practice more commonly associated with (and in addition to) clinical supervision, in line with the national strategy for healthcare professionals (DoH, 2017).
- **Recommendation two:** I recommend that practitioners receive a more structured, coherent CPD practice framework. Post-qualification training in skills and knowledge acquisition, peer-to-peer and interprofessional collaboration and participation in relevant research and teaching activities should be guided, facilitated and based on identified gaps in practitioners' knowledge and stage in development.
- **Recommendation three:** I recommend that CPD provision and practice be the shared responsibility of investors, stakeholders and partners in order to improve access and maintain standards of training and clinical provision. The research exposed a lack of training for HEI managers in CPD best practice education - in line with national strategy developments - and therefore I recommend this area to be a primary training objective.

Professional bodies, supervisors, senior managers, and clinical leads need to emphasise and encourage the value of a blend of formal and informal CPD activities, with due reference made to practitioner self-care. I believe guidance

in evaluating, reviewing, and integrating CPD activity into professional practice requires policy development at both a national and institutional level so as to ensure CPD is established as a central feature of best clinical practice.

8.8 Summary

My findings confirmed my assumption that therapists are generally highly dedicated to their personal and professional growth, particularly keeping abreast of new knowledge and developments in the profession to ensure good practice. They are also very committed to rising to work-based challenges and meeting client demand. The results from practitioners' accounts clarified some of my concerns about the lack of structural support for this core clinical activity, evidenced by an absence of a planned approach to ongoing learning pertinent to clinical requirements and stages of development. My sense was that this can lead to additional work-based anxieties for staff, with worrying implications for increased burnout or compassion fatigue, exacerbated by the lack of relevant CPD addressing practitioner self-care and the perceived non-transferability of some knowledge and skills activities to actual clinical practice.

Given the information and recommendations arising from the findings I can see a number of potential areas for future consideration and development:

- Future research could look at the role counselling and psychotherapy trainings and professional bodies play in providing education on CPD practice in clinical work. The professional expectations for continued post-qualification education to follow Kolb's Learning Cycle (1984), could be explored in terms of its effectiveness for continued use.
- Clearer guidance from professional bodies (and endorsed by employing institutions, managers, and supervisors) on how to adapt a research-informed practice and undertake research – while managing clinical responsibilities – as part of CPD, so as to innovate and advance practitioners and the profession.
- The development of post-qualification training in practitioner self-care to raise the profile of health care professionals' ethical duty to look after their own well-being in the interests of their clients. This includes leadership training for managers, several of whom described the challenges of providing adequate CPD provision for their staff in the current climate during the research.
- Education in and encouragement for the development of inter-professional partnerships in health care and well-being practices. This would further consolidate commitment to establishing health working environments in line with the "whole university" and "whole counselling professions" approach to practitioner wellbeing.

In this section I have charted the products and opportunities that have evolved out of my research and considered how they have added to the literature on psychotherapy practice, and specifically to understanding the work and needs of therapists employed in HE settings. I have highlighted the work I continue to lead and disseminate in public forums, and I have offered recommendations based on the research findings. I have also noted future considerations for development and additional research in the area of CPD. The final section offers a brief reflective view of my own developmental experience.

Section 9 Final Reflections

This final section draws on my experience of the research journey and provides a brief reflective account of working to bridge my own learning gaps and continue to develop professionally.

9.1 A Brief Overview of My Learning

From the very beginning of this research undertaking my mission was to draw attention to a phenomenon that I, and others, perceived as largely unacknowledged: the inadequate provision of CPD for therapists working in HE, an environment that has endured many structural changes and become more challenging as a result. I set out to explore how therapists experienced their ongoing development in such a climate and in doing so, I began another chapter in my own personal and professional development.

Embarking on a professional doctorate seemed like the perfect opportunity to generate useful knowledge to progress my small, and at times undervalued specialist area of the counselling profession, as well as to acquire knowledge and skills that would connect me with the core mission of my setting and clients. What I didn't consider at the outset were the inevitable learning challenges I would encounter along the way. Choosing a mixed methods approach brought me into contact with unfamiliar information formats and

processes, and evoked old feelings of being out of my depth and therefore incapable. Similarly, the responsibility I felt towards representing my participants and the profession appropriately induced a mixture of confusion and fear, which was overwhelming at times and led to temporary paralysis. However, both these feelings led me to seek out help, remain focused and trust in the process of "not knowing" as part of "getting to know".

The long and, at times, lonely research journey parallels many of the key learning endeavours I have experienced throughout my lifetime. I wrote about some of these, such as navigating feeling different as a child and the beginning of my professional life as a seminar tutor with a profound feeling of not being good enough, in the introductory section, whilst others have been documented in different contexts for different purposes. They are all united by the navigation of the experience of uncertainty, fear of inadequacy and a sense of shame and self-doubt, regardless of age and knowledge.

These are the feelings my students often share in the therapy process, that I support supervisees to acknowledge in the presentations they struggle with and that I continue to bear when faced with getting to know something unfamiliar in all of the positions I inhabit. I felt a similar terror when becoming a student, therapist, mother, and, now, a researcher. The research process was a deeper

learning endeavour than anticipated but perhaps the optimistic momentum of a new pursuit needs to blindside the realities in order to get started. And, by surviving the uncomfortable parts, I have come to re-recognise the power of the painful emotional components of learning, many of which are the result of primitive threatening developmental experiences, that underpin my occupation.

I know that my emotional vulnerability as an only child, with a depressed and displaced single parent, seeking refuge in a community of people opting out of mainstream life, brought me into contact with a profound sense of uncertainty and separateness. This experience, which identified me as different and thereby vulnerable, is also the reason I became adept at making friends, gained an ability to join groups and came to value belonging. My fear of not being good enough has borne a motivation to keep me learning and investing in the benefits of life-long education despite the inherent challenges. Even with the formative scars there are numerous summative experiences to balance out the early fear-based narratives and this research and its yield are simply the newest additions.

I can see now that learning in conditions without adequate support can cause a degree of trauma. As a child, navigating transitions to school, peer groups, and adolescence without sufficient parental support left me very vulnerable. Similarly, taking up the professional opportunity to join the academic staff

shortly after completing my undergraduate studies, with no teaching infrastructure, mentoring or professional experience to fall back on, left me overwhelmed with feelings of inadequacy and shame.

By contrast, learning to become a therapist, and more recently a researcher, has taken place within established structures, with others around me sharing the challenge and experienced figures guiding the emotional and intellectual process. This insight has been my defining "aha" moment from the research journey: learning is both painful and gratifying no matter how old or experienced one is and is integrated with more ease when supported.

This founding principle is what led to the development of student counselling as a profession and yet, strangely, the inbuilt support for learning has diminished for those who provide it. I feel a great sense of achievement in shedding light on some of the issues facing practitioners working in HE. I feel proud to belong to a small group of professionals who, in the face of adversity, continue to avail themselves to growth and development, often at great personal cost, to ensure they provide "good-enough" care and support. I feel we deserve to get the support we need to thrive – and not just survive – in the counselling work.

It is the commitment to thinking and development that bonds the university community. The vulnerabilities and fears that can be evoked as a result of intellectual development and growth are, I hope, beginning to be recognised as part of the learning and teaching trajectory and therefore it is the responsibility of all to receive as well to provide adequate support.

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Appendix 1
Practice Evaluation Project (PEP)

Learning to Continue to Develop Professionally: An Exploration of Therapists' Experience of Continuing Professional Development (CPD) in a Higher Education Setting - A preliminary study

Practice Evaluation Project (PEP) submitted in partial fulfillment of the requirements of Module (DPY443) as part of the Doctorate in Psychotherapy by Professional Studies Programme (DPsych), Metanoia Institute, December 8, 2017

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Abstract:
This qualitative practice evaluation project reports on findings from research exploring Higher Education (HE) therapists' experience of continuing professional development (CPD). A phenomenological inquiry with HE therapists' (three female and 2 males, aged between 38-55 years) utilising Thematic Analysis (TA) was conducted. The results confirmed findings in the literature that therapists are committed to CPD, but often their CPD is emergent rather than planned, as advised by professional organisations. CPD choices also seem to be guided by the interests of therapists rather than developmental needs. Finally, there was the perception of a lack of adequate and accessible CPD provision to support current training need in the HE sector.

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Background to the study:

I am a qualified and accredited dual modality (Psychodynamic and Cognitive Behaviour Therapy (CBT)) practitioner with over twenty years' experience of working in Higher Education (HE). I have held many positions in a University Counselling Service from a trainee placement role up to acting Head of Department and continue to work part-time as a CBT Psychotherapist and HE Supervisor. I am currently serving on the Executive Committee of the British Association for Counselling and Psychotherapy, Universities and College Division (BACP UC), having, in the past, been Vice Chair and Chair on the Conference Committee (1999-2002) and on the Executive Committee (2002-2004) of the then known Association for University College Counselling (AUCC) division.

My PEP interest has evolved directly from my professional experience of working in multi-modality and multi-disciplinary HE settings as well as participating in the professional committees mentioned above. I am an insider-researcher bringing a dual lens to the study and believe that 'interpersonal sources' (Rønnestad & Skovholt, 2013) of knowledge positively impact learning and development. Experience with interpersonal sources of knowledge is integral to the insider-researcher set of skills despite the inherent bias and

assumptions that go hand in hand with such a knowledge base (which I discuss in more detail in the ethical considerations section and the appendices section (Appendix 5 – Reflexive Statement of Intent)).

My accumulated experience in the sector has informed me of therapists' general overall commitment to CPD but equally I have observed a reluctance to respond to certain organisational demands (to integrate new knowledge/skills) to adapt their practice. One example of this is the slow integration of routine outcome measures (ROM) in many HE counselling services over the past 15 years. The research team at Sheffield University recently published a report stating that an absence of evidence-based measures in many further and higher education counselling Services remains despite expectations from stakeholders and suggested best practice (Broglia et al., 2017) for services to be led by outcome data, validating my own observations.

There are explanations offering insight into why this culture of resistance in HE may have evolved (Jenkins, 2017: Mair, 2016; McLeod, 2016). However, questions regarding the on-going challenge, for clinically relevant developments to impact practice, seem rarely addressed. I wondered why this situation persisted given my own observations alongside existing research documenting therapists' high motivation and dedication to personal and professional development (Fender, 2017; Mair, 2016; McLeod, 2016; Rønnestad & Skovholt, 2013).

CPD is commonly described as a diverse range of learning activities formal, and informal, which include books, courses, conferences, journal reports, workshops, supervision, therapy, peer group review, theatre/art, and participation in research. The British Association of Counselling and Psychotherapy (BACP), defines CPD as any developmental activity that can be integrated and is '*used for the systematic maintenance, improvement, and broadening of competence, knowledge and skills to ensure that the practitioner has the capacity to practise safely, effectively and legally within their evolving scope of practice. It includes both personal and professional development'* (BACP, 2016).

CPD prescribed by the main UK based counselling and psychotherapy organisations (BACP, BPS, UKCP) share similar CPD policies that emphasise '*best practice and keeping abreast with relevant developments in the field';* a requirement to remaining accredited. In addition, to clinical advancement and efficacy, continuing education has a pivotal role in supporting staff wellbeing and resilience. There is also no shortage of CPD as therapists are continually bombarded with a diverse range of learning materials and activities. And

therapists' consumption of CPD has, been reported to be limited, only by their time and financial resources (Fender, 2017).

While therapists are clearly very motivated to continue their personal and professional development and fulfill professional expectations, I am curious as to why there continues to be a significant gap in the acquisition of certain types of knowledge, namely research-led knowledge (McLeod, 2016). This is especially relevant given the emphasis in professional accreditation criteria and expectations of best practice from sector employers and stakeholders to acquire and integrate such knowledge.

A recently published report by The Institute for Public Policy Research (IPPR) stated that the "HE sector should collectively adopt student mental health and wellbeing as a priority issue, with individual institutions developing their own 'whole-university' approaches subject to audit and quality assurance, and underpinned by common principles which draw on best practice" (IPPR, 2017).

Simultaneously, recent publications such as BACP Universities and Colleges (BACP UC) Competencies Framework and the updated UC Sector Resources 003 (BACP, 2017), developed to provide benchmarked practice guidelines (in line with the new ethical framework for the counselling professions (www.bacp.co.uk/ethics/EFFCP.php)), reiterate therapist accountability and HE institutions expectations of a research-led practice. Perhaps the reality for many therapists, and the services' they work in, is the struggle to simply manage increased clinical load and risk – an understandable priority – but comes at the expense of informed strategic application that seems shortsighted in the longer term and thus requires further investigation.

The timely publication of the study conducted by Broglia et al., (op. cit.) which assessed the challenges for embedded UK FE and HE counselling services, reiterated an "absence of a culture of evaluation and a lack of strategic implementation that would enable collected data to be best used" to inform staff training and service development (2017:11). This study suggests a concerning gap in many HE therapists' knowledge base that is necessary to perform the role expected of them. In addition, the paper called for further research, as little exists, to fully understand the ramifications of the current situation.

The implications for therapists, service managers, and supervisors working within university counselling services are multifold. Many experienced therapists' (managers and supervisors) clearly have not developed a familiarity with research knowledge, language, and skills. This may in part be due to the limitations of original trainings stretching back years that did not incorporate the scientist/practitioner model and/or insufficient CPD provision, and/or

adequate time and/or resources to make up this deficit. Increased levels of depression, low morale and burn-out are apparent and likely to rise in the profession at large (CBT Today, 2016:11) so any research into how therapists choose, experience, and are (or are not) supported by CPD seems critical.

The overarching aim of the Practice Evaluation Project (PEP) therefore focuses on exploring how HE therapists choose and enact their professional responsibility of continued professional development in an attempt, to better understand this existing discrepancy. It felt timely to explore how therapists' experience and respond to changes in clinical practice given increasing pressure. Simultaneously, to assess whether current CPD provision is meeting the training needs of HE therapists to sufficiently manage these changes is an objective.

Qualitative methodology, as opposed to quantitative, was employed because it offered the opportunity to develop an idiographic understanding of participant's experience of CPD. Understanding is gained through the themes generated from participant's responses of what CPD means to them, within their socio-cultural reality, which in turn develops statements that can begin to explain shared phenomena and contribute to learning and progress (Biggerstaff & Thompson, 2008).

The choice to adopt the phenomenological stance stems from my assumption that therapist accounts of their experiences are a valid source of knowledge. Subjective knowledge is believed to be essential in providing insight into what is understood in a recounted lived experience and considered to be meaningful or not (Finlay & Evans, 2009).

The insight gained from therapist revelations of their CPD experiences may shed light on why therapists tend to minimise the value of some professional and research knowledge forms over others (personal and interpersonal sources), despite its governance in developing their skills and personal qualities to ensure they retain an effective practice in an increasingly pressured working environment (McLeod, 2016:20).

<u>Literature Review:</u>

The literature review conducted for this project (PEP) is an up to date, small sampling of the current literature available, at the time of writing (Summer, 2017). Searches using Ebscohost, Summon and Google scholar provided access to PubMed, PsycInfo, PsycArticles, APA Psycnet, and Web of Science using the search terms (and variations of) 'psychotherapy' and 'professional' and 'development' as well as 'higher education' and 'counselling'. In addition, hand

searches of relevant journals and grey literature (unpublished or uncommercial literature) was conducted.
The recommended systematic scoping review (Rowland & Goss, 2000) was not possible given the time restrictions of this small-scale study.

The relevant literature on professional development in the counselling and psychotherapy professions has increased vastly over the last five decades (Jennings & Skovholt, 1999: Orlinsky, & Rønnestad, 2005; Schon, 1983; Wampold, 2001; Rønnestad & Skovholt, 2001). The Society for Psychotherapy Research (SPR), founded in 1969 (http://www.psychotherapyresearch.org/default.asp?page=SPRHistory), continues to pioneer the knowledge base dedicated to understanding the 'personal and professional predictors of therapeutic work and professional development' (Orlinsky et al., SPR Conference, 2017).

Despite vast amounts of literature devoted to producing more knowledge on therapist efficacy across the mental health professions, the current review demonstrated little research specifically relating to the United Kingdom therapist population. There was less that related to UK higher education therapists and their experiences of CPD in the current climate of increased risk and organisational change. Most studies seem to concentrate on increased risk and severity of student presentations (RCP, 2011; Wallace, 2012), the challenges for university counselling services in meeting these demands (Caleb, 2014; Mair, 2016), the impact of widening participation and fees (Walsemann, Gee & Gentile, 2015) and finding creative ways to manage high demand with reduced resources (Brown, 2016; Grundy, Wang & Bero, 2016; Mair, 2016).

Research shows that 'therapists are dedicated to self-development but the nature of their development is more emergent than planned; with life experiences, learning from clients and acceptance in the professional community being valued above more traditional concepts of CPD' (Fender, 2015:3). Personal experiences and milestone events, learning from practice with clients, supervision and the professional community take precedent in terms of *perceived value* over more formal modes of learning and development (Fender, 2017; Rønnestad & Skovholt, 2013).

The research clearly indicates that the professional expectation on all therapists, regardless of clinical setting, to participate in life-long learning that will include the use of outcome data and research knowledge in making appropriate changes to clinical practice (BACP, 2013:5), does not appear to be valued nor adhered to in reality. This reality is concerning given, as stated earlier, there is increased stakeholder involvement and public scrutiny on competency adherence in the counseling professions.

Explanations exist to identify why therapists are reluctant to adapt and adopt a research informed practice-based lens (Castonguay, Locke, & Hayes, 2011; Castonguay & Muran, 2015; Morrow-Bradley & Elliott, 1986). Recommendations have long called for improvements in post qualification practitioners to adopt the scientist-practitioner model (e.g. The Boulder Model, APA, 1951), of integrating research-based knowledge into practice, to change the profession's 'resistant trend' post qualification (Rowland & Goss, 2000).

Perhaps what has long been overlooked are the needs of therapists to have more 'training, encouragement and support to plan and reflect on their CPD which would help them make better decisions about what CPD would be most impactful to their practice rather than which might be most interesting' (Fender, 2017:11). The role of supervision, CPD, peer led group work and regular work-based reviews could also play a more active part in supporting the integration of new knowledge into practice (Broglia et al., 2017).

Adapting clinical practice requires the full engagement and endorsement of its practitioners to succeed, not simply the application of theoretical models, technology and routine measurement tools being produced (Miller, et al., 2015). The practice-knowledge gap continues to concern the counselling profession, at a local, national.
, and international level to one degree or another. However, the challenge of how to effectively engage therapists in professional knowledge acquisition and practice remains an enigma, particularly given the complex and multifaceted spectrum of therapists involved with their heterogeneous experience, expertise, modality, and clinical setting expectations (McLeod, 2016).

Peer led CPD activities such as practice research networks (PRNs), the integration of research findings in seminars, workshops and sector-specific literature as well as improved primary counselling trainings all serve to make an impact, but it appears to remain a long-standing challenge for therapists across countries, clinical sectors, and modalities to employ and sustain a research lens over time (Castonguay & Muran, 2015).

According to McLeod (2016), the last fifty years have seen the development of a hierarchy of knowledge, with a vast amount of empirically dominated literature and training emphasis at the top. In part this is the result of the implementation of evidence-based treatments disseminated by international academic task forces in traditional CPD forums gaining notoriety, implementation and funding. The benefits have led to the proliferation of certain therapies available at the point of need. However, it also appears to have

inadvertently marginalised many of the target audience, working in the profession, and presents a real challenge to maintaining professional standards. Recent changes to the way psychotherapy research is being produced and the growing acceptance and validation of qualitative evidence in the counselling and psychotherapy professions (Levitt, et al., 2016) may begin to even out this imbalance and serve to break down such barriers. The increasing involvement of practice-based researchers (insider-researchers) in the production and dissemination of new practice-oriented research (POR), making research more accessible and relevant to therapists, will hopefully further impact research integration (Audin, et al, 2009; Barkham & Mellor-Clark, 2000).

Rationale for the study:
The literature searches highlighted studies reporting therapists' reluctance to read and participate in research-based knowledge thus somewhat minimising its significance on practice. Simultaneously, the profession at large appears dominated by concerns of a research gap that has been widely regarded as a barrier to the development of effective therapy outcomes/services and best practice.

CPD encapsulates the dissemination of all forms of knowledge – personal, interpersonal, professional, practical, and research and offers the potential to address these issues. A deeper understanding of how therapists make sense of and use CPD seemed a good place to start to begin understanding the current practice development divide. This study attempted to gain a better understanding of HE therapists' experience of CPD to identify and move towards encouraging and establishing a more fruitful knowledge-sharing premise that directly impacts practice and at present is lacking.

Methodology:
The choice of research design and methodology reflected my own view of social reality and an assumption that knowledge is socially constructed, and experiences subjectively interpreted. I believe understanding phenomena 'requires first person accounts and an acceptance of subjectivity in the construction of knowledge' (Finlay, 2011:187). Therefore, my research design adopted the qualitative phenomenological approach.

Thematic Analysis (TA) was chosen as the recognised qualitative methodological procedure because it is a widely used 'method for identifying, analysing and reporting patterns within data' and allows researchers to select their theoretical framework rather than the method defining these parameters (Braun and Clarke, 2006: 79). TA is often used to analyse verbatim accounts that seek to discover or better understand phenomena.

The current research aim was to explore HE therapists' experience of CPD. Their accounts are thus seen as a resource for better understanding their reality of CPD and provides a valuable source of knowledge to aid a shared sense of the phenomena.
TA is often recommended to novice researcher's unfamiliar with coding and categorising data because it offers more flexibility with the data sets when analysing interview transcripts than other forms of hermeneutic inquiry (Fereday & Muir-Cochrane, 2006). There is also a comprehensive framework guiding the novice through six phases of analysis.

Initially I considered interpretative phenomenological analysis (IPA) however it is said to generate exhaustive descriptions of the phenomenon and requires a loyalty to the philosophical foundations of hermeneutics that I feared would become untenable given the constraints of a small-scale study. Grounded theory (GT) was also considered but rejected, as it seeks to build a theory from the collected data, which again didn't fit the objective of this small study of looking for common themes as way of explanation of the phenomena (Tong, Sainsbury, & Craig, 2011).

Finally, TA whilst compatible with my social constructivist premise and free of any philosophical anchors served as a solid platform for further research utilising the current data results to inform the design and methodology (Holloway & Todres, 2003). The undertaking of the PEP was to test the feasibility of my research interest, gain experience and skills in conducting research and integrate this knowledge for use in refining any future project.

The table on page 18 (*Table 1:* The 6 phases of thematic analysis - Braun & Clarke, 2006) is an illustration of the processes involved in TA data analysis and I followed this format throughout the data analysis stage of the study. Familiarising myself with the data, as the first step, included repeated listening of the recordings (MP3 that were transferred into WAV files for transcription) and reading of the transcripts, line by line. Data coding followed, with initial points of interests recorded on the account and in the reflexive journal. An unpublished handout produced by Dr Stephen Goss on 'step by step qualitative data coding', (Research Challenges Module, Metanoia Institute, 2016), additionally guided the process.

Reoccurring patterns were noted, using interview reflexive journal notes made at time of the recordings and during the familarising stage. From these reoccurring patterns or themes, sub-themes developed (McLeod, 2011). These were then reviewed generating a 'thematic map' and eventually compared to the external researchers generated themes. Fortunately, the themes correlated, and the final step was agreeing on co-constructed definitions/names. Three major

themes were co-identified out of the eleven minor ones produced. Finally, transcript extracts were chosen to exemplify both existing themes found in the existent literature of therapists' learning and to identify emerging themes particular to the research aim and question for the report.

Table1: The 6 phases of thematic analysis (Braun & Clarke, 2006)

Phase	Description of the process
1. Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking in the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells; generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Method:

In-depth semi-structured open-ended interviews were used to ensure that the views of participants could be faithfully represented as stated above. These were digitally recorded and stored securely as audio files (MP3/WAV). The interviews followed a responsive interview style format with questions designed to elicit a rich, first person account of the perceived benefits and barriers participants experienced during a recently recalled CPD activity (see Appendix 4-interview schedule).

The aim was to gather a sample of HE therapists able to reflect on their CPD so I purposively recruited five volunteer participants (unknown to me), three female and two male (all were Caucasian). Their ages ranged from 38-55 years old (*m=46.5)*, two described themselves as integrative practitioners, one practiced primarily from a psychodynamic perspective and the remaining two were employed as cognitive
behaviour therapists. All five were currently employed in a British university counselling service with more than five years post qualifying experience in the sector. They all fulfilled the selection (inclusion) criteria that included the following:

Over 25 years old
Ability to speak and write in English
Accredited with a reputable organisation e.g. BACP, UKCP, BPS
Currently employed as a Counsellor/Psychotherapist/Psychologist in a University Counselling Service
Post qualification experience within HE of 5 years or more
The exclusion criteria included any interested parties under 25 years old as the intention was to interview mid to long term qualified therapists to gauge their experiences of CPD post qualification. The inability to speak and write in English was an exclusion criterion so as to enable the interview and transcript process to be as accessible and clear, as possible, ensuring participants understood the ethical parameters of the study.

Vulnerability at the telephone selection interview would also have been an exclusion criterion if detected (anxious reaction to recalling experiences, confidentiality issues etc.) to ensure risk to participants was minimised. Not having reached accreditation level with one of the main regulating bodies was again a criterion to ensure the recruitment of experienced therapists. Finally, any therapists known to me were excluded as they may have been influenced by past conversations over the benefits and barriers of CPD and thus would have overtly biased the data reducing validity and thus were excluded.

An email containing the recruitment flyer detailing the research (see Appendix 1 –participant recruitment flyer) was sent to as many therapists as possible via

their Heads of Service (HUCS) mail base as is the current practice in the sector as well as through the British Association for Counselling and Psychotherapy University and Colleges members mail base, of which many higher education therapists are members and active participants of. All five interested participants came through the above route.
Following interest, a pre-selection interview was conducted over the telephone, lasting approximately 10 minutes assessing for suitability and to expose any ethical issues before continuing. I was actively looking for any obvious vulnerability that may appear likely to result in distress and/or conflict, as well as encouraging factors such as interest in the subject, motivation and an openness to participate in research. Participation was deemed a legitimate CPD activity and all participants appeared interested in and motivated to be involved in the research study.

Prior to the agreed interview date, a participant information sheet and consent form was sent to all five volunteer participants (see Appendices: 2 information sheet & 3 -consent form) and an opportunity was offered to debrief on the latter at the start of each of the interviews. The location of interview was subject to each participant's choice, as was the date of interview, in order to facilitate maximum comfort during the 60-minute interview. All participants were given the opportunity for a second post interview debriefing if required and/or requested. No participant requested or required further contact or signposting following the interviews.

Quality Control:
In keeping with the humanistic philosophical foundations of phenomenological inquiry and to be reflexive and transparent within my remit of researcher, my membership to the profession and shared experience of CPD in HE was openly disclosed.

"Qualitative researchers often study concepts or topics that are personally significant and thereby involve themselves in self-examination, significant personal learning and change." (Stiles, 2003).

Throughout the study bracketing was employed (during the gathering, reading and interpretation of the data) to maintain quality and was reinforced by keeping a reflexive journal, alongside supervision of the whole research process (Finlay, 2011) (see Appendix 5 – reflexive statement). The purpose of the reflexive journal was to be able to record immediate impressions and reflections following the interviews and verbatim transcriptions to capture contextual information. These proved invaluable when coding the transcripts and the journal was integral component of a robust audit trail.

Before any of the five interviews took place a practice run with a colleague occurred offering valuable learning on areas, which needed refinement such as re-wording certain questions. Regular supervision and peer review supported the checking process and ensured transparency and replicability of knowledge production. This in turn, helped to ensure that the knowledge produced would resonate with the target audience.

In addition, an independent researcher experienced in thematic analysis was engaged to check my procedure of TA and feedback on the extracted codes and themes derived from the transcripts, ensuring that more than one interpretation had been considered. However, the fact that I (and contributors) had ideas about therapist's experiences of CPD before, during and after the data collection (and participants were aware of my membership of the HE clinical community) means that any pre-knowledge in this study is considered an integral part and 'not necessarily a "disturbance," but instead is viewed as a prerequisite to get to know something' (Rabu et al., 2015:740).

Ethical considerations:

This project was considered by the Metanoia Research Ethics Committee and approved on the 23rd of September 2016. Upon being granted approval by the Metanoia Research Ethics Committee I fully committed to the ethical process consistent with the BACP, BPS and Metanoia & Middlesex University guidelines (see Appendix 6 - stakeholder analysis) throughout the study.

As a registered Independent Commissioners Office (ICO) member, all data was collected, analysed and stored in accordance with the DPA 1998. Private details (names, places etc.) were omitted from the transcriptions and details of the participants in the report writing were changed to ensure anonymity. All participants were allocated a numerical code (see findings section).

Finally, measures were taken to ensure participants were given access to all material collected from them and information of sign posting and support following the telephone interview, actual face to face interview and there on in after should they feel any negative effects from their participation (see appendix 6 -stakeholder analysis - in Appendices).

Findings:

Thematic Analysis (TA) was conducted on all five (three female and 2 male) transcripts (by the main researcher and checked by the external researcher) guided by the premise that " a theme captures something important about the

data in relation to the research question, and represents some level of patterned response or meaning within the data set" (Braun & Clarke, 2006:82).

The research was influenced by my own interest and commitment to CPD, (see the introduction section of this paper), but I did not have a theory about the phenomena. The focus of the research was to formulate a better understanding through the themes identified in the qualitative data analysis. Themes became apparent after familiarising myself with data (re-reading data, paying specific attention to patterns that occurred and noting down initial ideas/patterns from interviews/journal/transcripts).

Generation of the initial codes happened through data reduction (collapsing the data into labels in order to create categories for more reliable analysis) followed by compilation. The latter involved making inferences about what the codes meant, collating codes into themes that accurately depicted the data. Collaboration with the external researcher facilitated an audit ensuring the main themes made sense in relation to the research interview question and data collected. A thematic "map" of the analysis was generated out of these conversations relating to the original codes;

> Theme 1: Commitment to ongoing development of skills & competency

Participant 001, an experienced female therapist who has worked in the sector for over 20 years, responded to the interview questions:

Q: *"Can you tell me in your own words what you consider and understand CPD to be?"*
A: *"Outside of it being an ethical requirement of good practice and continuing accreditation, I think it's an opportunity for me to think about my personal and professional needs to continue to work competently and effectively….to identify areas I need to continue developing or areas that perhaps are new to me…keeping myself up to date with client needs….."* (02:25).

Therapists demonstrated a clear understanding and commitment to undertaking CPD to maintain their skills and competency, in line with expectations of the main accrediting bodies (BACP, UKCP, and BABCP etc.). Reports of high levels of motivation towards personal and professional development above the expected minimum (of 30 hours per annum) were found across the data set. This is in line with the extant literature on therapists' motivation for ongoing development (Fender, 2017; Orlinsky et al., SPR Conference, 2017; Rønnestad and Skovholt, 2013.)

Participant 002, a 42-year-old male therapist with ten years post qualification experience responded to the same question of *"can you tell me in your own words what do you consider and understand CPD to be?"*

A:*"I see it as a kind of process of continuing growth. When I trained to be a therapist I never felt like, right I'm there, I can do this, I always thought it had to be an on-going learning process, so the way I view CPD is a way of ..like …keeping that training ongoing and also connecting with new people, learning new skills, getting and generating new ideas from a range of developmental activities"* (2:48).

All five participants reported engaging in a wide range of personal and professional activities, largely supported by their HE institution in terms of time and cost. Because they all exceeded the expected amount of CPD they rarely formally documented their hours unless requested to by their accrediting body via a random audit or for appraisal forms. This is compatible with other studies (Fender. D, 2015: 2017).
Interestingly when CPD was recorded, all reported documenting the more formal CPD activities (such as certified training days, seminars and conferences) stating that these were perceived to be more legitimate forms of CPD, possibly confirming John McLeod's suggestion of the existence (or at least perception) of a *'hierarchy of knowledge'* (McLeod, 2016). Similarly, David Fender's research conclusion that "…the professional requirement for CPD hours and the strength of the CPD industry encourages therapists…to take courses and workshops", and whilst these may be valuable activities they may not be as valuable as commonly perceived and/or promoted (2017:11).

The commonly held assumption that the formal CPD activities and professional CPD providers, often in association with accrediting and training bodies, are viewed to offer the best quality developmental forums may partly explain the second theme extracted from the data set.

> Theme 2: Practitioner autonomy & consolidation of professional identity

Participant 004, a 45-year-old female therapist with 8 years HE experience, reported;

"CPD and maintaining accreditation helps me to feel part of a wider professional community not just in my place of work (HE)…where often therapists are drawn from a diverse range of backgrounds …some umm..quite different in professional outlooks and training….it helps support ones autonomy".

Working in environments that employ a diverse range of therapists with different levels of experience and perspectives, can be challenging. CPD may provide some therapists with an external safe-space needed to manage such differences (and difficulties) that can arise in multi-disciplinary and modality teams. The support of
therapists' professional autonomy appears strongly correlated with their primary training and/or experience within a specific clinical setting.

Participant 003, a male Cognitive Behaviour Therapist (CBT) in his 40's responded to the question *"Can you describe how CPD has affected you as a practitioner?"* with;

"CPD enables me to feel confident and autonomous about my practice with students…interventions and research based therapeutic tools are continually being improved in CBT…based on researched informed facts not just people's ideas or my ideas like in clinical meetings at work and I like …you know….. having an informed research practice is what makes me the professional I trained to be.." (17:37).

The above participant recounted a recent CPD workshop he'd attended and expressed a need to be *'refreshed with new knowledge' that supported his… CBT based practice'* and this seemed in turn to support his autonomy as a therapist back at work in a HE multi-modality team. The theme of autonomy and consolidation of professional identity was detectable in all five participants' transcripts. The nature of CPD (being external and independently selected by the therapist) seemed to legitimise both the feeling of belonging to extended professional communities as well as their autonomous therapeutic practice with clients.
Participant 001 mentioned that CPD provided *"not just learning skills or practicing skills, but I also quite like these events in terms of connecting more to your peer group…other counsellors..because I have found over the years it can be quite lonely doing counselling…, week to week, day to day, of doing the work with clients and ,yes, you have your team in the university service but it's quite nice to have more of a sense of wider community …of counsellors."*

Professional development activity, according to the data, supports the personal development and/or lived-sense of being a competent professional. All respondents focused on what they personally took away from the activities they attended and in one way or another described the continual learning process involved in what they felt a competent therapist to be. The theme of integrating the personal into the professional is consistent with one of the ten identified developmental themes; theme 10 -*'professional development is a lifelong*

process' - in Rønnestad and Stovholt's seminal work '*The developing practitioner* ', (2013:150).

> Theme 3: Tensions over time, cost and lack of sector specific CPD

The third theme to be identified in this study relates to what therapists' considered barriers to their continuing development. Tensions expressed over 'time and cost' seemed to relate to perceptions about organisational support (or lack of) and action in planning for what would be most beneficial and at what points in the academic calendar. Universities are structured around academic terms or semesters and thus services and their staff often plan their annual leave and CPD activities accordingly. This structure may not necessarily fit with CPD calendar events or preferences.

Equally, many training events are scheduled for weekends to attract more consumers who may not want to miss the opportunity of paid employment (private practitioners) during the week. This can present a challenge for therapists employed in an organisation such as a university counselling service. The question that enquired about support when choosing CPD activities, participant 001 answered as follows;

A: *" I think sometimes there is a subtle tension in the service around training on the weekends…I did my training on a weekend in London which cost more because of travel expenses and was across two days that then meant the loss of 10 clinical hours..and that is going to disrupt the client work particularly as we are busy all year round now…it was never "you can't do it" but subtly culturally there is pressure because you will be out for a period of time" (21:18).*

Participant 005, a female integrative therapist in her 50's, disclosed feeling supported in some aspects of her continuing development, such as partial/full funding negotiations, but not in planning and skills guidance. She felt frustrated as an experienced practitioner not to have more guided help in what would be useful to attend, develop in etc. She states that;

"I've felt supported in some aspects of CPD like sometimes in funding certain workshops, events, etc.… but not really in how it relates to me as a practitioner. I don't think they are aware of what skills I possess. I mean they do have an idea of what I am supposed to do, but they're not the areas I am necessarily weak in in terms of therapeutic practice…in terms of my clinical practice I don't think they know what I am strong or weak on" (19:10).

The same participant acknowledged volunteering for the research study because she was attracted to and interested in the information that related to HE CPD. She had never thought about sector specific CPD before and felt it was very relevant to some of her frustrations about CPD in her current working environment. This she explained in terms of her own continuing growth and competence but also in terms of new recruits to the service from non-educational clinical settings and some of knowledge gaps she detected that concerned her.

"I was intrigued by your research subject choice…CPD in the HE sector and thought that sounded interesting…what exactly is pertinent to HE specifically when often the learning is more general…about a specific presenting factor or intervention….". (31:04).

She went onto to say *"I am aware of the recent unveiling of BACP UC competencies for HE and FE from the mailbase and I know there are grumbles from therapist's but I actually think having standards is really important and from personal experience.. and this may only relate to a minority..but there are people who come and work with this age group who have no knowledge or training of this age and their developmental challenges and lack real understanding of the work therapeutically as well as contextually".*

The last theme combines therapists' reported tensions with time and cost of CPD activity and the lack of CPD that directly relates to the emotional and psychological developmental challenges of students within an academic setting. Psychotherapy research documents, across the spectrum of the counselling professions, that clinicians' frustration with time and cost of learning activity is a known barrier. The decision to combine all three elements was based on the participants in the study perceived barriers with CPD.

However, with hindsight, therapists' concern with a lack of sector-specific CPD, particularly given the current climate in HE (as discussed earlier) and a possible skills deficit, means this ideally should have been deemed a fourth theme. The findings confirm the existing research: reporting a lack of evidence-based knowledge and practice among HE therapists' and this will feature in more detail in the discussion next.

<u>Discussion:</u>

The aim of this qualitative project (PEP) was to explore the role of CPD in UK HE therapists' in relation to their professional development. Better understanding of this complex and resource intense area is needed. The study

confirmed existing research on some of the generic benefits as well as the barriers of the continuing development of therapists';

* That they are committed to the expected ongoing development of their skills and competency and regularly exceed the minimum criteria.
* That they perceive CPD activity in its numerous and varied forms to be an integral part of their professional identity and clinical autonomy.
* That the ongoing challenges/barriers are associated with limited time and costs impacting planning of CPD.
* There appears to be limited sound CPD products related to particular clinical settings and development needs.

The commonly found high level of commitment to continued personal and professional development is a benefit. Mandatory and/or legal professional requirements are more than met but not necessarily as recommended by the accrediting bodies such as BACP, BABCP and UKCP (Fender, 2017). Participants' indicated that given some of the constraining parameters of working within a University (bound by the academic calendar) and the resource intense nature of taking time out of clinical practice for CPD activity often meant it was unplanned and not necessarily relevant to the needs of individuals and/ or the overall development in the team.

The current HE climate of demand outweighing supply further challenges the non-adherence to the recommended 'learning model' of CPD (activity planned as a result of identified development needs). Therapists' increasing caseload influencing their choice of CPD is understandable, but given the rise in risk and severity in the student population, may be unwise. Concerns from participants, related to the changing nature of HE therapists' work and clinical setting (introduction of multi-disciplinary teams to manage risk), were detected.

This could be cause for alarm given this study, among others, Broglia, et al., 2017; Fender, D. 2017), suggests there exists a gap in and/or disorganised approach to professional learning and skills acquisition fit for purpose. Currently there is a lack of the recommended planned approach to CPD (using a learning cycle structure) and CPD options do not appear to be based on identified skills need and/or update/refinement. Instead CPD is largely based on interest, availability and resource.

The Royal College of Psychiatrist's report (CR66, 2011) on student mental health encouraged the maintenance of embedded university support services in the current climate of increased severity and risk. It also reiterated the importance and professional requirement of an evidence base for treatment. If HE therapists are limited (as the current study has found) in the support they

receive to adequately plan and engage in the ongoing training needed for their practice and given little time to develop the suggested benchmarks from outcome data, there is a real of threat to their professional longevity and more immediately their efficacy.

Worryingly, Broglia et al., (2017) found that almost half of participating services (HE/FE/SFC) in their research reported not using a validated clinical measure, concluding "It is difficult to see how some services will be able to survive in the absence of evidence-based outcomes that can be benchmarked against relevant population norms" (2017:11). A small number of university counselling services have not survived and more may follow if the sector is not able to demonstrate the necessary skills for audit and evaluation of expected expertise and service to its community.

The reoccurring theme of needing more resources to implement routine outcome measures (ROM) that inform practice has tended to actualise in new posts in the sector, often targeting professionals with scientist/practitioner training (Counselling Psychologists, CBT clinicians and Mental Health Advisors), which is a benefit to the outlined challenges. However, the issue of some therapists having certain professional knowledge and expertise whilst others do not brings as many internal challenges to clinical teams as solutions.

Furthermore, the issue of integrating clinical evaluation from a different clinical population that may fail to capture the sector specific problems of distressed students highlights the lack of UK HE student population norms there to guide best practice. This further highlights a sector failure in prioritising funding for development and further research in the area.

The current study highlights concerns related to the specific training and development needs of therapists' working in the HE sector. If, as other studies have found (Broglia et al., 2017), there is a significant lack of service evaluation and strategic data collection and utilisation in UK University Counselling Services and, as this pilot study suggests, concerns among therapists about effective planning and support of sector specific training a real gap for future research exists.

Strengths & Limitations:

Limited literature exists on HE therapists' experience of CPD so the current practice evaluation project and any future research to come has the real potential of contributing to clinical development and change. However, caution should be taken when interpreting the PEP findings, as they are not representative of all HE therapists' due the small sample size. Reliability and validity are thus key limitations of the current PEP. This area is addressed in the conclusion/future

considerations section with a view to improvements in methodological design for future research.

Small sample sizes in research inevitably reduce credibility because interested participants are more likely to take part than those who are not. Perhaps this is a built-in confirmation bias. This factor further reduces validity, as interested respondents are more likely to confirm researchers' beliefs and bias any findings. Qualitative research methods are open to criticism because of the subjective (open to bias and non-representative) dual role of researcher-therapist despite the quality controls employed. However, the more researchers that adopt qualitative methodology and utilise good quality controls the more status is accrued to the method (Morrow-Bradley & Elliott, 1986).

Measures were taken in this project to adopt 'good enough quality controls' and the data did confirm some of my beliefs. Cynicism aside, any value the data may contribute to HE therapists' awareness of current continuing development issues could be because of the role of insider-researcher. Although this role can disadvantage the integrity of data from the traditional scientific perspective, it can also serve as and 'interpersonal source' of knowledge, which if made accessible to other therapists, can make an impact.

Interpersonal sources of influence (knowledge), as suggested by Rønnestad & Skovholt, (2013), can propel personal and professional development by initiating collective thinking and conversation. The current data whilst non-representative can also contribute towards an improved research design and focus. The theme relating to the perceived lack of time/cost and inaccessible/inadequate CPD provision for particular clinical settings inevitably could influence further investigations. It also exposes the politics of the 'marketisation' of education.

CPD, like the education sector, could be accused of becoming driven by the need to maximise 'profit' and minimise cost impacting quality and provision. CPD is a business in its own right, and therefore providers have an interest that differs from therapists, their organisations and professional statutes. Equally, CPD sanctioned by the institution might well benefit the needs of the institution at the expense of meaningful professional development for the therapists. The question of who is benefiting from current CPD provision could potentially reveal some uncomfortable truths.

This study has provided ample opportunity to learn and consider questions relating to HE therapist development and practice, notwithstanding my own. Since beginning the project I have re-joined the BACP UC Executive Committee (June, 2017). One of the areas I am spearheading on the committee

is the establishment of the BACP UC Practice Research Network (BACP UC PRN). Practice-based research developed through a sector specific practitioner's network (BACP UC PRN) could provide an accessible platform for engaging HE therapists' in research led knowledge. This knowledge could be directly relevant to therapist practice because it is developed by insider-researchers working in the shared clinical context and encountering similar concerns and complexities (Henton, 2012).

The acceptance of my PEP research for the brief papers/poster section at the Society for Psychotherapy Research (SPR) Conference, (Oxford, 2017) has added credibility to both the pursuit of a university and college practice research network (UC PRN) and interest in further research. A discussion, between the joint BACP Head of Research and myself recently took place. Both the establishment of a UC PRN and research collating the outcome data held in the sector, to assess feasibility of developing UK student population norms are currently under discussion. The process of undertaking this research has opened up my own and others affiliation with an area of practice sadly under-represented and unsupported institutionally yet so vital to our continuing development, endurance and efficacy as professionals.

<u>Conclusion and Future Considerations:</u>
The findings from the current study contribute a snapshot of HE therapists' professional development. The data has highlighted therapists concerns about the lack of sector specific knowledge and research in current CPD provision. Fears relating to a possible growing deficit in clinical evidence-based practice have now been somewhat substantiated by the recent publication of research calling for more attention to the area (Broglia et al., 2017).
With more information and further improvements in organisational knowledge (evidence based on training needs of therapists', allocation of resources, etc.) and behaviours (adoption of CPD sector specific framework, evaluation of Supervisors' role, etc.) the role of CPD could begin to be strategically considered and implemented.

The current data supports the feasibility of a future research study; one that is validated by a larger population to both enhance credibility and impact the target audience. To achieve this a Mixed Methods design (Creswell, 2015) has been considered combining quantitative and qualitative analysis. This methodology is better positioned to influence a broader audience and achieve a greater reflective and credible data set. This perspective would take a pluralist approach based on pragmatism over the limitations of paradigmism (Cooper & McLeod, 2011). The research focus leans towards practice and process/relations rather than epistemological foundations.

Mixed Method research is gaining popularity primarily because it addresses the deficits of any single methodological approach. By using both the research achieves greater validity, attention and therefore influence. Making an impact is an integral criterion of the PEP and the Doctorate in Psychotherapy (by Professional Studies). My commitment is to attempt to impact the sector by continuing to join those committed to raising awareness through research, publication, and network and committee collaboration in the hope that this will eventually lead to changes in clinical practice.

The processes' involved in supporting HE therapists' to continue to learn to develop professionally are clearly complex. CPD, supervision, peer review, professional regulation criteria, research and organisational management are influential components. Likewise, relational activities and development such as personal therapy, art, and cultural influences, equally impact therapist's ability to relate to their clients and practice effectively. Further research, into what enhances and refines therapists' practice in a rapidly changing environment in any area above, merits attention.

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Appendix contents:

1. Recruitment flyer

2. Participant information sheet

3. Participant consent form

4. Interview schedule

5. Reflexive Statement

6. Stakeholder Analysis (ethical considerations)

7. Signed Ethics Committee Form

8. Poster accepted and presented at the Society for Psychotherapy Research (SPR) Conference, Oxford University September 20th-22nd, 2017

Appendix 1 – example of participant recruitment flyer

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY
Doctorate in Psychotherapy Research Project

PARTICIPANTS NEEDED FOR RESEARCH EXPLORING THERAPISTS EXPERIENCE OF CONTINUING PROFESSIONAL DEVELOPMENT (CPD) IN HIGHER EDUCATION

Therapists are invited to take part in a study investigating their experiences of continuing professional development (CPD). Participation is voluntary and consent dependent upon the individual's choice to continue.
You would be asked to complete: a 60 minute recorded semi- structured interview at your choice of location and prior to interview to reflect on a recent CPD activity.
Your participation would involve the interview, thinking of & writing comments on the CPD activity, reading and feedback on your transcript before research completion and can be included in your CPD log for re-accreditation.

For more information about this study, or to take part, please contact:
Afra Turner - email: afra.turner@metanoia.ac.uk

This research project is being supervised by the following Metanoia Institute staff
Dr Ruth Caleb: ruth.caleb@brunel.ac.uk
Dr Stephen Goss: s.goss@metanoia.ac.uk

This study was approved by the Ethics Committee at the Metanoia Institute Research Ethics Committee, Metanoia Institute & Middlesex University on 23rd of September 2016.

If you would like to complain about any aspect of the study, please contact Metanoia Institute, 13 North Common Road, London W5 2QB Tel: 0044-208 – 57

Appendix 2 – example of participant information sheet

Metanoia Institute and Middlesex University

PARTICIPANT INFORMATION SHEET

Research Title: ***Learning to continue to develop professionally:*** *An exploration of therapists experience of continuing professional development (CPD) in a Higher Education (HE) setting.*

Invitation to take part: Thank you for your interest in the present study. The current research project is concerned with exploring the experiences of therapists continuing professional development (CPD) that they undertake as part of their professional practice in the Higher Education sector. Research into how CPD translates to clinical practice is restricted to quantitive self-report measures and this study hopes to contribute to the qualitative literature emphasising therapists experiences – the barriers and benefits - of CPD activity and specifically report any common factors found of therapists working in the Higher Education sector to improve the translation of CPD to practice.

Purpose: Your participation in the study contributes to strengthening our understanding of the role of CPD on practice and plays an important part in providing updated insight into the process of this phenomenon given the rapid changes in HE. Limited resources and increasing demand often dictate the CPD activity undertaken and this is an opportunity to gauge the therapists view on what supports their practice/learning and what does not. Following the recorded interview, experiences will be transcribed for analysis. A copy of the transcript will then be sent to you for comments and permission to continue. At this stage if you are not happy you are free to change, omit or withdraw your contributions from the project.

Confidentiality: All information gathered will be kept strictly confidential and all identifiable information coded for anonymity. Your anonymity as a participant is therefore assured in the writing up of this study as well as in any future publications.

Participation: All participants are free to choose to take part in the study and to also to withdraw at any time and/or change and amend their contributions if they choose too. A consent form will be given for all participants to sign. If you do wish to withdraw from this study, please contact the researcher and quote your participant code, found in right hand corner of consent form. This will enable your participation to be identified and your data securely removed from the research.

This study is subject to approval under the procedures of the Metanoia Institute Ethics Committee. If you have any further questions or concerns about your participation in this study, please contact the principle researcher Afra Turner at afra.turner@metanoia.ac.uk or the Supervisor, Dr Ruth Caleb at ruth.caleb@brunel.ac.uk.

Your participation is greatly appreciated and a valuable contribution to furthering our understanding of CPD & what improvements may be necessary and can be included as a CPD activity

Appendix 3– example of participant process consent form sent to participant/s

Metanoia Institute and Middlesex University
PARTICIPANT CONSENT FORM

Participant Identification Code:
Title of Project:
Learning to continue to develop professionally: *An exploration of therapists experience of continuing professional development (CPD) in a Higher Education (HE) setting.*

Name of Researcher: **Afra Turner**
Name of Supervisor/s: **Dr Ruth Caleb**

Please initial box

---1.	I confirm that I have read and understand the information sheet dated ....……………………for the above study and have had the opportunity to ask questions.	***
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.	
3.	I give permission for the researcher to contact me via email and/or telephone. And I understand that an encrypted questionnaire will be sent to me for return before the interview asking for demographic information and reflections on a recent CPD activity.	
4.	I understand that my interview will be taped and subsequently transcribed and that all data will be stored, analysed and reported in accordance with the Data Protection Act, 1998.	
5.	I agree to take part in the above study.	
6.	I agree that this form that bears my name and signature and may be seen by a Designated auditor.	

Name of participant	Date	Signature
Name of person taking consent	Date	Signature
Researcher	Date	Signature

Appendix 4 – example of interview schedule

Interview Schedule

Firstly to remind all participants that they may change, stop and withdraw fully from the interview process at any point during the 60 minute interview. Whilst there is minimal risk of any distress or harm resulting from the interview process or participating in any aspect of the research I would like to remind all participants that there will be an opportunity to debrief after the interview with myself and/or be sign posted to an independent therapeutic environment if requested.

The following questions have been designed to explore participants experiences of recent CPD activity undertaken as part of their professional duty as an employed HE therapist. CPD comes in many forms and takes place in numerous formats and locations. It is the choice of the participant to recall any experience that they wish to explore, holding in mind the value, indifference and/or barriers they may have felt and their understanding of how it may or may not impact their practice as a HE therapists involved in collaborative service delivery. All identifying details will be anonymised.

Can you tell me in your own words what you consider and understand CPD to be?
Are you able to recall a recent CPD activity?
How would you describe the impact of the CPD on you as a practitioner?
What was most significant and how do you feel you integrated this into your current work?
What was your recalled experience like in relation to other CPD activities
How do you feel about yourself as a therapist in relation to learning support & practice development and personal growth and professional expectations
Do you feel you are supported to develop to meet the needs of your practice

Appendix 5 – reflexive statement

Reflexive Statement of Intent

In committing to undertake good qualitative research and demonstrate reflexivity, I intend to follow L Finlay (2011) advocation of research being **relevan**t, **rigorous**, **reflexive** and having **resonance** as much as is possible for a novice researcher.

In undertaking the position of researcher, conducting a pilot study into HE therapists experience of CPD, in addition to my clinical role as an employed Higher Education Psychotherapist, I hold a dual position. My researcher-practitioner status requires transparency from the outset and I will at all times throughout the research process convey my position, experience (Conference organizer for BACP 1999-2003), bias's and assumptions (possible need for CPD framework to ensure equity of resource etc.) both as an intrinsic part of the research design and analysis and in holding an ethical stance with involved stakeholders (including my own self-care) (Etherington, 2004).

The measures adopted to ensure trustworthiness and quality (Tong, et al., 2011) will be applied throughout the research and continue post-dissemination. Supervision, peer review, therapy and journaling will ensure I am adequately supported and able to meet the aforementioned.

Appendix 6– example of Stakeholder Analysis completed in preparation for Ethical Committee Approval

Stakeholder	**Risk/Benefit Ratio**	**Management of risk to acceptable level**
Participant	There are minimal anticipated risks to participants in this study. However, emotional upheaval as result of recalling any disappointing &/or negative experiences may occur and provision has been made for such a situation. vs Participation in research can enable personal satisfaction & learning/insight. Research supports the view that interviews can be useful for participants (McLeod, 2011). CPD gained from participating is deemed a direct benefit.	Adopting the concept of process consent (Munhall, 1989), the researcher will be sensitive to checking on participant's consent and record in reflective journal of interviewers experience. All participants will aware that their accounts will be transcribed & any potential impact on them. If any distress occurs they will be offered a debrief with me & signposted to appropriate support services if required. In addition they will have the opportunity to change, omit and/or withdraw from research from initial participant info. sheet & consent form until final debrief pre-publication.
Persons & Institution/training providers identified in CPD audit or by participant during recorded interview	Any distress or upset experienced by a reader other than the participant such as * identifiable people & institutions * Pejorative comments about CPD providers vs Value of research in contributing to understanding the phenomenon of CPD better	Participants will be given final accounts to read and made aware before publication of the risk that identifiable people may read the final product and to anonymise further or omit if not able to protect the identity of others/sites.
Researcher	Stress caused by: *Dual roles of researcher & therapist = crisis in confidence *Immersion in data analysis	Researcher will factor in de-brief sessions with Academic Advisor/supervisor/colleagues & peers

	* Extenuating circumstances Vs Enhancing skills and contributing to qualitative literature & final	Researcher will consult with expert support during analysis process & write up Reflexive journal accounts kept throughout to learn and reflect from

Appendix 7 –Research Ethics Committee Form submitted for Ethical Committee Approval

Purpose of this form

This form is reviewed by the Research Ethics Committee in order to assess the ethical implications of your research project and your response to these implications. The research cannot proceed until ethical approval has been obtained. Applicants may be asked to review and re-submit this form in the light of the Research Ethics Committee's decision regarding whether ethical issues have been adequately identified and addressed prior to starting the research work.

DETAILS OF APPLICANT AND RESEARCH SUPERVISOR

Applicant's name: Afra Turner

1.2. Email address: afra.turner@metanoia.ac.uk

1.3. Telephone number: 07931993118

1.4. Research supervisor(s) name, qualifications and contact details:

Dr Ruth Caleb DPsych (Metanoia Institute / Middlesex University). B Sc Psychology with Sociology, PgDiploma Research studies (Thames Valley University)

Email: ruth.caleb@brunel.ac.uk

1.5 Institution/contact details (if applicable):

Brunel Counselling Service
Brunel University London
Kingston Lane, Uxbridge,
Middlesex UB8 3PH

Tel: + 44 (0) 1895265070

1.6 Do you have any external funding for this project? NO
If yes, please provide brief details including the name of the funding body:

1.7. Project title: ***Learning to continue to develop professionally:***

An exploration of therapists' experience of continuing professional development (CPD) in a Higher Education (HE) setting.

ETHICAL CONSIDERATIONS

	YES	***NO***	***N/A***
1. Will you describe the research procedures in advance to participants so that they are informed about what to expect? Please attach a copy of any recruitment letters and information sheet to be used.	***Yes–see participant information sheet: Appendix ii***		
2. Is the project based on voluntary participation?	***Yes–see consent form: Appendix iii***		
3. Will you obtain written consent for participation?	***Yes-see consent form: Appendix iii***		
4. If the research is observational, will you ask participants for their consent to being observed?			***n/a***
5. Will you tell participants that they may withdraw from the research at any time and for any reason and inform them of how they may withdraw?	***Yes-see Appendix ii & iii***		
6. Will you ensure that participants are not subtly induced, either to participate initially, or to remain in the project?	***Yes-see reflexive statement- Appendix v***		
7. Will you give participants the option of omitting questions from interviews or questionnaires that they do not want to answer?	***Yes-see all appendix above***		
8. Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	***Yes-see consent form Appendix iii***		
9. Have you made provision for the safe-keeping of written data or video/audio recordings?	***Yes-see consent form: Appendix iii***		

10. Will you debrief participants at the end of their participation?	***Yes-see info. Sheet, consent form, stakeholder analysis: Appendices ii,iii,vi***		
11. Have you ensured that your research is culture/belief/ social system sensitive and that every precaution has been taken to ensure the dignity, respect and safety of the participants?	***Yes-see all Appendices***		

Note: The items below cover all of those in the A/B categories of Middlesex University

If you have answered 'NO' to any of the questions listed in 1 to 12 above, then please provide further details on a separate page and attach it to this application.

	YES	NO	N/A
12. Is there a realistic risk of any participant experiencing either physical or psychological distress or discomfort? If YES, what will you tell them to do if they should experience any problems (e.g. who they can contact for help.)	***Yes-see Appendix vi-stakeholder analysis***		
13. Is there an existing relationship between the researcher and any of the research participants? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		***No***	
14. Your research does not involve offering inducement to participate (e.g. payment or other reward)? If YES, please describe the ethical implications and the safeguards in place to minimise risks.		***No***	

15. Will the project involve working with children under 16 years of age? If YES, please describe parental consent and safeguarding procedures.		***No***	
16. Will your project involve deliberately misleading participants in any way? If YES, please explain why this is necessary.		***No***	
17. Will you need to obtain ethical approval from any other organisation or source? If YES, please attach letter confirming their ethical approval.		***No***	
18. Are there any other ethical considerations in relation to your project that you wish to bring to the attention of the Research Ethics Committee that are not covered by the above? If YES, please describe on a separate sheet.		***No***	

If you have answered 'YES' to any of the questions listed under 13 to 18 above, then please provide further details on a separate page and attach it to this application.

CANDIDATE DECLARATION

I have read the BACP and the BPS guidelines for ethical practices in research and have discussed this project with my research supervisor in the context of these guidelines. I confirm that I have also undertaken a risk assessment with my research supervisor:

Signed*: Afra Turner*

Print name………....Afra Turner………………....….......Date…21.07.2016…....……
(Applicant)

RESEARCH SUPERVISOR DECLARATION

As supervisor or principal investigator for this research study I understand that it is my responsibility to ensure that researchers/candidates under my supervision undertake a risk assessment to ensure that health and safety of themselves, participants and others is not jeopardised during the course of this study.

I confirm that I have seen and signed a risk assessment for this research study and to the best of my knowledge appropriate action has been taken to minimise any identified risks or hazards.
I understand that, where applicable, it is my responsibility to ensure that the study is conducted in a manner that is consistent with the World Medical Association Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (see http://www.wma.net/e/policy/b3.htm).
I confirm that I have reviewed all of the information submitted as part of this research ethics application.
I agree to participate in committee's auditing procedures for research studies if requested.

Signed:……Ruth Caleb…………………………......

Print name…. Ruth Caleb

STATEMENT OF ETHICAL APPROVAL

This project has been considered by the Metanoia Research Ethics Committee and is now approved.

Signed:…………………………….......Print name……………………….........….
Date……....……
(On behalf of the Metanoia Research Ethics Committee)

Please note that the Metanoia Research Committee meets twice during each academic year. Submissions between these meetings are dealt with by chair's action in consultation with one other committee member. All applications are acknowledged in writing and considered at the bi-annual Metanoia Research Committee meeting.

Appendix 8 - Scanned Poster Presentation from SPR Conference, Oxford, Sept. 20-22nd 2017

Therapists Experience of Continuing Professional Development in a Higher Education Setting - a pilot study.

Afra Turner (primary author),
Dr Stephen Goss and
Dr Ruth Caleb,
Middlesex University and Metanoia Institute, London

Background:

- The purpose of this qualitative study was to gain insight into how higher education (HE) therapists' experience, and make sense of, continuing professional development (CPD) to better understand the current practice-development gap, against a context of increasing research awareness and activity within the counselling professions.
- All accredited therapists are required to undertake regular CPD activity to maintain and develop their knowledge, skills and personal qualities for safe and effective practice.
- However, there seems to be little evidence that CPD reliably improves clinical practice and, more importantly, a growing concern that a widening gap be

Methodology:

Following a literature review that explored the salient themes in the field five structured audio-recorded interviews were conducted to derive 'lived exper accounts of HE therapists CPD activity.

Participants' (3 female and two male), transcripts were analyzed using thematic analysis (Braun & Clarke, 2006) to identify common themes across the data set and gauge the concerns of practice based therapists current professional development.

Three major themes emerged out of 11 minor ones extracted by the lead researcher and an external data consultant:

Limitations:

This is a small scale pilot study limited by time and resources. The sample size was restricted to five participants to ensure manageability of data. Furthermore, the research was conducted by a Doctoral student undertaken to assess feasibility and the methodological design of a larger more in-depth investigation in to the area, thus reducing generalizability. Bracketing was applied throughout with the use of a reflexive journal and an external data analyst and supervision however the researcher is a University therapist undertaking regular CPD. The results are intended to be informative and transferable within therapeutic and qualitative research practice.

Findings:

In addition to the study providing a platform for participants to feedback their experiences in a practice based research context, the data collected suggested therapists motivation and commitment was strong, a finding consistent with the extant literature (Castonguay et al, 2013; Fender, 2014; 2017; McLeod, 2016).

Concerns were expressed about the generalizability of CPD activities to specific clinical settings, in this case HE, particularly given the expansion of multi-disciplinary services.

The data highlighted a lack of sector-specific knowledge and research in current CPD provision. Implications for future research considers the question, could sector-specific CPD (research explicitly related to working with student populations), improve clinical practice by engaging therapists in knowledge specific to their clinical setting?

Furthermore, the proposal of the development of a HE practice research network (PRN) may be a useful framework for such knowledge

Conclusions:

Further research in this area may usefully inform the training needs and knowledge base for university and further education college's therapists.
Practitioners working in individual clinical settings may benefit from more widely available provision of sector-specific CPD.
The development of CPD 'products', backed up with sound, practice-based research could make a difference to professionals utilizing existing expertise and engaging more frequently in new emerging research knowledge within their clinical setting and generally.
The development of a HE practice research network (HE) could provide a framework for developing, disseminating and encouraging engagement in research practice an essential part of best professional practice.

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Contact details: For further information contact lead author Afra Turner at afra.turner@metanoia.ac.uk

For information on the DPsych (Professional Studies) offered by the Metanoia Institute please contact Dr Stephen Goss at stephen.goss@metanoia.ac.uk
Background artwork © Christine Stevens from the cover of *Making Research Matter*, S. Goss and C. Stevens (Eds) (2016) London: Routledge.

Appendix 2

Poster Presentation from Society for Psychotherapy Research Conference

Appendix 3

Sample of UCC journal column

Notes from the Chair of research SIG

After months of coronavirus restrictions and a radical change in most therapists' counselling practice, it is a welcome task to stand back and reflect on the work of student counselling: to celebrate the profession's continual ability to creatively adapt to change. Our collective response to the pandemic is an example *par excellence* of the resilience and resourcefulness of services and practitioners, and these qualities shine through time and again in our continuing evolution as a profession.

This year marks 50 years of the professional representation of student counselling. The Association for Student Counselling (ASC) – founded in 1970 – subsequently became BAC and then later BACP, and is now the largest professional body for therapists working in UK further education, sixth form colleges and universities.

Throughout 50 years of BACP UC (formerly AUCC), there has been considerable evidence of the profession's ability to adapt to the demands of context-specific and wider sociocultural pressures. The range of progressive benefits for UC members – including the competences framework, *University & College Counselling* journal articles, and the JISCMailbase, to name but a few – show a deep commitment to championing the work of student counselling in the face of increasing complexity, challenge and scrutiny.

Much of the divisional work undertaken, irrespective of changes in name, structure and/or strategic objectives, demonstrates an ongoing commitment to represent the profession at local, national and international levels, and to respond to new and ever-increasing demands of working and delivering effective support to an increasingly diverse student population in a 21st century institutional culture, often driven by principles of marketisation.

What stands out very poignantly when reviewing the literature, published reports and guidance of the last decades is the huge contribution that BACP and BACP UC divisional members have made to this body of work – more often than not, in a voluntary capacity. Over the five decades, there have been numerous books, journals and peer-reviewed articles dedicated to the nuances of student counselling. All serve as an archive – the historic documentation of hard, work-based conundrums responded to time and again, whether as a result of a changing student profile, more complex mental health needs, or by developing creative forms of support, with minimal resources, in response to institutional need. The work quietly and consistently continues to rise to such demands, and often tolerates a lack of expressed appreciation from the institutions we serve – much as in therapy. As current Chair (2018–2021) of the Research special interest group, I'm proud to be part of a growing commitment within our profession to undertake the research that will underpin our work and reputation as we move forward from this significant milestone in our collective history.

It is important for us all to take this moment of reaching half a century, to celebrate belonging to, and collaborating among, such an innovative community.

Afra Turner
Chair of BACP Universities & Colleges Research SIG, CBT and psychodynamic psychotherapist and supervisor, BABCP and MBACP accredited, Kings College London
afra.turner@kcl.ac.uk

Appendix 4

BACP UC Conference Flyer

bacp | counselling changes lives

Working with research in practice - univeristies and colleges conference | Thursday 13 June | University of Cambridge

We often hear that it's important to use evidence-based interventions to inform our practice, but what does this mean when you work in a university or college?

To help us explore this topic, we'll be joined by practitioners and research professionals to discuss practical implications of the latest, ground breaking research, from our sector.

Visit the website for the programme, prices and booking.

Join us for a packed day of insightful presentations

Psychology in the era of evidence-based practice

Hear Dr Felicitas Rost talking about psychotherapy in the era of evidence-based practice, challenging its subordination to medical science and calling upon the need to build bridges between research methodologies.

Appendix 5

SCORE Article

Received: 11 November 2018 | Accepted: 17 April 2019

DOI: 10.1002/capr.12227

PERSPECTIVES

WILEY

Towards an evidence-base for student wellbeing and mental health: Definitions, developmental transitions and data sets

Michael Barkham[1] | Emma Broglia[2,3] | Géraldine Dufour[4] | Mark Fudge[5] | Louise Knowles[3] | Alan Percy[6] | Afra Turner[7] | Charlotte Williams[8] | on behalf of the SCORE Consortium*

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Abstract

Against a background of huge changes in the world of university and college students since the turn of the millennium, together with a multitude of reports on student mental health/wellbeing, this article argues that the field of student mental health is hampered by the imprecise use of terms, a rush to action by universities in the absence of a robust evidence-base, and a lack of overall coordination and collaboration in the collection and use of data. In response, we argue for clearer and more consistent use of definitions of, as well as differentiations between, student wellbeing and mental health, for a longitudinal approach to the student body that captures their developmental transitions to and through university, and a strategic and systematic approach to the use of bona fide measures in the collection of data on wellbeing and on the process of outcomes in embedded university counselling services. Such a coordinated approach will provide the necessary evidence-base upon which to develop and deliver appropriate support and interventions to underpin and enhance the quality of students' lives and learning while at university or college.

KEYWORDS

student mental health, wellbeing, university embedded counselling services, transitions, outcome measures

1 | INTRODUCTION

The mental health of students in national and international higher education (HE) settings is recognised as an important public health issue (e.g., Brown, 2016; Holm-Hadulla & Koutsoukou-Argyraki, 2015; also see comprehensive review by Sharp & Theiler, 2018). A range of organisations in Australia (Orygen & The National Centre of Excellence in Youth Mental Health, 2017), Canada (Beckett, Bertolo, MacCabe, & Tulk, 2018) and the US (American College Health Association, 2018) have produced reports raising concerns about students' wellbeing and mental health, in addition to reports and surveys published in the UK—for example The Insight Network and Dig-in (2019)—and also recent special issues of journals devoted to student mental health (see Brown, 2018; Cuijpers et al., 2019a). In the UK, key initiatives have included funding from UK Research and Innovation to support a research network focusing specifically on student mental health (see Student Mental Health Research Network; SMarTeN, https://www.smarten.org.uk/), as well as a 2018 government-initiated directive to establish a University Mental Health Charter (Student Minds, 2018; https://www.studentminds.org.uk/charter.html).

In the UK, the student's world has changed radically since the millennium with the advent, amongst other things, of tuition fees in 1998 and their subsequent rise to current levels (Universities & Colleges Admissions Service, 2017), the advent of widening

*Student Counselling Outcomes, Research & Evaluation Consortium.

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participation (e.g., Woodrow, 2000), and the early signs of student debt and its relation to mental health (e.g., Cooke, Barkham, Audin, Bradley, & Davy, 2004). Over time, there has been a steady increase in demand for student counselling services (e.g., Thorley, 2017), together with a parallel trend to outsourcing counselling services in the HE sector (see Lightfoot, 2018) and closures of some counselling services in further education (see Caleb, 2014). But against the tensions and debates surrounding such issues, it has been the national attention on student suicides that has particularly sharpened the focus of late (see Clarke, Mikulenaite, & de Pury, 2018).

Set against this background, the present article provides a perspective focusing on three specific aspects. First, we argue for greater clarity in *definitions*, as the blurring in terminology along the wellbeing–mental health continuum is problematic. Second, we consider the need for a clear focus on the *developmental transitions* of pupils from school, or elsewhere for those mature students returning to university or starting later in life to study. Third, we argue for the strategic and coordinated collection of quality *data sets* to provide an evidence-based approach to student mental health and wellbeing and for such an evidence base to inform service and policy decisions.

2 | DEFINITIONS: PSYCHOLOGICAL WELLBEING AND MENTAL HEALTH

In order to shape services that are fit for purpose, there first needs to be clarity regarding terminology and a differentiated focus of effort. There is a danger that using generic terms that attempt to capture the full range of student issues and experiences actually conflate substantially different student populations (see Hewitt, 2019). Much of the initiative and effort in recent years has focused on student wellbeing, which can be viewed as a population-based term targeting positive feelings about oneself and reflecting an inner capacity—a resourcefulness—to deal with the pressures and challenges of student life and learning. Examples of such programmes have centred on resilience and/or mindfulness in university settings and have been carried out in the US (e.g., Ramasubramanian, 2017) and the UK (e.g., Galante et al., 2018; Roulston, Montgomery, Campbell, & Davidson, 2018). But while programmes focusing on wellbeing are logical as part of a coordinated approach to the overall health of students, it has been argued by some prominent figures that various aspects, such as wellbeing campaigns, raise demands and place existing resources under strain (e.g., see Arie, 2017). Crucially, wellbeing programmes alone are not designed to address mental health issues experienced by those students most at risk. In contrast to wellbeing, mental health issues and psychological distress pertain to a subgroup of the student population where specific issues are having a negative impact on the person (e.g., excessive worry, panic, depression, isolation) and who do not feel they have the inner capacity to address these experiences.

Data on student wellbeing and mental health are informative but also problematic. In the UK, the *Student Academic Experience Survey* (Neves & Hillman, 2018; Neves & Hillman, 2019) utilised four wellbeing items designed by the Office for National Statistics (ONS) and referred to as the ONS4 (ONS, 2018a) tapping four key areas: life satisfaction, (things in a person's life that are) worthwhile, happiness and low anxiety. The data over successive years show students' wellbeing to be lower than a comparative sample of age-matched non-students, but having stabilised with the exception of low levels of anxiety. While such comparative data are useful, reliance on single-item questions and a focus on rating happiness and low anxiety in relation to "yesterday" raises methodological concerns. Further data from the UK have reported mental health issues to be rising from 0.4% in 2007–2008 (Equality Challenge Unit, 2014), to 1.3% in 2013–2014 (Equality Challenge Unit, 2017) and to 2.5% in 2016–2017 (Advance HE, 2018), an almost sixfold increase over this time period. But in another survey focusing on loneliness, 45.5% of a student sample reported mental health as one of their top three concerns (Trendence UK, 2019). Again, while the results provide a perspective, the use of the term mental health *issues* and the fact that the sample comprised 1615 students drawn from 103 universities—a theoretical mean of 15 students per institution—gives rise to concerns about the sampling frame and generalisability of the findings. However, a much larger annual survey comprising a sample of 37,544 UK students from 140 institutions reported that 21% of students endorsed an item stating that they had been diagnosed with a mental health condition, presumably at some point in their life (The Insight Network & Dig-In, 2019). It also reported that 3.9% of students reported developing a mental health *condition* (not diagnosis) while at university.

While the trend of all these accounts points to a rise in the awareness and occurrence of mental health within the student population, three observations are worth noting. First, all samples are self-selecting, and it may be that students who complete such surveys—irrespective of their responses—are not representative of the wider population of students. Even the larger sample of 37,544 from the Insight Network and Dig-In survey only represents approximately 1.6% of the UK student population. Second, each survey uses different terms: wellbeing, psychological distress, mental health issues, mental health condition and mental health diagnosis. Third, all the surveys utilise single-item indices, including the ONS4, to draw conclusions about differing aspects of students' lives, as opposed to employing a bona fide psychological measure.

Hence, the field is populated with a multitude of disconnected survey-based reports yielding differing estimates of student wellbeing/mental illness with no strategy for linking and combining data. In addition, there are poorly designed polls of students' health and resulting rates of mental health issues reported in the national press (Arie, 2017). The result is pressure on universities to respond with a rush to action by implementing policies and actions that are well-intended but not necessarily evidence-based (Nunez-Mulder, 2018).

A different approach has been taken in the WHO World Mental Health International College Student (WMH-ICS) initiative which takes its starting point in the collection, analysis and dissemination of epidemiological information using bona fide instruments on student mental health and targeting a defined sampling frame of

students (see Cuijpers et al., 2019b). Based on a sample of 13,984 students with a weighted mean response rate of 45.5%, Bruffaerts et al. (2019) reported the lifetime prevalence of depression and anxiety to be 21.2% and 18.6%, respectively. These rates were closely mirrored in the prevalence rates for the past 12-month prevalence for depression and anxiety (18.5% and 16.7% respectively). For students meeting a lifetime or 12-month prevalence criteria for any mental health disorder, 19.8% and 11.3% received treatment. In an earlier study in this major initiative, Auerbach et al. (2016; see also Auerbach et al., 2018) concluded that these psychological problems resulted from a complex set of risk factors including academic stress, financial strain, exposure to adverse life events, difficulties transitioning towards independence, difficult cultural adjustment for international students and other pressures. Poor mental health was, in turn, associated with disability and lower academic achievement and the potential escalation in risk of suicide in vulnerable individuals.

Suicide is, by definition, the single worst indicator regarding student mental health. There is understandable concern about student suicide rates that have instigated multiple initiatives at local university and national levels (e.g., Batterham, Calear, & Christensen, 2013; Farrell, Kapur, While, Appleby, & Windfuhr, 2016). As disturbing as this phenomenon is, however, results derived from the ONS show that between the 12 months ending July 2013 and the 12 months ending July 2016, HE students in England and Wales had a significantly lower suicide rate (per 100,000) compared with the general population of similar ages: 2.8 versus 6.7 (age >20); 4.9 versus 8.7 (21–24); 6.1 versus 9.2 (25–29); and 6.0 versus 12.9 (>30) (ONS, 2018b). Hence, prevalence rates of mental health using *diagnostic* tools suggest students are akin to age-matched adults and the rates of suicide show they are *proportionately* less vulnerable as compared with matched age groups. However, student suicides draw heightened media attention that is not shared when such events occur to young adults not at university.

3 | DEVELOPMENTAL TRANSITIONS

Given the state of evidence, what is absent is the collection of high-quality data using bona fide measures that differentiate between wellbeing and mental health and that are then considered beside both contextual and historical data. Such data would help progress our understanding of student mental health and enable the design and resourcing of evidence-based interventions and support systems that are strategically joined up in order to address student mental and psychological health.

The evidence that many of the issues experienced by university students pre-date their entry to university/college suggests that a generic diathesis-stress model (Monroe & Simons, 1991) provides a useful framework for delivering a joined-up approach to student mental health. One logical consequence of this model is that there needs to be a strategic focus on student health *prior* to university. Research efforts need to move back into 6th form colleges, further education establishments and other varied routes into universities, including the workplace for mature applicants, and place the process of developmental transition at the centre of any national student mental health and wellbeing strategy. Joining up research between these varied routes into universities enables this transition to be investigated. Such preparatory work is crucial as it is known from a UK cohort study that while levels of psychological distress rise on entering university and then fluctuate during the course of the time at university, on average they never return to pre-university levels (Bewick, Koutsopoulou, Miles, Slaa, & Barkham, 2010).

The focus on this pre-transition to university stage is, particularly in relation to younger people, a public health issue, and programmes can focus on the promotion of good mental health amongst young people in general (e.g., Sommers-Flanagan, Barrett-Hakanson, Clarke, & Sommers-Flanagan, 2000). In the UK, the Scottish government has committed to additional new counsellors for schools, colleges and universities (Scottish Government, 2018) while the Welsh government has a track record of investing in school counselling along with the use of standard outcome measurement (Welsh Government, 2013). Once at university or college, there is evidence from meta-analytic studies for the effectiveness of cognitive behavioural therapy and mindfulness interventions for depression and anxiety in students (Huang, Nigatu, Smail-Crevier, Zhang, & Wang, 2018), as well as evidence for the sustainability of effects for interventions addressing these conditions, but less so for interventions promoting positive wellbeing (Winzer, Lindberg, Gulbrandsson, & Sidorchuk, 2018). In the UK, a randomised controlled trial comparing mindfulness with usual support for students at a single UK university showed a moderate advantage to a mindfulness intervention in relation to relieving student examination stress (Galante et al., 2018).

Admirable as such initiatives are, they remain unconnected to the wider sampling data frame of students that may benefit from support if there were a policy of gathering information on wellbeing via bona fide measures at the transition into university and throughout the course of a student's university career. This then leads to questions about policies and strategies for obtaining high-quality data in relation to student wellbeing and mental health.

4 | DATA SETS: IMPLEMENTATION AND UTILISATION

The differentiation of wellbeing and mental health together with the need for a focus on developmental transitions lead to the need to obtain high-quality data on a systematic scale in order for universities and student mental health support services to focus their limited resources in the best way possible.

4.1 | Wellbeing in the student population and its measurement: Longitudinal cohort studies

The Evidence-based Practice Unit at University College London has published guidance on measuring student wellbeing and cite two candidate measures (Evidence-based Practice Unit, n.d.): the Warwick-Edinburgh Mental Wellbeing Scale (Tennant et al., 2007) and the GP-CORE (Sinclair et al., 2005). The former is a 14-item measure

originally developed with students but now used in population surveys. All items are positively worded. The latter also comprises 14 items and was developed for students and used in a large student wellbeing study (e.g., Bewick et al., 2010). Items focus on experiences and not problems with a mix of positive and negative items. But the selection of a measure also needs to be combined with strategic implementation whereby students are enabled to respond to such measures prior to starting their course so as to capture the nature and impact of this major developmental transition, as well as at key intervals throughout their time at university. As noted earlier, the Welsh Government mandates the use of standard outcome measures, principally the YP-CORE (Twigg, Barkham, Bewick, Mulhern, & Cooper, 2009) in order to provide annual reports on the effectiveness of independent school counselling (for example, see Statistical First Release, 2019).

4.2 | Student mental health, counselling and its measurement

The differentiation between wellbeing and mental health requires differing measures for the latter, with a focus on the adoption of bona fide instruments in student counselling services. A survey carried out by Broglia, Millings and Barkham (2018) comprising data from 65 UK HE student counselling services found less than half (47%) of services used a bona fide outcome measure and a further 47% did not use a validated clinical measure, although 15% used their own assessment or feedback form. The final 6% did not report on their use of clinical outcome measures. These data suggest that of those services that replied, approximately one-third did not use a validated outcome measure. University counselling services should aspire to implement and collect a minimum pre- and post-counselling data set as a component of good practice. In short, it is difficult to defend services that use no outcome measures in a context where such procedures are mandated in the Improving Access to Psychological Therapies (IAPT) initiative (Clark, 2011). Embedded student counselling services could then claim a national evidence-base, be transparent regarding their individual effectiveness and provide collective data at a national level.

A major contribution to designing and implementing a minimum outcome data set in counselling can be seen in the US initiative of the Center for Collegiate Mental Health (Castonguay et al., 2011). There is no need for the development of any new measures as there are sufficient bona fide outcome measures to propose that all services select their *preferred* measure and from which commonly derived indices of change (i.e., walk across tables) can be devised to make comparisons between differing measures (see Leach et al., 2006). For assessment, measures include the CORE-OM (Evans et al., 2002) and CCAPS-34 (or CCAPS-62; for UK data, see Broglia, Millings & Barkham, 2017).

4.3 | Coordination with NHS services and session-by-session outcome measurement

In the UK, there is now a clear aspiration to establish more effective ways of coordinating university and National Health Service (NHS) provision of mental health services for students (see NHS, 2019). Within the NHS, the Improving Access to Psychological Therapies (IAPT) initiative has had a major impact on shaping the delivery of services, particularly for primary care (Clark, 2011). One feature of the IAPT delivery model has been the implementation and collection of a minimum data set for *all* patients at *all* sessions attended. While IAPT services are mandated to use the PHQ-9 (Kroenke et al., 2001) and the GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006) for depression and anxiety, respectively, other generic measures are also available (e.g., the CORE-10; Barkham et al., 2013). Decisions need to be informed by a balance between interfacing with the NHS while also retaining the selection and implementation of measures that acknowledge the specialist setting of students being seen within university embedded counselling services.

5 | TOWARDS AN AGENDA IN SUPPORT OF EVIDENCE-BASED STUDENT WELLBEING AND MENTAL HEALTH

In summary, on the basis of adopting clear distinctions between student wellbeing and mental health, three areas of activity and research need to be carried forward: (a) a strategic approach to measuring wellbeing that captures developmental transitions prior to and across the course of university; (b) agreement on a unified approach to counselling measurement that includes session-by-session measurement using bona fide measures of mental health; and (c) the collation of data in support of the effectiveness of embedded counselling services and their coordination with NHS service provision.

6 | EPILOGUE

On 5 June 2019, the UK Office for Students announced £6m–£14.5m when valued with matched funding—focusing on finding innovative ways to combat the rise in student mental health issues and initiate a step-change in student support across the country (Office for Students, 2019). A week earlier, on 30 May 2019, the New Zealand government published *The Wellbeing Budget* (New Zealand Government, 2019), in which the 2019/2020 economic planning for the country will be premised on principles and policies of wellbeing rather than specifically productivity and performance. While the former national initiative provides a welcomed approach to address some of the specific issues concerning student suicide, identification of risk and the coordination of student services for mental health, the latter international event signals a fundamental reorienting of economic priorities at the highest level of a national government wherein rather than just measuring wellbeing, it is placed at the heart of economic decision-making and planning.

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