Competence acquired: the learning process of professionals within social care

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This article presents data collected in focus group interviews with 26 professional social workers and carers, such as nurses' assistants, assistant nurses or nurses, orderlies or staff in charge of coordinating aid, within Stockholm County, Sweden, after participation in a specific education and skills-enhancement programme, *the Secure Encounters programme*. The purpose was to study the learning process related to the competence needed while working with older people with mental health problems answering the following question: *How do the learners perceive their competence after completing training*? The talks in the groups were recorded and transcribed verbatim, and resulted in rich descriptions, since the participants shared personal stories illustrating their experiences. For this study, a thematic analysis was chosen, inspired by the idea of how the participants communicated about their newly acquired competence. The perception of their skills could be understood based on the dimensions of *conscious* and *unconscious competence* or *conscious* and *unconscious incompetence*, i.e. Lundby's skills-development stairway was used to interpret the participants' reasoning. The training course gave the learners an understanding that one doesn't necessarily have to be action-oriented. One also needs to know how to ask critical questions during every encounter, not just assuming that mental health problems explain every intention of the clients. They also talked about specific qualifications, in order to work with older persons suffering from mental health problems, such as taking a specific attitude. In other words, the staff members formulated during the talks a consciousness about their competence acquired.

Keywords: competence; mental health problems; older persons; learning process; social work

Introduction

Older persons suffering from mental health problems, such as mental illness or disability, have the right to be treated with respect by competent social work professionals. Professionals in their turn are entitled to adequate knowledge of how to establish reciprocal and secure encounters. Accordingly, it's important to determine how to train the professionals who work within the social care services for these older persons. We must also understand how staff members perceive the learning process related to expected competence. This essentially concerns how Evidence Based Practice, EBP, can lower the gap between theoretical knowledge and practice, in the sense that the professionals

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are consciously aware of how to integrate the client's perspective along with knowledge from systematic research in combination with proven experience (McNeece and Thyer 2004; Nelson and Steele 2007).

This article presents data collected during the evaluation process of a skills-enhancement project, the *Secure Encounters* programme, aiming at building skills for social workers in dealing with older persons. The purpose is to study the learning process related to the competence needed while working with older persons suffering from mental health problems and answering the following question: *How do the learners perceive their competence* after *completing training*? Nyström and Lützén's (2002) definition of competence reflects the intention of this study: to inspire the learners to understand their clients and to implement newly acquired knowledge and apply the skills required in the relationship.

Older persons with mental health problems, such as illness and disability

Along with advancing age, structural and functional deterioration occurs in most physiological systems, in addition to the presence of diseases. These age-related physiological changes affect a broad range of organ systems and functions and can, taken together, impact activities of daily living and lead to physical dependence. However, these negative effects can be postponed with adequate care and rehabilitation (Chodzko-Zajko et al. 2009).

Mental health problems in older persons can also impact activities of daily living (Alexopoulos et al. 1996) and lead to dependence on care services. Epidemiological studies show that mental illness is common in older persons. Diseases such as depression, anxiety disorders and psychoses occur in 20% of people aged 65 and older (Skoog 2011). One Swedish study found that nearly 30% of the oldest elderly have some kind of depressive problem that leads to functional impairment (Bergdahl 2007). Specifically, depression in the elderly has been associated with executive dysfunction (Lockwood, Alexopoulos, and van Gorp 2002), which in turn can impact activities of daily living. The psychiatric state of older persons is also complicated by somatic comorbidity, cognitive failure, loneliness and losses. As a rule, this leads to complex needs for medical and social care for older persons with psychiatric impairments. Preconceived notions of and attitudes towards ageing and mental illness as something stigmatising can make older persons less likely to seek help, and make it more difficult for professionals to discover the problems. Moreover, measures to reduce social isolation and loneliness are crucial for improving the mental health of older persons (Forsman, Schierenbeck, and Wahlbeck 2011).

Older persons with psychiatric impairments can be described as a neglected group in both psychiatric care and care of the elderly, irrespective of whether the person's mental illness is a new development or one that first came about in the person's youth or during their working life. The reasons for this neglect may be due to varying levels of knowledge and negative notions on ageing and/or poor interaction between social and medical caregivers (Jané-Llopis and Gabilondo 2008; National Board of Health and Welfare 2014).

In summary, older persons who suffer from mental illness often develop an impairment of their executive functions, which leads to a need for specific care. Social care staff, regardless of professional background, generally lack the skills to deal with older persons suffering from mental illness and need a greater awareness of attitudes towards them.

Competence required

Nyström and Lützén ([2002](), 173) studied how professionals within psychiatric and home care services discerned their own competence, defined as 'relevant knowledge and understanding of long-term mental illness, as well as an ability to use skills, to apply knowledge and to understand the performance of relevant tasks'. The researchers discovered that the interviewed professionals had limited apprehension of the specific qualifications needed. For example, home care service staff expressed insecurity and a lack of structured guidance in their daily work. However, some were able to focus on the individual needs of every client and to perform with the expected competence. Nevertheless certain skills can be considered as 'tacit knowledge', i.e. that the professionals intuitively sensed what to do in every situation with different clients. McAdam, Mason, and McCrory ([2007](), 46) though do stress that this concept is too ambiguous and diffuse, but can be defined as 'knowledge-in-practice developed from direct experience and action; highly pragmatic and situation-specific; subconsciously understood and applied; difficult to articulate, usually shared through interactive conversation and shared experience'.

Nevertheless, working in the clients' homes demands extreme sensitivity and respect for the integrity of the person involved (Karlsson and Rydwik [2013]()). Professionals should approach mentally disabled older persons on their own terms (Karlsson and Rydwik [2013]()), never compromising on respect for their integrity and self-determination (Magnusson, Lützén, and Severinsson [2002]()). It is evident that this kind of social care is 'a complicated and unpredictable activity' (Gould [2006]()). In all events, social care should be considered as 'relational work', as defined by Astvik ([2003]()), with the expectation that practitioners must understand their own attitudes in psychologically demanding relationships. Astvik states that psychological support is a part of social work, that time must be set aside for reflection and adequate knowledge must be provided so the work can be done. Staff members definitely need special support such as continuous supervision, with a 'characteristic of process-oriented learning' (Astvik [2003](), 52). In all events, Fakhoury et al. ([2002]()) specifically point out the need for knowledge about the training required in order to support people with mental problems, such as mental disabilities, in their daily life. Williams ([2010](), 130) highlights that 'learning is both derived from and focused on practice, enabling the learner to use their everyday experiences as the basis for their learning'. However, in its 2008 status report, the Swedish National Board of Health and Welfare stated that there was no lack of knowledge about mental illness and disability among older people and what methods were effective. Still, this knowledge is not sufficiently widespread and followed (National Board of Health and Welfare [2014]()). The Swedish Government has invested several million kronor in continuing education and development projects aiming to develop the staff's approach to people with psychiatric impairments. The project in question was one of few that applied for and received funding from the National Board of Health and Welfare for a project focusing specifically on the elderly. The data presented in this article are the results of one such skills-enhancement project.

The Secure Encounters project

The Secure Encounters project was conducted in collaboration with a psychiatric clinic, a regional research and development unit and eight municipalities in Stockholm County, Sweden, between 2009 and 2013. The purpose of the course was to build

greater skills in dealing with older persons with psychiatric impairments, based on current research and knowledge. The target group of the project was staff members who encounter older persons with mental health problems in municipal care of the elderly, psychiatry, primary care and geriatric clinics. Apart from staff from general adult psychiatry and from one home for patients with social psychiatric needs, the majority of the participants worked in care services with no specialisation in psychiatry. In addition, the participants from psychiatric care generally worked in services with no subspecialisation in the care of the elderly. The project included a basic training course and a coordinator training course, with the intention of creating secure encounters for both clients and staff members. The five-day basic course, spread over a period of four months, dealt with the approach to and attitudes towards mental health problems in older persons, with the intention of influencing staff work methods. A four-day coordinator training course involved training in communication skills. These coordinators were to serve as resources for colleagues in their respective workplaces when implementing newly acquired knowledge. The teaching methods in these courses consisted of active learning through interactive methods such as discussion in small groups and case methodology. Three hundred twenty people participated in the programme. The evaluation was presented separately (Strandberg et al. 2013), while this article focuses on the learning process with special emphasis on description.

Perspectives on learning: theoretical perspectives

Different theoretical perspectives have been developed to understand teaching and learning, and one of the most well-known is probably Bloom's taxonomy of learning (Bloom 1956; Anderson et al. 2001). Bloom (1956) emphasises three levels of learning: cognitive, affective and psychomotor. Cognitive is a knowable domain and the development of intellectual skills and abilities. Affective is an attitude domain. Psychomotor is a skill-based domain in which learning takes place through practice. Bloom's educational taxonomy is a useful tool, but has a teacher's focus, while the Lundby model (Bernler and Johnsson 1993) concentrates on the learner, as does the theoretical model developed by Dreyfus, Dreyfus, and Zadeh (1986), which categorises skill acquisition into five stages: novice, advanced beginner, competence, proficiency and expert.

Lundby's skills-development stairway was used in this study to interpret the participants' reasoning (Figure 1). In this model, learning is perceived as a step-by-step change, beginning with *unconscious incompetence*, in which the individuals often have naïve perceptions of their own abilities and knowledge. The second phase, *conscious incompetence*, can sometimes be emotionally difficult as the learners realise their inability and discover their need for training. During the third phase, *conscious competence*, the individuals are conscious that they have gone through a learning process and know what skills they have. In the fourth phase, *unconscious competence*, the individuals consider themselves knowledgeable and capable of learning to teach others. Obviously, the ideal is that someone who has received training will be able to pass knowledge along to others. However, learners go through the same phases again in the role of teachers or as conveyors of knowledge – starting out unconsciously incompetent, according to the Lundby model (Bernler and Johnsson 1993).

From time to time, people are dismissed as incompetent, in the sense that they would be poor or inferior at a task. In the same way, the word *unconscious* can be associated with lesser knowledge. However, this model does not have those connotations. Nor should we apply any moral judgements to the process of learning. Rather,
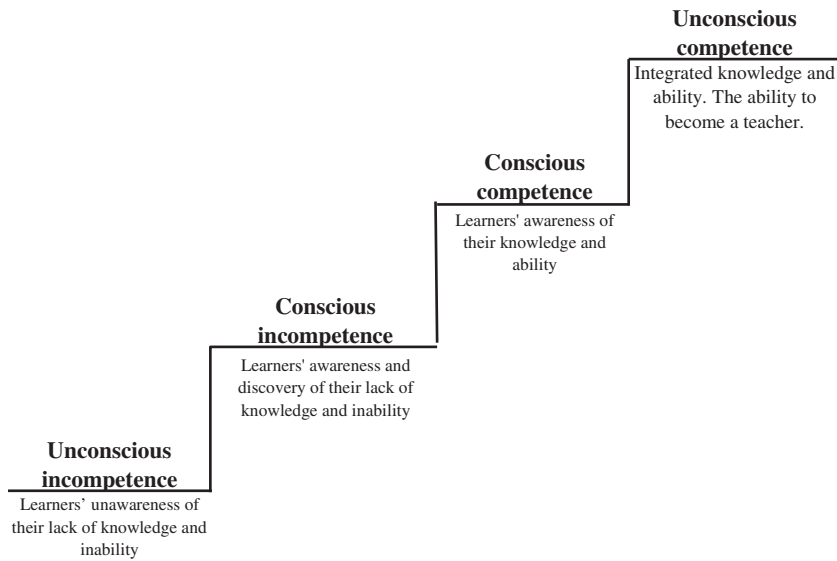
Figure 1. Lundby's skills-development stairway.

the Lundby model offers the opportunity to understand the complexity of the learning process. In our article, the Lundby model is used as well as a frame and a theoretical interpretation (Mouzelis 2003).

The educational theorist John Dewey (2007) emphasises that every form of education should essentially influence the learner to impose self-control and to reflect, i.e. postpone immediate action and instead aspire to observe and relate to earlier experiences. Dewey is referring to the old cliché 'stop and think'. However, the learner has to do more than simply observe; s/he has to understand the significance of her/his observations in order to act purposely upon them. Dewey warns against immediate activity, i.e. just fulfilling desires and following impulses. Rather, the learner should have a purpose, be able to intellectually anticipate consequences in order to fulfil the desire to act. Teachers who understand the learning process will be able to integrate this knowledge in their way of educating (Dewey 2007).

Challenges in implementing newly acquired knowledge: empirical studies

Transferring newly acquired knowledge into daily work is a challenge in itself and it is not enough to simply provide information and training (Denton, Vaughn, and Fletcher 2003). For successful implementation, a method must also be perceived as relevant and providing obvious benefits; it must also be consistent with the recipient's values and be easy to use (Greenhalg et al. 2004). An organisation that is positive to change, has clear strategic visions and good leadership, with a working climate that inspires creative thinking, has greater opportunities to succeed in implementing newly acquired knowledge (Greenhalg et al. 2004). However, the organisational structure or the staff's involvement in the implementation process is not in itself enough to be successful in applying evidence-based practice in social work. The client's perspective and involvement in the decision-making is vital (McNeece and Thyer 2004).

Method

To gather data, structured conversations were organised in five focus groups consisting of one moderator and 26 participants – 21 women and 5 men (Morgan 1997). Participants were social workers, nurses' assistants, assistant nurses or nurses and orderlies or staff in charge of coordinating aid. All of them had taken the basic course, and in two groups, all participants had also been trained as coordinators. Although professional background and age varied, the majority had extensive professional experience. Some participants were in their late 20s, while others were close to retirement. The mean age was 40. Discussions in the five groups lasted from 90 min to 2 h and followed an interview guide (available on request). The number of participants varied from two to seven and they were recruited at the last session of the training. The course participants were asked at the end of the courses in 2010, 2011 and 2012 to provide contact information if they were interested. Between nine and fifteen people responded at the end of each course. Six months after the end of each course, one of the researchers (Lis Bodil Karlsson) invited these individuals to participate in focus groups. However, not everyone who was interested was able to come, so they cannot be considered representative for all course participants; they are simply those who were able to take time off from work at the time of the focus group and who thought they had something to say. The talks resulted in rich descriptions, since the participants shared personal stories illustrating their experiences. The talks in the groups were recorded on tape and transcribed verbatim.

The process of analysis

One disadvantage of data collected via focus groups is that they are often jumbled, nor is there a standardised method for how these data should be presented, analysed or interpreted (Kidd and Parsall 2000; Karlsson 2008). For this study, we chose thematic analysis inspired by the idea of how the participants communicated about their newly acquired competence; '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 and Clarke 2006, 82). The thematic analysis focuses on searching in a data-set for 'repeated patterns of meaning' (Braun and Clarke 2006, 86). The analysis started with the intention of providing a nuanced and detailed answer to the question of how the learners perceived their competence after completing training. The process began with a read-through of each transcription to get an initial understanding of the essence of the discussions in our focus groups.

The second step was to manually code the participants' reasoning into categories that fit our research question: *Reflections on old and newly acquired knowledge; Feeling competent; Attitudes towards clients; Relations towards colleagues.* About 60–70 pages of transcribed text from each interview were reduced and condensed to about 10 pages. In this phase, an excerpt of the text was taken from its original context – a decontextualisation – focusing on what our data-set actually revealed of the focus group participant's learning.

The third step was to integrate our reflections. During this procedure, it was evident how the participants were actually examining the process of learning related to their competence in working with older clients who had mental health problems. The participants adopted different attitudes when they spoke about the training course in relation to their own and other colleagues' skills. The participants' perception of their skills could be understood based on the dimensions of *conscious* and *unconscious competence* or *conscious* and *unconscious incompetence*. It was obvious that the four initial

codes had to be revised (*Reflections on old and newly acquired knowledge; Feeling competent; Attitudes towards clients; Relations towards colleagues*), since they were connected to each other and actually recurred as aspects in every dimension of un/conscious and un/competence. Lundby's skills-development stairway was therefore used to interpret the participants' reasoning (Figure 1).

Still, the analysis had to be pushed further while reviewing the themes in a fourth phase, interpreting how the participants dealt with their approach and attitudes towards mental health problems in older persons and in relation to the methods of everyday work. For those participants who had taken the coordination course, their reasoning about communication skills in order to function as resources for colleagues were also of special interest. The fifth phase in the analysis can be characterised as focusing on what Braun and Clarke (2006, 92) call 'define and refine', i.e. 'identifying the "essence" of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures' (op. cit). The quotations and excerpts from the focus groups in our article should be considered as illustrations. We scrutinised the original transcriptions again to validate our interpretations (Kvale and Brinkmann 2009).

Our results and interpretations were presented orally and in writing to the management of Secure Encounters, during the sixth phase. Their responses not only confirmed the plausibility of our interpretations, but also inspired the management to continue developing the training project, specifically the use of the Lundby model of understanding the learning process. An indicator of credibility of findings is when practitioners and researchers actually consider them 'meaningful and applicable in terms of their experience' (Cutcliffe and McKenna 1999, 379). Awareness of the skills-development stairway can likely facilitate future training measures, and thereby contribute to evidence-based practice. Our data provided a collection of narratives, which formed the basis of a film produced by the project management. Our research thus contributed to returning practice-related knowledge back to the field.

Ethical considerations

The project was approved by the ethics committee at Karolinska Hospital, Solna, Sweden (2009/1382-31). Ethical considerations were key in the research process, which means that personal details that could reveal a participant's identity, such as age, are not provided. All names are fictional. However, the professional backgrounds of the participants – such as assistant nurse – were provided. Informed consent was essential for participation in the focus groups. Prospective participants were informed that their participation was voluntary and that they could drop out of the study at any time, and that the discussions were organised as a part of the project's assessment. The people were only asked *after* completing their training, so that none of them would feel that they had to 'pay back' for the training.

Results

The learning process of becoming conscious competent: how the first three phases interrelate

Under this heading, we present how data might be interpreted based on the first three steps of the learning process – that is, from the discovery of an unconscious incompetence, through the development of an awareness of one's incompetence, to the maturing of reasoning based on conscious competence. But initially, we must point out

that the discovery of gaps in one's own knowledge (i.e. being consciously incompetent) often leads to some discomfort. Discussing this in a social context, such as in a focus group, is extra difficult because it means revealing one's own personal shortcomings. Therefore, such revelations can in one sense be considered as something of a narcissistic violation for the person disclosing them about her/himself. Now and then the participants in our groups make statements that they 'didn't know' or 'had no idea' about certain knowledge. Nevertheless, they tend to talk in mitigating terms when they reveal their shortcomings. As an example of the participants' perceptions we present Alexander, who describes how he, as a nurse's assistant in home health services, found he had become inured to certain signals. At first, it was easy to dismiss the clients' worries as an expression of their mental illness. His attitude towards the clients changed after the course, which he illustrates with a story about a mentally-ill woman who frequently complained about rats on her balcony. Although he ruled out the existence of actual rodents, he did consider some alternatives:

> Alexander: I contacted the health centre and learned that the woman had been taking too much medicine. She lived on the sixth floor; there was no way rats would get up on her balcony. But instead of just taking that for granted, I started to, like … 'What if she's right?' So I started investigating.
>
> Moderator: You followed up on her complaints?
>
> Alexander: Yes, and that makes you think in a whole different way. Who am I to say she's wrong, really? Even though it sounds crazy. /…/ But you don't take things for granted [anymore]. There are routines for what to do in cases like this; you make phone calls and check. But a lot of times you just run on autopilot; you just follow the routines on paper and that's it.
> But now I've started looking into what might exist besides those rules. I'm thinking outside the box and checking what might be there. Could there be something else bothering her, instead of just taking it at face value?

It is obvious that Alexander would never have described himself to the focus group as initially incompetent. But he uses metaphors to capture his change, such as 'thinking outside the box'. He explains that he is no longer controlled by routines 'on paper' or just 'taking things at face value'. There may be other explanations than mental illness; 'something else bothering her'. Thus, previous assumptions and routines can be questioned. This also emphasises the value of not just doing one's job, 'running on autopilot' without reflecting on everyday occurrences. Alexander's narrative shows how he has shifted from unconscious incompetence – from 'taking things for granted' – to conscious incompetence, expressed as 'what if she's right'. And from there, the learner in question is developing a conscious competence – meaning that he started 'thinking in a different way', i.e. taking an investigative approach. This excerpt shows that he has begun thinking beyond the given framework and a learning process is initiated. Above all, Alexander emphasises the necessity of investigating and understanding more complex contexts in relation to clients, before even initiating any kind of measures. His changed attitude is best understood in terms of imposing self-control and his inclination to reflection, i.e. postponing immediate action and aspiring to observation, in accordance to the thoughts of Dewey (2007). We will return to this later on in our article.

The focus groups definitely presented an opportunity for self-examination. However, this does not necessarily imply that one wants to expose one's incompetence in the group. If the narrative above describes how the first three steps on the competence stairway interrelates, the next heading shows how the training enhances conscious incompetence.

Conscious incompetence: the second phase

The discussions in our focus groups have recurring passages, in which various participants describe the acquisition of knowledge that leads to changes in their attitude and in relation to the methods of everyday work. The discovery of need for more training and education because of lack of knowledge seems to be a humbling experience. But in the end, this influences one's attitude and perceptions. For example, learning of the high suicide rate among older people made Michelle, an assistant nurse, listen carefully to her clients. She is now aware that if she hears an older person say they want to take their life, she should not just dismiss it as idle talk. Even if she has colleagues who say: 'Oh, they're just talking!' Michelle explains, 'It's easy to say that they're mentally ill and that they just spout nonsense all day, and to just not care; "We don't have time to deal with it"'. When Michelle discovers her own initial incomprehension, or her unconscious incompetence, she begins to take note of others' limitations, i.e. only thinking in terms of psychopathology. By the same token, she nowadays hears how her colleagues dismiss the need for an empathetic attitude by pointing to a lack of time. Michelle is becoming aware of other colleagues' unconscious incompetence, while realising that she herself was previously incompetent in one sense. Our analysis reveals how the participants put their professional thinking and action to the test as a consequence of the learning process. It is not always a pleasant experience realising one's perceptions. The new and changed attitude disrupts earlier routines and the incompetence of colleagues is highlighted as well. Michelle illustrates, in other words, the essence of tuning in and listening in order to 'stop and think' (Dewey 2007), before any further action is taken. The learner should not only observe, but also understand the significance of the observations in order to act purposely upon them (op. cit). During the course of the discussions, it becomes clear that knowing how staff members may respond in a concrete everyday situation is empowering. Particularly the fact that they don't have to dismiss a client's wishes as expressions of pathology is remarkable. They can instead consider them as genuine human impulse or concern 'their sense of security'.

Conscious competence: the third phase

During the third phase of the Lundby's skills-development stairway, the individuals are conscious competent. As we mentioned earlier, they have gone through a learning process and know what skills they have acquired. Stella, a social worker, who is a group leader in home care services, points out that it is 'completely meaningless to just rush into a client's flat to start cleaning'. She emphasises the importance of creating trust in the encounter. Especially this is true, if the client absolutely does not want help. Even if their relatives think that they live in squalor. The first few times, perhaps the flat doesn't get very clean. But once a relationship has been established, it is actually possible to carry out a job such as cleaning, without offending the person who needs assistance:

> Stella: Not everyone knows that you can't start cooking and cleaning until you have earned their trust. If you know that they don't want help, then you have to talk and be pleasant and maybe sit and drink coffee with them. Do what they want. Not what's on the duty sheet. Forget about the assignment for a while, maybe two or three visits. It doesn't matter if the place gets dirty. But then you have to deal with it – the dirt in the flat.

To accomplish one's mission one has to 'forget the assignment for a while'. This at first seems to be a paradox. Being consciously competent brings to light others' demands and their previously internalised expectations of immediate correction. The initial encounter, before any action can begin, is de facto a part of the work itself – creating trust in order to create a secure encounter for both parties; 'It doesn't matter if the place gets dirty', is a clear statement stressing the attitude of the learner imposing self-control, not merely responding to impulses, i.e. doing 'what's on the duty sheet'. The learner in this case does not follow impulses to act, but comes clear with her purpose of why and when to act – in this case, first winning trust as a step in order to create a relationship. Working in the clients' homes demands respect for the integrity of the person involved (Karlsson and Rydwik 2013).

The social worker Amber expresses, 'The more the members of the staff know, the better they treat the clients'. She underlines what several participants in the focus groups explain they have learned, i.e. 'how important your approach is, practically the most important thing of all'. Previously, she used to focus on carrying out the actual tasks at hand. But now she understands that a correct approach to clients and their family members has its own value: 'It's completely fundamental. It can give a sense of security, and that's free'. A competent staff member has to have an investigative approach, is embracing a reflective attitude and showing an understanding of the context before even initiating any action. Or as Karlsson and Rydwik (2013) emphasise, an extreme sensitivity is required. It is okay to wait; sometimes you just have to grin and bear it. At the first glance, it may seem incompetent not to take any measures. But, acting should not be done for its own sake, actions that are considered as adequate require an investigating attitude in order to understand the situation (Dewey 2007).

With new knowledge, you can consider yourself as skilled, as Diana – an assistant nurse at a day centre – says: 'I often feel competent in difficult encounters. I can't put it into words what I do. But it has to do with my approach to the clients. /…/ When family members dare to tell me how they feel, it makes me feel competent, because I've gained their trust. They dare to come and tell me their innermost feelings'. One's professionalism develops into conscious competence, an understanding *that* you are actually doing a good job. But you cannot always explain *how*. In encounters with family members, you can consider yourself as skilled. Someone they can count on. The encounter appears to be essential. In an early article, Magnusson and Lützén (1999, 403) likewise stress the essence of professionals building 'a trusting relationship with patients and their families'.

Consider that the participants in our focus groups are not simply reflecting on the fact *that* they have something to do, or *what* they have to do, but also *how* (Astvik 2003; Wertz et al. 2011). Our talks show that the participants have compassion and they want to show it; at the same time, they are well aware that some of their clients' homes are deteriorating or appear to be a health hazard or that the older persons are suffering. As professionals, they sometimes even feel that they are responsible for the squalor that their clients live in. However, just rushing into a person's home and being task-oriented is actually being incompetent (Nyström and Lützén 2002).

Staff members should never compromise on their respect for the integrity and self-determination of their clients, according to Nyström and Lützén (2002). Their interviewed professionals expressed a lack of structured guidance in their daily work though. However, the professionals in our study were scrutinising their own attitudes, not only compared to how they worked before, but also in comparison with other colleagues, who had not been trained in the *Secure Encounters* programme. In other

words, the professionals perceive their competence in a specific way since they were now aware of their own change in attitude after going through a learning process.

Unconscious competence: the fourth phase

In the fourth phase of Lundby's skills-development stairway, *unconscious competence*, the individuals have integrated newly acquired knowledge and consider themselves as knowledgeable. The learner who has received training will be capable of teaching others.

After being trained as a coordinator, Dominique, an assistant nurse in community care, has become a special support to every staff member who is linked to a specific client. His colleagues turn to him when they need advice. He is not always available during the working day because he has to visit his own clients. Nevertheless, during lunch breaks when the staff members gather in their office, he has the opportunity to be a resource. 'I try to help them along and ask questions like: What is the problem? Why do you suppose that is? Why do they act that way?'

Dominique's goal is primarily to guide colleagues who visit clients with extra diffi-culties, and to be 'a rubbish bin they can dump their problems into'. He cannot empha-sise enough the importance of just talking. The staff members usually have a plan for how to approach the situation, even if they're not always aware of it. 'They arrive at a solution themselves. That usually makes things much better for the client, because the staff members know that things are going to work out'. Dominique's availability to the staff members gives them strength in their daily work and encourages them to believe in their own capacity. A stressed employee tends to get others worked up and actually to do a poorer job:

> Dominique: 'I can ask Dominique about that when I get back.' Then they don't get all worried. And if they don't get worried, they don't get the client worried, and then everything goes a little more smoothly.
> So that's what I try to work with above all, to look after my colleagues, make sure they have that peace of mind and the inner security to visit those difficult clients.
> Because if they're secure and feel that, 'Okay, this isn't a problem, I can deal with this!' Then things go much more smoothly than if they start to get stressed, because that stress affects others.

The discussion with Dominique highlights his desire to support his colleagues, primarily by assessing the facts – i.e. taking the attitude that no ready-made solutions exist, Dominique makes it clear that his colleagues are perhaps not aware of alterna-tives at first, but suggestions for changes in attitude develop through dialogue (Dewey 2007). Dominique makes it clear that their own worries and uncertainties sometimes distract them from feeling secure. This insecurity prevents them from acting as a com-petent staff member and can have a negative effect on the encounter with the older per-son. Dominique emphasises the value of asking assessing questions, which conveys the assurance that the staff members actually do have sufficient knowledge to decide how to act. Competent staff members, such as Dominique, are able to assist and guide their colleagues to complete more qualified tasks, and also to develop an adequate attitude in relation to their unpredictable daily work and not having all the answers beforehand (Gould 2006). Through his newly acquired competence, Dominique helps his colleagues to understand the qualifications of their observations in order to purposely act upon them. In other words, Dominique is aware of using his newly acquired

communication skills in order to serve as a resource to his colleagues. We can under-stand his reasoning by referring to Astvik (2003) characterising social care as relational work. Time for reflection and relevant knowledge must therefore be provided. Special support in the form of continuous supervision is needed as well, which is what Astvik characterises as process-oriented learning. However, according to the Lundby model, we go through the same phases over again in this new role as a conveyor of knowledge – starting out *unconsciously incompetent*. This will be discussed further in the following section.

The cyclical nature of the skills-development stairway

After coordinator training, several participants developed into resources in their work teams. Sometimes news about the participants' competence also spread to other work-places in the municipality. Daphne, who works at a care home, describes a mentally disabled woman who lived in squalor, but refused to let municipal home help staff members to clean up her flat. She would only open her door under one condition – if they just disinfected their hands. The story of Daphne contains several dimensions of how learning can be perceived. However, we are interested in two aspects; first, Daphne is an example of how a participant has integrated newly acquired knowledge into her professional attitude. She had become unconsciously competent. Second, our example illustrates the cyclical nature of the skills-development stairway. Even though one is competent as a professional, one seems to start over again as a teacher of others – sometimes simply being unaware of one's own attitudes. But let us get into the story of how Daphne was contacted by her home help service colleagues because they couldn't do their job. The members of the staff were troubled by un/conscious incompetence and no one was willing to budge on their positions:

Daphne: They had a problem with a woman who was mentally disabled. She didn't want to open the door and let the staff in. They had heard there was a woman named Daphne who could help them. So I said to them: 'What's it all about? What happens when you go there?'
'The woman wants the staff to disinfect their hands when they come into the flat.'
'And what happens when the staffs refuse? Why do they refuse? I mean, it is her home.'
Yeah, but it's totally disgusting in there. There's mould everywhere and it's dirty. And yet she wants the staff to disinfect their hands when they come in.
I said: 'But it's her home. If you don't do it, she'll never let you in. I mean, you have your instructions.'
'Yeah, the instructions are to clean the flat, decontaminate it. Those are the instructions we got from the municipality.'
So I said: 'You know, first of all you have to win her trust. So disinfect your hands, and then maybe you have to sit down with her and chat and maybe have a cuppa.'
But all the staff refused. They refused to drink any coffee with her; 'Cleaning that place up is a dirty job.'
But I said, 'Tell them to bring a thermos of coffee and some pastries in a picnic basket. That'll work with someone with a mental disability. They love coffee and pastries. It's their favourite thing. So start out with a coffee. Then, when they've earned her trust, then you start out with: 'Say would you like me to help you a bit with this?' It'll be tricky. But the way they're doing it now is completely wrong. /…/

> 'Sometimes it just has to take the time it takes. You have to go in and let it be dirty until she opens up to you, until you earn her trust.' I mean, a lot of people have extremely bad experiences of outsiders. It's very important to remember that. Sometimes it isn't the task at hand that's important. Sometimes you have to start out on a completely different level.

This older woman was in danger of being evicted. Daphne describes her municipal colleagues' heated emotions. Daphne emphasises though the importance of examining the situation with questions like: 'What is this about? What really happens?'. Then she tries to convey understanding and empathy for the woman's perspective. Daphne makes clear that the staff members will have to deal with the mess for a while – before they ever start doing something about it. Thus, this story is not just about being a coordinator. In addition, it is about teaching understanding to her colleagues; that even if a person is suffering from mental health problems, she still wants control over what help she receives. Regardless, if the home is in resolution because of squalor, the women should be treated with respect. Every human knows instinctively when treated with disrespect (Fuller 2006). The consequences of not feeling respected are destructive feelings, such as humiliation and insecurity (op. cit.). In other words, not a good starting point for communication. The situation described by Daphne elegantly demonstrates the necessity of considering who the client is. The staff members must distinguish between following the instructions for their task and adopting an instrumental approach. In some cases, the choice is between cleaning the older woman's home and 'starting at a different level' – i.e. approaching the woman with no preconceived notions; simply as a client in need of help in order to keep her apartment, instead of getting evicted. Once again, the prerequisite is that the learner is able to impose self-control and reflect in order to decide how to act purposely upon the observations done (Dewey 2007).

Daphne also has a teacher's approach. As a competent authority, she takes liberties, not only to educate, but also to formulate things drastically, for example, that 'people with mental disabilities love coffee and pastries'. A statement that cannot be misunderstood and is even enhanced with; 'It's their favourite thing'. It's a provocative statement. It could be interpreted as showing off her newfound skills and acknowledging that the client has desires and wishes as well. This could also be considered as a remnant of an unconscious incompetence, in which older persons with mental health problems are perceived as different from other people. Likewise, they are described in a simplified way – even categorised – as if they were a homogenous group. This reasoning actually shows how complex the learning process is. Even those who have come a long way in their professional development still have a way left to go, in particular how to convey their knowledge. It also shows how Daphne passes along acquired knowledge to her colleagues about imposing self-control and the necessity of reflecting while emphasising that their workplace is actually someone's home and that this client may have had bad experiences in the past. Creating trust and a secure encounter requires this essential kind of knowledge. However, staff members should never compromise on their respect for the integrity and self-determination of their clients (Magnusson, Lützén, and Severinsson 2002).

Discussion

How do the learners perceive their competence after completing the training? The training course gave them an understanding that one doesn't necessarily have to be action

oriented. One also needs to know how to ask critical questions during every encounter, not just assuming that mental health problems or preconceived notions about ageing explain every intention of the clients. The Lundby's skills-development stairway frames and pins down the learning process from the learners' perspectives and offers an under-standing of the learners already working in the field. Teachers need to be aware of this process when developing new training programmes. Not only can learning be facili-tated, but the staff members involved can feel less pressure if they are told that the learning process can occasionally be complicated, especially when the professional is not a novice in the field. This process creates significant discomfort, for example, when learners discover the gaps in their knowledge. In reality, this is not a disadvantage, but a sign that learning is actually occurring. Earlier research shows the necessity of more knowledge about adequate attitudes towards older persons suffering from mental health problems (Forsman, Schierenbeck, and Wahlbeck 2011). Our study actually describes the process of acquiring this kind of competence. The first and fourth steps of the skills-development stairway can be viewed as tacit knowledge, when the staff members' incompetence or competence is unconscious. Thus, our analysis also contributes to an understanding of why the tacit concept can seem too diffuse, in accordance to the rea-soning of McAdam, Mason, and McCrory (2007). During our focus group interviews, the participants formulated a consciousness about their newly acquired competence, such as taking a specific attitude and understanding the clients' perspective (McNeece and Thyer 2004). This distinguishes them from the staff that Nyström and Lützén (2002) interviewed, who stated that they worked more or less intuitively and without any real structure. Our participants conveyed an awareness of their attitudes and approaches. It is not necessarily a requirement that a professional must solve problems immediately. Rather, each meeting should be undertaken with an assessing, reflective attitude, both in the daily work and under the guidance of colleagues, in accordance with the perspective developed by Dewey (2007). An assessing attitude primarily means getting a grasp of the situation – without preconceived answers and without viewing the older person simply in the light of being old and/or mentally ill. The dis-cussions highlight the necessity of a process-oriented approach (Astvik 2003). Our analysis shows that the two pedagogical models developed by Lundby and Deway are actually complementing each other. The first model focuses on learning over time, while the second is deconstructing and related to what the learner has to understand in every specific situation.

By framing our data based on the Lundby model, we emphasise the value of reflec-tion on learning from both the learners' as well as the teachers' perspective. Evidence-based practice is about being aware of the 'best practice' dimension of research, but it also puts an emphasis on the perspectives of the professional *and* the client. The pro-fessional is becoming accountable, in dialogue with the clients s/he collects and assesses information – an evidence-based attitude (Nelson and Steele 2007). This is fundamental to an adequate approach towards the clients and their families. It makes sense, since as a professional one can 'provide a sense of security' and ensure a secure encounter for all parties, without incurring any extra expenses. However, this means that it is also crucial to create space for a reflective attitude in daily work (Astvik 2003). The purpose of spreading out the basic training course over a four-month period and holding the coordinator training course was specifically to develop a structure and a possibility for the staff to reflect on newly acquired knowledge. It should be a com-pletely natural understanding based on not only how learning occurs, but also in rela-tion to successful implementation (Denton, Vaughn, and Fletcher 2003). If the

organisation is open to changes, has good leadership and strategic visions (Greenhalg et al. 2004), it is more likely that the staff will be able to develop and maintain a reflective attitude. This is also our most important message to decision-makers and management.

Concluding remarks

The professionals are talking about their learning retrospectively and describe the acquisition of knowledge that leads to changes in their attitude. However, their learning could be considered as a continuous process, since newly acquired knowledge is being integrated in their daily work. The learners do scrutinise their own attitudes and compare as to how they worked before the education programme, but they are also noticing the incompetence of colleagues not being trained. Our study concerns how professionals respond to their awareness of prejudice on the persons' age or mental health problems, or the combination of the two. Therefore, the results do not necessary have to be limited to a Swedish context and/or old persons with mental health problems, but also when professionals in any other West European country are in need for adequate knowledge working with other categories of vulnerable people, such as old persons with alcohol problem.

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