When the Heroes Become Less Super: Coping with Problems of Professional Competence

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Abstract

This dissertation addresses the subject of problems of professional competency within clinical psychology. A review of the current literature on the subject begins with topics including recent changes in terminology, conceptualization, and prevalence of competency problems. Contributing factors, differences between practicing psychologists and trainees, and ethical issues are addressed. The review concludes with current perspectives for assessing and intervening for problems of professional competence. The second section provides the methodology for the study which was a mixed-methods design consisting of a quantitative and qualitative component. The primary procedure consisted of an educational intervention provided to first-year students of a clinical psychology doctoral program. Second-year students were used as a comparison group but were not given the educational intervention. The primary hypotheses presented were that first-year participants’ knowledge about the topic would improve and a shift in attitudes for intervening with competence problems would occur. The third section provided results for the study. Quantitative results indicated that knowledge increased and support-seeking attitudes became more favorable for the first-year sample. Results indicated that first year students’ scores on the self-report measure showed a significant change whereas the second year comparison did not. Qualitative data provided insights regarding students’ motivations in how they would approach a peer with competency problems. The fourth section provided discussion on relevant findings, including implications for the field and limitations within this particular study. The dissertation ends with concluding comments on the study.

**Keywords:** problems of professional competence, professional impairment
Superheroes manage to help others in need through the use of extraordinary powers and abilities. Yet despite all that they can do, there are always limits to who they are and what they can accomplish for those they intend to save. And when those limits are reached, who will be there to save them? It is this tension that makes it difficult to continue to keep up the fight. In this respect, psychologists are no different. Many enter the field for the same reason: to help those in need. But they must also struggle with their own limits and how far they can go in the service of others before they become affected by their own work. While psychologists may not be able to achieve superhuman feats, they know what it is like to feel the pressure of trying anyway.

The most common way that these pressures affect professional psychologists is through problems of professional competence. While the term has been the subject of some controversy in its definition (Elman & Forrest, 2007), general themes have emerged that focus on aspects of “foundational domains of functioning” (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012) and how those can be impacted in some detrimental fashion. A simple definition is proposed by this writer: Problems of professional competence are any aspects of a professional psychologist’s clinical performance that adversely affect his/her ability to practice effectively with his/her clients. While the ultimate concern is for the protection of clients, professional psychologists
experiencing competence problems are in need of support if they are to remedy their difficulties and continue practicing. Psychologists are encouraged to manage difficulties in the demanding emotional work in which they engage. However, it has not become clear within the field how far this degree of professionalism must extend. The question then becomes how far does an individual psychologist attempt to manage on his/her own distress before seeking additional help and will he/she be accepted when requesting this help?

One potential means for intervention can be seen at the training level in professional psychology. If student-trainees can be given a thorough understanding of problems of professional competence, what aspects to look for in their own practice, and how to care for themselves and their colleagues, the field as a whole can benefit. This dissertation will address problems of professional competence within the student-trainee population. A proposed intervention will be used to provide student-trainees with knowledge about problems of professional competence. It is hoped that through the benefits of learning more about the concept, trainees can learn to better recognize these issues in themselves and in their colleagues. By intervening with student-trainees, problems of professional competence can be seen not as a misunderstood or untouchable issue, but one worthy of the attention of professional psychologists. Even superheroes rely on each other from time to time, and so professional psychologists must learn to do the same.

From Professional Impairment to Problems of Professional Competence

Professional Impairment

This initial section provides a background on the term professional impairment and how it has been conceptualized within research. This explanation provides the basis for what would become the terminology of problems of professional competence. Up until recently, research
referred to problems of professional competence as *professional impairment*. Discussion will follow regarding the change in terminology, but it will be useful to discuss past research as it helps frame the issue and provide a lens for how the field of psychology has altered its understanding of competency problems. Professional psychologists are a unique population in and of themselves. Few other professions deal more closely with the intimate emotional details of those clients they work with. Professional psychologists as compared to their strictly academic counterparts experience lower rates of stress, and are more self-assured and self-aware (Thoerson, Miller, & Krauskopf, 1989). However, they can also experience high rates of stress when boundaries are not maintained, they become isolated, and focus too exclusively on cognitive aspects of their functioning rather than emotional/interpersonal ones. These aspects amongst others led to the recognition of psychologist distress within research (Sherman & Thelen, 1998; Thoerson, Miller, & Krauskopf, 1989). Sherman and Thelen differentiated from what marks distress versus what could become professional impairment. Distress entails the subjective experience of difficulties due to a variety of issues including stressors within psychological practice and those within the psychologist’s personal life. Impairment arises when these difficulties begin to have a significant effect on a psychologist’s ability to provide treatment to clients. A given level of distress is expected when doing psychological work but many psychologists are capable of managing these difficulties without them becoming a problem within how they practice. This is an important distinction to note between these terms as a psychologist under distress is not necessarily impaired. Sherman and Thelen conducted a national survey of practicing psychologists to determine how work issues and occurrences in life impact impairment. They described three primary types of impairment, including substance abuse, sexual indiscretions, and psychological disorders such as depression. Other areas of note
were relationship issues with a significant other or major illness as being the most significant areas related to impairment amongst other life events surveyed. The experience of professional impairment is not limited to professional psychologists. Student-trainees in doctoral-level psychology programs are also susceptible to these difficulties. The academic demands in classes, dissertation, practicum placements, and qualifying exams place a high level of stress on student-trainees as a population. In more recent years, there are other pressing concerns including debt from student loans and a heightened difficulty in obtaining APA-accredited internships. These factors are further complicated by other personal and environmental stressors that can occur to the individual during doctoral-level training.

**Shift in Terminology**

There were difficulties inherent within the term of professional impairment for professional psychology, and this section addresses how the need for new terminology came about. Despite increasing notice given to the concept of professional impairment in psychological research, the term itself did not increase in conceptual clarity. It has been noted by researchers within this area that professional impairment can be conceptualized a number of different ways depending upon who is discussing the concept (Elman & Forrest, 2007; Huprich & Rudd, 2004; O’Connor, 2001). As a result it was difficult to provide further information as to how to provide support and intervention for impaired psychologists and trainees when the term itself was not cogent. Impairment terminology broadened to include not only the typical issues like substance abuse but those including competence and ethical implications on the part of the practicing psychologist. Despite changing definitions on the part of researchers, these additions had not fully made their way into the more local levels of psychology, such as training programs. While student-trainees have expressed a desire to provide support based on surveys in regards to
impairment, it was still difficult to make into a reality as the term was misunderstood (Elman & Forrest, 2007). In addition, impairment as a term was perceived negatively with student-trainees based upon the idea that there is a lack of support and care present for trainees deemed impaired.

Overall, the use of the term impairment led to a misunderstanding of where and how the issues have developed. Elman and Forrest (2007) described this issue well, stating, “…the catch-all nature of impairment (a) merges descriptions of behavior with character and (b) commingles descriptions of behavior with causes of the behavior, thus making it difficult to distinguish whether the behavior is incompetent, diminished, unethical, or even illegal” (p. 503). These issues with the term also make it unclear as to how to approach intervention. Is the psychologist dealing with personal stressors that warrant attention or is the primary issue something more closely related to actual practice? The use of the term impairment does not adequately answer this question.

There were also legal implications that added to the necessity to change terminology and the following explains why impairment was detrimental terminology from a legal perspective. The most prominent legal difficulty is the relationship of the term impairment to that of the Americans with Disabilities Act (ADA) (Elman & Forrest, 2007). For the ADA, impairment is used to identify areas in which an individual’s functioning is limited or unavailable in some way. By using the term professional impairment, it becomes unclear as to what aspects of impairment the field of psychology is referring to as the ADA is already well established and has certain provisions under law. Falender et al., as discussed in Elman and Forrest (2007), describe several areas that expand on the legal ramifications of the term. If a faculty member, supervisor, or other gatekeeping entity were to state a student-trainee is professionally impaired when they actually have a disability of some type, this would be an illegal act. It is not just under the ADA to
question an individual with a disability as the law is designed to prevent those in positions of
authority from discriminating against those who are disabled. Even in the case where a trainee is
not actually disabled, there could still be legal trouble resulting from stating he/she is impaired as
the act could still carry the implications of discrimination and leave a supervisor or other
evaluator in a compromising legal position. The use of the term impairment also connotes that
an individual be provided with adequate support under the ADA provisions. This could also lead
to legal trouble if there were no adjustments provided. These reasons provided further evidence
that new terminology was needed.

Elman and Forrest (2007) worked with the Student Competence Task Force of The
Council of Chairs of Training Councils (CTCC) to develop a new term. The idea was to create
terminology that was cohesive, provided evidence of a deficit, based within functioning, and
maintained an attention to competence as the central feature. As a result of this effort, the term
problems of professional competency was coined. There are several potential benefits to the new
term as described by Elman and Forrest. The hope was that it can allow for better dialogue
amongst students and faculty as the emphasis has shifted to competencies rather than the notion
of character problems that were inherent within the term impairment. The term can aid faculty to
use competence issues as a framework for teaching particular skills rather than admonishing a
student-trainee. Another feature is that intervention plans can become more focused as they will
be based on concrete issues to be addressed by the student. The change in terms also means a
different emphasis for how trainee competence is assessed overall. It is hoped that faculty and
supervisors will be encouraged to make assessment of trainees more involved and
comprehensive. The term also falls in line more readily with the changing culture of
professional psychology as it relates to the issues of developing competencies, ethical concerns,
evidence-based practice, and how organizations become accredited. Finally, the most evident
benefit of the change in terminology is that there is no inherent relationship to the ADA and the
potential legal pitfalls that can arise.

**The New Concept Defined**

The shift in terminology to problems of professional competency requires a shift in
understanding from the concepts associated with professional impairment. This section provides
context for how the new terminology is distinct from professional impairment. While
professional impairment was primarily defined by the negative qualities associated with the loss
in ability to practice clinical work, problems of professional competency involves a
conceptualization of what aspects are present in order to understand when there are problems.
As a result, it is necessary to know what is meant by the term competency as it relates to training
in professional psychology. As stated previously, the overall culture of professional psychology
has taken on a sea change in the direction of understanding and developing competencies in
clinical work. As this understanding has evolved, so has the means to discuss competency itself.

Several authors (e.g., Elman & Forrest, 2007; Johnson et al., 2012; Kaslow et al., 2007)
have made reference to a well-rounded definition of competence as stated for physicians and
trainees in a study by Epstein and Hundert (2002). It is stated, “Professional competence is the
habitual and judicious use of communication, knowledge, technical skills, clinical reasoning,
emotions, values, and reflection in daily practice for the benefit of the individual and the
community served” (Epstein & Hundert, 2002, p. 226). Based upon this definition, it can be
gleamed what is expected to be contained within competence and provide a broader
consideration than that of the professional impairment terminology. This provides the basis for a
definition of problems of professional competency. Kaslow et al. defined it as a variety of
potential difficulties in areas including training, interpersonal functioning, psychological disorder, lack of insight, professionalism, and other areas to an extent that “they are unable to control and that affect their professional functioning” (p. 481). By using the term problems of professional competency, it allows for a more holistic discussion of how to identify problems as they occur and what may be necessary to intervene as it is not concerned solely with the negative aspects of clinical functioning. It is also hoped that by beginning with a conception of competence in the terminology it can allow for the term to be perceived in a less judgmental fashion, as this has been a criticism of the term professional impairment, both within the realm of practicing psychologists (Elman & Forrest, 2007) as well as student-trainees (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004).

**Limits to The Terminology**

Research within the area of problems of professional competency is still in flux and this section delves in what aspects are still being worked through. Despite the immediate utility with the updated terminology of problems of professional competence (Elman & Forrest, 2007), difficulties still remain as research has continued in this area. Johnson et al. (2012) note that there is a need to recognize that competence in and of itself is not a static construct that can be deemed achieved at a certain level through training and then remain unchanged. It must be taken into account that while a student-trainee has developed competence in the context of his/her training program and clinical placements, contexts will change as the individual progresses in his/her career. This means that while an individual may be more than competent in a community mental health setting for example, he/she would face a different set of challenges (and require different competencies) within a Veterans Administration (VA) hospital setting. With these considerations, it may be difficult to define exactly what competencies are necessary or sufficient
to keep in mind when considering whether or not an individual is experiencing problems of professional competence.

There are concerns inherent within the description of the terminology itself. Johnson et al. (2012) state one concern succinctly:

Although definitions of competence center around a psychologist’s ability to carry out certain tasks appropriately and effectively (Johnson et al., 2008; Kaslow, 2004), educators and supervisors remain keenly aware of the complexity of competence and the difficulties inherent in capturing its nuanced cognitive, affective, and relational dimensions. Although competence refers to an overall or integrated macro facility as a psychologist, competencies describes elements of knowledge, skills, and specific attitudes/values, or the essential micro components of competence (Bourg, 1990; Kaslow et al., 2004). (Johnson et al., 2012, p. 2)

As shown with the previous section of defining the terminology, there are several layers within the concept of competence or competencies that make it difficult to describe in a concise manner. While the use of competence as a concept provides a useful connection to the developments within clinical psychology as a field, is it involved within so many different areas that will make it difficult to accurately define what would be considered problems?

The difficulties of defining the limits for problems of professional competence are perhaps most salient within the population of student-trainees. It is important to consider that student-trainees are in the process of developing competency and that is effectively one of the goals of engaging in practicum and internship training (Schwartz-Mette, 2009). This consideration calls into question what the line is between an ongoing learning experience and a more serious issue that could be considered a professional competence problem. Falender and
Shafranske (2004) acknowledge that some of the difficulty arises from the fact that corresponding issues such as ethical behavior, personal trainee impairment, or the responsibility of the training program are all involved within the larger definition of problems of professional competency. This lack of consensus makes it all the more difficult for a supervisor or professor to know whether or not a trainee is having difficulty to the extent that intervention is necessary in the first place.

These discussion points are not meant as a means of dismissing the terminology of problems of professional competence, as there are clear advantages to continue use of this term over the previous professional impairment (Elman & Forrest, 2007). It is merely stated to keep in mind that this area of research continues to develop, change, and further refine itself. The use of clear and appropriate terminology provides more than just common ground to discuss these issues in the scholarly sense. It is also provides the groundwork for how to effectively assess and intervene with difficulties which is the purpose of this dissertation. It is also worth noting that while many researchers have adopted the new terminology (Elman & Forrest, 2007; Johnson et al., 2012; Kaslow et al., 2007), there are still those publishing recent research referring to the previous terminology of impairment, in both the populations of student-trainees (Schwartz-Mette, 2009) and practicing psychologists (Williams, Pomerantz, Segrist, & Pettibone, 2010).

While I will continue to use the new terminology of problems of professional competence within the primary content of this dissertation, relevant literature still using impairment terminology will not be overlooked. As a result, literature using both terms will be integrated to obtain a fuller perspective on these issues, particularly as it relates to useful information discussed prior to the more recent culture-shift emphasizing problems of professional competence as the preferred terminology.
What The Problems Are and How Often They Occur

Conceptualizing Competence Problems

With an understanding of the terminology of problems of professional competency covered, focus can now turn to what these competency problems are and how they are conceptualized. There are additional layers within how competence in discussed in research that can also shed light on how and where problems may develop. Kaslow et al. (2007) differentiate between aspects of competence that are deemed functional versus those that are foundational. Foundational areas are those concerned with the content areas covered in training and functional are more directly related to clinical practice. By making this distinction, it can not only differentiate where an individual is having difficulties if problems develop, it can help to provide guidance as to which parties may be more appropriate for providing support. For example, those difficulties that are considered more foundational may concern professors and others directly involved within an individual’s training program if discussing student-trainees, or licensing boards and other oversight bodies, in the case of practicing psychologists. Difficulties associated with functional aspects would most likely involve practicum/internship supervisors for student-trainees, or co-workers and peers for practicing psychologists. Kaslow et al. describe the means for identifying these issues:

Competence problems, indicative of interference in functioning, may be categorized based on origin (e.g., situational, developmental, due to personality and interpersonal dynamics); severity and chronicity; potential for remediation; and manifestation. They are observable through maladaptive patterns of behavior or via critical incidents (Kaslow et al., p. 481).

Johnson et al. (2008) state that there is also a difference between the moral character and the
psychological fitness of the individual. Moral character involves how an individual engages others and whether or not they are honest, empathic, and have other desirable values. Psychological fitness is more concerned with one’s affective/cognitive strength and how it pertains to successful and ethical clinical practice.

Another area for problems of professional competence to arise is when an individual is unable to complete given standards or achieve an acceptable level of clinical functioning (Kaslow et al., 2007). More specifically, these problems can exhibit themselves as limited training/experience, unprofessional behaviors, a dearth of self-reflection/insight, instances of overt prejudice, regular interpersonal difficulties, and a variety of others. More significant issues can emerge in the form of psychological disorders or substance abuse in some instances. Kaslow et al. also note that problems of professional competence can exist at a “specific” or “holistic and general” level. Specific refers to a concrete issue such as an inappropriate relationship with a client, and holistic/general refers to more broad-based issues like ongoing discrepancies in one’s professionalism. Regardless of the particular issue, it is expected that the contributing problem will lead to detrimental effects on an individual’s clinical work that is beyond his/her ability to manage.

Prevalence

Within the professional psychologist population. Regardless of how to define or discuss the concept of problems of professional competency, a larger question remains. How often is this phenomenon actually occurring within the field? Based upon older as well as more recent literature, it would appear that there is significant evidence to support a high prevalence of professional impairment within the clinical psychology field. In a study by Thoreson et al. (1989), 75 % of psychologists surveyed at this time endorsed personally experiencing some
instance of significant impairment over a three-year period. Instances of more specific symptomatology can be gained from a national survey of psychologists attending their own therapy conducted by Pope and Tabachnick (1994). It was stated:

A majority (61%) reported that, regardless of the major focus of therapy, they had experienced at least one episode of what they would characterize as clinical depression.

Over one out of four (29%) disclosed that they had felt suicidal, and almost 4% reported having made at least one suicidal attempt (Pope & Tabachnick, 1994, p. 225).

There are also significant rates of psychologists who have noticed problems of professional competence within their colleagues. In a survey study by Wood, Klein, Cross, Lammers, and Elliott (1985), psychologists surveyed stated that they believed roughly a quarter of their peers were affected by issues including depression, substance abuse, and “sexual overtures” that would negatively impact their client care.

More recently and perhaps even more distressing was another survey conducted by Barnett and Hillard (2001). Given a sample of 456 professional psychologists, 60% endorsed that they had continued to see clients despite feeling they were too impaired to do so. A rate of 60% was also found in an earlier study by Pope, Tabachnick, and Keith-Spiegel in 1987, where those surveyed recognized that they continued to provide services despite feeling too distressed to do so. It has been noted that many practicing psychologists make use of their own therapy with as high as 84% of 100 surveyed attending therapy at that time or previously in their career Pope and Tabachnick (1994). However, it must not be overlooked that the use of personal therapy could also be considered a preventative measure to cope with competence problems. It could be an indication of professional competence to take action in personal therapy.

**Within the student-trainee population.** Based on current research, graduate students
exhibit high rates of problems with professional competency (Schwartz-Mette, 2009). One study described by Schwartz-Mette suggested rates as high as 85% for students surveyed who knew of at least one individual with significant difficulties in their program. In a national survey study of training directors at APA accredited doctoral programs and internships, directors endorsed a high rate of competency problems for their student trainees. When asked whether they had at least one trainee over the past ten years who was impaired to the point of needing professional intervention, directors answered “yes” at a rate of 98% (Huprich & Rudd, 2004). In addition, 65% of program directors reported having one or more impaired trainees in their program at the time of the survey. High rates of competence problems can also be taken from data related to dismissals. Oliver et al. (2004) states, “Consistent findings across studies suggest that training directors have frequent dealings with students experiencing impairment, and that most programs have dismissed at least one student within a 3-year time span” (p. 142). These rates suggest that problems of professional competency are quite prevalent and in need of attention for individuals working with student-trainees at multiple levels.

Contributing Factors to Competence Problems

Psychologists as a Population

There are several relevant issues which place professional psychologists and student-trainees at risk to develop competency problems. Some of these issues reside within population characteristics of professional psychologists and others within the clinical work itself. The following sections address both of these points in detail. Psychologists represent a unique population that becomes intertwined with the difficulties they face in clinical work. They are not immune to the psychological issues that affect typical individuals and in fact, often come from difficult developmental trajectories themselves that may lead to additional risk for problems of
Psychologists as a population have high rates of abuse histories and alcoholism within their families of origin (Barnett et al., 2007; O’Connor, 2001). Around 1/3 surveyed also noted incidents of abuse as adults as well (Barnett et al., 2007). Rates of developmental trauma have reached as high as 69% for female psychologists as compared to control groups. It is also important to note that these female psychologists studied did not exhibit as many symptoms when psychotherapy was considered in analyses. Thoreson and Miller (1989) noted that for female psychologists, suicide rates were higher than the female population in general; however the inverse was true for male psychologists. It would appear that in general, female therapists have a heightened history of difficulty as compared to women that work within other fields (Barnett et al., 2007). Barnett et al. notes that women therapists experience greater instances of abuse growing up, alcohol abuse by parents, and other chaotic events within the family system when compared to their female counterparts in other occupations. It was also stated that they have a higher likelihood to have experienced the loss of someone within the family as well as inpatient hospitalization of a parent for mental health reasons.

Psychologists also often adopt the role of the “parentified” child within their families, thrusting them into the caretaker role at an early age (O’Connor, 2001). O’Connor has suggested that individuals used to these types of roles as children can be motivated to continue the role as an adult. O’Connor states, “This fact suggests a possible link between a history of abuse, alcoholism, or parentification in the family of origin, and a desire to enter a helping profession. Such a profession allows a continuance of the caretaking role, as well as the potential for mastery of chaotic environments, more generally” (p. 346). This hypothesis for the developmental and career trajectory of therapists maintaining their caregiving role and potentially using it to work
through childhood difficulties has also been suggested by other authors (Barnett et al., 2007). It is important to note these predispositions as it helps to place psychologists within the same context of struggles that would be attributed to any other person. By understanding this fact, it can be understood that psychologists also require support and the common understanding within the field that psychologists are expected to self-monitor may not be enough when problems of professional competence arise.

**Difficulties with Clinical Work**

The developmental, traumatic, and parentification considerations can set the stage for problems of professional competence in light of the inherent challenge that arises with all clinical work in psychology. Whatever difficulties a professional psychologist may face are challenged by a field that requires constant mental, emotional, and interpersonal involvement. Psychologists maintain a variety of roles on any given day, ranging from supervisor to professor to researcher, not to mention psychotherapist (O’Connor, 2001). These multiple roles place additional pressure on the already complicated nature of providing therapy to clients on a regular basis. Therapy for many clinical psychologists is often practiced session after session, with little to no space in between. If a particular session bears a heightened emotional encounter for client and therapist, there is rarely time for that therapist to regroup before beginning another session. The overall professional role and expectations are captured well by O’Connor:

As clinicians, the role encourages, if not requires, a heightened sensitivity to people and environment, a willingness to meet others’ needs before one’s own, the ability to withhold emotional response in the face of reported trauma and intense emotion, and the ability to tolerate intense emotion and ideation with limited or no outward personal response (p. 346).
These factors paint the picture of a highly demanding career that would apparently leave little room for the person of the psychologist and his/her own needs in the midst of what is needed to do the job. However, it is assumed that trainees learn how to cope with this inherent role strain as part of their training.

Beyond the difficulties inherent within the demands of the psychologist’s role, there are other more specific issues that are noteworthy when considering the risks of the job itself. In the forefront of this discussion are those issues that relate specifically to the clients seen by psychologists. The chronicity of particular disorders and the intensity of the emotional stress placed on the psychologist by presenting problems like personality disorders can place high strains on a psychologist (Barnett et al., 2007) and it has been found within literature that psychologists will face heightened “distress at some point during their careers” (Barnett & Hillard, 2001). Clients who have an ongoing history of high-risk behaviors and the potential for suicidal or homicidal action are also present. These client issues can place psychologists at risk for ongoing distress as well as vicarious traumatization in some cases (Barnett et al., 2007; Johnson et al., 2012). These difficulties are featured against the backdrop of insurance and administrative compliance and the structure of managed care (Barnett et al., 2007).

The question then becomes how are psychologists able to cope with these demands? Unfortunately, that answer is often not as well as one would hope. Despite their career choice, psychologists are often poor monitors of their own mental health and are likely to underreport difficulties which may affect their ability to practice effectively (Barnett et al., 2007; O’Connor, 2001). A possible explanation for this is that psychologists are as susceptible to such social psychology phenomenon as the self-serving bias as any other individual; meaning that they will have difficulty recognizing competence issues or ascribe them to other circumstances unrelated
to themselves (Johnson et al., 2012). While this is problematic, it would appear that psychologists are not alone in this regard, as it has been noted that medical practitioners experience similar difficulties in assessing competence. Perhaps most distressing is the fact that it has been demonstrated in research that individuals with the least objective competence levels are also the least likely to assess their competence well or make use of “benchmark exemplars” (Johnson et al., 2012) to help bolster their work functioning. Another inherent difficulty is that psychologists can often operate within contexts that are isolating (Barnett & Hillard, 2001; O’Connor, 2001), such as a private practice. This situation provides an even higher likelihood that a psychologist having competence issues will go unnoticed. Even when problems of professional competence are acknowledged, few psychologists make use of resources such as colleague-assistance programs available within their state (Barnett & Hillard, 2001). Some authors have also noted that psychologists may be susceptible to greater instances of competence problems as they get older (Johnson et al., 2012). This is particularly relevant as psychologists as a population often practice past the typical retirement age, including some that will practice up until the end of life. This tendency begs the question of what effects there are on professional competence as the result of a decline in executive functioning that comes with typical aging, let alone the other issues previously mentioned for psychologists’ ability to recognize competence problems or seek support.

Differences Between the Student-Trainee and Professional Psychologist Population

This section addresses the fact that student-trainees and professional psychologists face different challenges as populations in considering competency problems. Trainees represent a more vulnerable population than their more experienced peers. For many trainees, their initial training program is their first experience with providing psychotherapy and it can be quite
exhausting for those new to the experience (Schwartz-Mette, 2009). They also face multiple demands from several different areas as they adopt a variety of roles on any given day within the course of their training over several years. Schwartz-Mette provides examples stating, “They may attend classes, teach classes, conduct therapy, conduct research, and/or mentor undergraduates. Often trainees switch between these roles daily, if not hourly” (p. 92). The regular pressure and different demands placed upon trainees within these roles is set against the backdrop of financial worries, “pressures of evaluation (both formal and informal)” (Schwartz-Mette, 2009), and extensive amounts of time devoted to training in and outside of the classroom. Trainees may be at a higher risk for problems of professional competence as they are new to these stressors and have not yet fully developed coping mechanisms to help bolster their functioning. This combination of factors can leave trainees more susceptible to burnout before they have even begun their careers in the field.

Trainees are regularly evaluated within their training programs, practicum placements, and internships (Schwartz-Mette, 2009). Regular evaluation is a crucial component within training which is required at given intervals. This is not the same scenario for practicing psychologists, particularly as they enter settings with more independence such as private practice. This can leave many psychologists isolated and less likely to receive support prior to committing an ethical violation (O’Connor, 2001). This difference highlights the importance to intervene early within the student population as there is no guarantee that a practicing psychologist will be monitored in any consistent way later on in his/her career. In general, it has been stated within recent literature (Schwartz-Mette, 2009) that less is known about the incidence and impacts of impairment or problems of professional competence within the student
-trainee population as compared to professional psychologists. These points highlight the need to consider this population as a high-risk one in need of intervention and/or preventative efforts. It is this perspective that provides the rationale for this dissertation and the need to provide education and intervention for a student-trainee population. By doing so, it is hoped that trainees will be better able to manage problems of professional competence amongst themselves and their peers in addition to having a more balanced perspective on competence problems later in their careers as well.

**Ethical Ramifications**

This section explains the importance of problems of professional competency as it is not just an issue for trainees and active psychologists but an ethical one for the field as a whole. The most basic argument for considering the ethical impacts of this issue is its effect on client care. The very first general principle within the APA’s Ethical Principles and Code of Conduct (2010) regards this most basic obligation, stating, “Psychologists strive to benefit those with whom they work and take care to do no harm” (p. 3). The question then becomes how can psychologists continue to adequately care for clients and prevent harm when their competence has been compromised? There is some data available to help provide support for this association. A national survey done by Huprich and Rudd (2004) across doctoral programs and internship sites revealed that of those surveyed, 92% of the doctoral programs and 75% of the internship programs believed that competence issues had negatively impacted the trainees’ ability to serve clients. However, this data is limited to the survey of those involved in training and not the actual outcomes of the clients themselves and overall there is limited available research that acknowledges the effects of impaired or incompetent psychologists on clients (Williams et al., 2010).
This is an area in which psychology lags behind other professions as there are documented cases within medicine that show instances of competency problems indicated within the history of individuals under later disciplinary action when practicing (Papadakis et al., 2005). This issue becomes all the more crucial in regards to the practice of student-trainees. It has been argued that clinical supervisors and academic faculty have an ethical obligation to provide support and balanced evaluation to student-trainees to limit harm for clients and that trainees as well (Huprich & Rudd, 2004; Johnson et al., 2008; Schwartz-Mette, 2009).

The general stance within the APA ethical code is that psychologists are obligated to maintain a degree of self-monitoring. Specifically, “Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (APA, 2010, p. 3). However it has been argued within literature that it is not clear as to when psychologists should consider ceasing to see clients or what steps should be taken to make the necessary changes to return to competent practice (Williams et al., 2010). Their overall argument is that there is not adequate empirical research at this time to provide a decision point for when one’s impairment reaches a level that is deemed too detrimental to continue actively practicing and in need of intervention. It is also argued that this self-monitoring perspective is not reasonable for student-trainees as they are just beginning to develop their self-monitoring capabilities (Schwartz-Mette, 2009).

Other researchers debate that the self-monitoring perspective in general contains a flawed understanding for how to deal with problems of professional competence. Johnson et al. (2012) present this argument well, stating:

Notions of self-contained identity, preeminence of personal control, and presumed accuracy of self-assessment drive professional standards that make ongoing evaluations
of competence a largely private affair at the level of the individual psychologist. This is the case despite the fact that human beings are conspicuously inaccurate in their self-assessments of any characteristic or competency (Dunning, Heath, & Suls, 2004).

(p. 1)

These statements present a compelling argument for how the field of psychology views problems of professional competence and how to manage them so as to maintain ethical practice. These divergent and at times counterintuitive perspectives illustrate that this is a concept with far-reaching ethical consequences that is not well understood at this time.

Assessing Problems of Professional Competence

Aside from the ethical dilemmas and identification of problems of professional competence, it is also pertinent to consider how it is currently being assessed. This section addresses how competence problems are detected and who bears responsibility for this detection within student-trainees. The most basic form of assessment is done on an individual basis, as practicing psychologists are expected to do based upon ethical obligations discussed previously (APA, 2010). The assumption is that a psychologist will maintain an awareness of his/her own mental health, personal difficulties, or other areas that will impact their practice. This assumption appears shaky when considered against the poor reliability of individuals to maintain their own self-assessment (Johnson et al., 2012). It would stand to reason that the next source for assessing competence would be other practicing psychologists. This is another difficult assumption to make as often psychologists will be wary of commenting upon their colleagues’ competence issues even if they have begun to notice difficulties (O’Connor, 2001). O’Connor also states that oftentimes practicing psychologists will seek to distance themselves from
colleagues with competence issues. This provides less contact and therefore less possibility to make an accurate assessment when problems of professional competence arise.

Student-trainees by comparison have more regular contact with evaluative entities such as their training program and clinical practica/internships. As a result, it could be assumed that there would be more opportunities to assess for competence problems in an objective fashion. However it is often the case that student-trainees are the first to notice problems of professional competence (Huprich & Rudd, 2004; Oliver et al., 2004; Schwartz-Mette, 2009). Huprich and Rudd (2004) provided evidence that student-trainees often bring up issues of competence regarding their peers at high rates. These competence issues are typically related to interpersonal difficulties rather than larger ethical violations (Oliver et al., 2004). Peers appear to be a logical source of information to determine competence problems, but they are at best an informal means and the question remains as to who has the ultimate responsibility in assessing competence.

Some would argue that this responsibility rests with the clinical supervisors within a practicum or internship (Schwartz-Mette, 2009). However this route is not full proof either as many trainees will be highly aware of the evaluative responsibility of their supervisors or not come forward when they are experiencing difficulties. This leaves the supervisor to pick up on cues that may or may not be readily available, especially as supervisors have multiple responsibilities of their own. Overall the means for assessing problems of professional competence in trainees is a moving target at best as the methods for doing so are inconsistent and without concrete norms (Johnson et al., 2008; Kaslow et al., 2007).

**Responsibility for Monitoring**

Perhaps the larger issue is not how problems of professional competency are detected, but who has overall responsibility for assuring that this issue is noticed at all? This is a difficult
question to answer in light of all the different oversight entities that students encounter throughout their training. While it would appear that having multiple contacts for gatekeeping would help to vet trainees with competency issues, this is not always the case. Often different entities will continue to allow problematic students to continue in their training and make assumptions that the other entities should have taken action rather than themselves (Johnson et al., 2008). Johnson et al (2008) describes this issue with an apt metaphor:

I call this the *hot potato game* in professional training in that the last psychologist or board engaged with the problem trainee may indeed feel stuck with a hot potato and may be understandably prone to question whether others who have engaged the trainee have satisfactorily fulfilled their ethical obligations. (p. 590)

While this may be a valid concern, handling training for students in clinical psychology is hardly a clear endeavor, and it is not necessarily the case that many psychologists are ignoring a clear ethical obligation. The overall point of the “hot potato game” analogy highlights the fact that there is no formal system in place that provides guidance for who should be intervening with problems of professional competence (Johnson et al., 2008). And this process is made more difficult as those responsible for providing direct training to students often face conflicting obligations in their evaluative functions versus supportive ones. Johnson et al. discuss this dilemma through the concept of the *advocacy-evaluation tension*. This term encompasses the idea that over time those directly involved within training of a student often develop close interpersonal relationships that reflect a process of evolving into a status that more closely reflects that of a mentee or colleague. This can affect the ability to provide a more objective assessment of competence for the trainee in question.
An example of how this hypothesis is manifested can be seen in how supervisors approach letters of recommendation. It is noted in research that often supervisors are aware of their tendency to provide letters of recommendation for supervisees that are presented in a more positive light than is accurate based upon their experience with the trainee (Falender & Shafranske, 2004). This confusion adds to the already difficult picture in regards to managing problems of professional competency amongst student-trainees. It also punctuates the position within current research that this issue needs to be brought to the forefront of clinical psychology training through the use of a more organized procedure that is common amongst programs (Forrest et al., 2009; Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007).

**Providing Support and Intervention for Competency Problems**

**Response Within the Field**

This section identifies current practices and attitudes of professional psychologists and how the field as a whole has responded to problems of professional competence. Despite the high prevalence of such difficulties, the general attitude within the field is largely that of a “hands off” approach (Johnson et al., 2012; O’Connor, 2001), where psychologists with competency problems are given increasing distance from colleagues. Colleagues without problems are often hesitant to approach, report, or provide any support for an impaired psychologist (Gizara & Forest, 2004). Psychology as a field is behind other fields such as medicine that have clearly outlined procedures and methods for an impaired physician to receive support and education to ensure his/her well-being and that of his/her patients (AMA, 2011). At this time, few states have active colleague assistance programs in place for psychologists, and many have discontinued programs as a result of a perceived lack of need or use by impaired psychologists (Barnett & Hillard, 2001). There are some independent programs available, such
as the Patient and Colleague Assistance Committee (PCAC) of the Cleveland Psychoanalytic Center, which has a support system in place including workshops to educate professional psychologists about approaching colleagues with competence problems or addressing their own problems if they arise (Clemens, Horowitz, & Sharp, 2011).

Unfortunately too few of these types of programs exist and often the first time any competency issue is addressed is once a psychologist has already committed an ethical violation (O’Connor, 2001). At this point, the process is largely handled from a legal standpoint of a state regulatory board or ethics committee. There is little to no thought of support or rehabilitation for the psychologist with competency problems to return to practicing. To add insult to injury, the convicted psychologist becomes further isolated from colleagues, as they have now deemed him/her to be flawed in some way and should therefore be avoided at a time when he/she could use the support of colleagues the most.

Johnson et al. (2012) argue that the current perspective of the APA ethical code is embedded within an individualistic or Western tradition. This perspective downplays the need for consideration of the perspective of one’s peers and how in a broader relational sense, their well-being is intertwined within our own. This individualistic logic seems to be counterintuitive to the spirit of clinical psychology. It is well summarized by O’Connor (2001), “To abandon the psychologist who may be rehabilitated because the effort is difficult is inconsistent with the effort psychologists might be more willing to extend for their clients” (p. 348).

**Intervention for Trainees**

This section examines the response of training programs to problems of professional competency and current perspectives on how support is provided. In regards to intervention for problems of professional competence, the most basic means is an adherence to self-monitoring,
although this task has not been deemed sufficiently helpful within the trainee population (Schwartz-Mette, 2009). The next logical step for many training programs has been the recommendation of personal therapy for the trainee (Elman & Forrest, 2004; Forrest et al., 1999; Huprich & Rudd, 2004; Kaslow et al., 2007). It is in fact the most recommended form of intervention for competence issues, far ahead of any other options (Forrest et al., 1999). This practice is often the most sensible given that many training programs recommend a course of therapy regardless of competency problems (Elman & Forrest, 2004). Despite the assumption that therapy will be helpful within the case of the trainee with competence problems, there is not clear evidence to suggest that trainees receiving personal therapy improve in their clinical practice or overall competence.

Elman and Forrest (2004) surveyed training directors in doctoral psychology programs to attempt to gain insight into how they are using therapy as a remediation intervention for those trainees struggling with problems of professional competence. An overall theme emerged regarding how training programs struggled with finding a balance between maintaining confidentiality in treatment for the trainee versus obtaining the necessary information they needed to ensure that the trainee’s competency issues were being addressed. Many programs surveyed adopted a “hands-off approach” where they would recommend trainees to seek treatment but not make it a mandatory part of remediation measures. This approach also erred more on the side of confidentiality for the trainee as the process was largely left up to the trainee to obtain treatment and there was no further monitoring of progress or treatment goals. Fewer programs overall adopted a more active approach that outlined specific plans for how therapy would be used to assist the trainee. For this approach, distinctions were also made between minor and major issues which determined whether or not treatment was simply recommended for
ongoing developmental training or treatment was deemed mandatory and specific treatment goals were included along with contact with the therapist.

There are other potential options for a means of intervention for students with problems of professional competence. Schwartz-Mette (2009) offer additional practicum experience as another possible intervention but recognize the inherent difficulty in offering more clinical contact for a trainee with already established competency problems. Regardless of the specific means, any intervention is typically delivered within the framework of a remediation plan for the student-trainee in question. And it has been noted within literature that remediation plans are delivered and conducted in different ways by different training programs (Elman & Forrest, 2004; Kaslow et al., 2007; Schwartz-Mette, 2009). Thus is has been suggested within current literature that there is a need to develop more concrete guidelines for how remediation programs are conducted including clearly outlining expectations.goals for the student, providing useful means of evaluation, and maintaining transparency and open communication amongst all parties involved (Kaslow et al., 2007).

Professional psychology still requires additional structure in this area, and could draw on the processes for competency intervention being developed within other professions. The medical field has been working with how to provide intervention through a similar concept deemed professionalism, defined as, “the ethical and humanistic skills needed to practice” (Bearnstein & Fryer-Edwards, 2003, p. 742). Within the study by Bearnstein and Fryer-Edwards, trainees wrote a Critical Incident Report (CIR) as well as engaged in individual interviews with faculty members. The goal was to compare these two interventions in regards to promoting reflection on professionalism during the students’ training, in which the authors concluded that the use of interviews was most effective in eliciting reflection on the topic. This
study provides another avenue to consider within clinical psychology training. While the intervention provided in the study was not explicitly related to trainees who were already experiencing issues with professionalism, it could be considered a means of providing a crucial proactive intervention. By implementing faculty interviews with student-trainees in clinical psychology that focus specifically on experiences of competency within clinical training, direct intervention could be given prior to consideration of remediation.

**Summary**

Research within the area of problems of professional competency is growing but additional attention is necessary. It is already known that competency issues exist within the professional psychologist and student-trainee population. There is an ethical imperative to address these difficulties in order to protect and better serve clients. While there is existing evidence regarding the assessment and intervention for problems of professional competence, additional research is warranted within this area. Indeed, many current researchers provide extensive recommendations for creating structured and effective means to cope with and provide support for problems of professional competency within training programs (Elman & Forrest, 2004; Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007; Schwartz-Mette, 2009). Kaslow et al. acknowledge, “There is a paucity of information regarding the evaluation and management of competence problems” (p. 480). The proposed study by this writer seeks to address this issue directly through the use of an intervention program.

**Method**

**Research Questions and Hypotheses**

Research questions answered within this study focused on student-trainee knowledge regarding problems of professional competency and attitudes about its effect on their own
careers as well as attitudes about support-seeking when problems arise. The following hypotheses are based upon data taken from two groups across two time periods for each group. These time periods consisted of a pre and post-measure. An intervention was given in between these time periods to one group and no intervention was given to the other in order for it to be a comparison group. Further explanation is provided within the Procedure section. A brief qualitative measure was also used and further detail is provided in the Qualitative section under Results.

**Hypotheses.**

Hypothesis 1 – Participants in the first-year group will demonstrate an increased knowledge of problems of professional competence from the pre to post-intervention measure.

Hypothesis 2 – Participants in the first-year group will demonstrate more favorable attitudes toward seeking support for problems of professional competency from the pre to post-intervention measure.

Hypothesis 3 – Participants in the first-year group will demonstrate higher disagreement that problems of professional competency are an individual problem from the pre to post-intervention measure.

Hypothesis 4 – There will be a significant change in participant attitudes in the first-year group regarding likelihood to experience problems of professional competency in their careers from the pre to post-intervention measure.

Hypothesis 5 – Participants within the second-year group will show no significant change in scores on the self-report measure from pre to post-intervention.

**Participants**

This study took place within a Psy.D. program in New England. Student-trainees from
the first-year and second-year cohort were invited to participant in the study on a volunteer basis. Those choosing not to participate within the study were invited to attend the intervention presentation without participation in the self-report measure. Permission was obtained from faculty in order to engage student-trainees within the context of their Professional Seminar classes. I made a brief notification to the Professional Seminar classes in person to ask for participation in the study, while providing a brief outline of the study. An email notification was also sent to all students asking for their participation. At this time, both faculty and students were notified of anticipated risks and benefits to this study as well as the date and time for the intervention presentation. There were no anticipated risks of the study and benefits included increased knowledge about problems of professional competency and improved attitudes for support-seeking behavior. These benefits were demonstrated by a significant change in self-report data from pre to post-measure. There were 31 participants from the first-year group and 16 participants from the second-year group in this study. Additional detail regarding benefits and demographic data can be found in the Results section.

Procedure

The intervention consisted of a 50-minute powerpoint presentation conducted by this writer with time allotted before and afterwards to complete a self-report measure. The presentation consisted of relevant information about problems of professional competency taken from the content of the literature review of this document. A copy of this presentation is available in Appendix A. The intervention was conducted during the Professional Seminar class during the spring 2014 semester at the New England Psy.D. program. Participants completed a 10-item self-report measure both prior to and directly following the presentation intervention. The second-year group was given the same 10-item self-report measure at two different time
points but was not given the presentation intervention.

Measure

A ten-item self-report measure was developed by this writer as there are currently no established measures within the literature to gauge knowledge and attitudes regarding problems of professional competency. This measure was given to all participants as discussed above. The measure consisted of items asking participants about their level of knowledge of problems of professional competency and their attitudes about providing support for peers or seeking support from faculty/supervisors for themselves or others. A copy of the measure is available in Appendix B. In addition to the ten items, demographic data was collected in the form of age, sex, racial/ethnic background, and current year in Psy.D. program. No other identifying information was taken from the measure and all participants were given coded identification to ensure confidentiality of responses. A copy of the informed consent/demographic letter is available is Appendix C.

Data Analysis

Data from the self-report measure was analyzed primarily through the use of a within-group t-test to assess for significant changes across time. Specifically, the dependent variable consisted of scores from the self-report measure with the independent variable of time. The data was arranged in separate sections for individual questions from the self-report measure corresponding to the five hypotheses presented within this methodology section. Any significant differences were determined at the alpha .05 level. Significant results are presented within the results section and outlined within tables in that section.
Results

Quantitative Data

The samples for analysis consisted of 31 participants for the first-year group and 16 participants for the second-year group. Several surveys were discarded as individuals from both groups who took part in the pre-test survey did not respond to the post-test survey and vice versa. Specifically, three surveys were removed from the sample of first-year participants and one survey was removed from the sample of second-year participants. Demographic characteristics for the first-year sample are as follows: 30 females, 2 males, 29 identified as Caucasian, 2 identified as Asian/Pacific Islander, and 1 identified as other (Hispanic/Latino and Caucasian) for racial background, and all were within the age range of 22-44. Demographic characteristics for the second-year sample are as follows: 14 females, 3 males, all identified as Caucasian for racial background, and all were within the age range of 22-36. Note that these demographic samples reflect a sample size prior to eliminating inconsistent surveys as the demographic data and informed consent were collected at an earlier date.

Hypothesis 1. The first hypothesis was that individuals would experience an increased knowledge of the topic of problems of professional competence from pre to post-test. This hypothesis most directly relates to the first two questions on the survey. Question 1: “How knowledgeable are you regarding the term problems of professional competence?”; Question 2: “Are you confident that you understand how competency problems can affect trainees and professional psychologists?”. A paired-samples t-test was used to analyze survey data for the first year sample for all questions on the survey individually. Analysis showed a significant increase in mean scores for both Question 1 from pre-test (M= 2.38, SD=0.55) to post-test (M= 3.16, SD=0.73); t (30) = -4.50, p = 0.00 and Question 2 from pre-test (M= 2.58, SD=0.67) to
post-test (M= 3.32, SD=0.74); t (30) = -4.13, p = 0.00. The second year sample did not show a significant difference in scores from pre to post-test. This was expected as this sample acted as a comparison group and did not receive the intervention presentation.

**Hypothesis 2.** The second hypothesis was that participants would become more favorable in their attitudes toward support-seeking behaviors. This applies to both obtaining one’s own support and obtaining support for others. This hypothesis most closely relates to the content of questions 3, 4, 5, 6, 8, and 10 stated as follows: Question 3: “Would you feel comfortable providing support for a peer if you felt he/she had competency problems?”; Question 4: “Would you accept support from a peer if he/she discussed concerns about your own competency?”; Question 5: “Would you feel comfortable approaching a training faculty regarding concerns about a peer’s competency?”; Question 6: “Would you feel comfortable approaching a training faculty regarding concerns about your own competency?”; Question 8: “Do you feel confident that a peer could improve his/her competency if provided adequate support?”; Question 10: “Would you be willing to provide support for a peer if you felt he/she had competency problems?”. The hypothesis was supported in the areas of comfortability for providing support for a peer (Question 3) and approaching a faculty for a peer (Question 5). This was supported through the paired samples t-test analysis which showed significant differences in scores for Question 3 from pre-test (M= 2.35, SD=0.60) to post-test (M= 2.90, SD=0.87); t (30) = -2.72, p = 0.01 and question 5 from pre-test (M= 2.25, SD=0.81) to post-test (M= 2.74, SD=0.92); t (30) = -2.05, p = 0.049. The other questions pertaining to one’s own competency (Questions 4 and 6) and willingness to provide support (Question 10) did not demonstrate a significant change from pre to post-test. There were no significant differences in the second year sample in regards to these questions as expected.
Hypothesis 3. The third hypothesis was that participants would provide higher disagreement that problems of professional competency are an individual problem from the pre to post-test. This hypothesis was most directly related to the content of Question 7: “Do you agree that problems of professional competency are best left for the individual with competency problems to deal with?”. Due to the wording of this question and the nature of the hypothesis, this question was reversed scored prior to analysis by this writer. This hypothesis was not supported through analysis and the result of the paired samples t-test was not significant for this question for the first year sample. The second year sample also showed no significant change from pre to post-test for this hypothesis as expected.

Hypothesis 4. The fourth hypothesis was that participants will demonstrate an attitude that they are likely to experience problems of professional competency in their careers from the pre to post-intervention measure. This hypothesis most directly relates to the content of Question 9: “Do you feel that you could experience competency problems at some point in your career?”. This hypothesis was not supported through analysis and the result of the paired samples t-test was not significant for this question for the first year sample. The second year sample also showed no significant change from pre to post-test for this hypothesis as expected. All scores for the paired-samples t-test for the first year and second year groups can be found in tables 1 and 2, respectively.
Table 1

*First Year Sample x Time (Pre vs. Post)*

<table>
<thead>
<tr>
<th></th>
<th>Pre-test M</th>
<th>SD</th>
<th>Post-test M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
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<tbody>
<tr>
<td>Q1</td>
<td>2.38</td>
<td>0.55</td>
<td>3.16</td>
<td>0.73</td>
<td>-4.509*</td>
<td>30</td>
<td>.000</td>
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<tr>
<td>Q2</td>
<td>2.58</td>
<td>0.67</td>
<td>3.32</td>
<td>0.74</td>
<td>-4.135*</td>
<td>30</td>
<td>.000</td>
</tr>
<tr>
<td>Q3</td>
<td>2.35</td>
<td>0.60</td>
<td>2.90</td>
<td>0.87</td>
<td>-2.725*</td>
<td>30</td>
<td>.011</td>
</tr>
<tr>
<td>Q4</td>
<td>2.96</td>
<td>0.75</td>
<td>3.22</td>
<td>0.80</td>
<td>-1.489</td>
<td>30</td>
<td>.147</td>
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<tr>
<td>Q5</td>
<td>2.25</td>
<td>0.81</td>
<td>2.74</td>
<td>0.92</td>
<td>-2.051*</td>
<td>30</td>
<td>.049</td>
</tr>
<tr>
<td>Q6</td>
<td>3.03</td>
<td>0.87</td>
<td>3.48</td>
<td>0.85</td>
<td>-1.916</td>
<td>30</td>
<td>.065</td>
</tr>
<tr>
<td>Q7</td>
<td>4.64</td>
<td>0.55</td>
<td>4.87</td>
<td>0.34</td>
<td>-1.880</td>
<td>30</td>
<td>.070</td>
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<tr>
<td>Q8</td>
<td>3.58</td>
<td>0.99</td>
<td>3.83</td>
<td>0.93</td>
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<td>.292</td>
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<td>Q9</td>
<td>3.77</td>
<td>0.80</td>
<td>3.93</td>
<td>0.85</td>
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<td>30</td>
<td>.493</td>
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<tr>
<td>Q10</td>
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<td>0.88</td>
<td>3.51</td>
<td>0.92</td>
<td>-.538</td>
<td>30</td>
<td>.595</td>
</tr>
</tbody>
</table>

* = significant result
Hypothesis 5. The fifth and final hypothesis was that the second-year sample would not show any significant changes in scores from pre to post-test. Based upon the within-group t-test analyses, this was shown to be the case. A between-groups t-test was also used to detect any further differences between the first and second-year samples. Specifically, to see if there were any significant differences between the intervention group (first-year sample) and comparison group (second-year sample). This analysis was done using the entire mean scores for the first and second-year groups at the pre and post-test time points. There was no significant difference shown between the first-year (M= 3.09, SD=0.76) and second-year group (M= 3.42, SD=0.70) at pre-test; t (18) = -1.00, p = 0.33. There was also no significant difference shown between the first-year (M= 3.50, SD=0.60) and second-year group (M= 3.35, SD=0.64) at post-test; t (18) = 0.53, p = 0.60. Overall, while there were significant changes seen within the first-year group from pre to post-test, there were no significant differences between the first and second-year groups at either time point.

Qualitative Data

A four-item qualitative survey was given to the first-year sample to complete
approximately 30 days following the intervention presentation. These questions were used to gain any additional unstructured information that the participants could provide beyond what was asked within the 10-item quantitative survey. The follow-up survey had a response rate of around 50% as 16 participants responded of the 31 participant sample of first-year students. The qualitative data provided was analyzed using the Interpretative Phenomenological Analysis (IPA) method (Smith, 2008). The primary goal of IPA “is to explore in detail how participants are making sense of their personal and social world, and the main currency for an IPA study is the meanings particular experiences, events, states hold for participants” (Smith, 2008, p. 53). In this case, the analysis was interested in how first-year participants made sense of the particular experience of the intervention presentation event and whether or not it had any lasting effects on their experience following the event. Analysis via IPA is done by reading through responses multiple times, initially noting anything that is interesting about the responses, determining themes, and then arranging the themes into larger clusters. It must be noted for all qualitative data that the themes that emerged through the IPA process are based upon what could be gleamed from the responses given. Many respondents provided minimal information on some questions, often simply answering “no” or “no change” and close to all 16 respondents provided “no” responses on at least one question of the follow-up survey.

Several themes emerged from the follow-up survey that clustered into a smaller number of overarching themes. Most prominent was the attention given to responsibility in light of intervention for individuals experiencing competence problems. This theme was most apparent in Questions 1: “Do you feel your opinion on the topic of Problems of Professional Competence has changed since engaging in the intervention presentation? If so, what do you feel has contributed to this change?” and 4: “Are there any other thoughts or impressions you have
regarding the topic of Problems of Professional Competence since taking part in this intervention presentation that have not been addressed in the previous measure or this one thus far?” of the follow-up survey. Responsibility as a larger theme was expressed in several different ways for the respondents. The most basic delineation was made in the area of responsibility for self vs. other. Respondents acknowledged that they now felt more aware of the issue of competence problems, and that they could have an impact on a peer rather than leaving the responsibility to supervisors alone: “…feel that I have more of (an) obligation to approach my peers…before, it felt more as though that was a job for supervisors only.” Respondents noted that they felt a greater responsibility to the field of psychology: “…see the need for the field to discuss how to better address these issues.”

Another overarching theme was that of the relationship to peers experiencing competency problems and what impact that had on the communication process for intervention. This theme was most apparent in Question 2: “Have you discussed the topic of Problems of Professional Competence with your peers since engaging in the intervention presentation? If so, what issues have been most prominent in your discussions?” and Question 3: “How would you go about intervening with a peer experiencing competence problems and what do you see as potential barriers to intervening?” of the follow-up survey. Many respondents stated how the relationship with their peer could impact and be impacted by how they go about intervening with a peer experiencing competence problems. Respondents commented on the quality of the preexisting relationship: “…depend on my relationship with the person. If I felt comfortable enough with them, I would talk to them.” Relationship also informed the communication process in terms of trying to intervene with a peer with competence problems. Respondents focused on trying to maintain respect for their peer and engaged her/him openly and honestly when discussing
Relationships with peers not experiencing problems and supervisors also mitigated the process of communication and intervention. Respondents differed in whether or not they felt they should speak with the problem peer individually first or consult with other peers or a supervisor before intervening. When addressing the “potential barriers” aspect of Question 3 and what that would mean for the relationship with the problematic peer, defensiveness on the part of the peer was a common theme for respondents.

**Discussion**

The purpose of this study was to provide a pilot preventative intervention aimed at student-trainees within the field of clinical psychology. The primary goal of that intervention was to give student-trainees knowledge on the topic of problems of professional competence that would underscore the importance of this issue in their future careers and encourage them to seek support if they were ever to experience competence problems and/or provide support to colleagues experiencing these difficulties. There was little precedent available in the current literature on this topic, but the focus on preventative measures aimed at student-trainees is a common recommendation made by current authors in the area of problems of professional competence (Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007). It has been acknowledged that much of the literature on this topic to this point has focused on defining the concept, tracking incidence of competence problems, ethical implications, and other issues (Kaslow et al., 2007). Yet it has been noted that minimal attention has been given to how to manage problems of professional competence. This study is one of the first to my knowledge that directly proposes an intervention for individuals experiencing problems of professional
The results of this study both met and fell short of expectations addressed within the hypotheses proposed. First-year students did experience an increase in their subjective knowledge on the topic of problems of professional competence as shown with the significant results in Questions 1 and 2 that focused on student knowledge. First-year students’ attitudes toward support-seeking behaviors showed more mixed results. It appears that they felt more comfortable with the idea of supporting a peer and approaching a faculty about a peer as shown in the significant results for survey questions corresponding to these issues. However, significant results were not obtained through any of the other questions regarding support-seeking behaviors. It is interesting to note that most of these other questions related to obtaining support for oneself rather than providing it for a colleague. This finding is consistent with previous literature acknowledging psychologist’s reluctance to be open about their own competency problems for fear of judgment or negative consequences (Barnett et al., 2007; O’Connor, 2001). This could also be due to limited insight and ability to perform accurate self-evaluation, which while emphasized in ethical training, is known to be faulty due to the *self-serving bias* (Johnson et al., 2012).

This self-serving bias was not entirely supported by the results for Question 9 that asks whether or not participants felt they could experience their own competency problems in their careers. While there was not a significant change in attitudes for this question from pre to post-test, the mean scores are solidly within the “possible” agreement answer for the question. The same can be said for Question 7 that asks whether or not competency problems are an individual issue. Again, there was not a significant result for a change in attitudes from pre to post-test, but the mean scores for both time points show participants are within the “very” to “extremely”
disagree responses. It must also be noted that there was a similar pattern seen for several of the other questions on the self-report measure as participants did not have a completely negative attitude which would be evidenced in a low score. Yet there was not enough of a change in that attitude from pre to post-test to demonstrate a significant result. This was the case for Questions 6, 8, and 10 which showed neutral answers with scores of 3 that were neither in strong agreement or disagreement on the particular issue.

The second-year sample performed as expected within the stated hypotheses as they did not receive the presentation intervention. There was no significant change from pre to post-test for any questions these participants responded. There were also no significant differences between the first and second-year samples. This suggests that the first-year sample did not show significantly different attitudes than their second-year counterparts. Also, while the intervention presentation provided evidence for significant changes within the first-year population, it is not necessarily superior to the ‘training as usual’ that occurs within the doctoral curriculum already. Given these results, it cannot be determined whether or not the given intervention presentation would be useful beyond typical training. Overall, limited conclusions can be drawn about relationships between the two samples as the second-year group was only a comparison group and lacked the homogeneity in sample makeup that would be expected to be found within a true control group.

Qualitative results both agreed with and added to the findings of the quantitative analysis. The themes of increased awareness of the topic of problems of professional competence and its impacts is consistent with the significant findings on knowledge of the topic. The theme of responsibility also echoed that participants did not see competence problems as a wholly individual issue. The qualitative findings were also able to shed additional light on the mixed
results related to support-seeking behaviors. For both the quantitative and qualitative results, there was a clear delineation made between the self and other in regards to how support is given and sought out. The qualitative results provided more detail on the thought process and meaning behind this debate. The relationship theme in the qualitative results illustrates this point. It was clearly important to respondents that the quality of their peer relationships mattered in addressing competency issues and it shaped how they would go about providing support for a peer experiencing competence problems. Yet it also provided a more nuanced explanation of the quantitative results that showed greater comfort for providing support for a peer than receiving support for oneself. Many participants in the qualitative data provided evidence of their own motivations and personal meanings that is indicative of the IPA analysis (Smith, 2008). Many participants cited their own lack of comfort and confidence in themselves to provide adequate support. This was shown through the emphasis on obtaining consultation from peers or a supervisor or directing the problematic peer to a supervisor as their sole support. These findings from both quantitative and qualitative data are consistent with the current state of the literature as the process for conceptualizing, evaluating, and intervening for problems of professional competence are still in flux (Elman & Forrest, 2004; Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007).

**Implications of Research**

The study was designed to act as a preventative means of intervention for problems of professional competence. It sought to use an educational program as a way to provide useful information on the topic of professional competence in order to encourage current trainees to seek support of their own if they were to experience competence problems and provide support to peers experiencing problems as well. These goals are in line with recommendations outlined
for a restructuring of professional ethics with problems of professional competence in mind (Johnson et al., 2012). As a result, this study has much to offer the field in regards to what it can contribute to professional psychology training. This includes not only how student-trainees are being taught within their individual programs but how professional psychology programs as a whole respond to problems of professional competence.

One of the most noteworthy findings from this study is the response to Question 7 on the pre/post survey that asks the participant if he/she feels competence problems are best left for the individual to cope with. While this question did not show a significant difference in scores from pre to post-test, it did show the highest mean score for both the first (pre $M = 4.64$; post $M = 4.87$) and second-year samples (pre $M = 4.50$; post $M = 4.43$) of any question on the survey measure. Participants from both samples at both time points showed strong disagreement in the “very” to “extremely” range for this question. This suggests that the participants were well aware of problems of professional competence as a community issue that concerns student-trainees as well as professors, supervisors, and other entities. These findings coincide well with the “communitarian” approach to professional ethics emphasized by Johnson et al. (2012). This approach borrows from nonwestern cultures that are more collectivist and emphasize that interdependence of individuals upon one another for optimal functioning. This study could help to act as a litmus test of sorts to communicate to governing bodies within professional psychology that student-trainees are aware of the need to provide support to colleagues and challenge the individualistic self-monitoring approach emphasized in the current ethical climate.

Another broader implication to be made by this study is the complex nature of problems of professional competence. The inconsistency of attitudes within the quantitative data and wide-range of responses regarding the process of intervening with a peer illustrate that
participants within this study recognize that this issue is one to be handled delicately and encompasses many different aspects of training and professional practice. One particular qualitative response illustrates this point well:

Professional competence seems like a very big issue from an ethical perspective. If a psychologist is practicing outside the bounds of their competence they may be unwilling to embrace greater self-awareness and may be misleading clients…This can lead to psychologists developing a poor rapport with society.

These findings resonate with authors that have noted that competency problems lack conceptual clarity (Elman & Forrest, 2007; Kaslow et al., 2007) are dealt with in inconsistent ways amongst training programs (Huprich & Rudd, 2004), and have an overall lack of clarity for how to intervene with these difficulties and whose responsibility it is to do so (Johnson et al., 2008). The findings from this study can provide further evidence that training programs are in need of more explicit policies and procedures for how to assess and intervene when student-trainees are experience competence problems. It also highlights the need to consider multiple avenues to tackle this issue as it touches upon multiple aspects of training. Training programs could learn from these findings and adjust curriculum in classes to focus more explicitly on competence problems and their impact on professional ethics. Programs could also put in place remediation systems that are both comprehensive and supportive to help problematic students resume training activities as soon as possible. Practicum and internship sites could also benefit from increased coordination with training programs and adopt a rubric that clearly spells out which entity is responsible for which aspect of competence and how they will react if a competence problem arises.
Limitations of Study

There are several limitations to this study that are noteworthy. One of the primary limitations was the small sample size used. With samples of only 31 and 16 for the first and second-year samples respectively, the results of this study have limited generalizability. The ability to detect significant changes in the data may have been impacted by the small sample sizes as well. This is especially true in the case of the second-year sample, which was much smaller than the first-year sample and may have had an impact on the ability to detect significant differences in the between-groups analyses. The study would have also benefitted from a true control group which would have made the results more robust in their conclusions. As the second-year cohort is farther along in their training, have had more classes related to professional ethics, and have already engaged in their first practicum experience, there are likely several extraneous variables that made them unable to act as a true control group in comparison to the first-year sample. The fact that both samples were taken from the same institution also limits the generalizability of these findings to other professional psychology training programs.

The nature of the intervention is another potential limitation for this study. While the powerpoint format allowed for a simple means to convey information about problems of professional competence, it did not actively engage student-trainees and allow them to explore the more complex nature of the topic in the same way as an experiential intervention would have. This was a limitation that one participant explicitly mentioned in the qualitative data, stating that a script for how to approach a problematic peer would have been a useful addition to the presentation. An experiential activity could have allowed for student-trainees to practice approaching peers and engage in a more in-depth discussion on that experience and what they felt worked or did not work in regards to intervening. This form of intervention could have
allowed for more detailed results that could be generalized more easily to an actual remediation procedure within a training program.

While the qualitative data was analyzed via the process of IPA, data was not collected within the traditional IPA manner and this may have negatively impacted the ability to obtain more accurate depictions of the personal experience that is cornerstone to the IPA method (Smith, 2008). Typical IPA data is collected through interviews that are primarily open-ended as the researcher must be aware of his/her own impact upon the data gathering process. The questions given in the follow-up measure were more circumscribed and while the last question was open-ended it did not allow for the same depth of response that could have been obtained through interviews. The structured follow-up measure may have also limited the variety of themes that emerged as there were a small number of overarching themes within the study as it was conducted. Overall, detail within the qualitative data may have been sacrificed for ease of collection and to gather data in a timely manner following the intervention presentation.

The pre/post survey was another significant limitation as it is not an established measure within the topic of problems of professional competence. Instead, it was created by this writer as no available measure was found through a review of current literature on the topic. This writer attempted to include questions that had face validity as the content closely matched relevant aspects of problems of professional competence seen within the literature. However, this is a small part of a larger analysis of the psychometric properties of the measure and that limits its ability to be used reliably in a replication of this study or in another context. The likert-scale format of the measure had only a limited ability to assess participant attitudes on broad and complex topics such as providing support for a peer with competence problems. This is another area in which an experiential activity and more open-ended analysis could have provided more
detail on the conflicting nature of the attitudes shared by the participants in this study.

**Future Research**

The topic of problems of professional competence clearly requires additional research as it is currently misunderstood and relatively unknown within professional psychology research as a whole. Much of the research that currently exists provides background information related to conceptualization and assessment of competence problems but not the process and means for intervention for these difficulties, which is the primary reason for the intervention focus within this study. Future research should expand on how interventions are conducted and who is providing the intervention so that the “hot potato game” concept (Johnson, 2008) of allowing student-trainees with competence problems to continue forward in training is halted and ethical violations are avoided. In order to ensure this goal, research must be conducted at the larger programmatic level within professional psychology institutions. If pilot programs can be developed that make substantive changes within the core curriculum of a program and its policies for remediation, a much greater impact will be possible in the management and prevention of problems of professional competence.

While this study focused primarily on student-trainees, research with actively practicing psychologists in mind is also needed. The limited use of colleague assistance programs (Barnett & Hillard, 2001), high incidence of competence problems (Sherman & Thelen, 1998; Williams et al., 2010), and post-hoc nature of intervention (O’Connor, 2001) all illustrate that problems of professional competence are an issue worthy of further study. Further research is especially important for the practicing psychologist population as they become further and further removed from gatekeeping entities or the benefits of ongoing supervision that are readily available to student-trainees. Research into the use of group supervision programs or other potential
intervention tools would be extremely useful and much less costly in the long-term for licensing boards, malpractice claims, and self-care of the practicing psychologist.

Finally, additional work is needed in revising the current APA ethical code to better reflect the impact of problems of professional competence and what to do about them. Many current authors agree that the self-monitoring approach for competence problems and the individualistic nature of the current ethical code is insufficient for tackling competence problems across the field as a whole (Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007). New policies written into the ethical code and research conducted at the systemic level of governing bodies for professional psychology including the APA will help to ensure that problems of professional competence is seen as an issue that affects all psychologists. This would help to reduce the current stigma of colleagues with competence problems that adversely affects attitudes for support-seeking, further perpetuates the problem, and ensures ethical violations (O’Connor, 2001). Research that emphasizes the communitarian approach espoused by Johnson et al. (2012) will be most useful to increase awareness of problems of professional competence as an issue that is in need of overt cooperation on the part of practicing psychologists and student-trainees.

Closing Remarks

Superheroes provide an ambitious vision for society and a high bar of goals and ideals to strive towards. Yet it is often their failings and personal struggles that many find to be so compelling about these characters. The miraculous nature of these stories is not what the heroes achieve because they have no difficulties of their own, but rather what they accomplish despite them. In this regard, clinical psychologists are no different. The norm is not to maintain complete competence and control all times, but to continue to provide for clients despite the
ongoing challenges of this work. This goal can only happen when the difficulties are first acknowledged and allowed to be brought forth without judgment and recrimination. It is only through this process that those with competency problems can feel comfortable enough to seek support that will ultimately benefit not just themselves but their clients and the field of clinical psychology as a whole.

These goals are lofty and will likely take time and effort to achieve within a field that is still struggling to grasp the issue of problems of professional competence. However the difficulty of the task should not deter from its ultimate importance. Often superhero stories involve those tasks which at first can seem insurmountable to the individual but are overcome once many come together to form a greater whole. Clinical psychology is at the precipice of such a task. A task which requires not perfect individuals but a community willing to address and embrace its imperfection. And if this community can be created, there you will surely find heroes.
References


*Professional Psychology: Research and Practice, 16,* 843–850.
Appendix A

When the Heroes Become Less Super: Problems of Professional Competence

PRESENTATION BY:
GREGORY BETZ, M.A., M.S.

What are Problems of Professional Competence?

- To understand the problems, we first need to define competence
  - This definition has been used by many researchers and taken from medical literature: “Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community served” (Epstein & Hundert, 2002, p. 226).

- This leads to an understanding of Problems of Professional Competence: Kazlow, Forrest, Van Horne, Huprich, Pantescó... (2007) defined it as a variety of potential difficulties in areas including interpersonal problems, psychological disorder, lack of insight/self-awareness, significant distress, and other areas to the extent that “they are unable to control and that affect their professional functioning” (p. 481).

- This definition provides a broad scope and also begins to highlight the fact that it is difficult to adequately define this issue as it can encompass multiple areas of a psychologist’s functioning

- A more concise definition is proposed by this writer: Problems of Professional Competence are any aspects of a professional psychologist’s clinical performance that adversely affect ability to provide quality services to clients
Why So Complex?

- Competence problems previously defined as “Professional Impairment”, but argued that it needed to be changed for legal reasons related to disability (Elman & Forrest, 2007).
- Even with this change, understanding is still difficult as problems of professional competence can have broad or specific manifestations and multiple potential causes (Kaslow et al., 2007).
- Competence problems also cut across multiple aspects of the field of professional psychology as a whole. A short list includes the structure and makeup of training, potential for ethical violations, evidence-based practice, and the personal characteristics of the individual amongst many others (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012; Kaslow et al., 2007).
- Aside from the considerations of the field, the most basic impact of problems of professional competence concerns the care and welfare of clients receiving psychological services and the obligation to “do no harm” (APA, 2010).
- These are but a few of the areas of debate when discussing this topic.

Prevalence

- So how often are these problems occurring?
- For professional psychologists:
  - Professional psychologists self-report high rates of experiencing competency problems
  - 60% endorsed still providing therapy while aware of current competency issue (Barnett & Hillard, 2001)
  - 75% stated experiencing significant competency issue over 3-year period (Thoerson, Miller, & Krauskopf, 1989)
  - Specific difficulties include depression, suicidal ideation, substance abuse issues, and distress within personal lives (e.g. divorce from a spouse) (Pope & Tabachnick, 1994; Wood, Klein, Cross, Lammers, & Elliott, 1985)
Prevalence

• For student-trainees:
  • Trainees experience similar or higher levels of competency problems
  • 85% students endorsed that they knew at least one individual experiencing competency problems within their program (Schwartz-Mette, 2009)
  • 98% of training directors surveyed stated they had at least one trainee over a ten-year period with competency problems that required intervention (Huprich & Rudd, 2004)
  • The most common issue cited by a national survey of students in clinical training programs was interpersonal problems (Oliver, Bernstein, Anderson, Blashfield, & Roberts, 2004)
  • Prevalence data can also be gleaned from dismissal rates: Oliver et al. (2004) state, “Consistent findings across studies suggest that training directors have frequent dealings with students experiencing impairment, and that most programs have dismissed at least one student within a 3-year time span” (p. 142)

Contributing Factors

• Developmental:
  • Psychologists as population more likely to have developmental or sexual trauma histories and come from a conflictual family-of-origin (Barnett, Baker, Elman, & Schoener, 2007; O’Connor, 2001)
  • Also likely to be parentified as children and reseachers have hypothesized that they take on a “caretaker role” which contributes to career trajectory to become a psychologist
  • These factors and others suggest career course and desire to help people as well as susceptibility to emotional impact of providing psychotherapy
  • Difficulties inherent in clinical work:
    • Constant exposure to heightened emotional materials can be distressing to any practicing psychologist and it is compounded in the case of those clients with severe difficulties (personality disorders, suicidality, chronic conditions like severe depression) (Barnett et al., 2007)
    • This regular stress can have both immediate and long-term effects and in the most extreme cases can lead to vicarious traumatization or burnout (Johnson et al., 2012)
    • The current state of insurance reimbursement and managed care contributes as it leaves many psychologists expected to accomplish more in treatment with fewer resources (Barnett et al., 2007)
Contributing Factors

- Isolating environments – Many psychologists practice within contexts that leave them without support or outside supervision (i.e., private practice) to notice when problems are developing (O’Connor, 2001)
- Process is a gradual “slippery slope” which can eventually lead to an ethical violation and by that time beyond help
- Fellow psychologists may be reluctant to provide help as they may be worried about whether or not intervention is justified, if they will also face consequences from regulatory boards, and interpersonal concerns from the offending psychologist or their peers (Johnson et al., 2012)
- Psychologists having problems may be ostracized as peers may be worried that a “suspected psychologist will yield guilt by association, and therefore these individuals and their problems are frequently avoided” (O’Connor, 2001, p. 347)
- These factors support a culture that unfortunately leaves those with a competence problem without support when it is most needed

Competence Problems and Trainees

- Trainees represent a more vulnerable population than practicing psychologists
- Many are providing clinical intervention for the first time and this experience in and of itself can be distressing for novice clinicians as they have not yet developed adequate coping mechanisms (Schwartz-Mette, 2009)
- Competence is still in the process of being established and therefore fluctuates more readily than those who have been in the field for several years
- Trainees operate amongst several different roles on a daily basis including student, research assistant, clinician, supervisee, teacher, or mentor to undergraduates
- Added pressure can result due to multiple sources of evaluation throughout training both within the program and while on practicum/internship, which may leave students reluctant to discuss difficulties for fear of how it will impact their standing (Barnett et al., 2007)
Assessment

- Emphasis on self-monitoring (APA, 2010)
- However, self-monitoring unreliable (Johnson, 2012) and problematic for trainees as still within development (Schwartz-Mette, 2009)
- Question of who is responsible to monitor/assess trainees. Multiple gatekeeping entities (professors, supervisors, etc.) but no clear delineation of responsibility
  - Result in “hot potato game” as coined by Johnson et al. (2012)
  - Other concern of “advocacy-evaluation tension” (Johnson et al., 2008) term as difficult for supervisors and others to balance regulatory and support roles for trainee mentoring

Intervention

- For Psychologists:
  - Colleague-assistance programs exist but with minimal support and funding (Barnett & Hillard, 2001)
  - Individual programs aimed at educating psychologists to handle competency problems and provide support to others do exist (Clemens, Horowitz, & Sharp, 2011), but these are few and far between
  - Intervention may not come until actual ethical breach happens and then up to licensing board (O’Connor, 2001)
  - A prevailing attitude within professional psychology leans toward a “hands off” approach (Johnson et al., 2012; O’Connor, 2001)
**Intervention**

- For Trainees:
  - Student-trainees report noticing competence problems in peers (Huprich & Rudd, 2004) and are often the first to notice as compared to those in authority/supervisory positions (Huprich & Rudd, 2004; Oliver et al., 2004; Schwartz-Mette, 2009).
  - It is still unclear as to what can be reasonably done with this information as training programs vary widely in their response to competence problems in trainees (Elman & Forrest, 2004; Kaslow et al., 2007; Schwartz-Mette, 2009).
  - Training programs implement remediation plans, but with minimal established structure or follow-through (Elman & Forrest, 2004; Kaslow et al., 2007; Schwartz-Mette, 2009).
  - Primary intervention for trainees is therapy. Yet it is often not mandatory or monitored (monitoring also poses ethical/confidentiality tension) and there is little significant evidence as to its effectiveness in dealing with competence problems (Elman & Forrest, 2004).

**Future Directions**

- Researchers suggest a “communitarian” shift in professional ethics with an emphasis on increasing communication about competence problems within the field (Johnson et al., 2012) and amongst other organizations and oversight bodies (i.e. regulatory boards (O’Connor, 2001).
- By increasing interdependence amongst psychologists, it is hoped that competence problems will be reduced as it becomes less a misunderstood individual issue and more of a broader obligation that will have benefits for those experiencing problems, clients served, and the field as a whole.
- Psychology training could take aspects of what is done within medical training or other fields that have more concrete processes for evaluating and intervening with competence problems (AMA, 2011).
Future Directions

- A general recommendation is to take a proactive stance that begins with trainees as they will be able to benefit most from information about problems of professional competence in training early on and have a better chance of preventing future problems (Johnson et al., 2008; Johnson et al., 2012; Kaslow et al., 2007; Schwartz-Mette, 2009).
- This perspective is echoed by trainees: “Students were generally in favor of talking more about the issue-with consideration given to the confidentiality of all parties—and felt that there needed to be better supports to help struggling students, as well as more explicit gatekeeping practices” (Oliver et al., 2004, p. 144).
- Trainees educated on this issue can receive both immediate and long-term benefits that will prepare them to take care of themselves and colleagues in their professional practice: “New psychologists should demonstrate competence in providing peer review, in constructively engaging troubled colleagues in what may be difficult conversations about their competence, and in demonstrating care for colleagues, those they serve, and the profession” (Johnson et al., 2012, p. 9).

References

References


Appendix B

Self-Report Measure

1. How knowledgeable are you regarding the term *problems of professional competence*?
   1   2   3   4   5
   Not at all   Somewhat   Knowledgeable   Very   Extremely

2. Are you confident that you understand how competency problems can affect trainees and professional psychologists?
   1   2   3   4   5
   Not at all   Somewhat   Confident   Very   Extremely

3. Would you feel comfortable providing support for a peer if you felt he/she had competency problems?
   1   2   3   4   5
   Not at all   Somewhat   Comfortable   Very   Extremely

4. Would you accept support from a peer if he/she discussed concerns about your own competency?
   1   2   3   4   5
   Not at all   Somewhat   Accepting   Very   Extremely

5. Would you feel comfortable approaching a training faculty regarding concerns about a peer’s competency?
   1   2   3   4   5
   Not at all   Somewhat   Comfortable   Very   Extremely

6. Would you feel comfortable approaching a training faculty regarding concerns about your own competency?
   1   2   3   4   5
   Not at all   Somewhat   Comfortable   Very   Extremely

7. Do you agree that problems of professional competency are best left for the individual with competency problems to deal with?
   1   2   3   4   5
   Not at all   Somewhat   Agree   Very   Extremely

8. Do you feel confident that a peer could improve his/her competency if provided adequate support?
   1   2   3   4   5
   Not at all   Somewhat   Confident   Very   Extremely

9. Do you feel that you could experience competency problems at some point in your career?
   1   2   3   4   5
   Not at all   Somewhat   Possible   Very   Extremely

10. Would you be willing to provide support for a peer if you felt he/she had competency problems?
    1   2   3   4   5
    Not at all   Somewhat   Willing   Very   Extremely
Appendix C

Informed Consent/Demographic Letter

You are invited to participate in a study conducted by Gregory Betz, M.A., M.S., Psy.D. candidate, under supervision of Roger L. Peterson, Ph.D., ABPP. This study will provide psychoeducational information on the topic of Problems of Professional Competence for clinical psychologists. You were selected for this study based upon your current enrollment in a Psy.D. program.

Your participation in this study is entirely voluntary and there is no penalty if you choose not to participate. If you decide to participate in this study, you will be asked to complete a brief (10-item) measure inquiring about your knowledge of Problems of Professional Competence and your attitude toward particular issues within this topic. You will be asked to complete this measure both before and after a presentation given by this researcher. The entire process will encompass approximately one hour and it will be delivered during a portion of your Professional Seminar class at Antioch University New England. You will be asked to complete a brief qualitative measure approximately two months after this initial intervention, which will take approximately 25-30 minutes of your time. This measure will be open-ended and is meant as a follow-up to assess any additional comments or impressions you may have following the initial intervention. Any information obtained from you will not be shared with your Professional Seminar leader and will in no way impact your grading or evaluation in the Professional Seminar class. You may withdraw your participation at any point during this study.

There are no anticipated risks within this study. You may benefit from this study in regards knowledge gained about the topic of Problems of Professional Competence and a potential shift in your attitudes on the topic. It cannot be guaranteed that these benefits will occur. Your responses will be kept confidential and no identifying information will be attached to your data. Demographic information obtained below will be kept separate from other data to ensure confidentiality. Only the researcher and the advisor, Roger L. Peterson, Ph.D., ABPP, will have access to the data obtained from the measures discussed above.

If you have any questions regarding the study, you may contact Gregory Betz, M.A., M.S. at XXX-XXX-XXXX or via email at gbetz@antioch.edu. If you have any questions about your rights as a research participant, you may contact Dr. Katherine Clarke, chair of the Antioch University New England Institutional Review Board, 603-283-2162.

You will be given a copy of this form to keep.

BY SIGNING THIS FORM YOU ARE AGREEING TO PARTICIPATION IN THIS STUDY AND INDICATING THAT YOU HAVE READ THE INFORMATION PROVIDED TO YOU IN THIS FORM.

_________________________________  ______________________________________  
Date                                                             Name of Participant

_________________________________  ______________________________________  
Date                                                             Signature of Participant

_________________________________  ______________________________________  
Date                                                             Signature of Researcher
Demographic Information:
1. Sex: Male       Female       Transgender

2. Age: __________

3. Racial Background: African-American       Asian/Pacific Islander
                                            Hispanic/Latino       Caucasian
                                            Other: __________________________