SUPERVISORS' CONSTRUCTIONS OF INTERN IMPAIRMENT AND INCOMPETENCE AT APA-ACCREDITED INTERNSHIP SITES

By

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ABSTRACT

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This study examined the process by which supervisors at APA-accredited university counseling center internships identify and address intern impairment. Three university counseling centers were identified for inclusion based upon their reputation for being active in discussing and addressing intern impairment. Four participants were interviewed and provided background information at each of the three sites. The data were analyzed using the constant comparative method (Lincoln & Guba, 1985). The primary findings were that these participants tended to construct their definitions of intern impairment for the first time while in the process of dealing with a problematic intern; that they were often underprepared to deal with intern impairment; and that they believed that intern impairment is underaddressed or addressed too slowly. Factors that hindered these supervisors' intervention efforts were lack of training and support in the specialty of supervision; lack of consistency in collegial supervisory practice; lack of strong, healthy collegial relationships; and the emotional difficulty of dealing with impairment. Factors that supported these supervisors' intervention efforts were weekly supervisors' process meetings; respectful, positive collegial relationships; an agency moral norm of dealing with, rather than avoiding problematic situations; and having a Training Director and a Center Director who take a very active, collaborative role in the intervention process.

To my parents, with gratitude.

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Chapter 1

INTRODUCTION

Of all the complexities embedded in the process of clinical supervision, some of the most difficult and unavoidable challenges present themselves in the multiple roles that supervisors must establish and maintain with their supervisees. As Douce (1989) notes, supervision is a "separate skill, similar to teaching--but different; similar to counseling--but different; and similar to consulting--but different" (p. 5). Like within the therapeutic relationship, the supervisor must develop an environment of trust, acceptance, and support for the supervisory experience to be effective. Also like therapy, the supervisory relationship is private and emotionally charged (Frank, 1973).

Unlike in therapy, however, the supervisor is also responsible for continually evaluating the supervisee's clinical performance. In fact, Loganbill, Hardy, and Delworth (1982) suggest that overseeing and assessing the quality of client care is not only an essential supervisor function, but the supervisor's preeminent responsibility. This monitoring of competence, in the service of ensuring quality services to the public, is one of the defining characteristics of a profession (Gelso & Fretz, 1992; Sinclair, Simon, & Pettifor, 1996). This moral responsibility to monitor one's own professional competence out of obligation to the general public dates back to the origins of the Hippocratic Oath in 400 B.C. (Sinclair, Simon, & Pettifor, 1996). Like all professionals, counseling psychologists have "supreme responsibility to the public trust" (Gelso & Fretz, 1992, p. 52).

In spite of the clarity of this ethical imperative, the definition of professional competence in the field of psychology is not an easy task. As Bruch (1974) notes, "the tools the psychotherapist needs are his [sic] personality, his [sic] sensitivity to interpersonal processes, and his [sic] own reactions in relationship to patients" (p. 106). Both the intangible quality and the deeply personal nature of these "tools" begin to illuminate the difficulties embedded in the task of evaluating supervisees, and thereby protecting consumers from harm.

Nowhere are the pressures of this complexity more pronounced for supervisors than in clinical training experiences such as the predoctoral internship. And although the "privilege and responsibility of self-regulation" (Goodyear & Sinnett, 1984) lies with the psychology profession as a whole, training programs carry a unique burden to "protect entry to the profession, to train new members, and to socialize new members into the attitudes, values, and accepted practices of the community" (Sinclair, Simon, & Pettifor, 1996, p. 2). Because of the internship's terminal placement in a sequential process which is intended to create and verify competence, the evaluation processes within the predoctoral internship take on a particularly important function. In short, the predoctoral internship "serves the critical role of gatekeeper for professional quality control" (Holloway & Roehlke, 1987, p. 210).

One of the first indications that supervisors might have difficulty with the multiple roles embedded within the supervisory relationship is the reality that they are therapists, and a primary function within that role is to validate, support, and nurture. Not surprisingly, nurturing and evaluating can seem like contradictory processes, with therapists expressing a clear preference for nurturing--a preference which is maintained in their roles as supervisors (Goodyear & Sinnett, 1984).

Another factor which clearly contributes to clinicians struggling with the

complexity of the supervisory role is the deficient preparation they have generally received as supervisors. McColley and Baker (1982) reported that 80% of new supervisors had no formal training (course or seminar) in supervision. Hess and Hess (1983) reported that only 40% of internship training sites provided on-going training and consultation for supervisors. Because many clinicians enter into supervisory responsibilities with little or no training, and "typically believe they are pretty good at it" (Bernard & Goodyear, 1992, p. 3), they may overestimate their own abilities, and discount the need for a more focused examination of the supervisory process.

A much more serious indicator of difficulties with the evaluation of competence is the growing recognition of the alarming incidence of professional impairment at all levels within the field of psychology. In 1981, at the annual meeting of the American Psychological Association, an open forum on impairment marked the first time in the history of the profession that impairment began to be studied in a systematic way (Stadler, Willing, Eberhage, & Ward, 1988). In the fifteen years since this challenge was presented to the profession, strikingly few studies have been published regarding impairment, and yet, the ones which have appeared have reported serious findings.

In the profession at large, for example, impairment was found to be disturbingly present among practicing clinicians (Wood, Klein, Cross, Lammer, & Elliot, 1985). Large numbers of psychologists self-report working when they are too distressed to function effectively (Pope, Tabachnick, & Keith-Spiegel, 1987; Wood et al., 1985). Additionally, psychologists reported a strong reluctance to report (Wood et al., 1985) or confront impaired colleagues (Steward, Knox, & Satterfield, 1988).

The data emerging on impairment in psychology trainees are even more

sparse, and even more alarming. The initial findings are consistent: that the incidence of impairment in this population is troubling, and the problem is inadequately and haphazardly addressed (Boxley, Drew, & Rangel, 1986; Lamb, et al., 1987; Tedesco, 1982). Hahn & Molnar (1991) claim that "there may be a nationwide problem with internship sites graduating impaired interns" (p. 415). Counseling centers and training directors at APA-accredited internship sites have identified impaired interns as a major and critical challenge in the 1990s (Stone & Archer, 1990). And as studies document increased levels of distress in society at large, and on college campuses in particular, it is also evident that training programs must prepare to handle increased distress in their students and interns (Stone & Archer, 1990). As the "gatekeeper for professional quality control," training programs, and in particular, predoctoral internships, are struggling with this task.

Given the seriousness of the initial findings on impairment as well as the profession's stated intention to begin studying the issue in a serious and systematic way, the continued sparseness of published work on impairment is striking. One explanation for this absence is that impairment is clearly an intensely charged and personal issue, The topic demands a highly subjective exploration of values, judgments, and responsibilities; it also involves such high stakes as professional identity and livelihood. Clearly, this kind of professional self-examination is anxiety-provoking; clearly, as well, it is ultimately unavoidable.

A second possibility for why the existing work on impairment seems to be sparse and slow to develop is that the majority of these studies keep the focus of inquiry on the competence issues of the impaired clinician or trainee. These efforts contextually strip the issue of impairment before a knowledge base about the context has been established. Additionally, the examination of the

competence of an individual (or prototypic) clinician overshadows an even more basic and foundational domain of competence: that of the supervisor, the training site, and the profession to engage in an effective and responsible process of evaluation. Studies which provide rich and detailed information on this second critical arena of competence will provide a solid foundation for a body of literature on impairment.

Clearly, the critical and foundational knowledge addressing impairment lies embedded within processes and relationships, particularly at training sites such as the predoctoral internship. Impairment is not a uni-dimensional label, rather, it is a rich and multi-faceted construction acknowledged and shaped over time, and within a multitude of interpersonal interactions. As psychology begins to uncover the wealth of information about impairment within these processes, so will it move forward into ever greater maturity and responsibility as a profession.

Chapter 2

REVIEW OF THE LITERATURE

In 1981, the American Psychological Association formally recognized its responsibility and intent to more adequately examine and address the issue of professional impairment among psychologists (Kilburg, Nathan, & Thoreson, 1986). And, although this move was certainly commendable, it is noteworthy that among other professions such as medicine, nursing, social work, and law, formal investigations of professional impairment had been underway already, in some cases, for a decade or more (Annas, 1978; Kempthorne, 1979; Skorina, 1982). Compared to other professions, psychology's delay in investigating impairment is in need of examination itself.

The preliminary work on impairment within psychology focused on three primary areas: prevalence, implications, and definition. Wood et al. (1985) surveyed licensed psychologists, both academics and practitioners. Of three content areas on the survey, one explored the respondent's "self-reported incidence, attitudes, and experiences" of personal or collegial "excessive use of drugs or alcohol, sexual overtures toward clients, or symptoms of depression or burnout" (p. 485). A major finding of this study was the high degree to which this sample of licensed psychologists believed impairment to be a serious and current problem: 52% believed drug/alcohol abuse to be serious; 56% were aware of sexual overtures toward clients; 75% observed depression or burnout. The authors concluded that between 7% and 14% of practicing psychologists

were impaired and not seeking help.

A second major finding of the Wood et al. (1985) study was that this sample of psychologists expressed a strong reluctance to report impaired colleagues. 40% of the participants reporting knowing an instance of a colleague working while clearly impaired, but choosing to do nothing. The issue of shielding impaired colleagues has emerged as a critical component in the examination of impairment. Bernard and Jara (1986) demonstrated this problem with their study of clinical graduate students' understanding of ethical principles: nearly 50% of their sample reported, "I know what I should do as an ethical psychologist, but I wouldn't do it" (p. 321). A second study by Bernard, Murphy, and Little (1987) examined similar reluctance in clinical psychologists. Bok (1979, 1982) addressed this issue of concealment and avoidance among professionals and warned of the consequences of loss of public trust as well as increased litigation.

Thoreson, Miller, and Krauskopf also examined the issue of prevalence in "The Distressed Psychologist: Prevalence and Treatment Considerations" (1989). The use of the term "distressed" illustrated the on-going difficulty in the literature on the definition of impairment. The terms "impaired," "distressed," and "troubled" are often, and unfortunately, used interchangeably in the literature.

The intent of the Thoreson et al. study was to survey psychologists regarding the types of "distress" in physical and emotional health status that they experienced. This was the first empirical examination of self-reported psychologist distress. Although the survey methodology seemed otherwise adequate, a weakness existed in that all subjects were obtained through membership in a regional association. The authors also acknowledged that their sample varied from APA membership on several characteristics (more

women, counseling and clinical psychologists, and private practitioners). The primary conclusion drawn from these data was that distress is a "multifaceted phenomenon" which occurs at rates from 9% for multiple distress areas (e.g. marital distress and alcohol abuse) to 19% for single distress areas (e.g. depression). Although the authors note that, in general, the subjects seemed to be a fairly well-adjusted group, they were concerned by the hidden nature of several forms of distress

Two studies have explored the effect of impairment upon clients: Pope, Tabachnick, and Keith-Spiegel (1987) and Guy, Poelstra, and Stark (1989). A most powerful and disturbing finding of the Pope et al. survey was that 62% of the APA Division 29 (Psychotherapy) membership admitted to "working when too distressed to be effective" (p. 1004). The reported incidence of working under such conditions was "rarely" to "very often." A second disturbing finding was that 85% of these self-reporting psychologists considered it unethical to work while experiencing such high levels of distress, yet chose to work anyway.

The Guy et al. study extended this work by examining the degree to which various types of psychologist distress affect the quality of therapeutic service to clients. In their nationwide survey of APA Divisions 12 (Clinical), 29 (Psychotherapy), and 42 (Independent Practitioners), the authors concluded that there was not an "identifiable distress prone therapist profile" (p. 49). In short, a pattern did not emerge among the therapists who admitted that distress decreased the quality of their work, either in terms of psychologist profile or in terms of distress experienced. Importantly, the authors noted some patterns as to therapists who experienced distress, but who denied the potential impact on service to clients. These groups included older practitioners (although this finding did not reach statistical significance), practitioners experiencing job stress (which ironically, was the most frequently identified source of stress), and

substance abusers. The authors also expressed concern regarding the haphazard means by which distress is addressed, even among the group which recognized the potential impact of their distress upon client care.

One of the clear and persistent patterns emerging from this set of studies is that impairment, no matter how it is defined, is a serious problem among working professionals. Since the examination of professional impairment is in its infancy, these studies are, by necessity, descriptive field studies using survey methodology. Given the nature of such research, particularly as applied to self-reporting, many potential problems exist in estimating the real extent to which impairment undermines the functioning of the profession at large. It is highly possible that these studies underreport the actual incidence of impairment and its effect upon clients. Also disturbing is the increasing documentation of psychologists' apparent inability or unwillingness to address impairment as it affects themselves or their colleagues.

Stadler, Willing, Eberhage, and Ward (1988) asserted that establishing a common understanding for the term "impairment" is a critical first step. These authors raised a second challenge to the profession in claiming that impairment is a systemic, rather than individual, problem. They extended responsibility to training programs, individual supervisors, and researchers for the role they play in either enabling or addressing impairment in the profession.

Unfortunately, the minimal data which exist regarding impairment in psychology trainees suggest that the incidence in this population is also troubling. Furthermore, the few existing studies on intern impairment indicate that the problem is inadequately and haphazardly addressed. Even at the predoctoral internship level, which is presumably the most logical and critical point of evaluation of professional competence, the mechanisms for identifying and confronting impairment are minimal.

Tedesco (1982) was the first study of dismissal at this critical juncture in professional training. This survey of training directors of all APA-accredited internship sites suggested that actual termination is a relatively rare event, occurring at about a 2% rate. Since about half of these trainees left by their own choice, and since training directors considered termination for an additional 3% of interns but did not act, the authors justifiably question the ability of training programs to implement terminations when they are appropriate.

Boxley, Drew, and Rangel (1986) investigated how training programs identified and handled student impairment. One of the methodological limitations of this particular study was its low (29%) return rate. Nonetheless, this study made several initial important contributions to this line of inquiry. First, the authors used a broad, multi-faceted definition of impairment: "any physical, emotional, or educational deficiency that interferes with the intern's professional performance, education, or family life" (p. 50). Second, the data indicated that internship sites seem to either lack or not use formal guidelines to address impairment: 63% of impaired interns were dealt with "informally," and only 24% of the sites reported formal procedures. Finally, the study estimated an annual intern impairment rate between 4% and 21%.

The Boxley et al. study re-emphasized the realities of the incidence of impairment during the internship, and the weakness or absence of mechanisms to deal with it. The authors also attempted to delineate the problems categorized under the term "impairment," but unfortunately, the results are too broad to be useful, for example, "personality disorder," "depression," and "emotional problems" (p. 51). Furthermore, what constitutes "formal" and "informal" processes was not adequately defined.

In the last decade, three theoretical articles have directly addressed the issue of impairment during the internship. Lamb et al. (1987) strongly argued the

necessity for programs to deal directly and effectively with trainee impairment. The authors suggested further revisions to the definition of impairment, specifically, revising Boxley et al.'s definition to include general behavioral indicators. The authors also distinguished between "training problems" and "impairment," and argued the importance of training programs proactively developing clear, fair, and consistent procedures for addressing intern impairment.

A more recent extension of these arguments is found in Lamb, Cochran, and Jackson (1991). These authors presented a model differentiating impairment from other training problems, and recommended comprehensive policies and procedures to be implemented by internship sites. The third important contribution of this model is its anticipation of difficulties programs may face as they attempt to implement recommended procedures for terminating impaired interns.

A third article which contributes to the literature on intern impairment is Hahn and Molnar (1991). Although this article focused exclusively on a subset of APA internship sites, the university counseling center, it supported the growing consensus that trainee evaluation is highly inadequate, that an "increased sense of urgency" (p. 414) existed regarding this shortcoming, and that there "may be a nationwide problem with internship sites graduating impaired interns" (p. 415). The authors noted that the literature on intern evaluation is surprisingly minimal. In their recommendations for developing intern evaluation systems, the authors presented a 7-point rating scale and propose that interns should be required to reach a minimum of a 4-point rating in each of several categories in order to be considered competent.

Hahn and Molnar's recommendations, like the model proposed by Lamb et al., made a thoughtful and timely contribution to the effort to adequately address

impairment during internship. What these two models also highlight, however, is the glaring lack of adequate evaluation systems for interns. The implications of this void become even more bleak as researchers in counseling psychology begin to document how little is actually known about clinical supervision. In spite of the central importance of supervision and evaluation during the internship year, Holloway and Roehlke (1987) note:

> There has been no systematic study of efficacy of different training techniques at advanced levels, of evaluation procedures, of the types of professional activities most critical to training or the components of a training program that best predict successful outcome (p. 211).

Ellis (1991) concurs with the argument that the literature on supervision to date is essentially useless: "In general, we as clinical supervisors do not know what works, or why and how it works" (p. 239). This void in the literature adds a new dimension to the study of impairment: that some trainees may experience difficulties not because of personal shortcomings, but rather because current models of training, supervision, and evaluation have failed them as learners.

In summary, the glaring absence of knowledge on the topics of impairment, intern evaluation, and supervision combine to create an urgent challenge to the profession. There may, in fact be real and problematic limitations in the field's current capacity to adequately educate all trainees. In the meantime, however, we must not neglect our responsibility to the trainees and clients of the present. In short, the field has an ethical obligation to monitor the competence of its practitioners--regardless of its current ability or inability to adequately prepare all trainees. Given the numbers of impaired psychologists currently in practice, and more importantly, the numbers of impaired trainees who are graduated through the "gatekeeper of quality control" (Holloway & Roehlke, 1987, p. 210), namely, the predoctoral internship, the profession is clearly struggling, if not failing, in its efforts to address impairment.

In conclusion, the field of psychology is still struggling to establish a literature base about professional impairment. Although much of the information which has emerged is alarming, particularly in light of the profession's ethical responsibility to safeguard the welfare of the consumer, and to do no harm, the research in this area is surprisingly minimal. The existing studies, however, do point to two critical issues: the difficulty in defining impairment, and the reluctance of psychologists to acknowledge and address impairment when they do recognize it.

This study has been designed to provide foundational information about the definition of impairment and the processes by which clinical supervisors and training staffs choose to intervene or not with potentially impaired predoctoral interns. The guiding conceptual questions of the study are as follows:

1. How do supervisors at APA-Accredited counseling center internship sites define intern impairment?

a. What issues are critical in determining whether or not an intern is considered to be impaired?

b. What is a typical process in involving the intern or addressing the perceived impairment?

c. What are the most difficult problems in the process of addressing intern impairment?

2. What effects do supervisors have on each other during the process of considering and addressing intern impairment?

a. What formal and informal contexts exist for supervisors to discuss impressions of their intern supervisees?

b. How do supervisors perceive these interactions as influencing their perceptions of impairment?

3. What policies and procedures are in place at APA-Accredited counseling

center internship sites regarding intern impairment?

a. Is potential intern impairment considered during the selection process? How?

b. What formal evaluation procedures for interns exist?

c. What formal policies are in place for dealing with impaired interns?

d. What informal policies exist for dealing with impaired interns? (e.g. How many staff members need to agree on impairment? Do specific staff members need to be in agreement?)

Chapter 3

METHODOLOGY

Methodological Rationale

The Researcher's Paradigm

Since no inquiry is value-free, and since "all research is interpretive" (Denzin & Lincoln, 1995, p. 13), it is imperative that the researcher's unique ontological, epistemological, and methodological beliefs be identified at the outset of the study (Denzin & Lincoln, 1995; Miles & Huberman, 1984). My philosophical orientation is constructivist; therefore, this paradigm informed and guided decisions, observations, and meaning-making embedded within this study.

A constructivist paradigm assumes particular beliefs about the nature of reality and knowledge. My ontological position is relativist, specifically that reality is multiple rather than singular. In this study, for example, I assumed that "impairment" has many meanings. My intent was to examine the diversity and richness of meaning of this term as it is used by supervisors.

I also believe that knowledge and meaning are embedded in a process between the knower and the subject. This subjectivist epistemology guided the decision to explore the experience of the most immediate knower of impairment in an intern--the clinical supervisor. The supervisor is directly, continually, and uniquely in evaluative interpersonal contact with the intern. Consequently, the documentation of this very basic process will provide a critical foundation for further research on impairment.

This subjectivist stance also compels efforts to maintain context wherever possible. This study was designed to provide a rich description of supervisors'

construction of impairment over time within multiple dimensions: personal reflections; interactions with the intern; interactions with colleagues; within existing policies and procedures at the site. This multifaceted scope recognized that decisions about impairment are not made instantaneously, nor are they made in isolation.

Finally my constructivist beliefs also guided the selection of an interpretive case study methodology. This format is consistent with an emphasis on naturalistic procedures: the data collected were intended to be rich, personal, and descriptive; data collection occurred primarily via on-site individual interviews. This methodology was also highly appropriate to the current status of published research on impairment, specifically that existing studies are few in number, and as of yet, no theoretical base has been established. (Lincoln & Guba, 1985).

Methodological Procedures

Format

This study was designed as a collective case study based upon semi-structured individual interviews with supervisors, training directors, and center directors at three APA-accredited university counseling center internship sites. Additionally I collected background information about each participant, such as descriptions of theoretical orientation and supervisory style, years worked in the field of psychology, years worked in a university counseling center, and numbers of impaired trainees formally and informally supervised. Copies of intern evaluation forms and impairment policies were requested from training directors.

Participants

University counseling center internship sites, rather than other types of internships such as Veteran's Administration hospitals and community mental health centers, were selected for three reasons. First, university counseling centers (UCCs) have had, historically, the highest percentage of internship placements of counseling psychology students (Cameron, Galassi, Birk, & Waggener, 1989), and as well, have consistently employed a high percentage of counseling psychologists (Watkins, Lopez, Campbell, & Himmell, 1986). Second, UCC training sites have made strong public commitments to the study of impairment (Stone & Archer, 1990). Finally, because I have approximately six years' experience as either a staff member or a trainee at various UCCs, the selection of this type of site maximized my credibility with participants.

To select the three sites, a master list was developed of the 63 fully accredited UCC internships listed in the 1994-95 Association of Psychology Internship Centers directory. Descriptive information was recorded for each site, including numbers of full-time, part-time, and total staff members, as well as number of intern slots. Secondly, descriptive statistics were calculated for the entire group to provide general guidelines for dividing the list into sites of "small" (4-7 full-time psychologists), "medium" (8-11), and "large" (12+) size. Finally, each site was coded by geographic region using time zones as a general guide (e.g. East, Midwest, Central, West).

Next, target sites were identified from this list. This was accomplished through consultation with a group of twelve Ph.D. psychologists, who were asked in telephone or e-mail conversations to identify sites which they knew to be "active and concerned around the issue of impairment." Each consultant is employed either at an APA-accredited counseling psychology doctoral program, or an APA-accredited UCC internship. Specifically, this group

included counseling psychology faculty members, internship training directors, and counseling center directors. Three persons were consulted who have served as president of ACCTA (Association of Counseling Center Training Agents). Efforts were made to include consultants from different universities and different geographic regions of the country.

Although a large number of sites (20) received at least one recommendation, a clear pattern emerged in a smaller number of sites being named repeatedly by a range of consultants. The repeatedly identified sites were grouped by size and geographic region. Final decisions about target sites were made by considering: 1) perceived richness of information regarding impairment available at that site; 2) existing personal and professional connections to a site to facilitate recruitment; 3) the staff's perceived willingness to participate in the study; 4) available resources for travel; 5) inclusion of at least one "large" site; and 6) inclusion of sites from at least two geographic regions of the country.

At each site, the following four people were involved in the study: the Center Director, the Training Director, and two doctoral level clinical supervisors. The supervisors were self-selected, specifically, the Center Director was asked to take the researcher's request to a staff meeting and ask for volunteers.

The center directors and the training directors were included in the research design because of their unique and somewhat different working perspectives on the topic of impairment. Although both persons may be assumed to have a strong commitment to both the agency and the internship program, it is reasonable to believe that the Center Director's primary focus is on the agency as a whole, whereas the Training Director's emphasis is on the training and the interns. Both persons as well may be assumed to have unique insights into the interpersonal dynamics of the senior supervisory staff, both at the present time as well as within a historical frame. The perspectives of the center directors and

the training directors were intended to triangulate the data collected in interviews with supervisors, thereby enhancing the internal validity of the data (Miles & Huberman, 1984).

Recruitment

After the three target sites were selected, I asked a faculty member or colleague with personal connections at one of the sites to make an introductory phone call to that site on my behalf. In this phone call, my colleague briefly described my research project, and explained that the Center Director would receive a letter within the week to request the site's participation. The caller was also asked to share personal experiences with me as a clinician and researcher, specifically, my ability to respectfully and ethically handle complex and sensitive material. Once this call was made, I mailed the letter to the Center Director (Appendix A). In approximately one week, I called the Center Director to answer questions and determine the status of the request.

Although all three target sites agreed to participate, it was clear that this decision was initially tenuous. The first site required me to be cleared by two additional and complex Human Subjects reviews. The Center Director at the second site reported being "amazed" that the staff had agreed to participate, since they were "up to their ears in research requests." This Director noted that the Training Director's emphatic statement about the "importance of this topic," as well as the statements made by the caller about "the researcher's maturity and sense of ethics" made the difference. The third site reported that although they rarely approved research requests, they agreed to participate because: 1) they believed the topic was very important and under-researched; 2) the study used a qualitative design, and 3) I was willing to do on-site interviews.

Once a site confirmed willingness to participate, I worked with the Center

Director to identify a period of two to three days in which all four persons at the site could be interviewed. Special care was taken to avoid predictably heavy service demand periods in the academic calendar. At two of the three sites, the Training Director elected to arrange interview times and provided me a schedule when I arrived at the site. At the third site, I contacted each participant individually to schedule interviews. In each case, letters were sent to the site or to specific individuals to express my appreciation for their decision to participate, and to confirm the dates that I would be on-site (Appendix B).

Although two-hour interviews with supervisors, and one-hour interviews with training directors and center directors were originally proposed, it became clear at the first site that supervisors were generally unable to clear a two-hour block of time in their schedules. Additionally, it became clear that in many cases, one hour was sufficient to complete the interview. Accordingly, I changed my request to a one-hour interview for all participants. In two cases, the interview did not cover all the outlined areas in the span of one hour because of rich elaborations by the participants. In both of these cases, the participants expressed a desire to continue the interviews, offered time outside of their work schedule to do so, and did complete a continuation interview.

On-Site Data Collection

Interviews were conducted in the university counseling center offices of the respective participants. One follow-up interview was conducted in the private practice office of a participant, in order to accommodate that person's schedule. Each participant was asked to read and sign an informed consent statement before the interview began (Appendix C). Participants were provided a copy of the consent form for their files. I explained that confidentiality would be strictly maintained for individuals as well as sites in the study, and answered questions

as appropriate. I noted that the one exception to confidentiality was my dissertation director, who would know the identity of each site (and by extension, the identities of the participating center directors and training directors), and who would be discussing emerging issues in the research process with me as needed. I also explained that each participant would receive a transcript of his/her interview, and the opportunity to make additions or corrections.

At the beginning of the interview, participants were given a Background Information Form (Appendices D, E, F) which they were asked to complete at their convenience and return to me in the stamped, addressed envelope which was provided.

All interviews were audiotaped. Although the interview format was loosely structured to maximize spontaneity and allow reflectiveness on the part of the participants, I closely monitored the content areas as specified in the Interview Guide (Appendices G, H, I). Participants were generally prompted or redirected to ensure adequate responses in each content area.

Participants were thanked for their time at the conclusion of each interview, and center directors were thanked for their staff's participation as the researcher left the site. I kept a record of participants' expressed interest in the results of the study, and will make appropriate plans to share this information.

Data Management

Participants and sites were given codes to protect their identity (e.g. "Subject 1-A," "Site 3"). Identifying information from documents was removed and coded by site.

Tape recordings of the interviews were kept in a locked file in my private office until they were transcribed. Three tapes were transcribed by a

professional stenographer, and I transcribed the remainder. Following transcription, I listened to each tape and reviewed the transcript for accuracy. Once all interviews were transcribed, transcripts were returned to the participants for review. In some cases, I asked the participants for clarification or elaboration of specific sections of the transcript.

Data Analysis

This study utilized the "constant comparative method" as described by Lincoln and Guba (1985) to process data collected in interviews and documents into a theory about supervisors' constructions of impairment. This method was selected because of the absence of existing theory regarding the topic of intern impairment, and the method's focus on developing grounded theory.

Specifically, analysis proceeded through the following four stages: 1) comparing incidents applicable to each category; 2) integrating categories; 3) delimiting the theory; and 4) writing the theory. In the first stage,I created an intuitive "category domain list" which was guided by the specified content areas on the Interview Guide (Appendices E, F, G). The data were then reviewed and "unitized," or in other words, broken down into small but meaningful chunks. Units were first recorded on index cards, then coded by source. Secondly, the cards were assigned to a category based upon my intuitive sense of best fit.

Throughout the categorization process, I followed the guidelines laid out by Lincoln and Guba (1985), including procedures for comparing each unit placed within a category with other units already placed within that category. This comparison began to define the properties of the full range of units falling into each category.

As this process continued and distinct features emerged or else as conflicts arose in how to place a particular unit, I engaged in "memo writing" (Lincoln &

Guba, 1985, p. 342). In memo writing, the researcher interrupts the coding and assignment process to capture her/his current thoughts or conflicts about the evolving properties of a particular category. The series of memos which results from this process provides a "developmental history" of the category, and ultimately, it shapes a "comprehensive, useful, and universally applicable" (Lincoln & Guba, 1985, p. 342) definition of the category's properties. At this point, the assignment of units to categories shifted from an intuitive "look-alike/feel-alike" match to a "propositional rule-guided judgment" (Lincoln & Guba, 1985, p. 342).

The second phase of the constant comparison method is "integrating categories and their properties" (Lincoln & Guba, 1985, p. 342). This phase shifted the focus of analysis from comparing units to other units within categories to comparing units with the newly identified basic properties of a particular category. The emphasis in this phase was to test the categories themselves, but the individual units also received an additional round of scrutiny. In this "two-edged test," category properties became increasingly clear, and this clarity provided the foundation for the next step, "category integration" (Lincoln & Guba, 1985, p. 343).

Although the data analysis for this study has thus far been described in a linear format, the actual process was much more cyclical and flowing. In a broad and intrinsic sense, data analysis began as the topic was formulated, and as decisions were made about the study's design, and continued as data were collected. In an explicit sense, the analysis of this study used the multi-site design to combine the collection and processing of data. Formal data analysis began following the pilot study, and continued throughout the data collection process. This format has a "distinct integrative advantage" in that theory " is more likely to emerge by itself" (Lincoln & Guba, 1985, p. 343).

This integrative process is directly tied to the third phase of constant comparative analysis: delimiting the theory. As category properties became increasingly clear, solid, and comprehensive, new data fit into the categories with more ease and with fewer revisions. In this stage, the researcher begins "to realize both parsimony and scope in his or her formulations" (Lincoln & Guba, 1985, p. 343). Delimiting, in other words, was a process of eliminating, revising, and fine tuning categories, so that the ones remaining were highly efficient. And, because of the staggered data collection process and continuous analysis, the final data that were collected targeted any remaining areas of ambiguity, worked to saturate categories, and moved the study toward closure.

The final stage of constant comparison is writing the theory. In this, like in other aspects of qualitative research, little consensus exists regarding a preferred means for reporting findings (Miles & Huberman, 1984; Lincoln & Guba, 1985). Given the flowing, inductive nature of qualitative research, it is, perhaps, not surprising that a clearly defined results format is not identified *a priori*. It was critical, however, that the I remained clear about the values and purposes that informed choices in this process. In the study, the content and format of the results section were guided by three overlapping principles: epistemological consistency, the study's original purpose; and enhancing trustworthiness.

All three of these principles pointed to the case study as a potential model for theory writing. The case study maintains the richness and groundedness of content that meets all three criteria: it captures process and context; it allows the reader to identify and "build on his or her own tacit knowledge" (Lincoln & Guba, 1985, p. 358); it allows a credibility check via laying bare the researcher's process of meaning making. Because the case study seems to fit the criteria well, this format was chosen to guide the theory section.

In summary, the data analysis of this study utilized the constant comparative method as described by Lincoln and Guba (1985). The theory which emerged in these data is presented in a case study format.

Quality Criteria

Like in a research endeavor based in a positivist paradigm, this constructivist-based study must answer appropriate questions about the care and thoughtfulness of its process and outcomes. Unlike the positivist benchmarks of internal validity, external validity, reliability, and objectivity, constructivist paradigms base their quality upon the broad construct of "trustworthiness" (Guba & Lincoln, 1994). Although the four criteria subsumed under trustworthiness, namely credibility, transferability, dependability, and confirmability, have clear parallels to the positivistic standards, they are also unique and consistent epistemologically.

Credibility

The first standard, credibility, refers to a consistency between the constructions of the participants and the reconstructions of the researcher. This standard will be addressed in four specific ways within this study. First, my personal credibility is heightened because of my prolonged engagement with university counseling centers (six years' experience as employee or trainee, including employment at the time of data collection). I also chose to delay this research project for one year while I was actively engaged as a supervisor at a UCC, and participating in a supervisors' process group. These experiences significantly enhanced my "knowledge of the culture" of university counseling centers, and increased my ability to build trust in study participants (Lincoln & Guba, 1985).

Secondly, this study has incorporated triangulation (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Miles & Huberman, 1984) by using multiple and different sources of information (supervisors, training directors, center directors, documents) as well as multiple and different methods (interviews, surveys, document analysis). My recent experience as a predoctoral intern also added useful perspectives.

In the original proposal, peer debriefing was intended to be a third feature enhancing credibility. In the context of confirming sites, and conducting interviews, however, a complex network of interpersonal connections among the participants and proposed auditors emerged. Given the importance of scrupulously protecting confidentiality, I chose to abandon peer debriefing. Because I had already established (verbally and on the informed consent form) with all participants that my advisor would have full access to 1) the identity of my sites; 2) all interview transcripts; and 3) my subjective experiences during the research process, I elected to ask my advisor to fulfill this debriefing function. My advisor did agree to this role, and provided me with regular and timely opportunities to examine, clarify, and ground my thinking, as well as to open my thinking process to the scrutiny and feedback of others (Lincoln & Guba, 1985).

The fourth and final component which was included in this study's original proposal to support credibility was "member checks" (Guba & Lincoln, 1985). Member checks are a process in which participants of the study review the reconstructions of the researcher to confirm or dispute their accuracy. In this study, confidentiality issues again strongly suggested that the original design be modified, both because of transcript material about interpersonal dynamics at each site, as well the potential identifiability of participants and sites. I chose to provide each participant with an interview transcript and asked them to provide

changes or corrections as needed. In addition, I routinely incorporated verbal reflections of the participants' statements during interviews to give each person an immediate opportunity to verify their responses.

Transferability

Transferability is the second major component of trustworthiness (Guba & Lincoln, 1984). In a sharp departure from the parallel standard of external validity, in qualitative research decisions about the study's generalizability are assumed to fall in the domain of the consumer of the research, not the researcher. This study assists the consumer of research in that decision making process by providing rich, detailed, and clear data as it emerged from interviews. This study also leaves a paper trail in the form of memos which I routinely wrote at decision or reflection points in the process of the data collection and analysis.

Evaluations of transferability are also aided by my efforts to record and discuss decisions about sampling. Purposeful sampling (Lincoln & Guba, 1985) provides important information about context. This study's intent was to sample critical cases, namely university counseling center internships which are known and respected for their efforts concerning trainee impairment. The sampling of this study was also highly purposeful in that the targeted sites emerged from the consultation stage; that sample units were selected in a serial fashion; and that this format allowed focusing and adjustment (Lincoln & Guba, 1985).

Dependability and confirmability

Dependability and confirmability, the final two components of trustworthiness, are supported by the previously discussed debriefing, member checks, and

memo-writing. Dependability addresses a unique aspect of qualitative research: that changes in design during the research process are believed to be necessary and positive within an emergent and flowing inquiry (Guba & Lincoln, 1994; Lincoln & Guba, 1985). The critical issue in dependability is whether or not the researcher has discussed and documented decisions within this process. Confirmability is primarily supported by my having sought external auditing of both the process and the product of the study (Lincoln & Guba, 1985). This study was audited via the process of the dissertation review and defense; it will also be available for auditing by others via the developmental and informational history which is embedded within the final document.

Limitations

In the original proposal, three potential limitations of the research design were identified. These concerns were that the number of sites was being determined by funding and time rather than data saturation; that some coercion to participate might be possible; and that information might not be available on sites which declined participation. These issues proved to be either non-applicable or of minor concern.

Two emergent and significant limitations of this study are related to confidentiality. Because of the sensitive nature of the conversations, and the use of codes and unspecified labels (e.g. "the first intern") by both myself and participants, accurate triangulation was at times difficult. For example, I could intuit, but not confirm, that "Supervisor A" and "Supervisor B" had been referring to the same intern, or colleague in their respective examples and descriptions.

A second limitation concerned the limited external audit that was possible at this point because of concerns that the content of the transcripts, in spite of editing, contained potentially identifiable material. This was also complicated

by the fact that if an auditor happened to recognize the identity of a site, this compromised the identity of all participants at that site, and by extension, the interns who may have been described as examples. I elected to be cautious in protecting confidentiality at the expense of increased audits and confirmability. This limitation is expected to be minimized as I develop a larger data base.

A final limitation, which was determined at the outset to be beyond the scope of the current study, was the absence of predoctoral interns as participants. This information would clearly add a critical and unique perspective to the context of internship sites as they address impairment

Editorial Comments

Because of the efforts to balance clarity and accuracy with the need to protect the identities of participants,I have chosen to present the results of this study in varying degrees of specificity. Themes unique to sites are identified to the extent that anonymity is not compromised. Because of the socially constructed nature of gender and the consequent effects on perceptions and interactions, gender specific pronouns, when they are used in this report, are accurate to the identity of the participant or intern being described.

Direct quotations from participants have generally been used exactly as they were spoken, rather than in a more edited, and perhaps succinct manner. This decision was made in order to protect the richness of the statements as examples of thinking in progress. If I have made a clarifying addition to a quotation, it is placed within brackets.

Finally, the term "trainee" is used as a broader term than "intern," and refers to students at various levels of academic and clinical training. The term "intern," as used in this report, refers only to persons enrolled in a predoctoral psychology internship.

Chapter 4

RESULTS

Overview

This chapter is divided into five major sections. The first section examines the beliefs and values that I as the researcher bring to the project design, the interviews, and the data analysis. The second section describes the participants. The third section focuses on the participants' constructions of impairment. Specifically, this area explores definition issues, warning signs of impairment, intervention strategies, critical issues in the intervention process, and termination of an intern.

The fourth and fifth sections examine supervisors' experiences with their peers during the process of thinking about and intervening with an impaired intern. The fourth section focuses specifically on the impact of relationships and consultations. This section examines individual consultations; collegial group consultations, stances and conflicts in the supervisory group; barriers to effective collegial dialogue; and pre-existing collegial group relationships. The fifth section examines influences at an agency level, including the role of the Training Director; the role of the Center Director; assumptions about decision making responsibility; standards of supervisory and clinical practice; formal policies and procedures; consultations with academic programs; and recognition of moral and ethical responsibility.

The final section of this chapter focuses on the participants' personal experiences with intern impairment. Specifically, this area examines the

emotional impact that the process had on each participant, as well as what the participants have learned about themselves and about dealing with impairment.

The Researcher

Because this project is premised upon a constructivist assumption of knowledge, it is imperative that my beliefs and sensitivities around the topic of impairment are set forward, along with those of the participants. This information will assist readers in identifying my unique lens in the process of interpretation, as well as how my values are embedded in the interview process.

I believe that several experiences which sparked my curiosity in this topic may illustrate some of my perspectives. Early in my doctoral training, as I was teaching a counseling microskills course, I began to wrestle with the difficulty that some students had in understanding, even in a very elementary way, some of the basic skills required in a helping relationship. This problem intensified for me as I brought my considerable teaching skills to trying to help particular students "get it," but seeing no progress. I began to wonder, "Is this a developmental issue that just needs more time? Or are there some people who will simply never get it? How can you tell the difference? And at what point do I, as an educator and future supervisor, need to say, "This isn't good enough. At this level, you will end up hurting people, and that's not ok" ?"

A few years later, another incident further catalyzed my curiosity. As part of a practicum, I was sitting in on a counseling session with a more advanced student. In the course of the session, I began to notice behaviors on the part of the therapist which concerned me. As the session unfolded and as I sat in silence, my anxiety increased; my concerns on the behalf of the client grew. At the end of the session, the client elected not to continue in counseling and left.

I was deeply troubled by this experience on two levels: one, was that I intuitively believed that the client had clearly not been helped in this session, and even that she may have been harmed. The second level was something that actually disturbed me even more: that I had been sitting there the whole time, watching the interaction, having strong concerns, having the ability to intervene effectively with this client, and yet, I said nothing. In the days and weeks following this incident, I reflected upon possible contributors to my silence: my introversion, my dislike of conflict, my uncertainty about my clinical judgment, even my socialization as a woman.

But I also uncovered some other complex questions that I wrestled with both in that session and in the aftermath. I realized that some of my silence was grounded in a simple wish to be respectful of what I thought might be a different and equally valid approach on the part of the other therapist. I also remember trying to think through my emotional reactions in the context of my identity as a woman and a feminist, given that the client was a woman, and the therapist was a man. A complex paradox emerged for me out of these reflections. On the one hand my deep commitment to feminism demands that I continually challenge myself to be inclusive: to expand my understanding and acceptance of multiple human perspectives and realities. On the other, as I read articles in my ethics courses about psychologists "knowing the ethical thing to do, but not doing it, and often, ignoring the whole situation," I remained uncomfortable remembering my own silence, and my unwavering intuitive sense that the client had been harmed.

A final element which is important to highlight in my own perspective, is my strong awareness, perhaps even a reverence, for the power and responsibility the therapist holds in the counseling relationship. Even though I tend to work in a collaborative style with most of my clients, I believe that as a therapist I hold a

tremendous amount of power, and I enact that power in many ways: by how I construct and articulate my understanding of my client's distress; by how I choose to respond or not respond to my clients' constructions or affective experiences; by how I generally behave in relationship with my client.

I have grown to believe that one of the most delicate, dangerous, and unrecognized aspects of this power is its invisibility. In a field such as medicine, this power is much more evident and quantifiable: a surgeon's error may result in the patient's death; a diagnostic error may be challenged by a lab report; an inappropriate choice of medication may result in allergic reaction. Not only are errors more evident, but a general lack of progress, and the day-to-day consequences of that, are more recognizable as well. In the therapeutic domain, however, short of an extreme example such as client suicide, it is very difficult to estimate how much a client may be experiencing either direct or indirect harm within the therapeutic relationship. As counseling psychologists, we often focus on "normal, developmental, quality of life issues." How does one measure the cost of a lifetime spent in quiet despair when that despair, in the hands of a competent psychologist, would have been fully treatable? What is the cost to the client? To the client's family and friends? To society?

I believe that I do recognize and can accept that in psychology, like in all fields, there will be a range of practitioner abilities, from those who are truly talented in their work, to those who are simply competent, to those who are not competent and practicing anyway. I also believe that all competent clinicians sometimes make mistakes, and have more and less effective relationships with clients. In short, although I obviously have some strong feelings about the responsibilities and competence demands of therapists as members of the profession, I also believe that these expectations are realistic and appropriate. It is clear to me as well, that developmental issues of the profession as a whole

are germane to the struggle of determining who should not be allowed entry, or allowed to remain in the profession. If we are, as Gelso and Fretz (1992) suggest, finally resolving identity issues and reaching maturity in the 1990s, perhaps it makes sense that as counseling psychology educators and supervisors we are only now beginning to make progress with determining who does and does not adequately meet the standards for entry into professional practice.

Finally, and perhaps obviously, I have a strong belief along with Bakhtin (1986), Vgotsky (1978) and others that thinking is essentially a dialogic process. I also agree with the constructivist maxim that "to know what I think, I have to see what I have to say." I believe that decisions about impairment, and everything else, are embedded within a complex intra- and interpersonal process. Further, I believe that a rich and sustained dialogue, as opposed to a cursory and limited discussion, is highly preferable in making judgments about such complex constructs as impairment.

In summary, the beliefs and values that I bring to this specific project are: 1) that supervisors have a strong ethical and moral responsibility to actively assess the competence of their trainees, and to deny entry into the profession to those who are unqualified; 2) that the concept of "harm" is underdetermined and largely invisible; 3) that clients' rights to be protected from harm supersede trainees' rights to learn the practice of psychology; and 4) that supervisors must be provided adequate contexts to fully examine the complexities of potential impairment situations in order to make sound, compassionate, and responsible decisions.

The Participants

One of the striking, yet not surprising, commonalities among the six supervisors, three center directors, and three training directors, in the participant group was their strong personal commitment to training. As one of the center directors explained, "People come here to work because of the training.....just to see clients day in and day out, that would not be their identity, I wouldn't think." A strong emphasis on training was present, as well, in the descriptions of the supervisors of how they chose to participate in the study. "My dissertation research was on supervision," said one supervisor, "[Participating in this study] felt like an important professional investment to me." Several reported that they currently or in the past have facilitated supervision of supervision seminars; several serve on training committees at their respective sites. When asked to describe themselves as supervisors compared to their peers on staff, the responses reflected this value as well: "I'm a demanding supervisor," "a highly involved supervisor," "a real intern advocate."

The eight women and four men of the group were diverse on other dimensions. They held a fairly even mix of counseling and clinical psychology graduate degrees. They represented a range of ages: four participants received their degrees in the 1960s; two in the 1970s; three in the 1980s; and three in the 1990s. As a whole, the group averaged 14 years' work experience in University Counseling Centers, with a range of 3-30 years. The average number of predoctoral interns directly supervised (by the supervisor group only) was 10, with a range of 3 to 20. A very broad range of theoretical orientation was reported: humanistic/existential, object-relations, cognitive-behavioral, eclectic, systems, developmental, and psychodynamic.

Information was also collected regarding the participants' formal training related to addressing impairment in the supervisory relationship. Sixty percent

reported that they had completed a course in ethics; only thirty percent had completed a course in supervision. Interestingly, one training director reported having had three supervision courses.

Although the participants were also asked to provide numbers on impaired trainees (e.g. interns, practicum students) and other supervisees (e.g. master's level clinicians, postdoctoral residents) they had supervised directly or else as part of a supervisory group, the participants expressed difficulty with answering these questions. Upon reviewing the Background Information form (Appendix D), several asked the researcher, "But how do you mean "impairment" ? Should I put down people who I thought shouldn't be passed, but graduated anyway?" Several supervisors responded on the form that they had worked with zero to two impaired interns, and yet in the interview gave multiple (three or more) examples of trainees who they believed "should not have been passed on." The mean number of impaired interns reported by the supervisors as having been under their direct supervision was one. Of this group of interns, one person was dismissed from internship. Two interns were either in remedial or disciplinary processes at the time of data collection. In one case, a legal intervention was pending.

The Participants' Constructions of Impairment

Definition

"Can I look at the policy?" laughed one participant when asked how she defined impairment. "Boy, you've started with a really tough question" responded another, "Let me think for a moment." A third person, who has worked in the field of psychology for over twenty years, candidly replied, "Actually, it's really hard for me. That's why I'm glad you're doing this." One supervisor, at the end of the interview reflected,

> You know, it's odd. No one has ever asked me to articulate this before. Like how I'm thinking, and why I know what I know. In a way that feels like a compliment, like they really trust my judgment. In another, I wonder if that's really wise [to not ask supervisors to explain their decision making processes].

With the exception of the training directors, who were generally able to offer a fairly clear statement of how they conceptualized impairment, and how they had written it into their site's impairment policy, participants generally expressed or demonstrated "not having really defined this for myself before."

As the participants reflected, and recounted various experiences with problematic trainees, most arrived at a description of impairment that contained three central themes: the intern's behavior was either professionally harmful or deficient; the behavior was a clear pattern; and the behavior was not resolving. A fourth theme, which was often discussed, but which seemed to remain unclear in the minds of the participants, was the notion of impairment as a "noticeable shift" in the intern's level of performance.

Like most of the responses in this study, the participant's focal point in defining the problematic behavior varied. One supervisor's version clearly focused on the internal experience of the intern: "Impairment to me is when someone's functioning is compromised by issues they're dealing with on a personal level." Others seemed to use a more client-focused reference: "Impairment is an inability to behave ethically in relationship with clients." Others still used specific work functions as a guide: "I'd have to say it involves some sort of inability to engage in tasks that are described in the actual job description," and "It's an inability to follow through, on a noticeable level, with their duties as a therapist." Another category, which was frequently mentioned and which seemed to be particularly emotionally charged for the participants, was the intern's interpersonal relationships in the work place:

> There is a second piece that is....harder to define and....riskier to address. And it seems just as important. And this is the aspect of the definition that involves...impairment in the interpersonal relationships in the work setting. So that there is some level of difficulty, or trouble, or struggle in [those] relationships.

Although the majority of the participants used the concept of "harm" (i.e. harming clients), some also wrestled with whether demonstrable harm was a necessary condition, or if the clear risk of harm was sufficient: "I think that the awareness [of the risk of harm] could be enough.....Yea, I probably think that."

One training director offered an even broader version: "[Impairment is] really any incident that involves harm to the client. And well...that ranges all the way, you know. I think the other end of the range is when they don't help the client. Sometimes there's not that harm dimension."

The second clear theme which emerged as participants explored their experiences with impairment was an emphatic conclusion that the problematic behavior needed to be a pattern, not simply an incident: "I'm not talking about one-time occurrences here," said one supervisor, "Everybody makes mistakes. No one's perfect. So, I think I'm talking about patterns of occurrences." Another supervisor concurred, "And not just one time, but repeated. That seems important. That it's repeated.....in many contexts, across supervisors... That it's pervasive."

The third definitional theme, which seemed closely related to the recognition of the problematic behavior as a pattern, was that the behavior was not improving or resolving. Participants often noted that the best indicator of this lack of remediation was the amount of staff time and energy being spent on that particular intern. One training director explained: "Right from the get-to, we were talking about this particular intern. That was a real key that something was up. That we were putting so much time and energy into this one intern." Supervisors often expressed their frustration as they described their efforts to

help the intern: "No matter what the intervention is, the problem doesn't get resolved." One center director offered a striking description of the systemic indicators of intern impairment: "The way I would know impairment is there's a huge, persistent commotion [on the staff].....That goes on until you think it's interminable."

Although the participants seemed to struggle when asked to identify more specifically what seemed to be missing in the intern's response, or exactly what they are as staff were looking for, almost every participant eventually focused on the issue of the trainee's self-awareness: "[There is] an area of needed growth, [that the intern] resists looking at." "The intern doesn't acknowledge or doesn't understand it....doesn't change in response to feedback." One person captured the stance of the intern at this point in this way:

> I think I can do it; you don't think I can do it. We have that talk in a lot of different ways. And no matter what evidence you show me, I still think I can do it.

For many of the participants, their thinking processes seemed to lead them to a statement about the ability to reality-check one's own professional abilities. "For me," said one person, "impairment is very closely tied to judgment....or the lack of ability to make a judgment or decision about their impact on others." Another person concurred, "Somehow this person...it's outside of their awareness or they're not able to make a change and they're still trying to do their duties.....Somebody else has to step in and do something." A training director added a reflection from personal experience with an impaired intern:

> Although at times I thought she did some good clinical work, I think she would be a kind of practitioner who would be dangerous, because she wasn't able to moderate, to self-reflect very well. And she wasn't able to see that her personal life was causing enormous turmoil in her ability to deal with her clients.

Many participants seemed to vacillate concerning the difference between an

intern who was "unable" to integrate feedback from the training staff versus one who was "unwilling" to do so. "A person who does know that this is happening, but they're not resolving it?" asked one supervisor, "Hum..yea, I guess I'd still say that this person is impaired." Another supervisor disagreed, "No, I probably wouldn't . I describe impairment as being unwilling to take action." One participant suggested that the absence or presence of awareness was not the critical issue, but rather "the ability to make the judgment."

A fourth definitional theme, which remained ambiguous for most of the participants was the notion of impairment as a "noticeable shift." "The idea of a noticeable shift seems important," reflected one supervisor, "That it's different from their previous level of functioning....Either gradual or all of a sudden." Several participants included this concept in their initial definition, then in the course of the interview realized that they had been using examples which did not fit this criterion. When asked to capture the issues contained in these examples, the participants usually concluded that the other category involved skill deficits. One supervisor considered a hypothetical scenario of one intern who had skill deficits and one who was seriously depressed. She concluded: "They're both impaired, but I think maybe how I think about the prognosis is different." Another supervisor pondered whether or not she'd label both interns "impaired." Finally she laughingly replied, "Yes. Although I'd feel differently about them!" One training director, who acknowledged that skill deficits are often included in the definition of impairment, disagreed: "I don't know if that's really impairment or not."

This recognition of fundamentally different pictures of impairment led most of the participants to begin to categorize their responses into different "types" of impairment. Specifically, two subtypes seemed to emerge: one seemed to encompass issues of diminished functioning or, as several supervisors

described, a "noticeable change" in the intern's performance. The other subtype was generally organized around the label "skill deficits," and seemed to be fairly broad in nature, ranging from specific clinical skills, to interpersonal difficulties, to lack of self-awareness, to lack of professional responsibility. Interestingly, the vast majority of examples spontaneously offered by participants of impaired interns seemed to fall into this "skills deficits" category. One supervisor noted that this second type was "trickier, because I don't have a base reading," for example, of the intern's broader clinical performance or response to developmental challenges.

In general, supervisors seemed surprised to recognize this definitional subgrouping, and particularly to realize that most of their examples did not fit their original definitions of impairment. In the middle of one interview, a supervisor noted this discrepancy and began to re-frame her conceptualization, specifically, that the two interns she considered to be impaired did not fit the "diminished functioning" definition she originally set forth:

> It wasn't that something had happened [e.g. loss of a loved one, or other stressful life event] and they weren't able to respond to it, it was that they came in unable to fulfill those assumptions that we already have of an intern.

Other supervisors, while sorting out the various categories of impairment they seemed to be using, commented on the negative personal reactions which seemed to be particularly present when they were dealing with a situation involving skill deficits:

> I feel pretty overloaded by my workload here anyway, and then to have to take extra steps to assist someone whose program did not adequately prepare them.....I have a very negative reaction.....I feel pressured....I find it irritating.

A second supervisor concurred:

> I guess I have really strong feelings about us having to train someone, and how that would impact everyone else in the Center who we are

> trying to train and mentor...if we are trying to put all of our resources into trying to teach someone something that they should have already gained.

A striking feature of the subtype issue was how regularly either the researcher felt a need to redraw the distinction between them, and then to ask the participants to clarify their somewhat similar, but distinctly different, responses to the categories.

Warning Signs of Impairment

After the participants discussed their definitions of impairment, they were asked to describe their process of determining whether or not impairment existed. The researcher began by asking for specific examples of intern behavior which might put up "red flags" in the participant's mind, specifically which might cause them to feel somewhat alerted to potential problems. One supervisor offered examples of what she might observe that might even precede the more clear problem indicators. These "yellow flags," as she referred to them, were generally changes in the intern's affective state: "a change in mood that was rather chronic...in someone who was rather even...If usually they're invested in their internship and that seems to change."

The participant group offered a large number of potential "red flags," that have been grouped into the following categories: administrative tasks, clinical work, interpersonal relationships, requirements of the internship, attitude, and ethics.

1. Administrative tasks: not turning in tapes; not completing paperwork; not writing case notes; not keeping case notes current.

2. Clinical work: not able to describe sessions to supervisor; poor quality of diagnosis and assessment; not getting past advice-giving stage; abundance of no-shows; client dissatisfaction; client complaints; inability to develop caseload; inability to maintain caseload; responding selectively to client content; misperceiving what client was saying;

responses to client that seem squelching, punishing, critical, or judgmental.

3. Interpersonal relationships: not adjusting well to internship; not relating well to supervisors; problems with a supervisee; difficulty integrating into the intern group; not finding partner or colleague in the intern group; feeling isolated, being isolated.

4. Requirements of the internship: not showing up for training sessions; not showing up for supervisory sessions; not notifying anyone that they wouldn't be in; coming late to meetings; being disruptive by coming late.

5. Attitude: externalizing; being manipulative; lying; dishonesty; having difficulty assimilating topics of conversation; being oppositional; cutting corners: "Not breaking the rules, but bending them."

6. Ethics: talking about personal issues and not seeing their effects on their personal world and their work; difficulties with confidentiality.

One training director identified a potential warning in his own behavior: "Am I inordinately watching his/her behavior? Am I thinking about him or her.....how to approach him or her?"

Intervention Strategies

Next, participants were asked to describe a typical pattern of interventions they might make after noting intern behaviors which concerned them. Although there was a great deal of variation in the ways supervisors described their approaches, some similarities emerged in the way the severity of the concerns were grouped into mild, moderate, and serious. Most participants, for example, seemed to think of mild concerns as issues which were problematic, but which did not directly impact quality of client care. Interventions at this level seemed to have a supportive, didactic focus:

.....Often, I'll just acknowledge that it's happening. My experience is that people are less defensive if you don't ask them to justify...[I'll say] "Wow, I notice that you're really seeming exhausted...It must be hard

> to track in session." I don't ask them to confirm or deny...a lot of supervisees will head there if I give them the opening.

Many supervisors emphasized using their clinical skills in these interventions: "I'm going to try to see where they are, and try to present it in a way that's hearable for them...I prefer to start with the gentler approach first."

Another supervisor clearly takes a teaching focus: "I tend to go in at the simplistic level, assuming there's a lack of skill, and give feedback to the trainee just like we would do for a client." Others offered the following options at the mild level of concern: suggest therapy for the intern; ask for a videotape; ask for case notes; be more vigilant generally regarding the intern's performance.

The moderate level of concern seemed to encompass issues which began at the mild level and which were not resolved, or else issues in which harm to clients was possible. Supervisors offered the following, more confrontive, examples of their messages to interns at this point:

> You can help <u>us</u> to understand so that we can help you. Because at some point, this is not going to be ok any more. It will be enough of these behaviors or enough negative consequences that we will be moving to a different level of intervention.

Another supervisor echoed the warning: "I'll tell them that I have serious concerns, and if this continues, we'll have a problem." And a training director, after discussing the situation with the intern, takes this approach: "So then, I'll set down some firm guidelines. "This is what we need [from you], regardless of what's going on. And if that won't happen, we will need to escalate our response." Some people noted an increased need "to be pretty vigilant around ethical concerns" at this level. Various interventions suggested included: lowered caseload, no new clients, additional supervision, probation, having a second clinician sit in on sessions.

The third level of concern included issues which were persistently unresolved, or else behaviors which involved clear harm to clients. One

supervisor described her tradition of telling all of her supervisees at the outset of their relationship that they can "do anything with a client except hit them or sleep with them. We can fix everything else." She then described her perception of this statement's impact: it established that she was there to help the intern learn and that making mistakes was acceptable, but it also established that harming a client was unacceptable. This supervisor's response to concerns that were on this level was straight-forward: remove the intern's caseload, reassign those clients, then develop a corrective action plan for the intern.

The one behavior which participants identified which would automatically put an intern's standing into the "serious concern" domain, and which would potentially result in immediate dismissal was sexual involvement with a client. One supervisor noted that sexual misconduct had, in fact, resulted in immediate dismissal of an intern at another site where he had worked: "It was so outrageous that we terminated the trainee. It was just too outrageous....involved with a client." A training director added: "I wouldn't be crazy about someone having sexual involvement with a supervisee either."

In order to capture a process of intervention more fully, a description of one supervisor's approach is as follows:

Level 1: Concern emerges: write the concern down for myself, so that it is reflected in the supervisory record. Discuss concern with intern; monitor receptivity; ask for another work sample (in area of concern). Might check in with colleagues here to determine if they're seeing same concerns.

Re-check concern: if seems resolved/progressing, give intern feedback.

Level 2: Not seeing improvement. Re-think intervention. "What's another way to assist?" May provide additional readings or consultations

with other staff. Would go to Training Committee, describe concerns, ask for help in giving "extra assistance, across areas."

Monitor progress: if resolving/progressing, give intern feedback.

Level 3: Not seeing improvement. Check in with range of colleagues, determine if others share concerns or not. If not, have discussion with intern about possibility of relational issue between intern and supervisor, or difficulties with particular client or client issue. If concerns confirmed by colleagues, document in supervisory record; tell intern I'm taking situation to Training Committee; take to Training Committee.

Level 4: If concerns continue, ask for another specific work sample. If unsatisfactory, make full report to Training Committee of history of concerns, efforts toward remediation, evidence of lack of progress. Make recommendations to Training Committee (depending on situation); turn situation over to Training Committee.

It was interesting to note that this particular supervisor was the only participant who mentioned keeping supervisory notes as a routine part of her work with trainees.

Finally a training director offered the following hierarchy of interventions which provide both structure for supervisors and due process for interns: 1) verbal warning; 2) written warning; 3) schedule modification; 4) probation; 5) reduced clinical time; 6) program/outreach time eliminated; 7) reduced hours in the Center; 8) termination.

Critical Issues in the Intervention Process

Participants were asked to identify intern responses which might affect the intervention process. One center director pinpointed the intern's response to

the interventions as the determining factor in whether or not a trainee would be considered impaired. In general, participants focused on situations in which interns had been defensive or hostile in response to the supervisor's concerns and interventions. Supervisors unanimously reported this type of response as causing increased strain on the supervisory relationship, and moving the intern's status into a more serious domain. One supervisor described an intern's response to her statement of concern about his inability to maintain a caseload:

> He'd either lie, or maneuver. Not take any responsibility whatsoever. It was the client, the time [of day], the weather. It was just something other than, perhaps, what he was doing.

Another supervisor described the effects of an intern's dishonesty on her responsibility to protect clients. "I have a lot of trouble with [interns] who lie," she said:

> I'd rather have them decompensating than lying to me...because of the trust factor in trying to help them through their impairment. If they're telling me the truth...I can feel somewhat safer leaving them with clients.

A third supervisor concurred with these concerns about interns' trustworthiness and the impact on the supervisory alliance. She offered a specific incident with a former intern who had been dishonest:

> The end result is that....the trust in the relationship begins to get strained. One begins to wonder, "If this person seems so savvy about cutting this corner, then what other corners might he be willing to cut, and at whose expense?

Clearly, intern dishonesty and denial served to further increase supervisors' concerns about the intern's competence to ethically serve clients. Participants often reported that when they encountered such a response from a problematic intern, they responded by examining their own communications in a more careful and deliberate way, and also by increasing their collegial consultation.

Another description which emerged in discussions of "intern responses which could affect the intervention process," was the broad category of Axis II or characterological issues. Supervisors offered multiple examples of ways these personality dynamics in a trainee could "muck up" the process, for example, how they could cause senior staff members to split up and take sides, or how they could generally cause an intervention process to take some "odd turns." As one supervisor explained:

> It's kind of like when you're working with an Axis II client. Every time you see them, it's a different story. There's a new crisis, a new element of chaos.....You stand in one place in relation to that [person] one week, and then the next day or the next week, you're in a completely different position in relation to them. And so, in terms of trying to be methodical, and intentional, and helpful with this person .....and having those processes somehow discombobulated or diffused in different ways. So that has mucked up the process.

In addition to dishonesty and characterological issues, a third category of influential intern behaviors or attributes emerged. This category, the "likability" of the intern, seemed to surprise a number of the participants as they reflected on their experiences, but who were nevertheless quite candid in their descriptions. "When I really like the trainee, but I'm seeing things that concern me," said one supervisor, "I really wrestle with the dissonance." Another participant described the same dynamic regarding a specific impaired intern, "Everyone was really attached to him. I think it was more painful for everyone...I guess I want to say." The possibility clearly emerged that "likability" had a strong effect on supervisors' judgment, and that this effect was marginally clear to the participants as it occurred. One training director, for example, made both of the following two statements: "We had one [problematic] intern.....He had incredibly poor judgment. He wasn't impaired...he was innocuous and sweet." And this: "In this last incident [with an impaired intern], it may have been that we were more together [in our intervention], or it may have been that the person

was not that likable."

Finally, the participants noted intern behavior which would have the converse effect of the preceding examples, namely that the supervisors would be reassured, and inclined to move the intern's status to a less alerted level. Supervisors frequently mentioned the attitudes of investment, receptivity, and collaboration. "I think it's crucial to have the receptivity level there...to a high degree," said one. "I want them to hear it and take it in. I want them to be invested in....remedying the problem." Another supervisor offered an example from when he had confronted an intern regarding chronic lateness and exhaustion: "We talked about it, and she was pretty up-front [about what was going-on]." From there, he reported, they simply moved into a collaborative problem-solving mode and the concerns did not escalate. One supervisor offered her belief that a highly critical determinant of whether or not concerns would escalate was the quality of the supervisory relationship prior to the emergence of the initial problem.

Participants were also asked to identify decision points in the intervention process which seemed particularly difficult. Three of the major themes of these difficult decisions seemed to touch on the issue of diversity, specifically, diverse clinical styles, diverse levels of <u>acceptable</u> clinical competence, and diverse interpersonal styles. It was also striking to note that although strong patterns emerged in these responses, the difficulties were clearly not unanimous in every category.

Some supervisors reported that they vacillated in their decision about clinical choices their supervisees had made. "I don't know necessarily who's to say what 'right' therapy is," reflected one supervisor. "I don't struggle with whether or not to bring it up; it's whether or not I'm going to make them quit doing what they're doing." She reported that this decision had become even more complex

for her as she confronted interns on specific behaviors (i.e. intern holding a client on his/her lap; intern taking client out for a walk; intern explicitly describing own sexual experiences to a client), and the intern fully believing that he/she had acted appropriately, and in accordance with his/her theoretical rationale. "The range of different orientations and styles," said this supervisor, "makes it almost ok to approve of anything or disapprove of anything." Another supervisor seemed to echo some of this complexity: "It's very hard in the areas of clinical choices to pick out what might be the therapist's need to go beyond....beyond the therapeutic relationship into another kind of relationship."

Not only do diverse clinical styles make decisions about impairment more complex for some supervisors, but those styles also add another layer to the complexity of already diverse human beings. One center director expressed his frustration with this task:

> How do you acknowledge and value differences and diversities, and allow people to be who they are, and at the same time, have a set of standards below which, outside of which, the person is impaired?

The issue of a "threshold of competence" within this diversity was also articulated by this center director:

> And then you have the complexity of some people are better at therapy than others, regardless of if it's a trainee or a professional staff member. We can't demand the same level of competence of everyone. So what's the threshold below which the person is is impaired and needs to be doing something else? That's the tough question.

Added to the issues of diverse theoretical styles and levels of competence, supervisors identified the difficulty of making judgments regarding an intern's interpersonal relationships, particularly within the intern group. "That's the area that I have the most difficulty with," said one supervisor:

> That one always throws me, because I want to allow for differences. At the same time, there is a level of behavior at which there is some expectation. And we do expect, particularly interns, to work with their group and their peers.

Ironically, as often as participants mentioned their own struggles with various forms of human diversity, their descriptions were almost exclusively broad and generic, which gave the effect of talking about the issue without ever specifying particulars. Two notable exceptions to this pattern occurred: one supervisor briefly noted her curiosity regarding power dynamics between female supervisors and male supervisees. Another supervisor added a fascinating and candid admission about herself, and perhaps a comment about what is being role-modeled for some trainees in terms of dealing with diversity. A recent group of interns at her site were concerned that another intern was not "developing adequate cross-cultural sensitivity." "As a supervisor," this person reported, "I wouldn't touch that."

A final area mentioned by supervisors as containing complex decisions was when the impairment involved either a skill level which seemed slightly inadequate and which was not improving, or else impairment which involved decompensation. One supervisor described an experience with the first type. "As it turned out," he laughed, "I was sort of saved because that person decided that this wasn't their field. And so, I felt very much relieved." Others described frustration and fatigue: "There have been cases that, regardless of the lengths people went [to remediate].....they were not able to take in that information."

The second type of impairment involved decompensation, specifically, when the intern was known to have decompensated and harmed clients at least once in the past, and was showing signs of decompensating in the present. The supervisor who presented this issue also framed many questions which are not addressed in this study because of her vantage point in the particular

experience. At the time, she was seeing a trainee (from another training site) with these issues as a client in her private practice. The supervisor described many ethical issues which had emerged for her in the course of this work. Ultimately, she said, it seemed to come down to one question for her: "It's not like [the trainee's decompensation] was a one time thing.....How much of a risk are you going to take with these people?"

A final area which was explored for complicating factors in the intervention process was how participants' personalities, values, or other day-to-day issues might be relevant. My questions on this topic were intentionally phrased in a broad, non-specific way, and the responses were quite varied. One participant laughed when asked how "personal issues" might come into play. "That's a very good question," she replied, "I'd have to think all day on that one."

One supervisor spoke at length about her awareness of situations with interns, one in particular, which overlapped with some issues from her personal history. "When you feel some level of shame [in interactions with the person], when it taps into.....perhaps our own person issues or more cultural issues," she explained, it may be more difficult for a supervisor to clarify his or her stance on the intern's behavior. She described a specific incident which affected her in this way, and which she wrestled with alone for some time. "It was just subtle enough," she explained, "that I had to ask myself, '<u>Is</u> this really happening?' And when I finally got ok with that...." she then took the situation to a colleague who responded, "Are you kidding me? He's doing that with you, too?" "Eventually," the supervisor said,

> I did bring it up to the entire senior staff. And at that time, there were actually more than two of us that this was going on with. The other people were able to say "This <u>is</u> happening." And the person was confronted.

As this example illustrates, personal issues overlapping with an intern's

behavior might cause a supervisor to need more validation or confirmation in order to feel confident in his or her judgment.

Some participants were quite candid about struggling with negative emotions from the interns who were being confronted. They reported their belief that this struggle, did at times, impact the intervention process. "You get that resentment," said one, "I don't really like that so much." Others described interns who reacted with hostility. One supervisor tracked the impact that an intern's hostility seemed to have on multiple levels in the system:

> If there is a supervisee that is having difficulty taking in feedback about their performance in a particular area....being very defensive or hostile, I think that impedes the process. I know it impedes it in terms of.....maybe my hesitancy to bring it up with them. To be direct with them. Or maybe my hesitancy to take it to the Training Committee.....Or maybe the Training Committee's hesitancy to work with this person. In terms of, if we think we have somebody who is a high risk for litigation or something like that. I think that can impede the process. And, unfortunately, we have had a couple of those situations.

Clearly, these participants were suggesting that intern hostility could strongly affect the degree and manner in which the intern was confronted.

A closely related issue to an intern reacting with hostility is that as concerns become more serious about an intern, more people at the site become involved in the process, and more documentation, both known and unknown to the intern, occurs. One supervisor described the "two-pronged thoughtfulness" required of her at this level:

> There's thoughtfulness in terms of "What would be helpful to the person?" We're here to try to train. And yet, at another level, we're also thinking, 'And how do we cover our ass if the person does not meet us halfway?'

Several supervisors commented on the difficulty of maintaining a constructive relationship with a trainee who had reached a level of concern where documentation and other staff members, particularly administrators, were

involved.

Many participants identified their liking of the supportive, positive, teaching aspects of the supervisor role as, at times, being a hindrance to working with impaired interns. "Our training as therapists makes this hard," said one center director, "[We're trained] to be non-judgmental, to be empathic, to accept individual differences. That whole training and set of values make it difficult to do those opposite things which may need to be done: be pretty critical, judgmental, confrontive." A supervisor agrees: "I tend to think of helping people, you know, improving their skills....giving positive feedback rather than negative." This same supervisor described how this same positive focus sometimes gets him into trouble in the intervention process:

> I know for myself anyway...if I'm not careful, the tendency is to say, "Well....it will be ok." And then back off from conflict and problems.....Sometimes people will say, "Well, [the intern has] strengths and weaknesses, and some of the weaknesses you can work on." And then get away with that....of still moving the person on.

One supervisor described her struggle to give up her role as the intern's teacher regardless of how serious the level of concern had become.

> What I'm struggling with here is at what point, or <u>if</u> there is a point at all, in which I have to step away from my role as an educator in the service of client care.....I personally would have a hard time letting go of the hope that at some level, there may be some teachable moment in there, that the person could take away something really important.

One theme which reverberated throughout the participants' responses in this area was the strong, personal wish to give the intern "the benefit of the doubt."

This value of giving the intern "the benefit of the doubt," in addition to participants' general dislike of confrontation and dealing with disgruntled interns, led some participants to comment on their personal difficulties with the idea of dismissing an intern. Although every participant conceptually endorsed

the necessity of dismissing interns in some cases, many seemed to struggle with this task in practice. One supervisor, in spite of her firm opinion that a particular intern was impaired, described her struggle this way:

> [The hardest part was] deciding that someone is impaired, and imagining asking them to leave the internship. The deciding part is hard because there's this some of this "Holier-than-thou," "We have decided that you" kind of thing that.....Well, it just kind of messes with me (laughs). And then to actually ask them to leave the internship. It just seems unbelievable to me that I was in the situation

Other participants echoed this sense of disbelief and caution, at times even guilt, over the potential impact of the decision to ask an intern to leave. "The hard part is," said one, "you know, it's someone's career." Others commented on the internship being at the end of many years of work for the intern. "I'd like to think that if we take someone in.....We'll do everything possible to see them graduate. And if somebody has put years in, that makes it more difficult."

Finally, one participant offered an overlooked component of the supervisors' lives which could impact the intervention process with an impaired intern: the status of the supervisor's clinical caseload. This person described an extended period of time in which he was dealing concurrently with a seriously impaired intern and a "highly, highly lethal client." "The clinical work doesn't stop," he noted, even though a supervisor might be taking on many additional hours of work related to his or her supervisee's performance. "I remember having vivid dreams about it..... and waking up sometimes going 'What am I going to do?'.....Because it was pretty stressful."

Termination of an Intern

Participants were also asked to describe their beliefs and opinions about whether, and under what circumstances they would advocate for an intern to be

dismissed from the internship. One of the most striking features of this set of descriptions was the degree of ambivalence, struggle, and contradiction evidenced in some of the constructions.

First of all, participants were asked whether or not they believed that in some cases an intern should be dismissed from internship. Several replied with an immediate and firm, "Yes." One affirmative response seemed a bit more tentative: "Yes.....I think that's possible, sure." One supervisor, in spite of other statements agreeing with the need to terminate, and her history of having recommended that an intern not be passed on from the internship, seemed to be hesitant as well: "I wouldn't feel comfortable going there until...we had exhausted every other possibility.....I think it would take an awful lot to ask someone to leave the internship." A second supervisor balked when the researcher used the phrase "prevent the intern from entering the field of psychology." She asked for repeated clarification, then replied,

> What I'm separating out here is removed, or at least sort of an arresting of the process. And saying, "Until you get this taken care of," or "Until you address this, you may not complete the internship."

This supervisor concluded that she believed that she could advocate for an intern to take a leave of absence, but probably not for them to be dismissed from the internship.

One center director added an interesting component to the issue of asking an intern to leave. He reported that "as long as it seemed proper," his site would simply continue to work with the intern until the end of the internship year. "I think that's what happens," he said, "Almost all the time." This person also acknowledged the difficulty inherent in delaying a decision about an intern's performance: "It ends up that you work with the person almost the entire time of the internship. Which makes it hard. It's hard to come right down to the end of

something and say, 'Yea, you didn't do it.'"

A second question posed to participants about termination was "What would that take? For an intern to be terminated?" One supervisor offered a striking response: "Oh. An act of God. I haven't seen a system with the guts to do it yet." Other participants offered a range of examples which would justify termination: ethical violations "that had been clearly articulated"; psychopathology; inability to benefit from training and supervision because of a diagnosable disorder; sexual misconduct with a client; verbal abuse of clients; "horribly poor judgment that doesn't seem part of a major depressive episode or psychological decompensation"; a psychotic break.

As one supervisor pondered and described what would cause her "to cross that line" and advocate that a trainee be dismissed, she offered examples from her own experience:

> I have had some situations in which, a person upon hearing what was an appropriate way to interact with a client, sit with a client, work with a client.....Um, ignored that and continued to have..... quite inappropriate interactions with the client. And then having that situation again, and approaching the situation with increasing directness and saying, "This is <u>not</u> ok, to do, or say, or suggest. And having that person blatantly ignore. And elect to, sort of, do what they felt best in the situation. And having that tracked through several different supervisors. Regardless of supervisor, regardless of situation, this person was invested in doing what he or she thought best in the situation. With no regard for ethical or legal concerns, or what would be in the best interest of the client.

This supervisor summarized intern behaviors and attitudes which would cause her to advocate for dismissal as a sense of "blatant and pervasive disregard."

The discussions with participants about advocating for dismissal seemed to evoke the previously described subtyping of impairment. Several participants noted that the type of impairment made a significant difference in what their recommendations would be. Specifically, the issue of marginal or inadequate competence, as opposed to a decompensation, diminished functioning, or a

personality issue, seemed to re-emerge. One person described making a decision about marginal competence as the "hardest issue." He explained:

> If you've got someone who you think is just performing, you know, just at the minimum level.....When do you say, "This isn't good enough?" And when do you say, "Well, it sure isn't what I'd like, but....." I think that's really hard.

Another participant added that her developmental values added to the complexity of this question. "I see our profession as a process," she said, "So I don't think people are perfect and ready to go after internship."

A few supervisors were able to identify what would help them make a decision about whether to recommend dismissal for a marginally competent trainee. For one, the issue rested squarely on her perception of the trainee's investment in and commitment to his or her own learning. This supervisor described incorporating two major components into work with these trainees. First, she provides very specific, regular oral and written feedback to her trainee about areas of needed improvement. "I know that that goes back to their home program, in their file, and we also have it on record here. I want them to know how concerned I am about that particular area." Second, if the trainee's competence remains marginal at the end of the year, but the supervisor believes that the trainee's level of investment and commitment to learning is high, she will help the trainee make plans for continuing to identify and resolve deficient areas, for example, via a postdoctoral training experience.

A second supervisor reflected on her process in such situations and concluded that she usually made decisions about deficient skill based upon whether the deficiencies seemed to be across one or several areas of functioning. Interestingly, when asked to define an "area," she identified "clinical work" as one area, meaning that if serious deficits had emerged in that arena but not necessarily in domains such as testing or outreach programming,

she wouldn't consider dismissal.

Collegial Relationships

Individual Consultations

Participants were asked to describe their personal style and preferences in terms of seeking individual consultation with colleagues regarding a problematic intern. Although the three sites showed striking differences as separate groups, the supervisors also demonstrated some themes within the individual consultation they did seek. These themes involved 1) contacts chosen because of the consultee's relationship to the intern; 2) contacts chosen because of the interviewees' relationship to the consultant; and 3) contacts with the Training Director.

Many participants gave examples of consulting with a colleague who had particular knowledge about the problematic intern, for example, someone who had previously supervised or co-led a group with the intern. "Anybody who is working with them in a supervisory relationship," explained one person. "I want other supervisory samples." The participants described a variety of benefits from these conversations. "Past supervisors are really helpful in establishing if this is a pattern we have worked on before," said one supervisor. Another person described seeking multiple individual opinions to determine how widespread the problematic behavior seemed to be: "I'm looking for a reality check.....And I find that six other people are saying, 'I can't believe that that person is doing this. Listen to what they are doing [in this other context]. I thought it was just with me.'" Other supervisors specifically noted their intent to also identify disconfirming information as well: "But I think as I begin to reach out to other staff....I'm also looking for the flip side, you know.....Some case or time in which this supervisee might have handled this situation beautifully."

Clearly these supervisors identified colleagues with a working knowledge of the specific intern as an important consultation source.

Another striking category of consultation involved the Training Director. At one site, for example, all four participants separately confirmed that the Training Director would be informed and would play a strong consultive role from the very beginning of the process. One supervisor said, "When I first suspected anything, I would let the Training Director know, and let [the Training Director] know what I plan to do....my plan to operate from there." The Training Director seemed to describe an immediate, continual style of consultation as well: "I have a pretty good relationship with the supervisors. There's an awful lot of consultation that goes on around here."

In contrast, at a second site the supervisors described quite different realities in terms of the Training Director's involvement. One person explained that, in terms of both expectation and practice, supervisors at her site would take their concerns to the Training Director as soon as they emerged. "That always happens," she reported, "and I think that that's a good process." A second supervisor, however, contradicted this as she described her caution in approaching colleagues, including in some cases, the Training Director: "I wouldn't always go to the Training Director," she said, ".....it's the person who you think can handle it in an impartial, fair way for the trainee." Interestingly, at the third site, no mention was made of the Training Director's participation in these initial, individual consultations.

Another striking issue which emerged in the selection of a consultant were the consideration of the sense of risk for the intern, as well as the sense of risk for the supervisor, him- or herself. This sense of risk emerged as another subtle criterion guiding the selection of a consultant, and seemed strongly related to a sense of interpersonal trust across many dimensions of the consultant's

professional and personal identity. Several supervisors described choosing someone because of their "expertise" in handling a particular issue. One person specified selecting a consultant "whose perspective I trust, and who I trust the intern with.....having good boundaries, good clinical judgment, good administrative judgment...." "Realistically," this person noted, the field of options is narrow because "in any work setting you have peers that will fall along various points of the continuum on any of those dimensions."

One supervisor was clearly and emphatically protective of interns in the early stages of intervention: "I find that staff input.....it has an insidious effect....." Even at a moderate level of impairment, this supervisor reported trying to keep issues private out of concern for the trainee's reputation being irrevocably scarred: "That's been my experience.....[the interns] can't shake it."

Another supervisor described her own sense of vulnerability in approaching colleagues and why she would be quite careful in selecting a consultant: "Because I think, quite candidly, there is a felt level of risk, depending on to whom you disclose that you're struggling.....You know, in the training situation."

Clearly the patterns of individual consultation that supervisors described were influenced by both structures at the site and the quality of the interpersonal relationships in the group. For example, at the one site in which participants reported immediate, on-going, and broad-based consultation, there is a weekly supervisors' process meeting at which the supervisors report and discuss current issues with their supervisees. At the other sites, the supervisory group meets two to four times per year to complete formal evaluation of the interns. Otherwise, the supervisors consult: 1) when they choose to do so; 2) with whom they choose; and 3) when they have the time. And the time available, noted one person, might be "ten minutes between sessions."

Collegial Group Consultations

The participants descriptions of consultations with their collegial group fell into the same within-site pattern. At the site where the supervisors meet weekly throughout the year, the participants uniformly described group interactions as a critical, positive component of their interventions with trainees. The Training Director described the purpose of that meeting in this way:

> The supervisors report. They focus on two things: one is intern behavior, and they report on their on-going evaluation. They talk about their own experience, and problems, and conflicts dealing with interns. It's a pretty open, supportive, empathic meeting.

A supervisor at that site also shared impressions of the meeting:

> We discuss how things are going with the interns. Some of those discussions can get very esoteric! (Laughs) We talk about what theories they know or don't know, how they view clients. We talk about difficulties that any one person may be having. Or we may talk about supervisory theory. How we individually do supervision, and what we would do in a given situation.

The second supervisor at that site spoke at length about his convictions regarding the importance of such a meeting. "I really recommend regularly scheduled supervisors' meetings. That is very important. To start early, to be proactive." This supervisor compared his experiences working at different internship sites, some of which held supervisors' meetings only a few times per year. He described the effects of a group not being proactive with an impaired intern:

> When it gets to be so bad, then it's harder to deal with. Because [supervisors] have their issues. They stake out their positions and they get hardened. Versus early enough to be working together in a training mode, a problem-solving mode.....

This same supervisor also articulated the benefits of this type of group for the intern, specifically, that the trainee got the benefit of the whole group's supervisory skill, the benefit of early intervention, and hopefully, the benefit of

early resolution. This supervisor spoke quite eloquently as well, about his own need for the group in order to provide high quality supervision:

> I need consultation with my peers.....[I need] to be open to the idea that I, too might have feelings.....Which part is mine? Which part is the trainee's? And which part is an interactive effect?.....I think that it's so important to have other places where you can have consultation and discussion. Because supervisors can have blind spots.

A final benefit which seemed to emerge from this weekly supervisors' meeting was the supervisors' sense of trust and confidence in decisions that were made regarding impairment. One person, who was the primary supervisor of an intern who was dismissed from the internship, described her sense of clarity and validation because of the on-going discussion regarding about her impressions of the intern, her strategies, and her choices of intervention. When she had to make the "awful, awful" decision to not let her supervisee see clients anymore, the whole staff was behind her:

> So that when I come back and say..... "I don't think that this person should continue to see clients.....Then everybody knows, you know, the steps that have been taken ahead of time.

These descriptions stand in sharp contrast to the group process, or lack of it at the other sites. For example, at a second site, the norm seemed to be initiating extended group discussions about training and supervision <u>only</u> when an intern problem had reached sufficient severity. Participants at the site using this model did seem to want the staff to work as a whole to resolve the problems, but seemed to struggle to accomplish this. One supervisor described the message she tries to communicate to her colleagues when her intern has reached a serious level of concern:

> ....."It's really important that we do this as a staff.....that we offer a consistent opinion." I try to get staff support around that. [So that other staff members are not telling the intern] .."Oh, that's no big deal," like we all tend to do, like "Oh, we all have that happen." But

> instead, [we all need to say], "No, this has hit a level that we need to do this, and this...."

This supervisor reflected on dynamics she has seen in her collegial group when serious intern problems have come to the fore:

> I think that something weird comes up in [these] controversies..... I think maybe it starts [when we start talking about an intern being deficient] because some of the professionals are afraid of looking impaired themselves. I think it can cause some rigidity....You don't have the normal, comfortable discussion. People get fearful that they'll get judged next.

The second supervisor at that site added her perceptions:

> It's frustrating on about five hundred levels, mainly that my perceptions of our Center, and the personnel in our Center, is that we tend to be pretty hands-off. Then when we have a problem, we run around like chickens with our heads cut off, [saying] "Oh my gosh! We have a problem! We have a problem!"

This same supervisor noted that she has seen some improvement in the group, "now that we've had to deal with this a couple of times." Specifically, she said, "I think people are more willing to say, 'Ok, if we go ahead and put our heads in the sand, this is going to be a big ol' problem. So we need to get on it right away.'"

At the third site, a small group of staff members serve on a standing committee which responds to any training issues which have reached a level of serious concern. Consequently, the supervisors themselves, unless they happen to sit on that committee, do not necessarily experience group collegial consultation regarding their supervisory processes. The training director at that site expressed regret in being unable to have a regular supervisors' meeting, and cited the large size of the training program there as a central reason: "I'd like to be able to do that, but we just can't. It's just huge, huge....it's horrible organizing it." This Training Director did describe using a larger group in the intervention process:

> Every intern has [multiple] senior staff members working with them. [When an intern's performance is problematic, we have] each of those people give specific expectations, and then it's monitored. Then I'd be monitoring that intern's performance. It's like a net effect.

Stances and Conflicts in the Supervisory Group

Participants were asked to describe their experiences discussing impairment within their collegial groups, and to comment specifically on aspects of that process which seemed particularly difficult. Although strong, distinct patterns surfaced within groups, these data will not be presented by group because of the sharply increased possibility that a site, and consequently the individuals at that site, could be identified.

One center director identified group issues which are, perhaps, universally descriptive:

> A certain kind of "so many cooks in the kitchen" aspect is difficult. That everyone has their assessment, their opinion, their experience. That some folks are more patient.....Others more decisive.....Timing becomes a big issue. Some need more evidence than others. They want to see the [problematic] event several times.

This person's description seems to highlight the diversity of values, experiences, and decision making styles which exist in any group of supervisors. Other comments clarified specific, divergent stances which supervisors took when the process moved into direct conflict. One theme emerged around the tension between a developmental view of an intern and the need of the internship to serve as a gatekeeper. A training director described several incidents of supervisors debating this point: For example, one supervisor might maintain:

> "This is just developmental, of course, [the intern] will learn it."
> "The intern is just a young professional; she/he does seem concerned."

Other supervisors might counter that argument:

> "This is troubling."
> "This pattern is really troubling; he/she doesn't seem to be breaking it."

Several participants offered lengthy descriptions of their observations over the years of how supervisors' own personalities played into this process. One supervisor offered his memories from having served as the facilitator of a supervisors' group earlier in his career:

> [One thing that causes conflict among supervisors is] the interpretation of certain behavior. In the one camp, there were people who were sort of very similar to the trainee in terms of temperament and personality. And therefore, they got alone fine. And that breeds more respect from the trainee: "Well, you're great. You think like me. You're wonderful." And of course, they do all the things that the supervisor wants them to do, and the supervisor thinks that they're great, wonderful. Over here [in the other camp], there are certain differences: personality, orientation, choices of intervention. [And someone from the second camp would say] "This and this happened." And the first group would say, "I can't believe it! This is the best supervisee I've ever had!"

A center director also reported experiences which also involved supervisor/intern similarity, and how a supervisor's identification with that intern, and sense of loyalty to him/her could surface in collegial group tensions:

> Supervisors can identify with supervisees, and while they see the difficulties, they probably have a greater level of empathy and acceptance. So part of the staff might be saying, "Your person's really screwing up," and that supervisor, out of that loyalty, defending them.

This person and several other participants acknowledged that pre-existing interpersonal conflicts among supervisors frequently became factors as the discussion about a problematic intern became more serious or prolonged. "There may be times," reported the center director,

> ....that a lack of staff unity can get played out in the group process in dealing with intern problems. Like [one supervisor might say] "Well, <u>you're</u> seeing that problem, but you don't have as much

> credibility with me, so I don't pay much attention to it." Or else, "You and I have had that conflict before, so I assume that some of the difficulty you're having with the intern is <u>your</u> fault."

This person also tracked the effects of this kind of supervisory group conflict throughout the agency, including the effects on the intern group:

> ....then trainees align with one pole or the other, the the other pole is thinking that the trainee is not well-rounded, or is not doing therapy in a therapeutic way.

Several supervisors described their awareness of how they began to change their own behavior in the group when conflict became polarized. One person offered multiple examples of ways she believed that she observed trainees being unfairly pathologized and harshly judged in the group process. After one incident which was particularly disturbing to her, she decided to drastically curtail the content and amount of information she gives in group discussions about her supervisees. "I'll never approach supervision in the group process in the same way," she said. "I won't trust those people with information in the same way." This supervisor also reflected on her colleagues' behavior as she reached a decision to be more selective:

> I've already noted that supervisors at evaluation don't mention things that I know they know...and I've always wondered why they left things out. Now, I'm going, "Oh, that's why they're not sharing that." And I don't know what they're thinking.....if they're being protective of the trainee, or if they're being protective of themselves. Like, "I don't like admitting that my trainee is having this problem, and I haven't been able to get it taken care of.....

Another supervisor reported feeling more cautious in what and how much she said in a conflict depending on who in the group was taking an opposing stance:

> I guess what I mean to say, quite candidly.....There are some of my peers who.....um.....Let's see, how could I put this?...Seem to me, to have a different level of flexibility in the views of certain interns.

This supervisor noted that she experiences "needing to choose her battles" and

the need to couch what she does say about her concerns quite thoughtfully and carefully. She noted as well, that sometimes her colleagues seem to withhold information which might "challenge the prevailing positive valence toward an intern who has the support of key staff members."

Clearly, the ability of a supervisory group to engage in sustained, respectful conflict marked a critical difference in collegial consultation groups in which many experienced harm and groups which emerged strengthened. One site, which recently dismissed an intern, seems to currently have established collegial interpersonal norms that are helpful to all stakeholders in the situation. The Center Director there commented:

> I think the staff has a lot of sophistication about splitting, about dividing up.....the negative aspects of us dividing up and fighting with each other. We're able to talk about that very openly.

A supervisor at that site, when asked to describe what happens when supervisors view an intern differently, laughed and replied: "Oh, it's very interesting. Quite often it wouldn't get resolved and we would end the meeting with all of us in a different place. Which was ok." When asked to describe this process further, specifically, what would happen if consensus was not reached, the supervisor offered this:

> Then we come back and talk about it again (laughs). We continue to process it until we make a decision about what we're going to do. I think an important piece here is that everything is dynamic and usually things are changing as we are doing this. And so then we may say, "Ok, now I see it," and "Ok, I can go with this." Or the other person will say, "Ok, you're right, and I understand what you mean, and we will work this out in this way."

This supervisor's description seemed to capture several critical features of this group's current conversational style: that it is open, trusting, respectful, and on-going. A particularly interesting feature was that in spite of the group's ability "to process forever" as one supervisor put it, the participants did not seem to get

entrenched in their viewpoints. None of the participants at that site could identify issues that might cause the group to become "stuck" in processing a problematic intern. The Training Director offered this commentary:

> I don't know if the staff would get stuck. The staff would look for leadership and turn to me. And there would be a round-robin of discussion. And then I would take that discussion to the Director, my supervisor, who I have a very good relationship with. And then back to the specific supervisor to work out a course of action.

Another striking feature which emerged in this groups' descriptions of their group process was their degree of confidence in the decisions they made about impairment, and the degree of personal support they perceived from their colleagues in that decision making process. "It was the correct thing to do," said the primary supervisor of an intern who was dismissed, "for [the intern's] benefit, and for the benefit of the students, that was the correct decision to make. And...I felt very solid about that." The Training Director concurred and described a sense of feeling "absolutely comfortable" that the staff would be able to handle similar situations in the future:

> I have great trust in the staff. It's an absolutely terrific staff. And I have great trust in the Director in being able to manage whatever might come. And I have a lot of trust in my ability to consult with the staff and form relevant interventions that would be useful to the interns.

Even though every person at that site variously described the experience of dealing with impairment as "awful," "horrible," and "terrible," the pain of the process was clearly offset by the collaborative, respectful, and proactive interpersonal style they were able to maintain.

These interpersonal dynamics stand in sharp contrast to the descriptions of participants who reported various experiences in supervisory groups which remained deadlocked in conflict. One supervisor reflected on a time when a collegial group experienced painful conflict:

> .....We had two interns at the same time who were impaired. Well, one was a problem, the other one was impaired. There was a lot of splitting that went on on staff that was very hurtful to our agency and our relationships. [One person would say] "I believe such and such... but I don't believe such and such." Everyone was cross-talking, talking to trainees, talking to each other. It was all this weird.....it was like all the pathology out there came into our process. It was really ugly. For like the entire year. It was painful. Tons of splitting behavior. Not trusting each other. Mad at one another. Blaming..... Accusatory.....

In a curious side note to this supervisor's description, the Training Director at that same site, when asked to describe incidents of supervisors having a difference of opinion over a trainee, responded, in all seriousness: "I've never seen that happen before."

Other supervisors described relational patterns in which the conflict became more covert: specifically, in which they began to concede their concerns about a problematic intern. One supervisor offered her observations about her own behavior as she began to realize that colleagues were pulling away. "For the first time in my professional career," this person noted:

> I am very much the person who says, "The Emperor has on no no clothes." I'm very much the voice of frankness, of confrontation, and "Let's address this issue. Let's not pretend it's not there. Let's call it like we see it."

Often supervisors would make reference to "letting go" of their concerns, deferring to the opinions of others, and "hoping that everything would be ok." Unfortunately, three of those supervisors reported events which occurred later in time, in some cases after the intern had completed the internship, which supported the validity of their serious concerns. One supervisor, while describing the peer pressure she felt to pass the intern on, despite her opinion that the person should not be passed, make a striking gesture of covering her eyes with one hand while signing off with the other. She now reports regret over that decision. "It sounds kind of dramatic," she said, "But I didn't stand by

my ethics....I have a lot of regrets about that."

Another supervisor added an example of hindsight and regret. She offered an example of an intervention with a problematic intern:

> ....We had some issue with him while he was here. There was an intervention that happened, and we were all kind of tentative in thinking, "Oh, we don't think he's going to make use of this, but we hope he does."

In this particular incident, the intern was passed on from the internship, then at a later point in time, serious problems related to the person's performance during the internship came to light. "It appeared that we saw some changes in some ways," remarked that supervisor; "but we made a mistake. We assumed a level of professionalism.....and we got caught short."

One participant offered an insightful commentary on supervisory groups that become embroiled in conflict: "It's always interesting to me, that in our field, a lot of the time we don't use our own knowledge to apply to ourselves," he reflected. Clearly, the issue of impairment raises a difficult challenge for many collegial systems, and in many cases, the system is unable to maintain the same personal and professional skills that are a mainstay in their work with clients.

Barriers to Effective Collegial Dialogue

Participants were able to identify a wide variety of issues which they believed operated at the group level to complicate or prevent discussions about intern impairment. The first category was fear of negative affect from the problematic intern or from the intern group. Specific examples included: "afraid of being seen as heavy-handed," "afraid of being the bad guys;" "afraid of lawsuits;' "afraid that the other interns would be mad at us;" "looking like bullies or punishing people." One supervisor cited the complexity of dealing with one

intern's behavior without the freedom to explain the situation to the other interns. "So they end up getting one side of the story," she noted, "and there's fallout.....We have to deal with the disgruntlement...and it's unspoken, because it's not discussible."

A second category of barriers seemed to be a general desire to avoid or deny that impairment exists. "A lot of us are avoiders," concluded one supervisor; "We come into our offices and we close the door." One supervisor reflected on an experience in a group which seemed to simply wait:

> Hoping, in some strange way, that the intern would do that--that the intern would come forward and way, "I think I have a problem. Can you help me with this?" Which, of course, was <u>far</u> from the case.

A center director concurred in reflections of a staff prior to a difficult experience with intern impairment:

> Before the incident...We didn't have a policy. And I don't think we thought in terms of impairment. People were impaired at other places (laughs). They weren't impaired here.

For many participants, confronting impairment simply did not fit into their conception of a growthful learning experience. "Our orientation is to create a positive learning experience," said one person; "So it's hard to change that. We resist acknowledging that there's serious difficulty." Finally, one training director added an interesting and puzzling comment regarding the increased attention to intern impairment in recent years: "I assume that the interest and attention is a lot bigger than the actual problem."

A third category of barriers contained supervisors' fears about their <u>own</u> competence. One participant explained:

> I think it's very scary for supervisors to be vulnerable. And when you have an impaired intern, sometimes your work is under scrutiny....<u>Our</u> work as supervisors.

This person added an additional comment about how this fear of being

vulnerable and exposing one's own supervisory work can be compounded when collegial group interactions are less than respectful:

> When people feel attacked and unsupported, the next time they'll just say, "The hell with this. I don't need this. Keep away from me. I'll just sign the paper.

Several participants noted fears regarding not feeling capable of making appropriate judgments of such magnitude: "We might be afraid that we were wrong, or that this was just someone's impression." A related fear was the awareness of the degree of responsibility this decision making carried: "We might be afraid of the impact it would have on the person's career." Several participants noted feeling ill-prepared in their formal training to make decisions about impairment: "Nothing in my training," said one person, "taught me [to recognize serious competence problems when they exist] or how to deal with that." One supervisor while acknowledging her own sense of ill-preparedness for dealing with impairment, also described her frustration as her collegial group seemed to back away from it:

> Everyone kept reacting to the situation instead of saying, "Look, this is a problem. Let's not worry about all those other things. We just need to address that this is a problem. We do have some efficacy here. We can fix this problem." I felt as though people ran away from the issue.

A related area of supervisors' competence which seemed to be called into question when impairment issues emerged, was the selection of the intern in the first place. Given the intense effort that goes into the intern selection process, and the highly competitive nature of that process, most participants acknowledged that they are quite invested in their interns performing well.

> Part of it is that selection, part of it is our own identification with the interns. They're our interns. We like them. We want them to be successful.....We chose them because they were the best, and we wanted them. To decide that this intern is impaired is to

> impugn our judgment about selecting them.....We would probably have to be hit over the head two or three times (laughs), before we're willing to say, "Gulp, we made a mistake here."

Another difficult area of acknowledgment was in the situation of an intern who was initially well-regarded by the staff and who later, behaved in very problematic ways. One center director captured the difficulty some participants seemed to feel in integrating that dissonance: "I think it's been hard for us to kind of....accept the idea that you could have an intern, particularly one of your own, that could do something like that." This situation, again, seemed to challenge the supervisors' confidence in their own judgment, particularly when they retrospectively realized how slow they had been to respond to that intern's behavior. "That was hard," said one person, "to think that because of our opinion or perception of [this intern], that we let things slide longer than they should have."

A fourth area of resistance involves the cohesive effect that training activities play in some collegial groups, and a reluctance to negate that effect by addressing intern impairment. One center director described the importance of training activities in this way: "[Training] is a very important part of what we do. Almost to the point, sometimes, where it becomes a major thrust for some people.....So whatever goes on with this is something that strikes them at , you know, an extremely important place in their lives" Another person from that same site acknowledged not only the importance of training activities in her individual professional identity, but also those activities had on the group's dynamics. "Our whole staff can have a lot of tension and conflict," she said; "But the area of training is where things come together." A third person, however, added a statement that suggested that training activities only had a cohesive effect when all was proceeding smoothly with the intern group. She described her perception of people "moving back, dissociating from the process" as the

possibility of impairment emerged. She concluded:

> I think that ends up with a few people feeling a lot more drained. A few people take on even more responsibility. Fewer people are willing to take on the issues.

Consequently, in this collegial group the possibility exists that raising concerns about an intern may damage a predominant area in which the group experiences positive interpersonal relationships.

A fifth and final theme which emerged was the belief that the internship was "too late" in the training process to intervene with an impaired intern, or that there was not enough time within the internship year to make a good decision. One center director commented:

> Too often we hope that it will go away or get better, so we give it maybe more time than....give it the benefit of the doubt.....So that it almost becomes too late. Like, "If we haven't said anything for [half the year], how can we [say something now]?"

A training director described an incident, again involving evidence of serious problems emerging after an intern had completed the internship. This person reported the discoveries to the intern's home program, but noted that this report was simply an administrative matter of course:

> It was out of [the program's] hands anyway....There's not really much that they can do.....But there wasn't much we could do either. We had no control over the person.

In summary, participants described barriers to processing impairment in the collegial groups as falling into the following categories: 1) fears of negative affect from the intern or intern group; 2) a general desire to avoid or deny that impairment exists; 3) fears related to the supervisors' own competence; 4) fears of damaging the cohesive effect that training activities have within the collegial group; and 5) a perception of being "too late" for appropriate intervention.

Pre-Existing Collegial Group Relationships

Just as one supervisor identified the quality of the supervisor-supervisee relationship prior to the emergence of problems as a critical determinant to the eventual outcome, the pre-existing relationships among collegial group members seemed to be highly significant in determining the extent and quality of group support and dialogue about impairment. One supervisor concluded,

> I think [impairment] is bigger than a training issue. It goes back to the organization. It's an organizational issue.....The morale of the institution is very important for supervisors to do their work effectively.... the mood, the atmosphere.

A variety of participant experiences seemed to support this person's conclusions. "I hope I'm not introducing further murkiness to your project," this person continued,

> But it goes back to the facility's, the organization's history, too. If the supervisors have had problems in the past.....then it's harder to keep that out of the discussion about the trainee. It colors it.

A key and sensitive problem that supervisors seemed to have in the past addressing intern impairment involved what participants termed "colleague impairment." Participants often seemed quite tentative when these issues emerged in their descriptions. Although some declined to elaborate on how these situations, most were emphatic that collegial impairment was closely linked in multiple ways to intern impairment. "I saw [collegial impairment] as another huge obstacle to working with intern impairment," said one supervisor:

> It muddies the water for the trainee.....In order to intervene effectively you really need to be clear, and constructive, and so on. When the supervisor [is impaired], it unnecessarily provided an excuse for the trainee to externalize their problems and say, "Look, it's not me, it's the supervisor."

A center director added this perspective:

> We do a better job of supervising trainees than we do staff. We make the assumption that this person has gotten through all the other levels, then there is no impairment there.

In reality, this person reported, that is not always the case. One participant offered the following example:

> .....Several interns observed [problematic] behaviors of a senior staff person. But they really didn't tell us about it.....And I think there was a perception that nothing would be done. And in fact, nothing had been done, for years.

One supervisor offered multiple examples of situations in which she was working with an impaired trainee, and then having problems rapidly escalate because of other faculty members who were "unable to maintain appropriate boundaries" in the situations, including taking on the trainee as a private practice client while still having evaluative responsibility for the person in the program. "That's the other piece of supervision," this person noted; "How do you supervise your impaired colleagues?" Other participants noted the difficulty of collegial impairment as well: "I think if we have trouble doing interventions with interns, it's going to be even harder with upper level staff."

Another collegial group issue emerged at sites which trained practicum students and interns from programs within the same university, and sites which used adjunct faculty members from the community in the training program. One supervisor offered this explanation:

> There is a community element between the department and the Counseling Center where everyone wants to love each other. (Laughs). Which is wonderful. But the problem is.....it makes it more difficult for people to confront each other. People are very fearful of saying less than positive things. So I think that creates a culture that affects our staff, in terms of dealing with impaired interns. It's hard for people to take a stand.

Other supervisors commented on the complexity of various people "having an investment in a particular trainee being seen as competent." One training

director provided an example of difficulties which emerged when an impaired trainee had significant local connections. "When my colleagues [outside the Center] are angry because their advisees are under fire," this person explained, "sometimes it gets hard."

One person offered a related, but even broader perspective of the impact of a broader professional community on addressing impairment. Ironically, this point was highlighted as the researcher and this participant chatted before the interview started, and discovered a previously unknown, mutual, close personal relationship. "You know how small this field is," she noted, "Well, we just demonstrated that." She went on to describe a complex web of investment that various people may have in a particular trainee's competence. "I think one of the things that happens," she explained,

> Is that.....interns end up applying and coming [here] based on word of mouth connections. And that those connections, at some level, have an impact.....So.....I know that my good colleague, whose opinion I trust a whole lot who lives way over there in another state that says, "Oh, this [intern applicant] walks on water." Then there's a context in which somebody else is saying, "They're really flailing here." That's going to create a different kind of discrepancy than if it was just based on my own experience with the intern.

"I guess what I'm talking about," she continued,

> .....is the intern's reputation. And how they got that reputation. You know.....whose opinion plays into that. The players in the background. The impact of those external relationships. We definitely have invisible players in an internship site, by virtue of professional connections.

Clearly, the "players in the background," both locally and on a national level are entangled in a complex web of trust and caution about judgments regarding an intern's competence.

The Effects of Agency Norms on the Intervention Process:

This section presents additional information about the context in which supervisors both construct and address impairment. Specifically, information will be presented regarding: 1) how the roles of the Training Director and Center Director are conceptualized and enacted; 2) assumptions about decision making and responsibility within the staff; 3) norms of supervisory and clinical practice; 4) formal policy and procedure regarding impairment; and 5) norms of moral obligation. Like in the preceding sections, compromises in specificity have been made in the presentation of these data in order to protect the identities of participants and sites. Important group dynamics have been identified to the extent that identity could be safeguarded.

The Role of the Training Director

The three sites were diverse in how the role of the Training Director was conceptualized, ranging from a stance as a fairly distant administrator who is available for consultation, to a closely involved participant in the interpersonal aspects of the training activities. One training director acknowledged this multitude of styles: "Each internship site is different in terms of how they think about the role [of Training Director], and the kinds of interventions they're prepared to make."

As participants talked about their experiences with impairment, it was clear that training directors were involved in assessment and intervention in different ways. In one variation, the Training Director took an administrative, consultative role, and the supervisor held almost singular responsibility for decision making. Training Directors working in this manner described depending on the supervisors' judgment, and trying to stay out of the process between supervisor and intern. The following comments exemplify training directors who remain

available as consultants to supervisors, but who are not necessarily closely involved: "The supervisor is the final person knowing the trainee;" "If the supervisor doesn't catch [impairment], no one would;" "We generally keep the process between supervisor and intern. Bumps get smoothed out without my involvement."

A very different role conceptualization is illustrated by training directors who are actively involved in all facets of the interns' training, and who closely monitor and participate in the experiences of both interns and supervisors. Training directors who spoke from this stance seemed to take an active role in supporting both interns and supervisors, for example: "I really view my role as trying to help interns get through their internship. That's my bottom line goal." One of the strong features of this stance, which distinguished it from other styles, was the amount of Training Director activity "behind the scenes." Even in the early stages of identifying an intern problem, the Training Director seemed to be very actively supporting both interns and supervisors, albeit in ways that are initially invisible to the intern:

> It depends on the time of year, but typically, initially, I'll work pretty closely with the supervisor. As the Training Director, I'll try to stay out of it as much as I can. Because once training directors get involved, they bring an element of authority in that's severe, potentially severe.

Training directors in this mode also described their work to coordinate the efforts of the whole staff with regard to a problematic intern; making sure, said one person, "That everyone is on the same page....giving the intern the same message."

This level of involvement and activity also sharply contrasted other training director roles when the level of concern about the intern increased. In this model, the Training Director's role was to directly and rapidly intervene with the

intern. One person explained a belief in the need to move quickly: "The clock keeps ticking," this person reflected: "If the intern isn't responsive to feedback from the supervisor, I would get involved." The focus of the Training Director's efforts at this stage seemed to be multi-faceted. Clearly, this approach impacted supervisors, since the Training Director assumed at least an equivalent responsibility for monitoring, assessing, and intervening with the intern. One Training Director talked about having conversations with the problematic intern to determine the seriousness of the situation:

> What I really try to do is see if there's any empathy for what the other interns are going through in relation to this particular intern who's being identified as impaired. And if there's no empathy, my antenna go up, way high.....I think there may be some real big trouble.

Another facet of the Training Director's efforts in this process were to look after the well-being of the intern as a human being, rather than simply a trainee. One example of this component was this description of a training director's concerns regarding an intern who was becoming seriously depressed:

> I think there's pretty intense scrutiny [in an internship]. And somebody who's drifting into despair and hopelessness is doing all the scrutiny they need to do by themselves, without the rest of their professional world scrutinize them.

In summary, the role of the Training Director seemed to be defined quite differently in terms of level of participation in the supervisory process. Consequently, supervisors addressing impairment could be expected to function within a wide spectrum ranging from near total autonomy on one end to full collaboration on the other.

The Role of the Center Director

Although at a conceptual level center directors seemed to explain their roles in intern impairment scenarios in a similar way, dissimilarities emerged as

Directors spoke of what they actually did in practice. When asked to describe the roles that they would play as intern impairment emerged, all three center directors referred to their oversight responsibilities "Always I have that oversight responsibility as the Director," said one; "Trying to maintain a process, trying to protect both the Center and the intern." "As Director," said another, "I think first, it's the impact on our clients [that I would need to monitor]. That's first and foremost." This person elaborated:

> I would be very, very sensitive about, are they handling a suicidal client? I don't want to bear the risk as an agency of assigning a caseload that we have reason to believe they can't handle.

Clearly, center directors uniformly identified a direct responsibility to oversee the potential risk to clients when an intern's competence was in question

Center directors also identified responsibilities they believed they held with regard to the professional staff. One person explained:

> I think staff members, sometimes because of their relationship with an intern can be.....more empathic or sympathetic....or whatever the case may be. I think it's my job to [look] broadly, and to say "There are things that we've gotta do here."

Although all three directors spoke of responsibilities to oversee the effects on the agency, on clients, and on the supervisors, their behaviors in the service of enacting those responsibilities were quite different. When an intern impairment situation arose within their agency, the roles these center directors played in those processes fell along a broad spectrum of involvement similar to the one used to describe different conceptualizations by training directors. One director observed that the roles of the Director and the Training Director would "coalesce very quickly," and that the two responsibilities wouldn't necessarily be different. Another person seemed to take a consultative stance which primarily involved making sure that the staff members directly handling the situation had whatever resources they needed.

A very different position was taken by one Center Director, who like the Training Director at that site, took an immediate and consistently involved role in the intervention process. This person explained the "absolutely essential" coordination and active dialogue between the Director, the Training Director, and the impaired intern's supervisor who "had to be able to trust each other, and we had to be able to acknowledge that we were moving in different ways. That to some extent we had different priorities." This Director continued:

> It's more than coordination, it's real trust. It's a willingness to suspend where I am. It's "This is where I am. I'm telling you. But I'm going to suspend it in honor of where you are. And give you time to see whatever you need to see." Rather then pulling rank or issuing directives.

This person talked about the Center Director's responsibility to actively manage the process, particularly the importance of staying aware of the effects of the impairment on <u>all</u> stakeholders in the process:

> This may be particularly true when the supervisor is wanting to move very slowly, to give the intern every possible chance to work it out..... We had to keep all of those responsibilities and obligations, as it were, on the table at the same time. And keep saying, "Is the price too high? Is it too high today? Can we wait another week?"

Although this Center Director's concept of role was sharply distinct, a feature of this active, participatory style which set it even further apart from the other descriptions was the Director's direct monitoring of the impairment's effect on the <u>supervisor's</u> performance and well-being.

> I could make the same point about how much it takes out of the supervisor. What is is costing the supervisor to maintain the impaired intern? I would talk directly to the supervisor about how it is for them. What their hopes are. What is it they're trying to achieve. What do they see as the advantages and disadvantages of continuing to set certain limits versus not setting them.

This Director not only expressed a clear sense of responsibility for supervising the supervisor of an impaired intern, but also followed through with that

responsibility in active, direct, continual ways. In describing what would be cause for concern in the supervisor's behavior, the Director reflected:

> Well that is very, very tricky. Calls at home, letters at home, staying after work. Certain kinds of, dare I say, over-identification. I guess what I'd be concerned about would be either extreme. If the supervisor was too quick to set the limits or draw the line, and not do all that they could to support the intern in what that intern was able to do, I'd be concerned. At the same time, if I've got, you know, Joan of Arc or Florence Nightingale, or somebody who's really.....it's being taken out of their hide in some personal ways. That's hard. And that becomes a negotiation between us. A very sensitive negotiation.

Not surprisingly, given the active, participatory aspects of this conceptualization of the Center Director role, this person was the only director to give an example of a proactive behavior regarding the agency and impaired interns:

> I was talking to another Center Director this year, and they had had situations in the last three or four years in which they really thought they were dealing with impairment. And I said that I would go back and look at how you were selecting interns. I don't know specifically what I would say about selection, but I know if we were getting impaired interns three and four years in a row, as a Director, I would be raising Cain.

Assumptions About Decision Making Responsibility

Participants were asked to share their beliefs regarding who ultimately would make the decision at their site regarding an impaired intern. They were also asked to comment generally about the decision making style of the group. One center director laughed in response to this query, and explained that the staff of that Center had planned an in-service workshop to explore their decision making processes. "That's a good question!" this person concluded.

The responses to this question followed the same pattern as those to the conception of role responses. Specifically, most participants identified a collaborative model as what the groups attempt to use, with greater and lesser

success. When asked who, in practice, holds the power to make decisions about impairment, particularly when a more collaborative format was not working, the participants evidenced strong disagreement.

Again, the structure of a spectrum seems useful to portray divergent responses. On one end, this supervisor's comment captured the belief that the supervisor held a large proportion of the decision making power:

> I feel like I have, as primary supervisor, the ability to fully protect my trainee. My trainee would not be identified as impaired unless I thought they were.

A slightly different view, with the supervisor's opinion still being privileged but not enough to stand alone, is reflected in this description: "My perception of this person is not enough to put this [impairment procedures] all in motion.....If there's disagreement, the supervisor has more pull.....I wouldn't dream of the Training Director having that kind of responsibility."

A more moderate view emphasized collaborative decision making with the idea that if the group could not reach consensus, an outside party would be asked to mediate. Interestingly, three of the four participants at a site using this model identified specific, <u>different</u> people, who would ultimately make the decision. A supervisor, for example, identified the Center Director as the person who would make final decision regarding intern impairment. When asked if that was explicit, e.g. if that power was formally recognized and clear, the supervisor firmly responded, "It is to me." Another person at that same site, when asked if the Training Director or Center Director might step in and make a decision about an impaired intern responded: "No, that probably wouldn't happen."

The far end of the spectrum seemed to contain a model of collaborative decision making which was consistent in both intent and practice. One distinct feature of this model was the extent to which many parties (supervisor group, primary supervisor, Training Director, Center Director) were actively, fully, and

continually involved in the decision making process, and yet, there was an clear end point of collaboration where the decision fell into the domain of the administrators. A training director described this kind of process:

> So it was just.....part of it was waiting, part of it was leading. You know.....kind of like dancing. With the supervisor. Sometimes you lead, sometimes you follow.

This person used a dance metaphor to illustrate the "leading/following" dynamic that seemed to occur interchangeably within the group, in an effort to "balance all the needs," of the agency, the clients, the impaired intern, the intern group, and the supervisors. It was also clear that different people held responsibility for keeping a specific perspective "on the table." Again a training director explained:

> It seemed like what my role was, was to represent the program [i.e. the internship]. And the supervisor's role was to represent the intern. And the Center Director's role was to manage [the supervisor] and me.

Another striking feature of this model was the way that participants maintained the specific perspective they were responsible for to the very end of the impairment intervention process. As participants described a final conversation with an intern who was being dismissed, the roles were clear. In that conversation, the Training Director expressed a message of concern for the intern and the internship; the Center Director stated a conclusion of no confidence in the intern's ability to provide service to the Center's clients; the supervisor remained in a fairly quiet stance and provided support for the intern.

Participants using this model uniformly highlighted the need for working relationships among staff members to be solid <u>before</u> the group is required, by an experience of intern impairment, to enter this "dance." Otherwise, reported one person, "A lot of shit can come into play when it doesn't need to." Clearly, these relationships had been clarified and strengthened on many dimensions

including role definition and expectations, as well as positive, respectful communication norms.

Another striking element of this model was the consistency with which people identified what would happen if the group could not reach consensus about an impaired intern. As one person said, "It's usually the Training Director and the Center Director who make that decision....The final decision." This stance seemed to both value and limit the extent of collaborative decision making:

> Well, in terms of impairment, you can't process forever. You have to make a decision at some point.. You have to say, "This is how it's going to go." And you try to get some consensus if you can.... As best you can.

When queried about how it feels for the decision about an impaired intern to move out of the process group and into the hands of the administrators, supervisors identified a critical variable: feeling that their perspectives and opinions had been fully taken into account in the decision. As one supervisor reported,

> I think if [supervisors] feel heard.....by the rest of the staff, by the supervisors, by the Director, then they're pretty willing to go along with decisions. Even if they don't agree, they'll buy in. But there has to be an opportunity to be heard.....All of us recognize that there reaches a point where somebody has to make the decision.....I think the most important thing here for this staff is that everybody feels heard.

Standards of Supervisory and Clinical Practice

Although standards of supervisory and clinical practice within each site were not specifically included in the interview schedule, these areas emerged as distinct complicating factors in the process of addressing intern impairment. In general, these difficulties were attributed to a wide disparity in the degree to which supervisors tracked, assessed, and confronted interns. Specifically, the

following tasks were mentioned as highly variable among supervisors: whether or not interns were required to tape sessions; whether or not the supervisor listened to tapes at all; whether or not the supervisor listened to tapes other than segments selected by the intern; whether or not the supervisor checked casenotes; whether or not the supervisor asked about status of casenotes; whether or not supervisor explored intern's boundaries with clients. One training director noted differences in supervisors that seemed to be more attitudinal: "Some are more gullible than others, much more trusting, more laissez-faire. Others would be [saying] "Wait, wait, this isn't done."

One supervisor highlighted another complex aspect of variability among supervisors: the reality that trainees are aware of the differences in supervisory style and expectation, and that this information is communicated among students. This person reflected on this phenomenon at a previous workplace:

> It became very obvious who the impaired supervisors were because each class would tell the next one. It became very obvious because no interns asked for them.....That doesn't mean that every supervisor who is popular is good....It sometimes means that they don't care, and interns feel very safe with them.

Several supervisors reiterated this point: "The interns figure that out...some people don't listen to tapes."

Clearly, this variability created resentment among the supervisors who were the participants in this study. One person described her wish to know how other internship programs handled this issue:

> ....how they got supervisors working more parallel to each other. How they manage to keep expectation relatively fair across supervisors? At my agency, that's a part of the trust piece, there are all of these differences that we haven't pulled together yet.

Although no one stated this directly, the multiple examples of serious intern problems which were discovered <u>after</u> the intern left the site seemed to be directly related to supervisory carelessness. One supervisor alluded to this

point in an example of making problematic discoveries following a routine midyear supervisor switch. This person's new supervisee had "lied about the situation [to the previous supervisor], and that supervisor didn't check to get any external criteria about it, didn't know how [the intern] was doing." In addition to frustration expressed toward other supervisors, one person seemed to express frustration toward the Training Director at the site as well:

> When I supervise, I require tapes to be provided to me...that's an agency policy. But the Training Director doesn't back up that policy. Because the Training Director is the one that has power over procedures, trainees get away with not taping.

The frustration caused by uneven expectations and unenforced policies seemed to be further increased by the fact that problematic interns were intentionally assigned to supervisors who supervise carefully. This training director explained a rationale of intern-supervisor matchings:

> If a trainee seems really borderline competent, I really want a watchdog [supervisor] on that case. If someone is obviously really skilled and competent and professional, I'm not so worried.

The Center Director at the same site also implied that the "better supervisors" on the staff may carry a heavier responsibility:

> The Training Director makes decisions about assignments....takes into account the intern's request, but doesn't always [honor that request]. Often supervisors are assigned to try to get at an area of concern that may not be clearly identified by all staff, or clearly recognized.

Two training directors acknowledged their awareness of the inconsistencies among supervisors, and their struggles to make changes in that reality. Said one, "I've never been able to figure out how to make it more consistent. And so, there are very few threads of consistency. And somehow, we don't find the time to sit and talk about supervision." The other training director voiced a sense of futility about these efforts:

> We're going to go over the basic requirements of supervision [in a supervisors' meeting]. The things that do have to be monitored on a daily basis.....We're aware of things for a while, then you slip back into the role you had before the changes.

Interestingly, at two of the study sites, an intern impairment situation had recently caused the staff to re-examine clinical standards of practice that were in effect for the respective agencies. In one case, an impaired intern's behavior had had such a "huge clinical impact," that

> ...our site was able to finally push through a set of very specific guidelines in the form of a clinical services manual. We didn't have any such document at that level of specificity, until.....Well, it's not the only effect this has had, but it was a very strong argument that helped people decide, "Yea, we really have to put this down in writing."

Another site was in turmoil at the time of data collection for this study regarding an intern who was "written up," against the supervisor's wishes, for not meeting a particular clinical standard. That supervisor described arguing on behalf of the intern during staff discussions which were held, interestingly after the intern had been reprimanded, to set a clinical standard on the specific issue:

> We went in and we had to set up a standard around this issue. And I kept saying, "But we don't do this. This standard that you're asking for [from the interns], we don't do." And I kept hearing, "This is the standard." And I go, "I know this isn't a standard. Can't somebody agree with me? People don't do this." But I got no support. Two days later one of the people in the meeting came up to me and said, "Do you know what I did after that meeting? I went and cleaned up my blah-blah-blah." Which was telling me that, yea, they didn't meet that standard, and they didn't admit it in the meeting.

This supervisor made a further observation about a perception of different expectations for interns and professional staff:

> An interesting thing is.....I said, "I don't meet that one individual standard a lot of the time. And nobody has said to me, "Then we're going to write you up," or "We need to talk to you."

Whenever the issue of clinical standards emerged in conversations with

participants, the commentary seemed to be one of frustration: that standards didn't exist; that they were inconsistent; or that they were not enforced.

Formal Policies and Procedures

All three sites have developed formal definitions of impairment and due process procedures in the last five years. The documents and processes varied in degree of specificity, but had many commonalities. One of the striking features which distinguished the documents were the values which underlied their intent: a site which had difficulty in conceptualizing the final termination of an intern reflected this reluctance in its statement. A site which is highly interactive included a flow chart of involvement and decision making responsibility in its statement.

What was even more informative than the policies and procedures themselves was participants' statements about them, beginning with the recognition that the documents were developed only recently, and usually in response to an unusually challenging situation with an impaired intern. One of the sites seemed motivated primarily by pressures from ACCTA and APA to create a document.

"Well, the first time this came up, we didn't have a policy," said one training director. A center director at a different site commented on a similar experience: "At the time that we needed a process, we didn't have the document. So we started working step-by-step in terms of what we thought we needed to do." A supervisor laughed throughout her recollections: "At that time, we didn't have the [impairment] document, and we started flying by the seat of our pants." Participants seemed to concur that navigating such a complex and sensitive process without a previously thought-out plan was especially difficult. "You're constantly challenged by the intern," said one center director:

> Is this fair? And of course, you're also asking yourselves, "Did we give enough warning? We've set this as a deadline. Is it met? Is it reasonable? Is it enough to take the next consequence?

This same person described a sense of relief at now having a strong document in place, which strikingly, was rapidly developed at the Training Director's insistence a few months after dealing with a complex situation of intern impairment:

> We have never, thank goodness (laughs) had to use this particular policy. I say, "thank goodness," because to go through it once is enough. On the other hand, if we have to go through it again, this will be a godsend, because it's very hard to go through without a policy.

That same Training Director credited this difficult experience with having motivated the site to develop strong policies and interpersonal structures that will serve everyone involved well in future situations. This person concluded: "Absolutely. It was a great learning experience."

A second important characteristic of the reflections offered about formal policies and procedures was a recognition of a shift in milieu. "Whenever you have a problem," explained one center director,

> ...you're probably going to have to put that down in writing..... Because, you know, we live in a legal age anymore.....So if anything comes down at the end.....I think we've learned to build a case, if nothing else, to protect yourselves, in case you come to the point where you have to.....

A training director commented on the same issue:

> So, we've become a lot more rule-oriented (laughs). Unfortunately. This place has operated without a lot of rules and constraints. But we just can't do without them any more.....And so, I think we're much more likely to send information to each other [about problematic intern behaviors]..So we'd have a paper trail. Just being a little more formalized

Significantly, the only participants who talked about a recognition of the need

for policies and procedures were the administrators, namely the training directors and center directors. It was also quite clear that supervisors, in some cases, were completely unaware of the intervention steps outlined in their site's impairment document.

Unlike the administrators, supervisors typically reacted against procedures, and depicted them as a difficult invasion of the supervisory alliance. One supervisor explained in this way:

> I feel bad about that [being required to document intern problems]. I think if someone's impaired, the more supportive an approach you can take, the more apt they are to really delve into it.....It totally takes out of the supervision relationship sort of the feeling of confidentiality, the privacy, the protection.....

Another person recollected struggling with other supervisors around the need to place an intern on probation:

> I was very adamant about, "Probation for what? What does that mean?" We were either going to say that this [intern] was getting better.....or else [say] "You can't do the work." We batted that around for a long time.

In a sharp departure from the majority of the supervisors' views, one person explained a belief in documentation as an important teaching tool:

> I think there can be therapeutic training value for the [intern]. They get feedback.....and they get the feedback more precisely than they might get it in other cases. And they get the impact, hopefully, that it's an important thing.

In summary, impairment policies and procedures seem to have been developed only recently at these sites, and typically in response to difficult experiences with impaired or problematic interns. Secondly, training directors and center directors seemed both aware of and supportive of the need for these documents, but supervisors generally did not seem to view them as either necessary or helpful.

Coordination With Academic Programs

Although this topic was not a primary focus in data collection, a number of interesting comments related to expectations of the intern's academic program deserved mention in this report. First, participants generally implied a belief that academic programs held the responsibility to confront problematic students early in the training process. "You hope that some of those things are screened out in the normal process, as someone proceeds through a program," said one person, "So that they don't arrive at an internship with the full range of possibilities."

Although many participants expressed a belief that academic programs held this responsibility, it was clear that many believed that this task was haphazardly attended, or even ignored. Supervisors spoke of "being sold a bill of goods" on an intern applicant's vita, which later proved to be an inaccurate representation of the person's actual skill level. One center director commented: "

> It would be much, much better if.....(laughs). I suppose this is the lament of where the buck stops, but it would be better if it could be picked up the in academic program, and in the early practicum.

A supervisor spoke of feeling frustrated when realizing that an intern's skills were sub-standard, and that this would mean a great deal of additional work:

> I find too many people are not dealt with. In their programs, and on internships. Had someone taken the time to address those issues, it would be saving [the intern] some grief. As well (laughs) as myself.

"At the same time," this person added,

> ....I feel a level of responsibility. That, you know, we have the situation here, and it needs to be dealt with. And I want to make sure that it is dealt with and followed through with.

While expressing their frustration at what seemed to be a shortcoming in academic programs' ability to screen out or correct serious problems, several

participants acknowledged that some types of impairment were probably unforeseeable. A center director reflected that life events can function as "the straw that breaks the camel's back." And if that happens to occur to an intern "on our watch," the Director concluded, "That's life."

All three training directors were asked about contact with academic programs outside of the normal mid-year and end-of-year reports with regard to a problematic intern. The group responded that this type of contact ranged from non-existent to a bare minimum. Especially, explained one person, when the situation has escalated to the degree that the intern is considered to be impaired, "it's really hard" to contact the program and say: "Your person shouldn't be a psychologist." Interestingly, one training director reported a singular memory of contacting a home program. In this situation an intern had already been passed from internship and then serious problems were discovered. This person relayed the opinion that "Your [student] is not ready to be a professional" to the home program. Presumably the responsibility to take some action was relayed to the home program as well.

One program did report consulting with a home program in the midst of an extended intervention with an intern. The Center Director in that situation commented on the complexity involved:

> It is very sensitive. At that point, you have obligations to the intern, you have obligations to the academic program, but I think what overrides all of that is a sense of obligation to the profession.

In spite of the complexity, however, this site seemed to value the background information about an intern that an academic program might be able to provide. "We might call them for another perspective," said the Director. "[We might say] We're seeing these things. Did you see anything like that?" The Training Director at that same site, who clearly supported collaboration with home programs, described feeling disappointed by the program's response:

> They were not very helpful...We informed them when the trouble started. We consulted with them midway through, told them about the lack of remediation being made, and we told them that we were [dismissing the intern]. They said, "Ok, thanks for the information." They were not very helpful.

This Training Director expressed concern that that program would not follow through with its obligations to monitor this particular student, specifically, that a trainee with clear and demonstrated potential to be a danger to clients, might "be given another chance to get through and eventually make it." "We haven't taken another student from that program," the Training Director remarked.

Recognition of Moral and Ethical Responsibilities

A final and important example of an agency norm was the degree to which the sites seemed to recognize, wrestle with, and act upon their perceived moral and ethical responsibilities. Participants were not directly questioned about moral or ethical values, rather these beliefs were revealed in the responses. A striking consistency emerged in participants' descriptions which supported the conclusion that these were agency norms rather than individual values. If, for example, one person at a site spontaneously described his or her thinking about a sense of moral responsibility, it was likely that others at that site also spontaneously raised the issue. Inversely, when one person at a site presented an awareness of responsibility, but for whatever reasons, did not seem to carry that awareness through to action, other persons at the same site seemed to offer very similar information.

One example of an agency norm of being actively engaged in moral reasoning, and following through with the emergent responsibilities is captured by this center director's explanation:

> You're gatekeepers, and you'd better have really solid judgment. Because you're talking about someone's future employment, the investment of a lot of money, and a lot of time. You're playing a very decisive role in their future. At the same time, you don't want to let someone through all those tasks who really can't meet them. You don't want to let them into the profession.

This person continued by describing how very difficult this process often is, juxtaposed with recognition of how important it is to safeguard the welfare of many different parties:

> I think the thing that's difficult for me is the conflict between the personal impact on the intern.....How much is riding on it for them. And our obligations and duties to the students, the other interns, the working community.....And to the profession.

As this site's Training Director reflected on an intervention process with an impaired intern, identical elements were illustrated: the enormous personal difficulty of assessing impairment; the importance of making a sound decision; the obligation to many parties to carry out the decision. "It was horrible," this person concluded, "but it was absolutely the best thing to do for the intern, and for the internship. I have no doubt." The Training Director's recollections highlighted another sharply distinguishing feature: the awareness that the intern group would be constructing their own sense of professional responsibility via the process of watching the professional staff address, or not address, the impairment:

> Impairment can have a very powerful effect on the other interns. They're looking to see how you're going to handle it.....They're very affected by [the impaired peer].....For a while, [the professional staff experienced] a real lack of trust [from the interns]. That we weren't going to do anything about it. Because in their home programs, they've seen interns, or doctoral students, get through.....And their home programs made no intervention to stop the doctoral student from moving on. It's just like grade school, just pass them up to get the troublemaker out of the way.....So that was a sad commentary on our profession by these other students...that they... on some level...really didn't believe that any [kind of intervention] was going on.

At the conclusion of this specific experience, when the extent of this program's commitment to intervention became more public, the intern group "expressed great relief." What they learned from it, the Training Director concluded, "was that the agency would take a stand, and that it's important to take a stand and to be a gatekeeper."

These norms stand in sharp contrast to sites at which moral and ethical issues may be acknowledged, but not addressed. A different training director, for example, voiced an awareness of the responsibility assumed by the training staff:

> If it got out that we passed somebody.....[If] they became licensed and then their license got revoked for unethical behavior.....[And if] that got traced back to the internship and we had signs of it starting here and we did nothing.....Then I think we should be held, not legally culpable, but at least ethically and morally.....for turning out someone who would do harm.

What became strikingly consistent in examples given in sites such as this was how frequently moral and ethical responsibility was acknowledged, but not addressed. The same person continued:

> If it got out that we passed someone, put someone on the job market that was unethical or unqualified, then that would cast the whole internship in a dubious light. I'm not saying that we haven't done that, but if that became known, we'd be in big trouble. (emphasis added)

Clearly, this "avoiding responsibility/not getting caught" norm within an agency would be an insidious influence working against supervisors who might attempt to address impairment more directly.

Reflections on the Impairment Intervention Process

The final area of data collected from the participants captures the personal impact these experiences had on the individuals and the agencies, as well as their conclusions about what they have learned via these experiences.

Personal Impact

Of all the myriad issues embedded within these interviews, none brought the participant group together so dramatically as inquiries about the personal impact of dealing with intern impairment. The group was unanimous and emphatic about the experience being "horrible," "painful," and "very sad" for everyone involved. One of the striking points that many of the participants made was that the sadness is greatly increased by the fact that a relationship had already been developed with the intern: "It's awful," said one training director,

> ...because it never happens at the beginning of internship, it's always after you've already developed relationship with that intern, and you care about that intern. So, it brings up a lot of feelings of turning against somebody.....

Several other participants described their own sense of investment and loss:

> I think going through dealing with an impaired intern is traumatic to the staff. Because, you know, I think we're all in this helping profession because we want to help people. And it's hard to say, "No." To say, "We're not the ones who can help you achieve your dreams." That's a sad.....a sad thing.

> On the one hand, you have this sense of affection and personal relationship built up. With the interns, you have your investment, and your hopes. And to have it rubbed out.....There's a feeling that lingers for years.

> I hate to see dreams burst. That's a very sad process for me. I was still very sad. Because at the same time, there was some obvious, obvious impairment to me, this was also a person who seems to have so many talents.....And is also a very likable human being.

In this final poignant example, a center director captured the experiences in this way:

> I have a sense of taint of failure if we lose the intern....for impairment. I was watching Paula Zahn do a [television] program on the SeaBees. They're the Navy Seals, and they're just the crack of them. They train in San Diego. And [when they begin their

> training], they lose like, I think 90% of them in the first week. Now, these are the *creme de la creme*. They're prepared for [the magnitude of the loss], and so are the folks. Now in our profession, I don't think we.....(laughs).....The whole nature of our work goes against losing someone.....And I think the agency, and the individuals, you know, the staff, really do feel a sense of loss.... ....of defeat.....As does the intern.

In addition to these feelings of great sadness and loss, other descriptions seemed to emphasize the "awfulness" of the experience. "I think that it's an extremely emotional, gut-wrenching kind of experience," said one person, "I don't think it feels good on any level." "I just wouldn't want to go through that again," reported another. "I can't really estimate how awful it feels to be dealing with that stuff," said a third, "Even if it gets resolved. It still leaves a really unpleasant feeling for everyone involved." A final example captured a sense of shock amidst the "awfulness": "And then to actually ask someone to leave the internship. It just seems unbelievable to me, that I was in the situation."

A third descriptor offered by the group related to the enormous amount of time and personal energy that addressing intern impairment seemed took. Participants expressed memories of exhaustion and unending turmoil. One supervisor reported, "I mean it just felt like, this will never go away." "It was very, very difficult," concluded another; "It was very, very stressful." One supervisor expressed an on-going sense of fatigue related to being one of a minority of staff members at that site who were willing to "take on the issues." The time spent in self-reflection, for example, asking, "What could we have done differently? What might we need to change?" is "not legitimized by the agency." "We do that one our own," this person explained. In a poignant moment of one interview, I reflected that impairment situations seemed to take up a huge amount of time and energy. The supervisor smiled and quietly responded: "They do.....They do.....Yes, they do."

For one training director the energy spent on impairment seemed to be on-going. After this person described a complex and particularly difficult experience with intern impairment, the researcher asked if the potential for impairment ever crossed this person's mind while interviewing intern applicants. "All the time," was the quiet response; "It's on my mind all the time."

Within the participant group, supervisors seemed to experience an especially heavy emotional price because of the close relationship which had already been established with the trainee. Being on the "front line" of the confrontation with the intern often resulted in in painful return fire: "[The intern] was initially extremely angry with me," remembered one supervisor. "Even [later, the intern] would call me at home to say to me once again, "Why did you do this to me?" Supervisors' descriptions also highlighted the fact that their long, intense investment in an intern's growth made decisions to reduce or prevent client contact even more painful. That decision, remembered one supervisor, was "horrible.....I mean it was really very, very distressing. This....this was very distressing for me." This supervisor recalled a long, difficult process of explanation when the stance with the intern shifted from providing inordinate support and assistance to a decision that the intern could no longer see clients: "It was very, very stressful. I spent many hours explaining why I had made the decision that I had made. Finally I said, 'There are no more words to explain why this happened. I've told you everything I can tell you.'" Another supervisor, who was also quite clear in a conclusion that a particular intern was impaired, demonstrated the on-going sense of concern on the intern's behalf. In an aside, this person noted:

> My only concern is that, you know, even still.....that this [intern's] identity be protected [in the research document].....Which is sort of, as many feelings as I've had about this, it's just amazing to me. But I do still care about that.

One significant description which emerged from the supervisor group, which was clearly not shared by the training directors and center directors, was a sense of isolation within their experiences with impairment. Training directors and center directors either named or implied various opportunities they had to discuss their experiences within their broader professional communities. Supervisors, on the other hand, expressed a distinct "sense of relief to be talking about this." "I would love to talk to other supervisors who have been in this situation," said one. Another described a private process of self-examination: "Like, geez, was there something I missed? Something that I could have done different? Could I have found a teachable moment? Was there a teachable moment I missed? (Laughs). You know, those sorts of things." One person also extended this sense of isolation to the lack of professional literature on the topic:

> I think the emotional elements of this experience don't get validated because there's not enough out there on the topic. So knowing people's affective reactions to working with these situations. To get the validation. I think I'd like that for myself personally.....To hear the emotional responses from other people from other Centers would have a very different impact. I would find that helpful.

In summary, participants described their personal experiences of dealing with intern impairment as being "awful," "gut-wrenching," "exhausting," and something they "never want to do again." Participants unanimously expressed strong feelings of sadness and distress, significantly, regardless of the type or outcome of the intervention. Supervisors expressed a sense of professional isolation in their experiences, and a desire to know more about other supervisors' experiences dealing with impairment.

Moving Forward

In spite of the enormous difficulty of dealing with intern impairment, it was also quite evident in these participants' reflections that they had learned a great deal from their experiences. As one center director concluded, "I think they have, in my time, they have learned to be thoughtful about this process, and will come to deal with the issues. But it's not an easy thing." "So, you know," commented a training director, "We learn every time." Another center director described how that site shares the benefits of their learning with each intern class, primarily through routine training sessions about responsibility and carrying that responsibility out. "We tell them," explained that person, "that there's this process in place [now] that assures all of us what our roles are, and that the right things are going to be done."

Although these participants were in very different stages of a learning process about impairment, their commitment to remaining engaged with the issue was clear. When I asked participants to comment on what they had learned in their experiences, and what they might change as they moved forward, this commitment came into sharper focus. The group seemed to draw three primary conclusions about their experiences with impairment: 1) that it had caused them to become better supervisors; 2) that they were now more skilled at recognizing the "threshold" of intervention efficacy and when they should discontinue their efforts to remediate; and 3) that in the future, they would intervene sooner, and dismiss interns faster.

One person spoke at length about how serving as the primary supervisor of an intern who was dismissed affected this person's own supervisory skills. "I'm not afraid to be the bad person anymore," the supervisor laughed; "I think at one time I may have been. I wanted the intern, or whomever.....to like me, and that's not so important any more." When asked what specifically contributed to not

needing to be liked as much, this person responded:

> .....the thing that's had the greatest impact....was that I <u>was</u> supervising an impaired intern here. And I really had to be very careful and be very aware of what I was doing, and what I was saying, and how I was consulting with others. It made me very conscious.

As this person explained how this experience of forced carefulness about supervisory style impacted work with interns in the present, this person laughed again. "I think I've become a better supervisor," was the response. "I am more conscious of boundaries and limits and limit-setting. And I set them.....and I expect them to be met.

A different supervisor also spoke movingly about personal growth as a result of experiences with impaired interns:

> I think this is the hard part about impairment that I'm still grappling with, and that we as an agency are still grappling with. I don't think that either of those [interns] should have been passed on. I made that recommendation for one of them, and they were passed on anyway.
>
> I think I went along a little more than I should have. Basically, people were telling me, "Well, try this," and "Don't you think it will be ok?" and basically, "Let it go." And I said "Ok." And I don't feel good about that. Maybe I didn't have enough confidence in my own decision, and so.....It just didn't feel right. And I should have followed my gut. It just didn't feel right.....So I really.....I regret that. I did not have the words to put that into motion the way I think it should have happened.

In the end, this person concluded, "I've learned from that situation. I don't think I would let that happen again."

Other participants seemed to reflect more broadly on their values as educators, and seemed to alter their philosophy to a less "all accepting" stance that seemed to give trainees more responsibility. "We try to help every trainee be successful," said a center director, "maybe more than we should." One person specified the primary conclusion he has drawn about himself throughout

his experiences with intern impairment. "I try...," this person explained,

> ....to recognize and try to not bend over so far backwards giving the benefit of the doubt to the trainee. That at times in the process, being too empathic and understanding may not be in the best interest of the trainee in responding to impairment.

Another supervisor agreed in her reflections about needing to learn about how to recognize when it's time to stop "trying to educate."

The second broad area of learning seemed to be about recognizing the threshold of impairment, or as many participants put it, when "that line had been crossed." From one supervisor who now "trusts her gut" when it says that "things are not right," to another who thought an intern "probably wasn't going to make use" of an intervention, but actively "hoped that he did," to a third who concluded, with certainty, that a supervisee could not competently see clients, the participants displayed continually increasing abilities to make these complex decisions. A training director also articulated how having been through an impairment intervention process solidified a sense of trust in knowing when the line had been crossed. This person recalled a particular moment in that experience in which the futility of the intervention became clear: "I just thought it was harmful all the way around. It was absolutely clear to me that nothing was going to change." This person now has a reference point for future decisions: "I think that's when I would move [to dismiss].....When it feels hopeless."

The third theme which emerged from the participants' descriptions of their own learning was a resounding and unanimous conclusion that interventions need to occur sooner and faster. For some participants, this conclusion seemed to take shape for the first time during the interview. "As I listen to myself here," said one training director, "maybe we need the mechanism to address this earlier (laughs), or easier somehow." Other participants seemed to have

already recognized this need, but reported difficulty in enacting it:

> It seems like a lesson that we, and I guess I should say I, have to learn over and over again, is deciding to raise the issues earlier versus later.
>
> We let something go for a whole half a year before we really got on top of it.
>
> Every year I think, "I'm not going to let things get as far before I step in." And every year we as a staff admonish ourselves for not seeing things earlier and nipping things in the bud before they become problems.
>
> We talk about confronting clients.....for the most part those confrontations are pretty gentle, and the timing is based on when the client can hear it. If they're not at that place, we don't confront them. The issue is, with an impaired trainee, they're not going to get to that place. Yet we keep working to get them to that place. We elongate the time, rather than confronting as early as we have to.

Two participants were strikingly similar in their endorsement of the "sooner, faster" theme, yet stood in juxtaposition in their sense of efficacy about terminating an impaired trainee. "My experience in watching people who fall further along the continuum of impairment," said the first person, "is that the faster you stop them, the better it will be. And it's almost impossible to stop them." The second person, in contrast, had not only terminated an intern, but when asked if any changes would be made if the process could be repeated had only one comment: "I'd do it faster." When asked to elaborate, this training director explained:

> Because we gave [the intern] a lot of rope.....I knew what I was looking for, and I saw it. Because everything was there for us to move on. And the longer we tried to deal with it, it just became more disruptive.

Clearly this group of participants recognized both the necessity and the difficulty of confronting intern impairment expediently.

In summary, the participants identified three primary areas in which they had

increased their awareness or ability to respond to intern impairment. As supervisors, participants reported having become more clear and firm in their expectations of interns, as well as less willing to compromise their own sense of the degree of impairment they believed existed. Secondly, participants reported an increased trust in their own ability to recognize the threshold of impairment, specifically, when an intern could not competently serve clients. Finally, the group emphatically concluded that interventions needed to occur more rapidly than they typically do.

The Researcher's Subjectivity

A final area of data collection for this study focused on the systematic recording of my own emotional reactions related the interviews and the data analysis. The primary means of documenting these experiences was a field journal in which I recorded my thoughts and feelings following interviews, and in which I captured broad reflections before, during, and after traveling to a site to collect data. The second phase of self-monitoring and reflection took place during the prolonged and laborious transcription process. I found it fascinating to notice how clearly and similarly my reactions were evoked during the many hours of repeatedly listening to the audiotaped interviews. Finally, my field journal contained observations about my dilemmas, reactions, and emotions as I engaged in data analysis and writing the results.

Peshkin (1988) described the researcher's responsibility, regardless of the type of methodology used, to identify one's own subjectivity. Subjectivity, he wrote, "is like a garment which cannot be removed" (p. 17). Eisner (1990) concurred with this challenge to the existence of ontological objectivity, and advocated instead a careful recognition that:

> ...whatever it is we think we know is a function of a transaction between the qualities of the work we cannot know in their pure, non-mediated form, and the frames of reference, personal skills, and individual histories we bring to them (p. 10).

Consequently, the field journal of this study, and the following three themes which were observed within it, is an effort to identify the key points of interface between researcher and subject.

The three most prominent themes, or as Peshkin (1988) referred to them, "subjective I's" (p. 18), that I discovered involved 1) judgment I perceived toward me from some participants; 2) critical reactions of my own toward some participants; and 3) difficulties related to my positive feelings toward the participant group. As Peshkin noted, some subjective I's have the function of potentially distorting an experience, others tend to soften conclusions. I believe that the first two themes fall into the distortion category; the final theme clearly has the effect of softening.

I discovered my first major "subjective I" in the midst of an interview at my initial site. At the time, I was filled with the excitement of getting my project underway, and feeling pleased that this group of "exemplary" and very busy professionals had agreed to participate in an interview with me. During an early interview, however, I abruptly experienced a sharp increase of anxiety as a participant elaborated on an opinion that "being critical.....and being judgmental" isn't part of "what we do as psychologists." It felt very much to me, in that moment, that I was being told that my topic and questions were basically inappropriate, and that I perhaps was guilty of being an overly critical and even perfectionistic person. In another interview, this part of me that felt criticized re-emerged as a participant told me that the current attention being paid to intern impairment was "probably much larger than the actual problem."

I think that these comments caused me to feel anxiety for two primary

reasons. The first involved the aura of admiration and respect I accorded my participants, which was intensified in a few cases by having "heard of them" (as people within my profession) prior to them emerging in my survey as potential participants. To perceive that a well-known person in my profession might be telling me that my interest in this topic demonstrated that I didn't understand the nature of what psychologists do and don't do, was disconcerting at best.

I think that this discomfort, and "feeling judged" was also connected to my own experiences of addressing the topic of competence within various peer groups. One of my disorienting discoveries has been the recognition that I have been professionally socialized to believe that it is my responsibility to examine my own competence continually, as well as to support, and when necessary, confront other professionals in their own self-examination processes. What I have learned over the years, is that others within my profession have been clearly socialized into a more "hands-off" stance, and from that stance, can perceive my behavior as highly inappropriate. I remember one colleague telling me that if feedback to another professional was in order, that feedback was only appropriate from the person's direct supervisor--and never from anyone else, no matter how carefully, appropriately, or privately that feedback was presented. Clearly, my professional self-concept is in conflict with the person who made that statement; clearly as well, I did not expect to find this issue in my participant group and was surprised in some cases when it emerged.

The second "subjective I" that emerged in my self-examination process was an I which became impatient and critical when participants expressed "how difficult" or "uncomfortable" dealing with issues related to an incompetent intern were. These feelings emerged particularly when the participant or site did not follow through on the action believed by them to be warranted because they

were worried about the consequent difficulties. Some of my reactions here are connected to my sense of self-efficacy around these tasks: as an educator, I have failed students in my classes and have successfully endured formal challenges to my decisions; as an administrator I have fired employees; as a clinical supervisor, I have restricted a supervisee's practice because of competence concerns. All of these experiences were emotionally difficult, but in my opinion, they were sound and necessary decisions what were my responsibility. I think that in the rare moments in interviews when participants described "not doing what they ought to do because it was hard," I surely felt annoyance because of the systemic effect I perceive this to have, namely to make these tasks more complex for those people who do try to carry them out.

Surely, as well, I believe that this particular "I" is guilty of some arrogance, and some naivete which is based in developmental differences between my participants and myself. I have never been a training director or a center director, and I have never supervised a predoctoral intern. Consequently, I may have limited or distorted understanding of the complexities participants are referring to when they reported backing away from various situations.

The third "subjective I" was the one that in many ways surprised me the most, and that was the most difficult for me to sort out in my writing process. Interestingly, this issue also clearly paralleled a dilemma that participants identified--one which I believed I would not personally have difficulty with. What I found was that as I wrote the results of the study, I became very concerned about not wanting to make my participants "look bad." I became aware of my strong liking of the entire group, with all their variations, as human beings. I also was deeply appreciative of the group's courage in offering their candid descriptions of their own struggles, successes, and failures. I envisioned them reading a copy of my dissertation someday, and felt distinctly uncomfortable at

the prospect of them disliking what I had written. I suddenly had a new empathy for the portrait artist who worries about the image she paints, and how the subject will react to the finished result of that type of mirroring experience.

This third "I," my liking, appreciation, and protectiveness of my participant group, has the effect of softening my conclusions. Although I frequently stopped and attempted to examine this issue, I know that my personal connection to the human beings behind the quotations in this study has not and cannot disappear. My therapist self has concerns about the power of my clinical skills as embedded in the interviewer role, and the consequent potential to overstep what my participants agreed that I could disclose. My researcher self knows that we all consented to a process of discovery that none of us could have predicted fully before it happened. A tension between these two stances permeates my writing. I am aware that in some cases, I have understated an impression (and in fact, not pursued a line of questioning in an interview) which may have been helpful to the understanding of this topic, but which surely would have had the effect of "cornering" the participant. It was humbling to discover this "I" after hearing participants talk about intervening much more slowly with "likable," but problematic interns, and believing that I would not experience the same reservations.

These three themes identify important potential points of interface between the topic, the participants and the researcher of this study. They suggest areas in which, consciously or unconsciously, my own presence within this process may more strongly impact the outcome.

Chapter 5

SUMMARY AND CONCLUSIONS

Intern impairment has been identified as a major and critical challenge facing university counseling centers in the 1990s (Stone & Archer, 1990). Despite the critical role that internships play as the "gatekeepers to the profession" (Holloway & Roehlke, 1987), only a minimal and uneven literature base exists to assist supervisors in the exceptionally difficult process of making judgments regarding an intern's competence.

The purpose of this study was to explore and describe supervisors' constructions of intern impairment. Specifically, supervisors were asked to identify typical components of that process, discuss critical incidents in their decision making process, and describe the influence of interpersonal (collegial) interactions. Secondly, this study intended to identify factors that would both support and hinder supervisors in addressing intern impairment. Finally, this study was intended to provide broad and rich description of the process of addressing intern impairment, thereby supporting the development of a theory base as well as stimulating further research.

The participants of this study were twelve psychologists who are currently employed at three APA-accredited university counseling center internship sites. At each of the three sites, the Training Director, the Center Director, and two self-selected supervisors were interviewed. All participants were asked to describe their experiences with impairment; training directors and center

directors were also asked to comment on impairment policies and procedures and the history of the site's interpersonal relationships.

An important characteristic of this participant group, which is also true of me, the researcher, was that they may be considered unusual among their professional peers by their degree of commitment to recognizing and examining problems in an intern's level of performance. Sites were identified and recruited for participation on the basis of their reputation for being willing to talk openly about this highly sensitive and complex issue. Consequently, the participant group may be assumed to represent a unique subsection of the general professional population, namely a group responsible for the training and supervision of psychologists that believes in the existence of "impairment." Secondly, the selection of this particular group influenced the outcome of the study in that these participants generally agreed that impairment was a serious and compelling issue.

The selection of this group of participants prevented the collection of different types of information about impairment. For example, in the consultant group which was used in identifying sites, one training director was puzzled by my request to identify "university counseling center internship sites which actively address or discuss intern impairment." This person reported his belief that "[intern impairment] really doesn't happen very much, and certainly not at APA-accredited sites." He further suggested that I focus my efforts on non-APA internships: "You might be able to find some situations there." Clearly, this person's perspective, which appears to acknowledge but minimize, if not deny, the existence of intern impairment, would be important in documenting a fuller range of beliefs. Likewise, the selection of this participant group prevented the collection of information from professionals who do not believe in the concept of "impairment." It would be quite useful, for example, to explore more fully the

terms "impairment" and "incompetence" meant to a broader range of professionals, as well as what kinds of training issues were particularly challenging to them as supervisors.

Limitations

The primary limitation of this study is the absence of the perspectives of predoctoral interns. Although including intern's impressions and experiences was beyond the scope of the present study, it is important to recognize that they represent a critical component that is missing from a study which otherwise carefully explored systemic influences.

The conclusions of the study would be further strengthened by the inclusion of additional sites. The decision to use three sites seemed generally adequate, but was also constrained by available funds.

Finally, this study is subject to the general concerns related to qualitative methodology, namely it contains a bias in favor of depth of understanding rather than precision. This methodology also creates some limitations in generalizability due to the inherent subjectivity of the researcher, and the focus on broad, rich, site-specific insights rather than rigorous sampling and measurement. The conclusions of the study are best viewed as "suggestive rather than definitive" (Babbie, 1989, p. 286).

Participants' Constructions of Impairment

Three primary conclusions may be drawn from the participants' descriptions of their process of construction. First of all, it was clear that supervisors did not enter the practice of supervision with the benefit of previous examination of these issues, namely the role of evaluation within supervisory relationships and the reality that some supervisees' performances would fall short of an

acceptable standard. Unanimously, supervisors described a process of "learning by doing," and generally feeling surprised, even shocked to find themselves in the position of dealing with persistent problems with an intern. Several clearly stated that the interview was the first time that they had been asked to articulate their thinking process or beliefs on these issues, even if they had previously dealt with an impaired intern.

It was clear as well, that the sites were generally motivated to develop policies and procedures about intern impairment after they had struggled through an experience with an intern without a policy, and then realized the necessity of such planning and documentation. Interestingly, supervisors often were not familiar with the impairment policies at their own site, and if they were, often expressed an dislike of those policies and procedures.

A second primary conclusion involved the highly problematic use of the term "impairment." Although participants consistently used impairment as an umbrella term to encompass a variety of problematic situations, they routinely had to break impairment down into subcategories in order to answer subsequent questions. In all cases, the essence of what seemed to be captured by the concept "impairment" was an inability to provide competent clinical services. The reasons behind that inability, however, seemed to send descriptions into quite different domains. The purest form of impairment seemed to involve a temporary reduction in a person's baseline professional competence, for example, when an intern had experienced a significant life stressor. Other subtypes seemed to involve a more stable inability to perform at the expected level or an inability to reach a threshold of competence. These subtypes included such areas as inability to master basic skills; inability to appropriately self-monitor; and inability to integrate ethical expectations of the profession. As participants offered examples from the variety of subtypes, they

often noted their fundamental differences, and in some cases, began to change their language to reflect the distinction between temporary reduction and substandard competence.

The third important finding in the area of definition was the ease with which participants were able to identify what they would consider to be early warning signs of impairment, as well as to describe how they might begin an intervention process with the intern. Clearly, for this particular group of participants, the task of deciding whether intern impairment was difficult, but not as difficult as implementing whatever interventions seemed appropriate. These reports of difficulties in implementation were consistent with the supervisors' conclusions that intern impairment is underaddressed and that the profession is much more avoidant than overzealous in its efforts.

Barriers to Intervention

Participants identified several significant factors which negatively impacted their ability to deal with intern impairment. The first involved their training as supervisors, or perhaps more accurately, their lack of training as supervisors. Many participants seemed to express a sense of frustration that their skills as a therapist (being nurturant, accepting, patient) did not adequately match tasks demanded of them as supervisors of problematic interns. Several reported feeling like "nothing in their training or orientation" prepared them to do what they needed to do.

A related finding was the impact of the wide variation in standards of supervisory practice. One of the themes which clearly emerged in situations of intern impairment involved supervisors who were fairly detached and unaware of the specifics of an intern's clinical performance. The seriousness of such problems were only realized when the intern switched supervisors, or in some

cases after the intern had already left the site and complaints or other problems emerged.

A second major barrier to supervisors effectively dealing with intern impairment was a lack of consistent, appropriate, and ethical collegial behavior. Participants noted that inappropriate collegial behaviors often encouraged the impaired intern to externalize responsibility for their problems, and also lessened the site's credibility with the intern. For example, if particular inappropriate behaviors of the professional staff were routinely tolerated or ignored, it was much less likely that an effective intervention would take place with an intern on similar issues. Supervisors also expressed a need for dialogue, reflection, and reality-checks from their peers in order to make careful and sound decisions about intern impairment. If the professional peer group had not been able to able establish norms of trusting, respectful, and sustained dialogue, the supervisor was operating without a critical source of support, and it appeared likely that the ability to intervene with the intern was sharply curtailed.

A final significant barrier to addressing impairment existed in the sheer emotional difficulty of the process. Although participants unanimously described their experiences in strongly negative terms, it was a significant finding that sites which successfully implemented the intervention which they perceived as appropriate consistently reported that the experience had been horrible, but that they were also very certain that they had made a sound, fair, and ethical decision. Sites which had not implemented interventions which they believed were probably called for seemed to experience an extra layer of distress in the form of regret for not following through on ethical responsibilities or else worry that some day they would get caught and held accountable for graduating impaired interns.

Factors that Support Intervention

Factors which seemed to significantly support supervisors' intervention efforts were striking in their juxtaposition to the previously described barriers. Both, significantly, were embedded in the interpersonal relationships among the professional staff at the site. The first important finding in this area concerned the quality of those relationships, and the ability of the group to dialogue effectively and respectfully in order to fully examine a myriad of relevant perspectives and concerns. Another result of such an effective collegial work group seemed to be the richness of consultation available, and the consequent benefit to both the supervisor and the intern.

A second essential feature of this work group was the availability of a regularly scheduled time in the work week for supervisors to discuss their work. These meetings served a variety of functions: 1) they communicated to supervisors that their training activities were important and worthy of this use of the agency's time; 2) they communicated that supervision and therapy are not identical tasks and that supervisors deserve resources and support as they continued their learning; 3) they provided protected time in the work week for supervisors to process and develop strong effective interpersonal relationships; 4) they provided proactive and continual monitoring of the training needs of the interns. Clearly, the features of having a regular meeting time and having established positive working relationships are interdependent. A group having a regular supervisors' meeting, but also having destructive interpersonal norms would not necessarily benefit from this structure.

A third significant supportive feature was an agency norm of addressing difficult issues rather than avoiding or denying them. Regardless of the diversity of various supervisors' opinions on what should have happened with problematic or impaired interns, the agency norm determined what did, in fact

ultimately occur. Clearly, a supervisor with serious concerns about an intern supervisee was more able to effect a range of interventions if the norm within that agency was to address the issue.

Finally, supervisors seemed to be supported in enacting interventions with impaired interns when the Training Director and the Center Director at that site took an active, involved, and clearly defined role in the intervention process. One of the sharply distinguishing features of this type of administrative style was the extent to which supervisors expressed a feeling of being heard, respected and supported. Another unique feature of this administrative style was the degree to which this type of active collaboration was successful in continually monitoring and protecting the welfare of all stakeholders in the process. Supervisors in these situations indicated a striking degree of confidence in their interventions, and a striking absence of regrets regarding the choices they made with impaired interns.

Implications for Practice: The Training of Supervisors

One of the strongest implications emerging from this study is a challenge to the professional norm that assumes that if a person is a competent clinician, he or she is prepared to be a competent supervisor. Clearly the supervisory role requires many skills, abilities, and values that are different from those of the therapeutic relationship, and yet "relatively little systematic examination of the theoretical and applied underpinnings of supervision is offered to graduate students" (Russell, Crimmings, & Lent, 1984, p. 625). Consequently, supervisors are essentially left in a vacuum to develop their own knowledge and skills. The reality that the supervisors in this study were so underprepared to deal with the more extreme situation of an impaired or incompetent intern calls into question the less visible but equally important level of supervisory

competence in more typical situations.

The sense of isolation expressed by these supervisors, who are notably, an exemplary group in their commitment to training and supervision, was striking. Regardless of the extent of their previous training in supervision, or their degree of familiarity with literature on supervision, most supervisors perceived their preparation as being "unhelpful" or "not enough" to deal with serious intern competence problems. Additionally, supervisors often reported a perception of "not having talked" about these issues before. Clearly, some of this sense of isolation points to a failure in academic training programs to adequately ground students in a base of supervisory literature, to provide adequate experiential practice in supervision, and particularly, to orient students to the evaluative components of the supervisory role. These oversights by the counseling psychology profession seem particularly unfortunate given the vast resources so readily available from our close colleagues throughout the field of education, most notably those professionals in teacher education who have wrestled with strikingly parallel complexities in supervising the practice of developing teachers (Cogan, 1973; Feiman-Nemser & Featherstone, 1992; Goldhammer, 1969; Holly & Mcloughlin, 1989; Soled, 1995).

In addition to supervisors' expressions of isolation concerning the practice of supervision, and in particular, evaluating a supervisee's competence, many also voiced or demonstrated a perception of detachment as a supervisor within their own agencies. In some cases this isolation was clearly reinforced by the agency's "not having time" for consistent attention to supervisory practice, or by the agency's taking a "hands off" approach to supervisory relationships. One of the dangers of this isolation appeared to be an inordinate emphasis by the supervisor on "being liked" by the supervisee in order to support a perception of the relationship as effective. In contrast, persons who felt concretely supported

and valued by their agency for their supervisory work recalled "moving past their need to be liked" as a supervisor, and "becoming a better supervisor," as a result. These patterns offer a caution germane to the training of competent supervisors as well: that we must attend carefully to the implications and dangers of creating and supporting a culture of isolated, strongly individualized supervisory practice. Again, our colleagues in education, for example, Lortie (1975) and Little and McLaughlin (1993), have offered rich and valuable information about the implications of a culture of non-interference and "closed doors" upon the goal of shared standards for good professional practice.

In summary, this study highlights a critical need for academic programs to formally address supervision as a unique and critically important area of professional practice. Specifically, programs should: 1) make supervision courses and practica mandatory; 2) engage students in prolonged examinations of professionals standards of practice to assist in their evaluative tasks as supervisors; 3) develop students' abilities to not only recognize ethical responsibilities, but to be able to tolerate the difficulty of those situations, and to know how to engage in an effective process of addressing those difficulties; and 4) demonstrate for students and actively develop a professional norm of shared responsibility for good practice.

Implications for Practice: Training Sites

The results of this study indicated that the group dynamics and norms of an individual supervisor's collegial group had a profound impact upon the intern impairment process. Although the supervisor group reported that the process of reaching an individual decision about an intern was difficult, it was clear that the level of relational effectiveness or ineffectiveness in the collegial group determined the outcome with the intern. For example, some supervisors who

believed strongly that their intern should not be passed reported that when the issue reached the collegial group the discussion became unproductive and inflammatory, and ultimately, the intern was passed anyway. These supervisors reported multiple experiences of regret and concern over interns who were passed on from their internship. In contrast, sites which had established strong, effective collegial relationships clearly provided supervisors with the support they needed not only to make sound decisions about problematic interns, but also to confidently enact those decisions.

These findings strongly point to the need for internships to follow through on their commitment as training sites by formally recognizing and concretely supporting the work of supervisors in three major ways. First of all, training sites must allocate regular staff time to support the development and practice of supervisors. This study found that even within an exemplary group of professionals the ability to make and enact sound evaluations of intern competence was rare. Furthermore, in the small minority of situations in which a serious and necessary intern intervention was not only considered but enacted, the collegial group--without exception--participated in routine meetings devoted to the examination and support of their supervisory practice.

A closely related implication for supporting effective supervision is the necessity for agencies to use existing professional knowledge and skill to actively build and maintain positive, effective collegial group relationships. The literature from several disciplines, including counseling/psychotherapy (Corey & Corey, 1987; Yalom, 1975); organizational psychology (Cohen, et al., 1988; Hare, 1962; Tubbs & Moss, 1974) and education (Glickman & Bey, 1990) is plentiful with scholarship on the critical, and not surprising connection between task effectiveness and positive collegial group relationships. One of the "most extensive studies" of secondary school teachers concluded that "good morale

and the routine of people working harmoniously together" (Rutter, Maughan, Mortimore, Ouston, & Smith, 1979) was a critical determinant of the overall success of the teaching and learning taking place. As several participants of this study noted, surely it is a somewhat embarrassing irony that as the profession which is perhaps best equipped to attend to and facilitate good interpersonal relationships, we as psychologists regularly fail at using these same skills in our own collegial groups.

Finally, agencies must support the efforts of committed, effective supervisors by attending to issues embedded in the reality of widely discrepant supervisory practices at internship sites. This study found that inconsistencies in supervisory practice: 1) negatively impacted supervisor morale; 2) increased collegial conflict; 3) complicated the intervention process with problematic interns; and 4) and often, prevented serious intern competence problems from being discovered and addressed in a timely manner. Additionally, since most professionals "learn their own supervisory skills or strategies through their own experiences as supervisees" (Russell, Crimmings, & Lent, 1984, p. 625), the erratic modeling of supervision that some training sites are providing is highly problematic. Without an agency commitment to the maintenance of current supervisory standards of care, such as delineated in Austin, Moline, and Williams (1990) and Harrar, VandeCreek, and Knapp (1990), supervisors and training programs will remain undersupported in their efforts to effectively intervene with problematic interns.

Implications for Practice: The Profession

One of the most critical implications of this study is the challenge to the use of the term "impairment" as a general label for an intern's inability to provide competent services. The definition of "impairment" has been quite controversial

(Katz, 1986; Lamb, et al., 1987; Stadler, Willing, Eberhage, & Ward, 1988), and the trend has been, unfortunately, to steadily expand the term to include a broad range of scenarios. The sustained confusion regarding the construct of "impairment" has had multiple negative effects.

First of all, the inconsistent usage of the term has prevented the development of a codified professional language base. Authors writing about "impairment" must begin their work on by defining the various ways they personally use that term. Since the usage continues to vary so widely, the effect upon the existing literature on this topic is that it seems highly disjointed, and in many cases is difficult to locate in literature searches.

Secondly, in a more applied domain, the result of bringing together fundamentally different issues under the one construct "impairment," and then attempting to deal with them as though they were similar created striking and unnecessary complexity for the supervisors in this study. Throughout the interview process, the participants wrestled with the complexity of providing distinctly different responses to the subgroups of "impairment" that they identified and must confront. Given that such different scenarios and issues are grouped together within such ambiguous professional terminology, it is not surprising that the body of literature on impairment seems sparse and stagnant, nor is it surprising that supervisors perceived the literature as being "of no help."

The findings of this study strongly support the assertion (Kutz, 1986) that the term "impairment" be used only in situations involving diminished functioning. One of the most critical, yet ignored diagnostic questions within this domain is whether the person in question has reached, and has demonstrated an ability to maintain, an adequate level of professional competence. If this level of adequate functioning has been established, and then for whatever reason, that functioning is negatively impacted (or as it is often termed in the literature,

"temporarily diminished"), that person would be accurately referred to as "impaired."

On the other hand, if a person's professional functioning has not yet reached or has never reached an adequate level of functioning, the problems associated with these person's work should not be conceptualized as "impairment," rather they should be labeled more precisely and accurately as "incompetence." Using language which blurs the source and nature of the problem (e.g. referring to "incompetence" as "impairment") not only leads to ineffective intervention strategies (e.g. providing emotional support for a skill deficit), but also increases the likelihood that professionals will not be aware of literature which could assist them in their decision making and interventions. The existing literature on intern evaluation, for example, is much more likely to be helpful to a supervisor dealing with an incompetent supervisee than the articles grouped under "impairment."

Clearly, the predoctoral internship is in a unique and challenging position in a process of diagnosing impairment vs. incompetence because that experience is designed as a final major training experience to establish baseline competence. The internship also has the unique feature of working with an intern within a circumscribed time frame, typically, one year. Importantly, the supervisors in this study reported only minor difficulties in determining whether they were dealing with temporarily diminished functioning or a more fundamental situation of incompetence which was resistant to training efforts. The latter problem, which was consistently considered to be the more difficult of the two, is clearly embedded in an extended span of time involving years of education and training that was unsuccessful in developing baseline competence. Clearly, this scenario is quite different from one in which a competent trainee's performance suddenly changes; clearly as well, separating

the two constructs opens up highly sensitive topics such as the shared responsibilities and liaison issues between academic programs and internships.

In summary, this study strongly advocates that the term "impairment" be used only to describe a situation of temporarily diminished functioning in a person who has previously demonstrated a consistently adequate level of professional functioning. Situation involving a refractory pattern of inadequate functioning should be termed "incompetence," and addressed accordingly. Establishing a clear and consistent set of professional language around these issues will assist supervisors, academic programs, and internships in their diagnostic and intervention efforts, and will support the foundation of a solid and useful body of professional literature to examine and guide these tasks.

Recommendations for Future Research

The next logical step in furthering this research on the evaluation of intern competence would be to address the primary weakness of this study: the absence of rich descriptive information on the experiences and perspectives of predoctoral interns. This information would be useful in a number of dimensions, for example: 1) to further triangulate and enrich the constructions of supervisors; 2) to add more information regarding the systemic responsibility for intern incompetence and impairment; 3) to capture intern experiences of concealment in supervisory experiences; 4) to capture interns' own constructions of incompetence and impairment with regard to other students, other interns, and faculty. Qualitative designs are recommended for these studies because of their strength in maintaining and illuminating process and context.

A study which would extend the current examination of supervisors'

constructions of impairment could focus exclusively on the issue of harm. Specifically, supervisors could be asked to describe how they conceptualize the issue of client harm, and how they recognize when harm is occurring, especially when then the level of harm is not obvious or severe, such as in cases of therapist sexual misconduct. After a base is established using qualitative methods, this work could be very productively extended via survey designs, perhaps asking participants to respond to case vignettes.

An important area which could be addressed via quantitative studies is variation within supervisory practice at internship sites. For example, these studies could explore the degree to which supervisors believe that monitoring supervisees' work is necessary (for example, listening to tapes, reviewing case notes); and the degree to which supervisors actually engage in these tasks. Identifying the reasons behind supervisors not engaging in these tasks would also be productive, as would be systemic supports and barriers to these aspects of the supervisory role. This information would be particularly helpful from a random sample of supervisors at internship sites, rather than from exemplary or self-selected supervisors.

Another productive area for research is the beliefs and constructions of psychology graduate students about incompetence and impairment. Since these participants are in an active process of being socialized into the professional norms of the field, and since they have a unique vantage point from which to observe the behaviors of their potentially impaired or incompetent peers and the responses (or lack of response) from their faculty members, their perspectives are potentially very important. Again, qualitative methodology is recommended for this work.

Other productive studies might explore the beliefs and perspectives of supervisors, internship sites, and academic programs who do <u>not</u> struggle with

the evaluation of intern competence.

Summary

This study of supervisors' constructions of intern impairment suggests that supervisors are often underprepared to deal with intern impairment, and generally shape their ideas and intervention strategies for the first time while they are in the process of dealing with a problematic intern. Supervisors were able to offer specific intern behaviors and attitudes which they would consider warning signs of serious difficulties; they were also able to describe a wide range of possibilities for intervening with a problematic intern. Supervisors identified two critical factors in determining whether a situation would be resolved or escalated: the intern's attitudinal response to the supervisor's confrontation, and whether the problematic behavior was a pattern which occurred in different settings and relationships.

Several factors seemed to hinder supervisors in carrying out interventions they believed to be appropriate: their own lack of training and efficacy as supervisors; wide variation in supervisory practice among peers; conflicts, lack of support, and impairment among professional staff; and the emotional difficulty of dealing with such complex situations. Other factors facilitated effective interventions. Sites which reserved weekly times for supervisors to discuss their work, and which had established positive, respectful working relationships created a highly effective context for supervisors to on-goingly process and consult. Agency moral norms of dealing with or avoiding ethical problems also played a significant role in determining the extent of intervention. Finally, when training directors and center directors used a highly collaborative, involved, and active style in dealing with intern impairment, supervisor reported feeling very supported, and very confident in their decisions.

Finally this study suggests that academic programs and internships sites need to recognize supervision as a specialty area, and to reject the traditional assumption that if a psychologist is a competent clinician, then he or she will automatically be a competent supervisor. Additionally, agencies housing internship programs must follow through with their responsibilities to training by providing staff time to support supervisors; by monitoring the consistency of supervisory practice; and by promoting positive, effective collegial group relationships. The study also argues for the term "impairment" to be used only to describe situations in which an otherwise adequate baseline of professional competence has already been established, but has been temporarily diminished. A second category, inadequate competence, is proposed to provide diagnostic clarity.

APPENDICES

Appendix A

April --, 1996

Dr. ----------
Center Director, University Counseling Center
University of ----------
City, State 00000

Dear Dr. ---------:

I am writing to request the participation of your staff in my doctoral dissertation study: Supervisors' Constructions of Trainee Impairment at APA-Accredited Counseling Center Internship Sites. My intent, at the conclusion of the study, is to be able to identify key issues and influences within the process of trainee evaluation, and thereby, to increase the knowledge available to supervisors in the difficult position of making judgments about impairment.

Your internship was listed among sites recommended to me by a group of counseling center faculty members, training directors, and counseling center directors as ones which are known professionally as being thoughtful and active around issues of impairment.

Participation in the study would involve four persons at your site: yourself, the Training Director, and two doctoral level psychologist supervisors. The selection of the two supervisors would be up to you and your staff. Although it would be helpful to interview your most experienced supervisors, my preference at this point is to interview people who have interest in the topic of impairment, and who would feel comfortable participating.

Each of the four participants at your center would be asked to complete a one-page background information form, and then engage in a two-hour on-site interview. Additionally, I would ask the Training Director to send descriptive materials about the internship, policy/procedure statements about intern evaluation, and forms used in intern evaluation. Finally, I would invite participants who are interested to review and share their reactions to the results section of my study as it emerges.

Because I currently work as a staff therapist in a university counseling center, I want to assure you and your staff that I am quite sensitive to the time demands and limitations of that environment. I am prepared to be as flexible as possible with the scheduling of interviews. I also wish to note that the identities of of individual subjects and sites will be carefully protected, both within the research process and in the final document.

I will call you in approximately ten days to answer any questions that you or your staff might have concerning the study, and discuss your possible participation. You are also most welcome to call me or the chairperson of my committee, Dr. Linda Forrest, with questions at any time. Thank you for considering this request. I look forward to talking with you.

Sincerely,

Sharon Smith Gizara, M.Ed.
Doctoral Candidate
Counseling Psychology
Michigan State University

(541) 341-1647

Linda Forrest, Ph.D.
Associate Professor
Department of Counseling,
Educational Psychology, and
Special Education
Michigan State University
East Lansing, MI 48824

(517) 355-8502

Appendix B

April --, 1996

Dr. ---------
University Counseling Center
University of ----------
City, State 00000

Dear Dr. ----------:

Thank you for agreeing to meet with me and describe your thoughts and experiences regarding intern impairment. I look forward to talking with you in your office on April --, 1996 from 10:00 a.m. to 12:00 noon.

Should you have questions or need to contact me, I may be reached at (541) 346-3227 (office), (541) 341-1647 (home).

Sincerely,

Sharon Smith Gizara

Appendix C

Consent to Participate in Research

My signature below indicates that I give my consent to participate in a research project entitled "Supervisors' Constructions of Trainee Impairment at APA-Accredited Internship Sites." This study will be conducted by Sharon Smith Gizara, M.Ed. under the sponsorship of Linda Forrest, Ph.D. and the Counseling Psychology program at Michigan State University.

I understand that the only requirements of the study will be to complete a one- or two-hour audiotaped interview an a brief background information form. If I am uncomfortable being audiotaped, the interviewer will take notes instead. I will also have the option of not answering questions, if I so choose. After interviews are completed, participants will be asked to review the transcript and to alert the researcher if their identity seems compromised in any way.

I understand that the results of this research will be coded in such a manner that my identity and the identity of the counseling center where I am employed will not be physically attached to the data. The key listing identities and code numbers will be kept separate from the data in a secure location, and will be accessible only to the researcher. In addition, I understand that the purpose of this study is to examine the experience of groups of individuals, not to evaluate the performance of a particular individual.

This study is expected to provide further information on the process which supervisors make decisions about potentially impaired interns. I understand that the results of this study may be published or otherwise reported to scientific bodies, but that I will not be identified in any such publication or report. I understand that my participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and discontinue participation at any time.

I understand that this project is not expected to involve any risks of harm any greater than those ordinarily encountered in daily life. I also understand that it is not possible to identify all potential risks in such research, but that all reasonable safeguards will be taken to minimize the potential risks.

If at any time I have questions about this project, I understand that I may contact the researcher at (541) 341-1647 or the researcher's advisor at (517) 355-8508. Finally my signature acknowledges that I have received a copy of this form.

Signature_____ Date _____

(Adapted from Heppner, Kivlighan, & Wampold, 1992)

Appendix D

Background Information

1. In what field/year did you receive your doctoral degree?_____

2. How many years have you worked in a university counseling center? ____

3. How many years have you worked in a professional position in the field of psychology? _____

4. How many predoctoral interns have you supervised? _____

5. How many other persons have you supervised in clinical work? (e.g. master's level trainees or clinicians, post-doctoral clinicians?) _____

6. How many interns have you supervised directly for whom the issue of impairment was considered? _____

   b. indirectly? _____

   c. other trainees? _____

7. Was a course in ethics a part of your formal training? _____

8. Was a course in supervision a part of your formal training? _____

9. Please provide a brief description of your theoretical orientation:

10. Please provide a brief description of your supervisory style:

Appendix E

Interview Guide: Supervisors

I. Construction of impairment

a. personal definition

"How do you define impairment?" or "What does the term 'impairment' mean to you?"

Issues to note and follow-up:
**variations on definition; clarify different "types" of impairment
**what options would supervisor consider in response to different impairment scenarios?
**does supervisor believe in "absolute impairment," i.e. that trainee should be dismissed from internship/prevented from clinical practice?
**under what circumstances should trainee be dismissed?

b. process of construction

"What would you consider to be warning signs of potential impairment?"

Issues to note and follow-up:
**chronology of decision-making: single or multiple events? quick or extended process?
**critical events/issues in process?
**degree of certainty of decisions?
**what did supervisor vacillate about?
**did supervisor seek external input? Type?
**did supervisor seek disconfirming input? Type?

c. perceived difficulty of process

"How difficult is this process (evaluating impairment) for you?"

Issues to note and follow-up:
**what makes process difficult?
**regrets about earlier decisions?
**what learned over time/experience?
**what helpful in process?

II. Influence of professional peer group

a. norms of evaluative conversations about interns

"Do you typically discuss your supervisee's performance with other supervisors/persons?"

Issues to note and follow-up:

**what is routine conversation? (frequency, content, participants, scheduled v. spontaneous?)

**what is "atypical" discussion? (triggers, frequency, content, participants, scheduled v. spontaneous?)

**with whom does person consult individually? why this person(s)?

b. Degree of agreement/disagreement in evaluative conversations

"When you have been part of a discussion about a potentially impaired intern, what has been controversial?"

Issues to note and follow-up:

**disagreement: what issues?

**agreement: what issues?

c. Effect of interaction on decision-making

"To what degree do you as a supervisor make a decision about impairment yourself?"

Issues to note and follow-up:

**what is the supervisor's decision-making style?

**what, in particular, influenced individual's decisions?

**what is this staff's decision-making style?

III. Closing questions:

"Of all the supervisors on this staff, why did I end up talking with you?"
"What values/perspectives do you represent?"

"Is there an important piece of this process (supervisors considering impairment) that we haven't talked about?"

"What would you be most interested in knowing about other supervisors' experiences with this topic?"

Appendix F

Interview Guide: Training Directors

I. Construction of impairment

a. personal definition

"How do you define impairment?" or "What does the term 'impairment' mean to you?"

Issues to note and follow-up:
**variations on definition; clarify different "types" of impairment
**what options would TD consider in response to different impairment scenarios?
**does TD believe in "absolute impairment," i.e. that trainee should be dismissed from internship/prevented from clinical practice?
**under what circumstances should trainee be dismissed?
**changes over years? Definition/policy?

b. process of construction

"What would you consider to be warning signs of potential impairment?"

Issues to note and follow-up:
**chronology of decision-making: single or multiple events? quick or extended process?
**critical events/issues in process?
**degree of certainty of decisions?
**what did TD vacillate about?
**did TD seek external input? Type?
**did TD seek disconfirming input? Type?

c. perceived difficulty of process

"How difficult is this process (evaluating impairment) for you?"
"For your staff?"

Issues to note and follow-up:
**what makes process difficult?
**regrets about earlier decisions?
**what learned over time/experience?
**what helpful in process?

II. Influence of professional peer group

a. norms of evaluative conversations about interns

"What types of interactions does your staff have regarding the performance of interns?"

Issues to note and follow-up:

**what is routine conversation? (frequency, content, participants, scheduled v. spontaneous?)

**what is "atypical" discussion? (triggers, frequency, content, participants, scheduled v. spontaneous?)

**with whom does person consult individually? why this person(s)?

b. Degree of agreement/disagreement in evaluative conversations

"When your staff has been discussing a potentially impaired intern, what has been controversial?"

Issues to note and follow-up:

**disagreement: what issues?

**agreement: what issues?

c. Effect of interaction on decision-making

"To what degree do you as a Training Director make a decision about impairment yourself?"

Issues to note and follow-up:

**what is the TD's decision-making style?

**what, in particular, influenced TD's decisions?

**what is this staff's decision-making style?

d. Confidence in skills, structures, policies

"How comfortable are you now with your staff's ability to deal effectively with impairment?"

Issues to note and follow-up

**changes over years?

**what supports/hinders?

**changes you'd still like to make?

III. Closing questions:

"Is there an important piece of this process (supervisors considering impairment) that we haven't talked about?"

"What would you be most interested in knowing about other Training Directors' experiences with this topic?"

Appendix G

Interview Guide: Center Directors

I. Construction of impairment

a. personal definition

"How do you define impairment?" or "What does the term 'impairment' mean to you?"

Issues to note and follow-up:
**variations on definition; clarify different "types" of impairment
**what options would CD consider in response to different impairment scenarios?
**does CD believe in "absolute impairment," i.e. that trainee should be dismissed from internship/prevented from clinical practice?
**under what circumstances should trainee be dismissed?
**changes over years? Definition/policy?

b. process of construction

"What would you consider to be warning signs of potential impairment?"

Issues to note and follow-up:
**chronology of decision-making: single or multiple events? quick or extended process?
**critical events/issues in process?
**degree of certainty of decisions?
**what do staff vacillate about?

c. perceived difficulty of process

"How difficult is this process (evaluating impairment) for you?"
"For your staff?"

Issues to note and follow-up:
**what makes process difficult?
**regrets about earlier decisions?
**what learned over time/experience?
**what helpful in process?

d. effect of process on agency

"What kinds of agency issues come up for you when impairment is considered?"

II. Influence of professional peer group

a. norms of evaluative conversations about interns

"When you have been part of a discussion about a potentially impaired intern, what has been controversial?"

Issues to note and follow-up:
**disagreement: what issues?
**agreement: what issues?

b. role of Center Director in decision-making process:

"What role do you, as the Center Director, play in making/ implementing decisions about impaired interns?"

Issues to note and follow-up:
**what is the CD's decision-making style?
**what, in particular, influenced CD's decisions?
**what is this staff's decision-making style?

c. Confidence in skills, structures, policies

"How comfortable are you now with your staff's ability to deal effectively with impairment?"

Issues to note and follow-up
**changes over years?
**what supports/hinders?
**changes you'd still like to make?

III. Closing questions:

"Is there an important piece of this process (internships considering impairment) that we haven't talked about?"

"What would you be most interested in knowing about other Counseling Centers' experiences with this topic?"

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