USING THE RIGHT TOOL FOR THE RIGHT SITUATION: TAILORING REMEDIATION PLANS FOR PROBLEM TRAINEES WITHIN ACCREDITED MARRIAGE AND FAMILY THERAPY PROGRAMS

by

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B.A., Centenary College, 1994
M.A., University of Louisiana-Monroe, 1996

AN ABSTRACT OF A DISSERTATION

submitted in partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY

Department of Family Studies and Human Services
College of Human Ecology

KANSAS STATE UNIVERSITY
Manhattan, Kansas

2007

ABSTRACT

Within the field of medicine and clinical/counseling psychology, there has been an overabundance of research and literature devoted to specific areas of focus such as trainee impairment, remediation, and dismissal procedures. Although literature does exist in relation to the specific types of remediation methods being used by graduate training programs, no research to date, however, has addressed what types of remediation methods would be most effective in response to the various types of impairment experienced by therapists-in-training (Russell & Peterson, 2003; Forrest et al., 1997). Using a modified version of the Delphi method, the present study seeks to bridge this existing gap by exploring the types of remediation methods deemed most effective for the specific types of impairment experienced by trainees within master's and doctoral level accredited Marriage and Family Therapy graduate training programs.

The purpose of the study was to answer the following questions:

1. What, given a list of impairments and remediation methods would, supervisors and/or professors within MFT graduate training programs list as the most effective type of remediation method for a specific type of impairment?
2. Given the initial answers of experts, once they are provided the answers from their colleagues, can they come to a greater consensus about the most effective remediation methods for specific types of impairment?

Those remediation methods chosen by panelists that had a median of 6.00 to 7.00 and interquartile range of 0.00 to 1.50 made the final profile. Results indicated that, given the initial answers of experts, the panel of experts was able to reach a greater consensus

about which types of remediation methods they deemed most effective in responding to the corresponding types of impairment. Furthermore, during the first phase of questioning, the panel of experts also generated relevant commentaries with regard to responding to student impairment. Finally, limitations and directions for future research are discussed.

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ACKNOWLEDGMENTS

What little did I know when I began this journey that it would take me a total of seven years to complete my doctoral studies. As my major professor, Dr. Jurich, once said many years ago, “Kara, you are not your dissertation”. I guess this impressed upon me the importance of continuing to nurture my emotional and physical well-being by living my life to the fullest while also continuing to work toward the completion of my dissertation. To my major professor, thank you for all of the guidance, support, words of encouragement, and patience you have provided from the inception of my dissertation topic.

To Dr. White, I would like to express how much I appreciate all that you have done for me during my doctoral studies. It is with your guidance that I have learned so much, especially ways in which to become a better writer and researcher.

Dr. Webb, thank you for being an integral faculty member on my dissertation committee. Your “tell it like it is” approach was always helpful, especially when it was important for me to view things from a different perspective and to enhance my work to a much greater level.

I would like to thank Dr. Lynch for being such a great statistics professor and for making learning about statistics less of an intimidating process. It is having you on my committee and receiving assistance from Nancy Sprauve to help analyze my data that I could even fathom using statistics as part of my research project.

Dr. Geyer, thank you for agreeing to take the time to be the member of my dissertation committee who helped unite all of us together so that the entire process from beginning to end would be met with great success.

Thank you so much to Dr. Baptist for stepping in to help me complete my dissertation defense with the least amount of stress possible. Your willingness to step in at the very end and take on this added responsibility is greatly appreciated.

I would like to thank all of the faculty members at the Marriage and Family Therapy program at Kansas State University for giving me the opportunity to learn from and be guided by you throughout my doctoral studies. This experience has afforded me the opportunity to continue to grow, professionally as well as personally.

To my colleagues at Emory Family Medicine/Department of Family and Preventive Medicine, I would like to express my appreciation for all of the patience and support you have shown throughout this entire process. I am thankful for the professional opportunity that I have been granted and grateful for the fact that I may to continue to grow where my roots have been planted.

To my friends and family, thank you for being there for me not just while I was completing my doctoral studies, but always.

There are truly not enough words in the English language to help me express the depth of my gratitude to both my spouse and my parents. I am eternally grateful for all of the love, support, encouragement, and above all, PATIENCE, you have shown prior to and ever since this journey began.

DEDICATION

I dedicate this dissertation to my parents and spouse. It is with your continued support and sacrifices that I am where I am today. THANK YOU!

Chapter 1

INTRODUCTION

Dating back to 400 B.C., the Hippocratic Oath provided assurance to the public that professional competence within the field of medicine would be monitored and quality services upheld. This concept remains one of the defining characteristics of a profession, whether medicine, law, psychology, nursing, or social work (Gelso & Fretz, 1992; Sinclair, Simon, & Pettifor, 1996). One task in particular that accompanies this professional promise is the "responsibility to engage in informed, complex, and difficult decision making involving great human stakes" (Forrest, Elman, Gizara, & Vacha-Haase, 1999, p. 628). An additional defining characteristic of a profession is to screen and select new members, to educate and train those members selected, and to establish and articulate ethical standards of practice (Sinclair et al., 1996). According to Forrest, Elman, Gizara, and Vacha-Haase (1999), a critical obligation of a profession to the public is to train students and effectively decide if those students are competent to provide services to the public.

Throughout the years, the field of psychology has established definitions of professional competencies and skills. This has led to a better understanding of the harm that can be caused by those practicing professionals who may be impaired, incompetent, or unethical. Educators in professional psychology training programs face a problem that is complex and emotionally stressful when one or more of their students is not making progress and their respective training program must respond, educationally, ethically, and legally (Forrest et al., 1999). The literature, regarding ways in which to resolve these difficult decisions, has evolved slowly. Furthermore, educators and trainers within the

field of psychology continue to struggle with balancing both gatekeeping and educational responsibilities (Hahn & Molnar, 1991; Holloway & Roehlke, 1987). The other helping professions have drawn from the lead presented by the field of psychology, but they, too, struggle with the next generation of therapists.

According to Russell and Peterson (2003), it is the responsibility of marriage and family therapy (MFT) training programs to prepare therapists who are "self-aware, conceptually sound, ethically sensitive, and effective in the work that they do with clients" (p. 329). Faculty, working within graduate programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), serve as gatekeepers to the profession. The faculty provide assurance that those students, who graduate from their respective programs, possess the necessary knowledge, skills, and personal characteristics to practice in a competent manner (Russell & Peterson, 2003). Generally speaking, a therapist is considered competent if he/she has the ability to create a desired change with clients within the therapeutic context (Herman, 1993; Shaw & Dobson, 1988).

In Herman's (1993) assessment of the predictors of therapist competence, the following three areas of therapist competence were identified: (a) knowledge, training, and experience; (b) theoretical orientation; and (c) personal characteristics of therapist. First, it is important for students to recognize when certain situations present ethical dilemmas and to respond in a manner consistent with professional ethical guidelines. Second, theoretical orientation relates to the student's ability to translate theory into practice. Students should be able to apply what they learn in didactic classes to cases within the clinic. Third, personal characteristics of the therapist have received growing

attention in the MFT literature, due to their impact on the outcome of therapy (Herman, 1993). It is suggested by Asay and Lambert (1999) that the therapeutic relationship contributes to approximately 30% of the variance in the outcome of therapy. So, upon graduation, therapists-in-training must be able to effectively work with and engage those clients who are from differing backgrounds (Russell & Peterson, 2003).

An additional concern of graduate program faculty is the emotional well-being of therapists-in-training (Russell & Peterson, 2003). In a review of various studies pertaining to the emotional well-being of therapists, Beutler, Crago, and Arizmendi (1986) concluded that both the process and outcome of treatment is facilitated by the emotional well-being of therapists. In 1994, Beutler, Machado, and Neufeldt further reviewed a supplementary set of studies regarding the emotional well-being of therapists and client outcome. The authors concluded that if a therapist displays a high level of distress or disturbance, it may prevent the client's growth or even induce changes that are negative. Furthermore, the authors contend that the possibility of the therapists' emotional problems having a negative impact on their clients should be given more attention (Beutler, Machado, & Neufeldt, 1994).

Although the concept and definition of impairment will be discussed in greater detail in Chapter 2, the encompassing definition of impairment is also defined below as an important part of introducing the research topic. The definition of impairment has gone through numerous translations since the beginning of the 1980s (Forrest et al., 1999). To date, Lamb and his colleagues (1987) offered the most comprehensive and significant definition of impairment within the context of training:

> an interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to

> acquire and integrate professional standards in to one's repertoire of professional behavior; (b) an inability to acquire professional skills to reach an acceptable level of competency; (c) an inability to control personal stress, psychological dysfunction and/or excessive emotional reactions that interfere with professional functioning (p. 598).

Between the years of 1975 and 1995, numerous studies were conducted to explore trainee impairment (Bernard, 1975; Biaggio, Gasparikova-Krasnec, & Bauer, 1983; Boxley, Drew, & Rangel, 1986; Bradey & Post, 1991; Gallessich & Olmstead, 1987; Levy, 1983; Mearns & Allen, 1991; Olkin & Gaughen, 1991; Tedesco, 1982; Vacha-Haase, 1995). Within several of the studies (Boxley et al., 1986; Olkin & Gaughen, 1991; Vacha-Haase, 1995), the most common forms of impairment identified included clinical deficiencies, interpersonal problems, problems within supervision, depression and personality disorders. Although the reported rates of student impairment within graduate training programs are below 5% (Mearns & Allen, 1991; Olkin & Gaughen, 1991; Boxley et al., 1986; Tedesco, 1982), the existence of impairment presents several concerns that will be discussed in great detail in Chapter 2. Only one study, cited above, included MFT programs within their sample (Olkin & Gaughen, 1991). Therefore, MFT is understudied.

Once a therapist-in-training is identified as having a specific impairment, it is the responsibility of the faculty and graduate program to address any and all impairment issues during the training process (Lamb et al., 1987). Lamb and his colleagues (1987) contend that addressing impairment issues earlier during a student's training is both desirable and proactive. According to Wakefield (1995), if impaired professionals were viewed as a "public health problem," a medical-model of intervention could be utilized (p. 84). The medical-model intervention is described within three categories, primary,

secondary, and tertiary. First, primary prevention would be to avoid the illness all together. Attempts are made to educate those within the healing professions about possible vulnerabilities and their responsibility to protect themselves against impairment problems. Healing professionals are informed and reminded that practicing while impaired carries possible penalties, such as lawsuit or loss of state license. This message is brought about through workshops, seminars, insurance companies, professional affiliations, journals and newspaper articles. Secondary prevention focuses on curing the illness once it occurs. Once the professional is deemed impaired, he/she may be required by the state licensing board to seek necessary assistance. The focus of tertiary prevention is on reducing any further damages that might result from the professional's illness. This occurs if the professional refuses to recognize and seek assistance for impairment. Often, it is difficult for professionals to recognize when they are impaired, due to defense mechanisms such as denial and/or rationalization. The professional may clearly see the shortcomings of others but, in the process, fail to see their own impairment. On the other hand, some professionals may know what they are doing is considered an impairment but continue to do so because no sanctions have been imposed upon them. Therefore, tertiary prevention most often consists of restrictions on practice, such as removal of one's license (Wakefield, 1995).

The medical-model intervention, more specifically secondary and tertiary prevention, is prefaced because it serves as segue to the present research topic, which is tailoring remediation plans by pairing specific types of remediation with specific types of impairment. Within the literature, conceptual articles have been written describing the different types of remediation (Bennett, 1986; Frame & Stevens-Smith, 1995; Jensen,

1983; Knoff & Prout, 1985; Lamb et al., 1987), and studies have been conducted in which various types of remediation have been utilized by graduate training programs (Russell & Peterson, 2003; Kacamarek & Conner, 1998; Olkin & Gaughen, 1999; Vacha-Haase, 1995). Two studies in particular provided information about graduate training programs using personal therapy as a type of remediation once a student was deemed impaired (Boxley et al., 1986; Bradey & Post, 1991). Furthermore, the professional literature regarding impairment has focused on the use of personal therapy by impaired practicing psychologists (Deutsch, 1985; Guy, Polestra, & Stark, 1989; Mahoney, 1997; Pope & Tabachnick, 1994) as well as the use of personal therapy as a remediation method for those mental health professionals who have had sexual contact with their clients (Brown, 1997; Gonsiorek, 1995; Layman & McNamara, 1997a; Pope, 1994; Schoener & Gonsiorek, 1998). Forrest et al (1999) suggested that remediation plans should: "(a) identify and describe deficiencies that are directly tied to the program's evaluation criteria, (b) identify specific goals or changes that need to be made by the trainee, (c) identify possible methods for meeting those goals, (d) establish criteria for judging whether remediation has been successful, and (e) determine a timeline for reevaluation" (p. 650).

As stated above, literature exists in relation to specific types of impairment being used by graduate training programs. However, no research to date has addressed what types of remediation methods would be most effective for the different types of impairment (Russell & Peterson, 2003; Forrest et al., 1997). This study draws from the literature the types of impairment and remediation methods and attempts to link the two.

Research Questions

The following questions were used to help guide the research:

1. What, given a list of impairments and remediation methods, would supervisors and/or professors within MFT graduate training program list as the most effective type of remediation method for a specific type of impairment?

2. Given the initial answers of experts, once they are provided the answers from their colleagues, can they come to a greater consensus about the types of remediation methods they deem most effective in response to the specific types of impairment?

Definitions

1. Impairment

   "An interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate professional standards in to one's repertoire of professional behavior; (b) an inability to acquire professional skills to reach an acceptable level of competency; (c) an inability to control personal stress, psychological dysfunction and/or excessive emotional reactions that interfere with professional functioning" (Lamb et al., 1987, p. 598).

2. Remediation Plan

   "(a) identify and describe deficiencies that are directly tied to the program's evaluation criteria, (b) identify specific goals or changes that need to be made by the trainee, (c) identify possible methods for meeting those goals, (d) establish criteria for judging whether remediation has been successful, and (e) determine a timeline for reevaluation" (Forerest et al., 1999, p. 650).

3. Gatekeeping

   Process that serves to protect consumers from therapists who may be unskilled, inadequately trained, or just beginning and require assistance during the early stages of the learning process (Storm et al., 2001).

4. Supervision

   Process in which a "qualified therapist monitors professional development and socialization of partially qualified clinician" (Storm et al., 1997, p. 2).

Chapter 2

LITERATURE REVIEW

Over the past decade, there has been a plethora of research and literature dedicated to trainee impairment, remediation, and dismissal procedures within the field of medicine and clinical/counseling psychology. Unfortunately, gaps exist in the MFT literature regarding these issues. This is why it is essential that professionals within the field of MFT incorporate their distinctive training and systemic perspective when identifying and helping problem trainees (Elman et al., 1999). The focus of Chapter 2 will provide a brief overview of training and supervision, a literature review of trainee impairment as well as the process of identification, remediation and dismissal, a systemic perspective to trainees' problems within programs, and a hypothetical case vignette.

Historical Overview of Trainee Impairment

Between the third and second centuries B.C., an oath that became an important part of medicine was termed by historians as the Corpus Hippocratum. This oath is preserved in one of the greatest libraries of the ancient world, the Library of Alexandria. Currently called the Oath of Hippocrates, medical practitioners promised early on in their careers that they would protect their life as well as the art of medicine with pure and holy intentions. The oath, on the other hand, is rarely noted for the passage that states a physician promises to hold he who is teacher as someone who is equal to his or her parents. It further promises that the student will financially assist the teacher, teach the art of medicine to the teacher's children, and equally hold them as he would his own brothers (Schoener, 1999). This establishes an apprentice model of training for physicians. The psychology field, which is to some extent a descendent of early medicine, also depends

on apprenticeship as a model of training (Schoener, 1999). Training involving apprenticeship includes demonstration, case examples, videotapes, practica, and internships. Since the public relies on the effectiveness of our training and assumes that those who graduate have the ability to provide safe and effective services, it is critical that educators implement effective gatekeeping procedures (Schoener, 1999).

The adjustment and mental health of those professionals practicing in the mental health field has increasingly become a public issue over the years. In the mid-1970s, the majority of states began to license psychologists. During this time, it was learned that, in order to justify the need for licensing, persons within the field had to acknowledge and indeed, actually prove, that practicing mental health professionals were capable of harming clients. Essentially, the public had little awareness of this issue at the time and consumers rarely made calls for accountability (Schoener, 1999). Phyllis Chesler's (1972) Women and Madness, however, was one of the few exceptions. In the 1970s, actions taken by licensing boards and ethics committee findings were essentially undisclosed as far as the public was concerned. During the mid-1980s, the licensure boards within most states began to issue press releases about the misconduct of mental health professionals. Every so often, the media devoted attention to misconduct by those in the mental health profession or colleagues working in related fields. By the 1990s, the media coverage was very dramatic at times. For instance, in the April 13, 1992 issue of Newsweek, a number of pages were devoted to the cover story, "Sex and Psychotherapy." This particular cover story was devoted to sexual misconduct by mental health professionals (Beck, Springen, & Foote, 1992).

Another topic that has received serious attention, often the subject of cartoons and jokes in the media, is the personal and professional adjustment of mental health professionals. One of the first examples includes the piece titled, “Wounded Healers” (Maeder, 1989) which was covered in the Atlantic Monthly. This specific article focuses on the emotional instabilities displayed by those persons working within the helping profession. Within the article, the author cited a survey that included psychologists, social workers, counselors and nonmedical psychotherapists. The results of this survey indicated that 82% reported relationship difficulties, 57% experienced depression, 11% admitted to substance abuse, and 2% attempted suicide (Maeder, 1989). Of course, this survey is not indicative of all persons working within the helping profession, but it does address the simple fact that persons within the helping profession also experience personal and professional problems, and these problems must be addressed.

The second example, “Why Do Shrinks Have So Many Problems?” was covered in Psychology Today (Epstein, 1997). The author discussed the emotional toll practicing therapy takes on therapists’ lives. Empathically listening to the problems of clients, balancing and managing the demands of one’s distress with that of clients, meeting increasing demands of managed care, and problems therapists experience through relationship difficulties, substance abuse, and feelings of suicide are all examples of how practicing therapy may affect the emotional well-being of therapists (Epstein, 1997).

The rehabilitation of impaired professionals has also received attention. The New York Times ran a story entitled, “Dr. Smith Goes to Sexual-Rehab School” (Abraham, 1995). In this article, the author tells the story about a physician, Dr. Smith, who was accused by one of his patients of sexual misconduct. Although Dr. Smith was found not

guilty by a jury, the medical board in Minnesota decided that he should go to “Sexual Rehab School,” or as it is termed within the medical profession, the “Professional Assessment Program” (P.A.P). According to the author, P.A.P. serves as preventive medicine for “sexually incorrect” professionals within the medical, legal, corporate, educational, and accounting professions (Abraham, 1995, p. 46). More specifically, the program serves to evaluate and rehabilitate sex offenders within the above stated professions. Although the most typical client is either a psychologist or psychiatrist who has engaged in sexual contact with his/her client, the program has also assisted physicians (e.g., physician who has an outburst in the operating room) and attorneys (e.g., partner who berates paralegals within the office). In reference to Dr. Smith, he was required to submit to two conditions in order to practice medicine again. Condition one pertained to “Dr. Smith” submitting to a medical examination and both psychological and neurological tests in order to determine or rule out a much deeper psychological and/or medical basis for his behavior. The second condition included a boundaries course that focused on “sensitivity training and part defensive medicine” (Abraham, 1995, p. 49). The psychologist teaching the boundaries course focused on the effective reading and responding to nonverbal cues of patients who may be trying to indicate their feelings of uneasiness. The boundaries course also focuses on physicians talking to their patients, especially women, and telling them what they are doing while they are conducting an examination, and just simply knocking on the examining room door before entering (Abraham, 1995).

Public task forces have studied the issue pertaining to sexual involvement between therapists and their clients that also included training issues in prevention. One

of the authors, S. Michael Plaut (1996), provided two brief case vignettes based on actual occurrences between mental health professionals and their clients in the state of Maryland. The first vignette is as follows: “a psychologist tells his patient that she must become more comfortable with her body and her sexuality and suggests that she masturbate on his office couch while he observes” (Plaut, 1996, p. 1). This example has been called “therapeutic deception” by the Task Force (Plaut, 1996, p. 4) because the mental health professional presents the sexual act as something that will benefit the patient when, in fact, it only benefits the psychologist. The second vignette, “a psychiatrist ’falls in love’ with a war veteran she is treating for post-traumatic stress disorder and has a sexual relationship with him” (Plaut, 1996, p. 1), represents a “sexually exploitative relationship” (Plaut, 1996, p. 4). A “sexually exploitative relationship” may either occur inside or outside the professional’s practice site and develop after the professional relationship has been terminated.

A major portion of a report done for the governor of Maryland (Nugent, Gill, & Plaut, 1996) was devoted to preventive education. According to Catherine D. Nugent (1996), prevention is a “humane, compassionate, and cost-effective response” (p. 9) to ensure that sexual exploitation does not occur. The Task Force recommended that, in order to prevent or reduce sexual exploitation of patients and/or clients, preventative education must exist for healthcare professionals and consumers, possible consumers, institutions and employers, licensing boards, and church and/or synagogue affiliations (Nugent, 1996). First, the Task Force recommended that education about effective professional-client boundaries, definition and prevention of boundary violations, roles professionals may play when responding to boundary violations, risk factors (e.g.

isolation from peers within profession), and warning signs (e.g. looking forward to a client's appointment), be taught within the following five areas of need: (a) Pre-licensure (i.e., pre-degree or residency training); (b) Post licensure (i.e., continuing education); (c) Institutional (e.g., churches, mental health departments, hospitals, and clinics); (d) Rehabilitative (i.e., rehabilitation programs for offenders); and (e) Specialized education (i.e., licensing boards, ethics committees, and/or credentialing committees) (Plaut & Schank, 1996).

Second, although it is the healthcare professional's responsibility to maintain effective boundaries with clients at all times, consumers who are educated and informed may be able to identify early warning signs of possible boundary violations (Nugent & Schank, 1996). According to the Committee on Physician Sexual Misconduct (1992), many patients have limited knowledge of what constitutes effective boundaries between healthcare professionals and clients and the power dynamics inherent within this type of professional relationship. In addition, many consumers are unaware that licensing boards and support systems exist and what recourse they may have if a boundary violation has occurred (Nugent & Schank, 1996). To address the above stated problem, the Task Force developed an informational brochure containing an explanation of sexual exploitation, as well as its potential emotional and physical effects, and lists what one can do if a transgression has occurred. The Task Force recommended that the brochure be distributed to healthcare and mental health agencies, public libraries, and religious institutions for their patients and/or clients, included in the initial licensing or renewal packets to healthcare professionals, provided by healthcare professionals to clients if informed that an alleged sexual exploitation has occurred, and sent by licensing boards to

complainants once a complaint of sexual exploitation has been received (Nugent & Schank, 1996).

Third, since agencies and institutions that employ healthcare professionals have the responsibility of overseeing their employees' actions and behaviors, it is imperative that they help prevent sexual exploitation by applying necessary sanctions, such as demotion, suspension, or termination when transgressions occur, set standards for effective professional practice, and familiarize employees with respect to these professional standards. The issue of sexual exploitation may be addressed by institutions formulating specific guidelines and procedures. These specific guidelines and procedures may include using a comprehensive definition of sexual misconduct, implementing preventive measures (Plaut & Mandel, 1996), such as screening potential employees for past ethical violations (Schoener, 1995), addressing allegations of misconduct through a formal institutional policy, and examining the institution's culture and eliminating any beliefs, values, and attitudes that may be supporting the abuse of power (Plaut & Mandel, 1996). Educating professionals in the prevention of sexual exploitation, may assist in repairing the damage of a profession's reputation when one of its members transgresses and enhancing the community's trust and confidence in the profession once again (Nugent, 1996). Based on this information, it is apparent that, in some states, the public is paying attention to what persons within the mental health profession may or may not be doing to prevent professional misconduct (Schoener, 1999).

Overview of Training and Supervision

The following section will provide a brief overview of training and supervision. Training and supervision are two of the most active and rapidly expanding subsystems

within the field of family therapy. Throughout the past decade, training and supervision have experienced exponential growth in which there exists more knowledge, publications, conferences, and experts. This growth has resulted in a specialty within the field of family therapy that is more sophisticated and varied with regards to its mission, content, and methods.

The context of training is characterized by a number of factors, such as backgrounds, biases, intentions, and objectives (Storm et al., 1997). The context of training is characterized by the dissimilar or similar backgrounds of both the supervisor and supervisee. For example, if a supervisee has grown up in an upper middle-class household and is now working with lower-income families of all racial and ethnic backgrounds, it is extremely important that the supervisee is taught the importance of tolerance and sensitivity to diversity. Biases also characterize the context of training (Storm et al., 1997). For instance, a female supervisor, who is a lesbian, may correct the terminology used by a supervisee and encourage him/her, when inquiring about one's significant other, to use words, such as "partner" rather than "husband" or "wife".

Furthermore, training is conducted in various ways, depending on the institute's goal and objective. Is the goal to expose students to a family approach or is it to prepare them to work with families once their degrees are obtained? "Previous clinical training in family therapy and in other models, as well as formal instruction in supervision and the personal characteristics and interpersonal styles of trainers and trainees, all interact to define and shape the training" (Liddle et al., 1988, p. 3). The training context influences the processes and outcomes of supervision and training (Framo, 1976; Haley, 1975; Liddle, 1978). The training site's financial stability, developmental stage, involvement

within community, plans/prospects for future, and physical facilities all influence the nature of the training being provided (Liddle et al., 1988). First, the training site must have the ability to sustain itself financially through the employment of quality professionals and acceptance of superior students into its program. Second, what is the developmental stage of the program? Is it a fairly new or well-rooted program? Has the program met accreditation standards? Without accreditation and a well-rooted and strong reputation, a training site may experience difficulties in recruiting quality professionals to provide the necessary training. Third, it is important for a training site to provide services to persons within the community and to be involved with other agencies within the community in order to provide as much training as possible for the students in the areas pertaining to culture, gender, ethnicity, and economics. For example, students who work as interns at the community mental health agency provide an invaluable service not only for themselves but for other persons as well. Fourth, what is the training site's goal for growth? It is imperative for a program site to always search for new ways in which to grow and change what may not be working in order to provide the best possible training. Finally, does the training site have the necessities (i.e., faculty, therapy rooms, and video equipment) to make training possible? Furthermore, one must consider the personal and interpersonal characteristics of trainers and trainees that also codetermine the definition and context of training. For instance, if a supervisor is structured and organized in his/her personal life, there is a good chance that the training context may also be structured and organized in a way that includes a supervision contract outlining expectations and entire context of supervision. The meaning of family therapy, therefore, depends on the above stated factors (Liddle et al., 1988).

There seems to be an unstated notion that conducting supervision is just something that one does. Often, persons take for granted how difficult it is to make the transition from therapist to supervisor because it requires a leap in thinking, skills, and role identity. Today, the subsystems of training and supervision are vital to the field of family therapy because they help to transmit values, knowledge, professional roles and skills to other clinicians by serving as vehicles through which the field grows and changes (Liddle et al., 1988). “They prepare future generations to be the representatives and developers of the field’s viewpoints, with the hope that they will move beyond their mentors in conceptual, therapeutic, and professional development” (Liddle et al., 1988, p. 4).

Supervision is defined as a process in which a “qualified therapist monitors professional development and socialization of partially qualified clinician” (Storm et al., 1997, p. 2). Supervision that is effective prepares trainees for a career in the family therapy field, improves the profession, and advances the field. Thus, supervision involves more than the transference of technical knowledge and clinical skills. It personally and intellectually challenges trainers and trainees in a context in which their best and worst styles can surface. For example, the supervisory context often provokes anxiety for both the trainers and trainees. A trainer and trainee may experience some fear of exposure in relation to their personal, interpersonal, cognitive, and professional inadequacies, such as performance anxiety, competitiveness with colleagues, and resentment due to being in the learner role. With this in mind, the supervisory process consists of shaping properties, (e.g. cognitive, affective, and behavioral) that are mutually influencing. For instance, the process of supervision shapes what one thinks, which may then result in a change of how

one feels and then chooses to behave. These properties also serve as a multifaceted piece of the broader puzzle that assists in shaping the training field (Liddle, 1988).

As in other professions, it is important for counselor educators to balance the protection of clients from impaired students with the identification of student deficiencies. However, in counseling and other mental health graduate programs, this may create tension because the training itself is unique in nature. Training aims to increase the trainee's skill in conducting therapy as well as, in many cases, to modify her or his personhood (Cohen, 1980; Schoener, 1999). There is an "intent to change the therapist's behavior to resemble that of an exemplar therapist" (Mead, 1990, p. 4). The latter task requires that counseling educators assess the students' ability to learn necessary therapy skills as well as their suitability, interpersonally and intrapersonally, within the mental health field (Olkin & Gaughen, 1991).

Trainee Impairment: Process of Identification, Remediation, and Dismissal

Next, I will review the literature regarding trainee impairment and the process of identification, remediation, and dismissal. Albert Ellis, the founder of Rational-Emotive Therapy, noted the phenomenon of impaired students during his time as a graduate student. Ellis recalled that, while his classmates were gifted intellectually, the majority admitted to entering the field of mental health as a way to attend to their own emotional problems (Ellis, 1972). Kaslow and Friedman (1984) validated Ellis' observation through their interviews with psychology graduate students. It was during their interviews that many of the students either demonstrated or disclosed significant emotional disturbances. It was concluded that these disturbances were not situational, but a result of inborn personality deficits. Khan (1974) insisted that many graduate students often make

attempts to resolve their emotional problems through graduate training in psychology. Impairment within the mental health profession has come to light only in recent times. It is possible that the performances of impaired therapists may threaten the welfare of their clients and the preservation of professional standards. The majority of the literature pertaining to impairment stems from the fields of medicine and psychology and may guide therapists in addressing the problem (Stadler et al., 1988).

Reasons to be concerned about student impairment. The concern of impairment is both short and long term. It is important to consider how the short-term concern pertaining to the student's suitability for graduate training, as well as the long-term issue about how the student's mental health, either negatively or positively, affect the outcome of therapy (Corey, Corey, & Callanan, 1993). The core concern pertains to the possible relationship between student impairment and potential harm to clients. There are a number of reasons why counselor educators and supervisors need to be concerned about this particular issue. First, therapists are mandated by ethics to do no harm and to practice nonmaleficence (Kitchener, 1984). The welfare of clients should be first and foremost. Although the goal of therapy is to strive for therapeutic effectiveness and positive client change, the minimum standard is to do no harm (Frame et al., 1995). Second, research has consistently shown the power of therapists' interpersonal influence within therapy (Beutler, Crago & Arizmendi, 1986; Childress & Gillis, 1977; Goldstein, 1971; Heppner & Dixon, 1981; Heppner & Heesacker, 1982). Depending on the therapists' emotional well-being, they can either negatively or positively affect their clients (Corey et al., 1993). Due to the power of the therapeutic role, impaired therapists who are unable to effectively perform their tasks within therapy or focus on their needs rather than the

clients' needs, may possibly inflict harm onto their clients. As a result, graduate programs and faculty members who supervise may also be held liable for the malpractice of their students (Frame et al., 1995). This point is exemplified by the 1994 lawsuit filed against the counseling program at Louisiana Tech University (LTU) (Enochs & Etzbach, 2004). In this particular case, attorneys included within their lawsuit the therapist's training institution on the basis that the institution inadequately trained the counselor. The attorney declared that "a university has an obligation…. That a person who graduates from its program is competent in the area in which the degree is bestowed" (Custer, 1994, p. 7). Although the aforementioned lawsuit was settled for $1.7 million before Louisiana Tech University was included (Kerl, Garcia, McCullough, & Maxwell, 2002), this case implies that universities that graduate therapists-in-training who may not have been properly trained and prepared to conduct therapy can be held liable for the harm the therapists-in-training inflict onto their clients (Enochs & Etzbach, 2004). This is precisely one of the reasons why those in a supervisory role must understand and take seriously their responsibilities as gatekeepers.

Gatekeeping. Within the mental health field, therapists in training are viewed as ready to treat clients because of their involvement in supervision with qualified professionals who oversee their therapeutic work (Slovenko, 1980). There is an underlying assumption that supervision is a process that serves to protect consumers from therapists who may be unskilled, inadequately trained, or just beginning and require assistance because they are in the early stages of the learning process. It is believed that one of the trainer's responsibilities is to identify trainees who may be impaired and/or

incompetent and to remediate them. On the other hand, what is commonly being practiced within the profession is somewhat different (Storm et al, 2001).

Frequently, marriage and family therapists, as well as other mental health professionals, utilize what is termed the consumer-protection argument to support regulations within each state. The implicit assumption is that supervision is a significant part of consumer protection. Typically, the supervisory process is one in which supervisees are expected to communicate with their supervisors about their cases, especially those cases that involve issues such as self-harm or harm to others. As a result of this process, one might infer that there are fewer suicides and harm to others by clients, less exploitation by therapists, and a higher level of service being offered by the profession. To the contrary, the above stated inferences rest only on faith (Storm et. al, 2001).

Furthermore, little information is known about how many trainees are not allowed to practice as well as the gatekeeping criteria used by trainers. Presently, clinical criteria that are generally recognized, accepted, and utilized by supervisors from all disciplines within the mental health field to determine whether or not graduate students should graduate from their respected programs, be recommended for membership in professional/national organizations, or endorsed for state licensure, do not exist. Even if a set of criteria were established, it is unknown whether or not trainers would be in agreement because there may be different levels of competence and competencies that trainees must possess prior to and after graduation. It appears as though supervisees are evaluated by different criteria depending on the stakeholders, such as consumers, politicians, graduate training programs, and state licensing boards. For example,

academic trainers may have different criteria for evaluating trainees in comparison to consumers and politicians. Supervisors within academic settings, for instance, are primarily focused on teaching supervisees necessary interviewing, listening, and assessment skills as well as evaluating whether or not they can apply what is being learned in clinical settings. The ultimate goal is to help supervisees in becoming competent, ethical, and self-sufficient therapists. On the other hand, consumers and politicians view supervision as a process of protection from therapists who may be incompetent, unethical, or impaired and provide little insight to how this should be achieved (Storm et. al, 2001).

Within the field of marriage and family therapy (MFT), however, the American Association for Marriage and Family Therapy (AAMFT) has collaborated with interested stakeholders to develop core competencies that licensed marriage and family therapists (MFTs) must possess in order to practice independently (AAMFT, 2004). Although the definitive goal of developing the core competencies is to enhance the quality of services provided by MFTs, the knowledge areas and necessary skills in each area that comprise the practice of marriage and family therapy are also defined. More specifically, the core competencies were structured to include both primary and secondary domains. The six primary domains include the following:

1. Admission to Treatment-includes all interactions between a therapist and his/her client prior to the establishment of a therapeutic contract.

2. Clinical Assessment and Diagnosis-focuses on the identification of presenting problems to be addressed in therapy

3. Treatment planning and Case Management-focal point is course of therapy

4. Therapeutic Interventions-activities tailored to assist client with improving presenting problems that brought him/her to therapy

5. Legal Issues, Ethics, and Standards-includes those laws, policies, principles, and mores of MFTs practicing within the field

6. Research and Program Evaluation-involves the methodical analysis of therapy and how it is carried out both effectively and efficiently (AAMFT, 2004).

It is important to note that in the primary domain, Legal Issues, Ethics, and Standards, of the AAMFT Core Competencies, *evaluative* subdomain, "marriage and family therapists must monitor attitudes, personal well-being, personal issues, and personal problems to insure they do not impact the therapy process adversely or create vulnerability for misconduct" (AAMFT, 2004, *evaluative* subdomain 5.4.2). Furthermore, in the *professional* subdomain of the Legal Issues, Ethics, and Standards domain, it states that "marriage and family therapists must consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinic work" (AAMFT, 2004, *professional* subdomain, 5.5.2)

The five secondary domains center on the knowledge and skills that MFTs must develop and possess. These areas include (a) conceptual, (b) perceptual, (c) executive, (d) evaluative, and (e) professional (AAMFT, 2004). Within the conceptual subdomain, trainers assess and determine the trainee's ability to organize therapeutic concepts and constructs in a theoretical manner (Openshaw, 2007). This frame of reference is important because it serves as the base for the trainee to be able to formulate clinical hypotheses and to inform his/her process of clinical thinking. The foundation of the perceptual subdomain is the trainee's ability to organize a compilation of concepts and constructs (e.g. viewing a system as a whole in which each part of the system is mutually influencing).

The executive subdomain pertains to the trainee's understanding of the specific laws and conduct that govern behavior, intrapersonally and interpersonally, and serves two main functions. The first function of the executive subdomain is to allow the trainee an opportunity to preview and review his/her clinical hypothesis before implementation. The second function within the executive subdomain focuses on what is necessary for the trainee to manage the client's case, whether administratively and/or managerially.

The fourth subdomain, evaluative, refers to the trainee's ability to carefully assess and appraise the significance of an event given its facts and context. For instance, if a trainee is conducting family therapy, he/she would need to be able to assess the family member's interactions with one another and ways in which these interactions may be mutually influencing. The evaluative subdomain also includes the trainee's personal plan within therapy, meaning for example, how a trainee plans to self-evaluate in order to avoid or to respond to transference and counter-transference. The professional subdomain involves those legal and ethical aspects that trainees must concern themselves with while practicing within the field of marriage and family therapy. This is also linked to the trainee's professional character as well as his/her involvement in the marriage and family therapy profession (Openshaw, 2007).

It is suggested that the field provide support for the role that supervision plays in the consumer protection plan, information as to the extent to which supervisors hinder unqualified trainees from obtaining clinical membership and/or licensure, and the criteria/methods being used to help trainers make and implement these decisions. It would be useful for stakeholders to define their definitions of competence and to agree upon what competencies should be attained by trainees during their training and after

graduation from educational programs. Knowing the criteria would assist trainers in becoming more effective gatekeepers and increase the level of credibility for the supervisory process. Two options are for trainers to join together and set criteria for new graduates or share the progress of their trainees if they transfer from one supervisor to another (Storm et. al, 2001).

In summary, not only do trainers have a responsibility to their trainees and to act in a role as gatekeepers, but they must also consider the quality of care given to clients and their ethical responsibilities to the profession and community. First, trainers are responsible for training competent and ethically sound trainees and passing on necessary knowledge and skills. Second, trainers serve as gatekeepers and at times, serving these two roles may present a conflict. An illustration of this pertains to a trainer who has invested an enormous amount of time and money into training a student who was found practicing unethically and then must take action in order to protect current and future stakeholders, such as consumers. These two roles require a careful balancing act, as each is extremely important (Storm et al., 2001).

Definition of Impairment. It seems that the term "impairment" is defined differently among the various disciplines. For instance, an impaired physician is defined by the American Medical Association (AMA) as a person who is "unable to practice medicine with reasonable skill and safety due to physical or mental disabilities, including deterioration through the aging process or loss of motor skill, or abuse of drugs or alcohol" (Robertson, 1980, p. 45). Within the fields of medicine, nursing, and social work, there are well-established definitions of impairment which offer a starting point for the field of psychology (Forrest et al., 1999). The term impairment is commonly used to

describe “the inability to deliver competent patient care resulting from alcoholism, chemical dependency, or mental illness (including burnout or the sense of emotional depletion which comes from stress)” (Kempthorne, 1979, p. 24). In addition to the medical profession, the field of psychology also defines the term “impairment”.

Within the field of psychology, the definition of impairment has gone through numerous translations since the beginning of the 1980s. During this time, the term impairment was used to identify and explain circumstances involving deficiencies in one’s performance (Forrest et al., 1999), such as a therapist who sexually exploits his/her clients. Goldenson (1984) defined mental health as “a state of mind characterized by emotional well-being, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stress of life” (p. 451). There are three main points on the psychological health continuum. It is understood that “good mental health” is at the positive end of the continuum. “Emotional distress” lies in the middle of the continuum. It is at this point in which psychological problems exist but do not impair the individual’s functioning (Frame et al., 1995). According to Nathan (1986), “a distressed professional is someone who…experiences the subjective sense that something is wrong—whether or not that feeling is associated with actual impairment in any area of life functioning including the professional” (p. 27). It was Nathan who differentiated emotional distress from “impairment.” He stated that, although “impairment” may frequently accompany distress, it does not mean that impairment is always a part of distress (Nathan, 1986). At the opposite end of the continuum is “impairment.” To date, Lamb and his colleagues (1987)

offer the most comprehensive and significant definition of "impairment" within the context of training:

> an interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior; (b) an inability to acquire professional skills to reach an acceptable level of competency; (c) an inability to control personal stress, psychological dysfunction and/or excessive emotional reactions that interfere with professional functioning (p. 598).

In order for trainers and professionals within the mental health field to develop effective policies and prevention/intervention strategies, it is imperative that a well-defined definition of impairment is devised and adhered to and the terms incompetence, unethical, and impaired are distinguished from one another (Sherman, 1996).

Throughout the years, the word impairment has been used as a broad term, but it seems as though authors have argued the semantics of impairment, incompetence, and problem. It has also been argued that the definition of impairment should include issues relating to professional behaviors that are both unethical and incompetent (Lamb et al., 1991). Through extensive work with physicians who are chemically dependent, LeClair Bissell (1983) distinguished the differences between "incompetent", "unethical", and "impaired physicians". Not only do these categories overlap, but it may also be difficult to distinguish among them. First, Bissell described the incompetent physician as one who is poorly trained and not current within the profession. Quality control and gatekeeping into the profession are issues relative to professionals who are considered incompetent. Reeducation is the resolution used most often to address problems of incompetence. Second, Bissell (1983) described the unethical physician as one who is dishonest or apathetic about the welfare of others. Bissell (1983) believes that cases involving

unethical physicians are uncommon and require disciplinary action, which may include revoking or suspending a license, loss of employment, and/or expulsion from a professional membership (Layman & McNamara, 1997). Third, the impaired physician is described as one who is ill but neither uninformed nor malevolent. Some physicians who are impaired with an irrevocable organic syndrome may not recover. On the other hand, impaired physicians with chemical dependencies and/or emotional difficulties can be expected to recover. Bissell's position is that impaired physicians are ill and should be treated in a manner that is nonpunitive and noncoercive. Bissell recommends that impaired physicians should be diagnosed and treated. Treatment may possibly involve the physician becoming a member of Alcoholics Anonymous and if needed, an appropriate treatment program (Bissell, 1983).

Unfortunately, the associated fields of psychology and psychiatry offer little clarification on this issue because their definitions of impairment are too narrow in focus (Bemak, Epp, & Keys, 1999). Psychologists define impairment as "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (Laliotis & Grayson, 1985, p. 84). The definition of impairment within the fields of psychology and psychiatry focus predominantly on diagnosable DSM-IV Axis I (American Psychiatric Association, 1994) conditions. This definition, however, does not include the more subtle, yet ominous, personality disorders often encountered in graduate students and associated with the meaning of the term "impairment" (American Psychiatric Association, 1992; Laliotis & Grayson, 1982; Stadler, Willing, Eberhage & Ward, 1988). Impaired graduate students who meet the definition of impairment by Lamb and his colleagues (1987) present a wide array of problems. Substance abuse, pronounced

personality disorders, and/or prejudicial attitudes and values are considered more blatant problems and easier to identify and address than the problems that are less obvious. Less obvious problems include insensitivity, narcissism, pathological desire to "parent", to control, to be omniscient, or to be a rescuer or savior, sublimated sexual gratification, and projected sadism (Sussman, 1992). According to Herbert J. Freudenberger (1986), "having sexual relations with clients or abusing chemicals or drugs is often a sign that an impaired professional is manifesting a feeling of omnipotence (p. 136). In the case of substance abuse, impaired professional may have the belief that they would never become addicted and would be able to handle the use of chemicals without any difficulties (Freudenberger, 1986).

Graduate students who are impaired may also incorporate personal agendas, such as religious beliefs, damaging directive techniques, or aversion towards persons of a different age group, gender, sexual orientation, or racial and ethnic background, into their philosophy of therapy. Furthermore, impaired graduate students may project their personal problems onto their clients or use the lenses through which they see their personal problems to better understand their clients' problems. A graduate trainee's unresolved problems may lead to him/her engaging in counter-transference with his/her clients. (Sussman, 1992). What may differentiate impaired graduate trainees from those who are not is their lack of insight in understanding and resolving their own personal problems so as not to hinder the process of therapy (Bemak et al., 1999). For instance, if a graduate student is having marital problems, he/she may not realize or understand the impact his/her problems may have on clinical work with clients. Robert Epstein (1997) contended that professionals within the mental health field do a substandard job of

monitoring their own mental health problems, much less those problems experienced by their colleagues. Typically, impaired professionals experience distress, but may not recognize these problems as personal impairments (Sherman, 1996). According to Stadler, Willing, Eberhage, and Ward (1988), the "obvious first step" is the clarification of impairment within the field (p. 260). It is imperative to have a clear definition of impairment because it influences the identification of problem behaviors, types of remediation being used, and reasons for dismissal (Forrest et al., 1999).

Between the years of 1975 and 1995, 10 different studies using survey methods were conducted to explore trainee impairment within three master's level programs in Clinical Psychology, Counselor Education, and Mental Health, five doctoral level programs in Clinical Psychology, Counseling Psychology, APA Clinical Psychology, APA Counseling Psychology, and APA School Psychology, and two APA internships (Bernard, 1975; Biaggio et al., 1983; Boxley et al., 1986; Bradey & Post, 1991; Gallessich & Olmstead, 1987; Levy, 1983; Mearns & Allen, 1991; Olkin & Gaughen, 1991; Tedesco, 1982; Vacha-Haase, 1995). The research focused on issues such as prevalence and type of trainee impairment in academic, as well as internship, programs and policies and procedures for evaluating trainees, especially the ways in which programs identify, remediate, and dismiss impaired trainees. One is encouraged to exercise caution when drawing conclusions from these studies due to concerns about population representation, survey construction, and the use of methods and analyses (Forrest et al., 1999).

Rates and Types of Impairment. First, the review of the research identified the rates of impairment within four different academic (Mearns & Allen, 1991; Olkin &

Gaughen, 1991) and internship (Boxley et al., 1986; and Tedesco, 1982) programs as well as types of ethical violations (Fly, Van Bark, Weinman, Kitchener, & Lang, 1997). The results suggested that 66% to 95% of the programs reported having one impaired trainee during the past five years with an annual impairment rate that varied from 4.2% to 4.8% (Forrest et al., 1997). The common forms of impairment identified in several of the studies (Boxley et al., 1986; Olkin & Gaughen, 1991; and Vacha-Haase, 1995) were clinical deficiencies, interpersonal problems, problems within supervision, depression and personality disorders. An example specific to clinical deficiencies may pertain to a graduate trainee who is struggling with the ability to apply learned clinical skills in a therapeutic setting. Furthermore, problems within supervision may occur when a trainee is not receptive to constructive feedback, does not follow directions such as getting a "No Suicide Contract" signed as requested, and minimal self-assessment. Although the study conducted by Weinstein (1983) focused on medical students who attended therapy at their university counseling center, one may relate the results to trainees within the mental health profession. The results indicated that 38% of the medical students being seen at the counseling center were experiencing depression secondary to academic stressors and disenchantment. The primary concern that led to the depression was burnout (Bennett, 1986).

In 1997, Fly and his colleagues conducted a qualitative survey using a critical-incidents technique in order to determine the types of ethical violations made by psychology graduate trainees. The 89 incidents of ethical violations were placed into the following eight different categories with percentages of ethical transgressions: (a) confidentiality (25%), (b) professional boundaries-sexual and nonsexual (20%), (c)

plagiarism or data falsification (15%), (d) student welfare (10%), (e) procedural violation resulting in ethical repercussions (10%), (f) competency (9%), (g) integrity, such as dishonesty (8%), and (h) credential misrepresentation (3%). In reference to the category professional boundaries-sexual and nonsexual, the authors discussed one incident in particular in which a student in his/her practicum phase of training invited a client, who was visibly depressed and lonesome, to his/her apartment over the weekend in the event that the client happened to be depressed or lonesome. One of the above stated categories that may not seem as self-evident is the impairment pertaining to a procedural breach that resulted in ethical repercussions. More specifically, this category focused on incidents in which the student failed to comply with policies, rules, or standards set forth by the department, graduate program placement, or clinic. The article cited a particular incident in which a student took a client's chart home in order to work on case notes. Removing records from the clinic site was in direct violation of the facility's policy.

In addition to the medical profession, professionals within the field of mental health have also had vast experience in studying distress and impairment problems. For instance, during the annual convention held in 1981 by the American Psychological Association, the open forum focused on impairment (Stadler et al., 1988). The problems mentioned most frequently pertaining to impaired psychologists were identified as handicaps, emotionally and physically, substance abuse, sexual contact with clients or students, mental illness, and suicide (Thoreson, Nathan, Skorina, & Kilburg, 1983). According to Freudenberger (1986), since some of the clients he worked with had this strong desire to feel needed, they "rationalized taking drugs as doing something for themselves" (p. 138). The author also indicated that other clients he worked with began

using narcotics in order to resolve their feelings of exhaustion. On the one hand, they expressed a great sense of dedication but on the flip side, they denied the fact that their substance abuse may in fact lead to further devastation.

In a recent study conducted by Russell and Peterson (2003), faculty provided descriptions of their "most troublesome" student (p. 332). Specific problem descriptions included the following: (a) inability to accept feedback from supervisor; (b) duplicity; (c) depression; (d) unprofessional and/or ineffective behavior, such as racist and sexist comments made to colleagues, deficient boundaries with clients, and missed clinic appointments; (e) ethical dilemmas, such as not completing case notes or following guidelines for maintaining confidentiality; (f) decrease in academic performance; (g) substandard clinical skills; (h) eating disorders; (i) alcohol abuse; and (j) thought disorders, such as suicidal ideation as well as impaired decision making and impulse control. It was reported that one student even committed suicide (Russell & Peterson, 2003). In the pursuit to learn more about the reasons there seems to be a higher rate of suicide among psychiatrists (Freudenberger, 1986), Chessick (1978) suggested that the higher rate of suicide among psychiatrists may be explained by certain demands and expectations that professionals within the mental health profession face on a daily basis, such as the need to feel needed within the profession and community, truth seeking, and the need to belong to something that is of much greater value than one's life, individually. Furthermore, in a study conducted by Deutsch (1984), psychotherapists reported that the most stressful events encountered at work pertain to their clients' suicidal ideations and the perception that they are unable to help those clients who are experiencing acute distress.

In addition, impairment may also be manifested in the following ways: personal conflict (Laliotis & Grayson, 1985), job stress and burnout (Maslach, 1986), and emotional demands of graduate school (Millon, Millon, & Antoni, 1986). With respect to the emotional demands of graduate school, not only must therapists-in-training juggle the day-to-day responsibilities within their personal and professional lives, but they are also required to achieve a level of clinical and academic competence. Since all of these demands take considerable time, energy, and emotional sacrifice (Millon, Millon, & Antoni, 1986), it would seem that impairment could potentially result if therapists-in-training are not effectively balancing their personal and professional lives, especially the pressures and demands placed upon them while attending graduate school. Furthermore, Farber and Heifetz (1982) asserted that when problems are surpassed by "intolerable working conditions or by unusually stressful therapeutic work…personal pressures may intensify drastically, and stressors may appear disproportionate to satisfaction, and burnout may occur" (p. 298). Lastly, impaired therapists may display behavioral indicators, such as an inability to concentrate, mood swings, arrogant and insensitive remarks made to family members and/or clients due to feelings of irritability, inability to keep schedules organized, decline in grooming and attire, and display of unprofessional behavior, such as difficulties with colleagues and disclosing personal information regarding their problems to clients and/or students (Freudenberger, 1986).

Whether focusing on the medical, legal, or mental health profession, information obtained from the literature seems to indicate that impairment is a widespread problem and issue of concern. In addition, the literature seems to suggest that not only do the types of impairment vary anywhere from ethical violations to substance abuse but that

impairment may be manifested in various ways, whether academically, emotionally, and/or behaviorally. Being aware of this information is essential for all educators so that they may begin to identify and evaluate those students displaying behaviors that may be considered impaired.

Evaluation. Within graduate programs, the evaluation process should typically include three different phases. The first evaluation phase occurs at admission when graduate programs base a student's acceptance into the program on undergraduate grades, standardized test scores, personal interviews, letters of recommendation, autobiographical essays, and experiences prior to admission (Bradey & Post, 1991). However, many counselor educators do not believe that the admission criteria stated above effectively screen out those students with psychological impairments and may even allow them to go undetected (Bradey & Post, 1991; Grayson, 1982; Gimmestad & Beard, 1973; Jones, 1974; Markert & Monke, 1990; Redfering & Biasco, 1976; Young, 1986).

The second phase of student evaluation should occur on an annual basis to determine if the student is learning and has the ability to apply what has been learned and, in addition, to develop a remediation plan if any clinical/academic deficiencies exist. One of the problems identified in the literature is that some training programs do not conduct annual performance evaluations on their trainees (Bernard, 1975; Biaggio et al., 1983; Bradey & Post, 1991; Olkin & Gaughen, 1991; Vacha-Haase, 1995). Across five different studies, 35% (Bernard, 1975) to 100% (Biaggio et al., 1983) of programs reported that they conduct evaluations on an annual basis. With regards to criteria used for evaluations, little information is available (Forrest et al. 1999). Only two empirical studies were found that studied the criteria used by programs to evaluate their trainees

(Biaggio et al., 1983; Olkin & Gaughen, 1991). According to the study, conducted by Biaggio and his colleagues (1983), only 29% of the master's and doctoral level clinical psychology programs reported evaluating ethical behavior. On the other hand, 80% of the master's level clinical programs (i.e. clinical/counseling psychology, counseling, marriage and family, counselor education, community psychology, and child psychology) in the study conducted by Olkin and Gaughen (1991) reported evaluating ethical conduct. The findings from these two studies suggest that many of the programs do not evaluate their trainees on a regular basis in critical components relating to professional performance, such as assessment, interpersonal skills, and ethical conduct. According to Forrest et al. (1999), graduate training programs may find themselves vulnerable in identifying problem trainees in a timely manner if they are not routinely evaluating trainees on the critical components stated above. Consequently, this may also result in a delay in efforts to identify graduate trainees displaying problem behaviors and to implement remediation plans.

In addition to evaluating therapists-in-training on an annual basis, graduate training programs should also utilize summative evaluations prior to graduation in order to determine if the graduate trainee has competently completed the program and if the program further endorses the graduate trainee in furthering his/her career in the mental health profession (Lamb, 1999).

As mentioned previously, the case involving Louisiana Tech University seems to imply that universities may be vulnerable to litigation for the harm their therapists-in-training inflict onto their clients after graduation if they had been inadequately trained, therefore, ill prepared to conduct therapy (Enochs & Etzbach, 2004). Based on this case

alone, it is imperative that graduate trainees are evaluated prior to graduation to determine if they have met both the clinical and academic requirements set forth by their respective programs. For instance, within the field of Marriage and Family Therapy, the accreditation standards of the American Association for Marriage and Family Therapy states that "student performance in both coursework and clinical practice is evaluated by faculty and supervisors and reflects achievement of expected outcomes. Evaluation policies and procedures are defined, published, and consistently applied" (AAMFT, COAMFTE Standard IV-A, 2005, p. 12). Although the accreditation standards do not specifically state that an evaluation must be conducted before therapists-in-training graduate, it does indicate, however, that programs must "provide evidence that the program's graduates have achieved the competencies congruent with the combination of the elements of the Professional Marriage and Family Therapy Principles the program has adopted" (AAMFT, COAMFE Standard IV-3, 2005, p. 13).

According to the authors Michael O'Sullivan and Richard Gilbert (1989), if graduate training programs fail to evaluate therapists-in-training on an ongoing basis it does the profession a disservice in various ways. First, it does a disservice to the public by allowing therapists-in-training who may not be cognizant of their deficiencies to enter the mental health profession. Consequently, the mental health profession's reputation may be undermined. Furthermore, it does a disservice to the state licensing boards because they would then be placed in the position of identifying and screening out those individuals whose deficiencies would not qualify them from practicing within the mental health profession (O'Sullivan & Gilbert, 1989).

Without established criteria for character, presentation, and emotional adjustment, graduate programs depend primarily on evaluations pertaining to academic performance that is inexact and misleading as a measure in which to screen those therapists-in-training who wish to pursue a career in the mental health profession which is clinically oriented (Bemak, Epp, & Keys, 1999). As a result, a small number of counselor educators have recommended that the current approach to training and evaluation be more rigorous and clinical in nature (Bradey & Post, 1991; Lamb, Cochran & Jackson, 1991; Lamb et al., 1987) so that faculty may be able to identify graduate trainees who are experiencing emotional and academic difficulties as well as clinical deficiencies that may deem them incompetent to practice therapy (Bradey & Post, 1991). Yet, despite this opinion, Bradey and Post (1991) reported that only 13% of counselor programs in the United States have formal identification and dismissal procedures.

The ethical guidelines from the American Counseling Association (ACA) called upon graduate training programs to engage in a self-monitoring process (Bemak et al., 1999). The ACA requires counselors to discontinue conducting therapy if it is possible that their physical, mental, or emotional problems will harm clients (ACA, 1995, Section C.d.g.). Likewise, the Association for Counselor Educators and Supervisors (ACES) Ethical Guidelines for Counselor Educators and Supervisors (ACES, 1993) requires that educators within graduate programs monitor the personal limitations of their graduate trainees that could possibly affect their professional work, provide remediation, and terminate from the program if/when necessary (Bemak et al., 1999). Within the field of Marriage and Family Therapy, it is with expectation that "marriage and family therapists seek appropriate professional assistance for their personal problems or conflicts that may

impair work performance or clinical judgment" (AAMFT Code of Ethics, 2001, Principle III-Professional Competence and Integrity, section 3.3). Furthermore, throughout the supervisory process, MFT approved supervisors are required to evaluate the development of their supervisees on a regular basis and consider issues, such as whether personal, ethical, and/or legal concerns have materialized during supervision, therefore, needing to be addressed (AAMFT, 2002).

In addition to evaluating graduate trainees throughout the entire educational and training process, graduate training programs must also have shared views regarding the criteria to be used and how to evaluate their trainees according to the set criteria in order to be effective. One way in which training programs should evaluate the performance of supervisees is to guide themselves by professional codes of conduct (Bradey & Post, 1991; Claiborn, 1982; Frame & Stevens-Smith, 1995; Lamb et al., 1987; Nagy, 1989; Olkin & Gaughen, 1991; Skorupa & Agresti, 1993; Stadler et al., 1988; Vacha-Haase, 1995). Ethical standards and codes of conduct mandate that trainers evaluate the trainee's performance so that trainees do not misuse their influence, harm their clients, or allow their personal problems to impede their functioning while working with clients (Forrest et al., 1999). Therefore, programs must implement the following components into the evaluative process: (a) trainers must provide effective feedback to trainees; (b) trainers must base performance on specific guidelines such as ethical standards; (c) trainers must conduct performance reviews by providing either verbal or written evaluations; and (d) evaluations should focus on assessment, ethical conduct, interpersonal skills, knowledge/application of professional standards, competency, and personal functioning (Forrest et al., 1999). According to information obtained from the literature, it seems that

it is necessary that educators within graduate training programs utilize programmatic evaluation guidelines as well as professional codes of conduct as a guide when attempting to identify and respond to student impairment throughout the entire educational training process.

One program in particular seems to incorporate some or all of the above stated components in the evaluative process. At Southwest Texas State University, the counseling faculty developed the Professional Counseling Performance Evaluation (PCPE) (Kerl, Garcia, McCullough, & Maxwell, 2002) to evaluate the performance of graduate trainees and to establish a more formal structure in which to identify and respond to student impairment as well as to meet due process requirements (Lumadue & Duffey, 1999). Using a 3-point Likert-type scale to rate each criterion, PCPE is used to evaluate graduate trainees on fundamental skills such as communication, counseling, ethics, personality or behavior qualities (e.g. empathy, impulse/anger control, maturity level, professional conduct, and observance of ethical guidelines) that may impede the graduate trainees' ability to provide quality care to their clients. The faculty at Southwest Texas State University may use the PCPE in all classes, whether "didactic" or "experiential" (Kerl et al., 2002, p. 328). The faculty members note in the syllabi that if a graduate trainee receives a poor evaluation on the PCPE (i.e. one or more scores of 0), he/she will fail the course regardless of the letter grade assigned for work that has been completed orally or written. If the graduate trainee does not meet the criteria set forth by the PCPE, the faculty member will inform the student during an individual meeting. It is during this individual meeting with the student that the faculty member may initiate a remediation plan. For more serious concerns, such as illegal or unethical behavior or

behavior that is persistently problematic or has been resistant to remediation, the graduate trainee would be referred to the faculty review committee (FRC). The FRC consists of three faculty members within the counseling program who have been referred by fellow colleagues and appointed by the chair of the department. The faculty member who referred the student as well as the student will both meet with the FRC on an individual basis to discuss their concerns. The majority of the time, the cases referred to the FRC result in a remediation plan that is developed with input from the referring faculty member, FRC, and graduate student. If the graduate trainee does not agree with the FRC's decision, he/she may submit an appeal to the chair of the department and then to the dean of the college. The dean, who makes the final decision, reviews the FRC's recommendation and provides assurance that all procedures have been appropriately followed and actions were not arbitrary (Kerl et al., 2002).

The concern that presents the most difficulty is how to evaluate and remediate with sensitivity those graduate trainees displaying psychological problems and/or personality deficits, yet performing fundamental counseling skills in a competent manner. It is during the practicum and internship phase that students typically receive intensive individual and group supervision. If, during this time, unresolved intra/interpersonal issues surface, the faculty and/or clinical supervisor will recognize and address them (Bemak et al., 1999). It is entirely possible that during the practicum and internship phase, graduate programs may guide themselves through the identification and remediation process by utilizing the evaluation tool and course of action developed by the Southwest Texas State University. With regard to remediation, specific interventions may vary from leaves of absence for personal growth or psychotherapy (Bemak et al., 1999).

The identification process is a time in which faculty members within graduate training programs assess the development of graduate trainees by utilizing the criteria and procedures developed by their respective department and communicate with one another when concerns pertaining to a particular student arise to determine the next course of action (Bemak & Keys, 1999). There are only two studies that focused on what occurs after the identification of trainee impairment. Olkin and Gaughen (1991) reported that within master's level graduate programs in mental health (i.e. clinical/counseling psychology, counseling, marriage and family, counselor education, community psychology, and child psychology), less than half of the trainees identified as impaired are given a remediation plan in order to resolve the concerns noted by faculty. In contrast, the results from the study conducted by Biaggio and his colleagues (1983) revealed that 88% of the doctoral and 73% of the master's level clinical psychology programs give the trainees a warning and an opportunity to change. In reference to the types of remediation, the results of three studies indicated that most programs used personal therapy as a remediation method (Kaczmarek & Conner, 1998; Olkin & Gaughen, 1991; Vacha-Haase, 1995). Olkin and Gaughen (1991) seemed to believe that recommending personal therapy may be a suitable option if the therapist-in-training is experiencing inter/intrapersonal difficulties, such as in a case involving a graduate trainee who may be experiencing suicidal ideations and requires preventive and supportive services outside of the program (Russell et al., 2007). Furthermore, it may be perfectly appropriate for graduate training programs to encourage all of their therapists-in-training to attend personal therapy as an additional piece to their training experience (Russell et al., 2007). However, Olkin & Gaughen (1991) also indicated that recommending personal therapy

has disadvantages. Bemak, Epp, and Keys (1999), cautioned that there is a danger in making a recommendation that is therapeutic in nature. They contended that no matter how the directive for psychotherapy is delivered, the graduate student may misconstrue the recommendation as degrading or intrusive, especially if it involves a matter that is personal in nature. Furthermore, graduate trainees may not be receptive to opening up to a therapist if they feel as though what they say may place them at risk for being dismissed from their program. This presents somewhat of an irony in that impaired graduate trainees frequently shun or refuse to submit to the therapeutic process through which they guide their clients (Bemak et al., 1999). In addition to the graduate trainees misinterpreting the recommendation to attend therapy as degrading and intrusive (Bemak et al., 1999), there also exists ethical issues involved in using personal therapy as a form of remediation (Ford, 1979; Hassenfeld & Lavigne, 1987; Jensen, 1983; Lamb et al., 1987). These ethical issues include resistance to therapy, concern for privacy, conflict between mandating and recommending therapy, and conflict between the graduate trainer's gatekeeping responsibility to the trainee and program.

In addition to recommending personal therapy as a remediation method, additional remediation interventions may include repeat coursework, repeat practicum, leave of absence, increased supervision, and extra coursework (Lamb et al., 1987). In 2003, Russell and Peterson (2003) conducted a study that included all COAMFTE accredited marriage and family therapy programs. The research study addressed the indicators program directors use in order to identify impairment, the amount of time that faculty must devote to problem trainees, and the frequency in which student dismissal occurs within the program. Just focusing on remediation, the methods chosen most often

by research participants were therapy referral, increase in supervision, leave of absence, increase in contact with advisor, and repeat coursework. Although chosen less often, participants also opted for the following remediation methods: (a) extra coursework, (b) tutoring, (c) seminars, (d) peer support groups, (d) particular assignments, and (e) referral to the ombudsperson. Furthermore, respondents generated a number of different remediation methods, such as meeting with the trainee in order to discuss concerns, signing a remediation letter by faculty member and trainee, conducting cotherapy, "shadowing" by a fellow colleague and mentor, and starting the "counseling out process".

Most recently, Russell, DuPree, Beggs, Peterson, and Anderson (2007), conducted a survey that included supervisors from COAMFTE accredited master's level programs. Participants were provided with vignettes that portrayed gatekeeping and remediation difficulties supervisors may encounter when working with graduate trainees. Participants were then asked to choose from the remediation options provided and to give an explanation for their response selection. Additionally, telephone interviews were conducted with three of the participants to further inquire about how decisions are made within the process of supervision. According to the results, the remediation methods chosen most often were to "have a conversation with student about perceived problem" and to "discuss problem with other faculty" (Russell et al., 2007, p. 235). The purpose of doing so is to better understand the context of the trainee's problem behavior and to consult with fellow colleagues prior to determining what the next intervention step should be (Russell et al., 2007). These two remediation interventions were followed by beginning due process and increasing interactions with the therapist-in-training which included direct observation, supervision, and informal communication/interaction. The

more severe remediation methods, such as dismissal, probation, and filing a complaint with the ethics board, were chosen by participants for the vignette depicting duplicity (Russell et al., 2007).

Prior to determining what type of remediation needs to be implemented, it is important that the graduate trainers conduct a meeting to make certain that all concerns have been expressed and noted and then to determine as well as to agree upon what changes need to be made so that the decisions are made by the faculty as a whole rather than one individual faculty member (Lamb et al., 1991). Based on the identification and evaluation process at the Southwest Texas State University, faculty may also involve the therapist-in-training in the discussions so that his/her perspective regarding the situation may be shared and if needed, to provide necessary input regarding what types of remediation methods he/she deems most appropriate and effective given the situation (Kerl et al., 2002). It is important for graduate trainers to not make exclusions just based on the suspicion of a graduate student's emotional problem or not to allow the student an opportunity to make improvements (Bemak et al., 1999). The authors, Bemak, Epp, and Keys (1999), contend that it is essential for graduate training programs to be based on the assumption that graduate trainees can change and develop. It was suggested by Porter (1994) that the same considerations therapists take into account when determining and distinguishing whether or not the presenting problems experienced are unique to the clients or may possibly stem from differing cultural, ethnic, and socioeconomic backgrounds must also be kept in mind when assessing impaired graduate students. For instance, one may infer from the following example that if a graduate trainee is consistently late to his/her scheduled therapy appointments with clients and turns in

academic assignments late which has had a negative effect on his/her clinical and academic performance, it is very important that the supervisor and/or graduate training program determine if this problem is unique to the student or stems from his/her cultural background as some cultures may not view tardiness as a problem.

Some of the literature has focused on the legal risks associated with rehabilitating impaired practitioners (Jorgenson, 1995). At the present time, it would appear that, if a student is deemed impaired, the graduate programs or institutions should follow a standard of care in which a qualified professional, not associated with the program/institution, conducts the independent evaluation. The advantage of requesting an evaluation from a qualified professional outside of the graduate program is that the independent evaluator will be able to conduct an evaluation that is impartial. On the other hand, if a faculty member were to conduct the evaluation, he/she would be in two positions, one of teacher and one of evaluator which would be considered a dual relationship (Schoener, 1999). “It is no longer sufficient to simply guess at what the trainee needs, for example, by referring them for therapy. The student’s limitations as a practitioner must be ascertained” (Schoener, 1999, p. 2). Cobia and Boes (2000) recommended that this may be accomplished if supervisors incorporate both a “professional disclosure statement” and a “formal plan for supervision” in order to minimize any potential ethical conflicts, provide informed consent, uphold the law of due process, and protect the trainee’s right to confidentiality during the process of supervision (p. 293). According to Cobia and Boeas (2000), the statement of disclosure is a document that supervisors may use to outline all of the services being rendered throughout the process of supervision, such as the rights and responsibilities of the supervisor and

supervisee, supervision limitations, evaluation tools, and the possible risks as well as benefits of taking part in supervision (Disney & Stephens, 1994; McCarthy, Sugden, S., Koker, M., Lamendola, F., Maurer, S., & Renninger, S.; and Storm & Haug, 1997). The plan of supervision, on the other hand, may be described as "an individualized learner contract (Cobia & Boes, 2000, p. 293). The supervision plan outlines the supervision goals agreed upon by both parties, the evaluation tools that will be used to track progress, when evaluation will occur, and the responsibilities of both parties if the supervision goals are not met (Tanenbaum & Berman, 1990).

Although it was indicated by some professionals that therapy was helpful, there is no compelling evidence from the research stating that referring an impaired therapist for psychotherapy will make a difference (Schoener, 1999). Research studies pertaining to harmful therapy experiences of professionals within the mental health field have been less than encouraging (Grunebaum, 1995, 1986). Henry Grunebaum conducted a study in which mental health professions from various disciplines (i.e. social work, psychology, psychiatry, and other professions within mental health) were interviewed and encouraged to describe their experiences within personal therapy including any specific events deemed detrimental. Based on the results, "the harmful therapies were therapies characterized as distant, cold, unengaged, and lacking in 'human quality', or therapies characterized by intense emotional and/or sexual involvement" (Grunebaum, 1986, p. 165). According to the author, Gary Richard Schoener (1999), personal therapy is not a sensible answer under the Americans with Disabilities Act unless an assessment has been conducted to determine whether therapy would be helpful and what type of therapy would be beneficial. According to Frame and Stevens (1995), a graduate trainee who is

deemed impaired by faculty could claim a disability under the Americans with Disabilities Act. The Americans with Disabilities Act

> gives civil rights protections to individuals with disabilities similar to those provided to individuals on the basis of race, color, sex, national origin, age, and religion. It guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, state and local government services, and telecommunications (U.S. Department of Justice, The Americans with Disabilities Act, 1990)

Therefore, graduate trainees must be provided with the necessary accommodations and given the chance to strive and meet the professional standards set forth by their respective graduate training programs if they make a claim that the impairment in question is a direct result of their disability. Furthermore, the Rehabilitation Act of 1973, "provides that reasonable accommodation is made for persons with a disability and stipulates that modifications of academic requirements may be necessary to ensure that a qualified person is not discriminated against due to a disability" (Forrest et al., 1999, p. 660).

Unfortunately, the step that is missing often is the evaluation process which must be conducted by someone other than faculty members. The author and his colleagues receive referrals from employers and training directors to conduct evaluations and assessments (Schoener, 1999). The evaluations and assessments followed the same approach used by Schoener (1995) during his work with professionals who have engaged in sexual boundary violations with clients. Schoener's approach involves the collection of extensive data compared to the information typically gathered during a psychological assessment. For instance, the following data may be obtained: information from interviews with training director and faculty members, student's or employee's file, work history, and interviews with family members. Testing and interviewing the graduate trainee or employee is only a piece of the information used to determine what type of

rehabilitation is needed. Upon completion of the rehabilitation process, a reevaluation is conducted by the independent evaluator to determine or plan the individual's reentry into his or her respective program or job. "To assume that the choice of therapy, or therapist, can be done without any evaluation overlooks one of our most important and unique skills as psychologists" (Schoener, 1999, p. 4). Furthermore, teaching faculty cannot assume that a student therapist will have the ability to determine what is wrong. Schoener's work suggests that therapists typically address what the students want to talk about, rather than the school or work-related problems that actually brought them into therapy (Schoener, 1999).

In summary, the evaluation process is an extremely important component for graduate training programs to guide themselves by when attempting to identify and assist graduate trainees who may be displaying problem behaviors. Based on the literature, the process of evaluation within graduate training programs must take into consideration the gatekeeping responsibilities of faculty and graduate programs as well as due process by including necessary elements, such as established criteria for evaluating the students' academic and clinical performance and the process in which to provide feedback to students throughout their training. Once the problem behavior has been identified, the type of remediation method should be determined based on the concerns of faculty members and the needs of trainees as opposed to just making an assumption. Schoener (1999) does caution, however, that faculty may want to consider using a professional not affiliated with the program to conduct an impartial evaluation so that faculty do not place themselves in a compromising position which is one of educator and evaluator.

Dismissal. The decision to dismiss is the final and most stressful way in which trainee impairment is managed (Forrest et al., 1999). This decision is difficult to make for persons within the mental health profession because their primary responsibility is to support and facilitate the growth of others. This is especially true for those who work closely with the trainees during the remediation process (Gizara, 1997) and want to protect them from the personal and professional consequences associated with being asked to leave a program (Hahn & Molnar, 1991). If graduate trainers are faced with the decision to dismiss a trainee, they may feel as though it reflects on their abilities as a professional (Gizara, 1997). For example, from a systemic perspective, if a graduate trainer is faced with the difficult decision to dismiss a student, he/she would not place blame. Instead, the graduate trainer would carefully examine the role his/her teaching and supervising may have contributed to the problem.

The decision to dismiss occurs when trainees have been evaluated as not meeting professional standards and they have participated in the remediation process but do not make the necessary improvements. Some of the dismissal literature is obtained from seven studies. Five of the studies focus on dismissal information from a variety of academic training programs, such as master's level counselor education and clinically oriented programs in mental health, doctoral level counseling psychology, and doctoral level APA clinical, counseling, and school psychology programs (Bradey & Post, 1991; Fly et al., 1997; Gallessich & Olmstead, 1987; Olkin & Gaughen, 1991; Vacha-Haase, 1995) and two from APA internship training programs (Boxley et al., 1986; Tedesco, 1982). Fifty-two percent (Vacha-Haase, 1995) to 86% (Biaggio et al., 1983) of programs report the dismissal of at least one trainee every 3 to 5 years. In summary, the dismissal

rates for impaired trainees varied from 12% to 22% (Forrest et al., 1999). Furthermore, four percent to 24% of the attempted dismissals were contested (Forrest et al., 1999) thorough avenues such as the university's formal grievance process (Bradey & Post, 1991) or the process of litigation (Tedesco, 1982).

The reasons for dismissal in both academic and internship programs (Biaggio et al., 1983; Bradey & Post, 1991; Gallessich & Olmstead, 1987; Vacha-Haase, 1995; Tedesco, 1982) include poor performance clinically, interpersonally, and academically, unethical behavior such as breaching a client's confidentiality, and psychological problems including emotional instability, personality disorders, psychopathology, and unprofessional behavior. Of course, if the trainee cooperates by withdrawing from the program, the dismissal process will not have to be implemented (Knoff & Prout, 1985). If the "counseling out" process is unsuccessful, the subsequent step would be for the faculty to propose a more formal dismissal which involves the graduate trainee being notified in advance in written form of the reasons surrounding the possible dismissal so that the graduate trainee may prepare a response to the written notification and request that his/her case go up for review. During the formal review process, the graduate trainee will have the opportunity to present his/her case regarding the concerns in question. Once a decision is made, a formal recommendation would be sent to the academic administrator within the college or university (Knoff & Prout, 1985).

In the meantime, there exist numerous barriers to the dismissal process. These barriers include the following: (a) discrepancy between academic and clinical performance; (b) no evidence to support decision to dismiss; (c) dismissal procedures that are inadequate to support decision to dismiss; (d) emotional distress experienced by

faculty and others involved; and (e) fear of legal consequences (Bernard, 1975; Boxley et al., 1986; Bradey & Post, 1991; Gizara, 1997; Lamb et al., 1987, 1991; Vacha-Haase, 1995). First, faculty may have reservations about giving a poor evaluation to a student who excels on papers and examinations but displays deficiencies in other areas of professional development (Bemak, Epp, & Keys, 1999). Second, according to Olkin and Gaughen (1991), approximately half of the clinically oriented master's level graduate training programs that participated in the study did not have policies and procedures that were written. One-third of these programs did not discuss evaluations with graduate trainees on a regular basis, and when evaluations were communicated, they were done so verbally and not in written form. The authors eloquently stated that "from a programmatic perspective we are undermining our own efforts-if we wish to dismiss a student we may well be forced to abandon our efforts because we have not laid the necessary groundwork to show compliance with due process" (Olkin & Gaughen, 1991, p. 285). Third, graduate faculty and clinical supervisors may be reluctant to pursue remediation or dismissal proceedings and hesitate to deny or delay graduation if the student is in the practicum/internship phase and near graduation. One reason may be that faculty members do not want to interfere except in the most extreme cases because they are aware of the amount of time, effort, and money put forth by students in pursuing their future career (Bemak et al., 1999). Finally, instances have occurred in which counselor educators have allowed impaired graduate students to graduate because either formal procedures to address student impairment were not established or the cost, time, demands, and documentation required for litigation following a dismissal were being avoided (Bemak et al., 1999). The fear of litigation also serves as a barrier (Tedesco,

1982). For instance, one APA internship program that participated in the study conducted by Tedesco (1982) indicated that although the process of failing the intern due to incompetence had already begun, it was thwarted due to the intern contacting and involving an attorney who used tactics to intimidate administration into not continuing to pursue dismissal. The attorney's efforts to intimidate were successful.

Most of the professional "gatekeeping" is performed at the informal level in which impaired graduate students are advised to choose another course of study (Bemak et al., 1999). A study, conducted by Gaubatz and Vera (2002), investigated whether a program's formal gatekeeping process and program-level characteristics, such as the ratio of faculty that are part-time compared to full-time, influenced the rate at which impaired graduate trainees graduated from their respective counseling programs. Approximately 118 faculty members reported that educators in the counseling profession are confronted by pressures to avoid investigating those graduate trainees who may possibly be impaired due to litigation concerns or apprehension about the possibility of receiving teacher evaluations from graduate trainees that are compromised. On the other hand, faculty members in programs accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and/or in programs with gatekeeping procedures that are formal seemed to follow through more effectively with their concerns about graduate trainees showing any deficiencies. This is due to the accreditation standards set forth by CACREP which supports quality training provided by an institution/profession (Gaubatz & Vera, 2002). Although faculty members seemed to extensively agree that if there is a poor fit between graduate programs and graduate trainees, graduate trainees should be screened from their training programs, the literature

suggests that many faculty members may be unhurried in addressing potential student deficiencies (Bradey & Post, 1991; Gibbs, 1994; Olkin & Gaughen, 1991; Vacha-Haase, 1995; Wheeler, 1996; Younes, 1998). Possible reasons for the slow response on behalf of graduate trainers may include lack of familiarity with their specific program's procedures in responding to student deficiencies, uncertainty with screening nonacademic problems, such as mental health concerns (Bradey & Post, 1991), and the time and stressors involved in identifying and remediating graduate trainees displaying deficiencies (Olkin & Gaughen, 1991).

Graduate trainees displaying deficiencies may be more common than formerly thought (Gaubatz & Vera, 2002). While research has suggested that between 4% and 5% of therapists-in-training may lack interpersonal competence or psychological wellbeing to effectively work with their clients, it is important to consider that these figures only reflect those graduate trainees who are actively screened out by faculty members. There is a convincing reason to be concerned about the considerable number of other students who are deficient and may graduate from their respective training programs unaffected by gatekeeping procedures (Forrest, Elman, Gizara & Vacha-Haase, 1999; Woodyard & Canada, 1992). This concern, in particular, is supported by a comparison of data from separate although related studies (Gaubatz & Vera, 2002). For instance, it was reported by 93% to 95% faculty and graduate trainees within APA internship, doctoral level APA Clinical Psychology, and master's level clinically oriented mental health graduate programs that they have observed impaired graduate trainees within their programs. Furthermore, within only 66% to 76% of programs have faculty members reported their programs actually remediating or dismissing impaired graduate trainees (Boxley, Drew,

& Rangel, 1986; Mearns & Allen, 1991; Olkin & Gaughen, 1991). This discrepancy seems to suggest that there may be more impaired graduate trainees than those with whom faculty members actually intervene (Gaubatz & Vera, 2002). This finding is augmented by a survey conducted by Wheeler (1996) with British counselor educators. Wheeler's survey found that 44% of counselor educators reported allowing student counselors to pass although they would consider the graduate trainees to be inapt.

Probably one of the most critical aspects involved in dismissing trainees, legally and conceptually, is due process. Citizens are guaranteed due process under the Fourteenth Amendment in which they shall not be "deprived of the right to a liberty or property interest without benefit of the protection afforded by due process" (Forrest et al., p. 655). Previously, due process cases involved primarily medical students but now, it is also being applied to training in psychology and other mental health professions. In order to understand the implications of due process, one must take note of two principal distinctions. The first distinction is that due process in education pertains to academic as well as disciplinary dismissals. Although the decisions pertaining to disciplinary dismissals only have a small bearing on the termination of graduate trainees within the field of psychology, they do provide a foundation that is both historical and precedent-setting with regard to due process (Knoff & Prout, 1985). For instance, the disciplinary case, *Dixon v. Alabama State Board of Education* (1961), involved students at Alabama State College being dismissed from the program due to breaching the program's codes of conduct regarding demonstrations. The court's ruling did not uphold the students' dismissals due to the law of due process (Knoff & Prout, 1985) which will be discussed below in further detail.

The second distinction relates to the difference between two types of due process, substantive and procedural. The term, "substantive due process," means that the criteria and procedures of training programs must be consistently and fairly applied. On the other hand, "procedural due process" "requires that the individual being deprived of a constitutionally protected interest receive proper notice" (p. 657). Providing trainees with proper notice entails notice about academic rules, deficiencies in performance, and opportunities for them to be heard. Legal evidence suggests that, if faculty properly handled the due process well, the courts will uphold their decision to dismiss (Milam & Marshall, 1987). For example, one case in particular that further supported previous rulings related to student dismissal was *Harris v. Blake and the Board of Trustees of the University of Northern Colorado* (1986). In this case, Blake, who was the graduate psychology professor of Harris, advised that he not register for practicum on the grounds that the deficiencies (e.g. inattention and lack of interpersonal skills, such as genuineness, empathy, and effective listening) observed with both his clients and fellow colleagues were considered incompetent and unethical (Frame et al., 1995). It would be beneficial to graduate programs if faculty implemented judicial decisions, such as the case mentioned above, as well as their implications as a way in which to screen, assess, and respond to student impairment so that both ethical and legal matters are being addressed (Frame et al., 1995).

Ethical Considerations. Another area of concern pertains to how confidentiality may be used to protect professionals and divert the public's attention from problems within the mental health field (Bok, 1984). Siddela Bok contented that if, and when, a claim of confidentiality is used to support secrecy about mental health practices, it

undermines what confidentiality is supposed to protect, which is respect for clients in addition to the bond formed between therapists and their clients. If a professional justifies not intervening due to colleague confidentiality, then the welfare of the professional's client is not being protected. In the most severe cases, the professional's obligation to prevent harm to the client far outweighs loyalty to his/her fellow colleague. When conflict exists in less extreme cases, however, the professional should take into consideration any harm that may result from the behavior in question (Bok, 1984). In either case, professional impairment must be addressed and not swept underneath the rug due to the potential for litigation and deterioration of trust within the community (Stadler et al., 1988).

An additional area of ethical concern relates to psychotherapy for those professionals deemed impaired. Confidentiality issues arise and may keep professionals from seeking treatment. Requesting therapists to treat impaired professionals places them in a bind or dual relationship in which they provide treatment in addition to monitor progress and submit reports to governing boards. Experiences within the medical profession demonstrate the necessity to expect and attempt to avoid any conflict of interest dilemmas through the formulation of policies on how to treat impaired professionals. Impairment is a serious matter within the profession and involves numerous ethical quandaries (Stadler et al., 1988).

Professional Response to Impairment. Over the past fifteen years, professional organizations, professional licensing boards, and individual professionals have begun to recognize the problems surrounding professional impairment. Consequently, programs have been developed in response to this concern so that assistance may be made available

to those professionals in distress (McCrady, 1989). In 1980, the American Psychological Association conducted a meeting and one of the focal points brought to the forefront was the concern about and problems associated with professional impairment (Kilburg, Nathan, & Thoreson, 1986). As a result of this meeting, a committee was formed specifically to examine the concerns pertaining to professional impairment. Two important outcomes resulted from the committee's exploration (Sherman, 1996).

First, to express their concern for impairment, APA has published the book, *Professionals in Distress: Issues, Syndromes and Solutions in Psychology* (Kilburg et al., 1986). As the book description states on the American Psychological Association website, the authors organized their work into three different segments. The first section spotlights and defines the problem of profession impairment. The second section of the authors' book focuses on the "syndromes" experienced by those professionals experiencing distress, such as but not limited to alcohol/chemical abuse, sexual exploitation, stress, and burnout. The final section of the book provides "solutions" about ways in which professional colleagues, loved ones, and other interested parties may be able to intervene and assist the distressed professional (APA Books Online, retrieved April 17, 2007).

Second, the self-help group, Psychologists Helping Psychologists (PHP), was developed in 1980 with a "planning committee" of approximately fourteen psychologists who were in the abstinent phase of their own recovery (Laliotis & Grayson, 1985, p. 87). PHP is a national, non-profit organization that provides confidential referrals and treatment to psychologists at the doctoral or doctoral candidacy level who have

experienced or currently experiencing problems with alcoholism and/or chemical dependency (Laliotis & Grayson, 1985).

Systems Perspective to Trainee Impairment

A systems perspective may be utilized to better understand problem trainees, evaluative process, power, structure, shared responsibility, and prevention. From this point on, I will substitute the phrase, "problem trainee," for impaired trainee because I believe that the word "impairment" implies that something is broken and cannot be fixed, whereas "problem trainee" does not. From a systems perspective, everything makes sense given its context. Briefly, systems theory directs our attention to relationships and patterns of interaction with an emphasis on reciprocity, recursion, and shared responsibility. These interactions are viewed as noncausal and mutually influencing in which each person's behavior influences the other. Furthermore, systems theory attends to the context, or processes that provide meaning to events. Most importantly, it is a theory that helps guide MFTs to better understand events that are occurring and changes that need to be made (Becvar & Becvar, 1993).

First, with this in mind, it is important for MFT faculty and supervisors to consider the interactions and roles they play in improving the identification and evaluative process of problem trainees within programs (Elman et al., 1999). When a graduate program has identified a problem trainee, an independent evaluation should be sought outside of the program (Schoener, 1999). Seeking an outside assessment all depends on when the question arises. This type of assessment would be most effective during summative evaluations which may be conducted prior to graduation when questions have surfaced regarding remediating or dismissing a trainee and which legal

repercussions may result due to the trainee's incompetence (Elman et al., 1999). Elman et al. (1999) indicated that systemically thinking, Schoener's work regarding evaluations suggests that an independent assessment should focus on the trainee as well as those persons involved in the training context. Issues addressed in the assessment may include the makeup and timing of training activities in relation to the stressors and circumstances of the individual trainee (Elman et al., 1999). For instance, information obtained from the assessment may indicate that the distress experienced by the graduate trainee had a negative impact on his/her work, academically and clinically, as a result of beginning the practicum phase of the program while also in the midst of an impending divorce and custody battle.

Furthermore, there also exist systemic factors (Elman et al., 1999) in clarifying evaluation criteria and strategies among academic, training, and internship programs (Lamb, 1999). These systemic factors may be impeding the collaboration process among graduate trainers within different programs. For example, training programs may risk the possibility of nonplacement if they reveal information about a problem trainee. In order to increase the trust among graduate trainers and provide quality training, policy proposals regarding communication about graduate trainees' problem behaviors must be implemented among these systems (Elman et al., 1999). In the study conducted by Olkin and Gaughen (1991), 23% of clinically oriented master's level training programs reported that they learned about problem trainees from supervisors who were off-site. Lamb (1991) recommended that graduate training programs communicate with off-site practicum programs to ensure that their evaluation criteria are similar, off-site programs have procedures set in place that respect the law of due process, problem behaviors are

communicated in a timely manner, and the lines of communication remain open to deflect any possible conflicts of interest that may thwart accurate evaluations of the performance of graduate trainees. This is exemplified by the fact that off-site supervisors may be reluctant to give negative feedback for fear that they will no longer have trainees at their practicum site (Lamb, 1999).

Second, from a feminist and multicultural perspective, Vasquez (1999) asserted that it is essential to communicate the presence and effects of power within the process of supervision. Trainees are in a position of subordination, structurally as well as institutionally. Vasquez seems to believe in the importance of clearly communicating criteria and expectations while at the same time being cognizant of the presence of power within the supervisory relationship. She contended that providing advanced information and informed consent empowers trainees (Vasquez, 1999). If developed and implemented prudently, the process of clarifying criteria, defining performance that may be inadequate or impaired, and evaluating can be conducted in a way that is less hierarchical (Elman et al., 1999). During the process of training and supervision,

> trainers and researchers need to be clear about who we are and the voice that we use to address the definition and treatment of trainee impairment, so we can clarify the values of the dominant culture, which are often the values of those with more power, and make certain that discrimination on the basis of those cultural values and assumptions is avoided in the training process" (Elman et al., 1999, p. 715).

Third, it is important for graduate programs to be receptive to self-examination as to the effects program stressors have on its students and faculty. Issues within each program are often overlooked, yet play an influential role in student impairment (Schwebel et al., 1994; White, 1997). The progression and structure of training programs often create competition and stressful demands on trainees. More specifically, training

programs can be structured in a way that prevents both behavioral and performance problems throughout the course of training and supervision (Elman et al., 1999). According to the authors, Elman, Forrest, Vacha-Haase, and Gizara (1999), the recommendations pertaining to the analysis of power within the supervisory relationship as previously discussed (Vasquez, 1999) and training on professional boundaries (Lamb, 1999) which will be discussed further both serve as examples of how graduate training programs may circumvent any potential problems that graduate trainees may experience during the process of training and supervision (Elman et al., 1999).

Fourth, there is great debate regarding who should take responsibility for problem trainees (Holloway & Roehlke, 1987; Lamb et al., 1987; Overholser & Fine, 1990; Stadler et al., 1988). The term, "social loafing" (Latane, 1981), was developed to describe some of the efforts made by those involved in a group or system of professionals. Empirical evidence suggested that when persons act as part of a group, they may feel less accountable and as though their contributions to the system are not as crucial (Harkins & Szymanski, 1989; Kerr & Brunn, 1983). Thus, there is a mistaken belief that someone else is responsible for the problem (Elman et al., 1999). For instance, if a faculty member identifies that a therapist-in-training is experiencing difficulties both academically and clinically and makes the assumption that the issues of concern are being addressed by one or more of his/her fellow faculty members, and in actuality, the problem behaviors are not being attended to, it is entirely possible that the problem trainee may fall through the break in the system. When trainees engage in behaviors that are viewed as unethical and/or unprofessional, it is imperative that both training programs and professional

organizations make the covert overt by responding ethically and responsibly (Kitchener, 1992).

Fifth, difficulties experienced with problem trainees are events that occur over an extended period of time. These events are embedded in the context of the system, beginning with admissions and then throughout the process of training and supervision (Elman et al., 1999). Lamb (1999) asserted that there is a gap in the literature regarding prevention. According to Elman, Forrest, Vacha-Haase, and Gizara (1999), this gap is addressed by Lamb's contribution to the literature regarding boundary violations and the importance of addressing any boundary violations during the course of training and supervision. The authors also contended that distinguishing between boundary crossings and boundary violations may be helpful in providing a clearer definition of impairment in addition to further our understanding of how problems develop over an extended period of time (Elman et al., 1999). A distinction between boundary crossings and boundary violations has been provided (Smith & Fitzpatrick, 1995). A boundary crossing involves a departure from what is commonly practiced and accepted within the mental health profession. A boundary crossing may or may not be advantageous to the client (Smith & Fitzpatrick, 1995). On the other hand, a boundary violation, such as engaging in sexual contact with a client (Lamb, 1999) is a departure that places the client as well as the process of therapy at risk (Smith & Fitzpatrick, 1995). Of course, there are numerous behaviors to consider besides the one stated above, but this concept may serve as a guide in clarifying and distinguishing the difference between behaviors that are considered unethical or impaired. There is a sequential relationship between boundary crossings and boundary violations, in which one precedes the other, respectively (Elman et al., 1999).

For instance, according to Folman (1991), the “erosion of boundaries (particularly self-disclosure) is the most consistent precipitant to a sexual relationship (between client and therapist)” (p. 170). Therefore, it is extremely important for graduate trainers to recognize and identify behavioral indicators that may possibly lead to further incompetent or impaired behavior and effectively address these problems as a preventive measure early in the process of training (Elman et al., 1999). In summary, impairment is a concern that must be addressed by all graduate trainers. In order to better understand trainee impairment, the problems faced by therapists-in-training during their training, and the ways in which the context of the system, in this case, the graduate training program, may or may not be playing a role in impairment, graduate trainers may employ a systemic perspective. It is critical that graduate trainers are aware of those boundary transgressions that may potentially lead to more severe violations so that they may respond preventively and prevent further damage from occurring. Furthermore, academic, graduate, and internship training programs must also communicate closely with one another to ensure that their evaluation criteria is similar and trainers are aware of the appropriate steps to take in the event that a problem trainee in encountered.

Case Vignette. Based on the systemic framework previously stated, the final section of this chapter will focus on a case vignette. Before discussing the vignette, the underlying assumption is that the trainee has already taken a course in ethics and has been screened to begin conducting therapy. Both the trainer and trainee have met to devise a supervision contract that specifies and clarifies the supervision context, trainer’s expectations, trainee’s goals, evaluative process, etc.

The case vignette begins with a 21-year-old single, Caucasian female attending therapy conducted by a 23-year-old single, Caucasian, female master's student. The client's presenting problem relates to difficulties forming and maintaining friendships. Based on the trainee's perceptions voiced in case consultation and the supervisor's observations during live supervision, it seemed as though the trainee has formed a strong working alliance with her client. As time progressed, some "red flags" in how she was handling the case began to emerge. The red flags related to several comments the trainee had made during case consultation. Once, the trainee reported that she had recently seen and spent the majority of the evening talking with her client at a party. She proceeded to say that, since they have formed such a strong bond in therapy and have a lot in common personally, it would be nice to extend a friendship outside of therapy.

At this time, the supervisor took the opportunity to make the covert overt by addressing the concerns for potential problems. First, the supervisor strongly encouraged the trainee to review the codes of ethics and other information learned in the ethics course pertaining to multiple relationships and confidentiality. Once the trainee completed her review, the supervisor discussed the problems further and explained the concerns and professional/personal consequences associated with engaging in multiple relationships and not maintaining confidentiality. Second, the supervisor addressed self-of-the-therapist issues with the trainee because it is assumed that their therapeutic relationship is isomorphic to other interpersonal relationships. "What purpose is this relationship serving for the supervisee? How is it affecting her therapeutic effectiveness? How will it influence or impact their therapeutic relationship?"

Since the supervisor determined that the trainee's self-of-the-therapist issues (i.e., difficulties setting and maintaining effective boundaries) were contributing to her lack of boundaries with this particular client, increased case consultation, increased live/videotape supervision, and extra coursework/workshops on ethics and boundaries were strongly recommended. Immediately following the discussion, the supervisor completed a formal follow-up letter explaining the concerns and what was being done to remedy the situation. A copy of this letter was given to the trainee and placed in her program file. Throughout the course of supervision, the supervisor attended to this concern by providing ongoing formative feedback on improvements and areas for growth, increasing case consultation and live/video-tape supervision, and conducting follow-ups on completed coursework/workshops. At the end of the supervisory process, the supervisor met with the other faculty/supervisors in the program and determined that since the trainee had been successfully remediated, she was able to continue her graduate studies within the program. Once a summative evaluation was completed, it was then shared with the trainee and placed in the program file.

In summary, the supervisor took effective steps in identifying and helping to remediate the trainee. When the supervisor recognized the "red flags", the supervisor dealt with the situation by making the overt covert. The supervisor did not ignore the behaviors and perspective of the trainee because she has a strong sense of responsibility and accountability to her trainee, the trainee's clients, and the community. The supervisor considered her part in the system and immediately communicated her concerns and the possibility of professional/personal consequences with the trainee. Next, the supervisor determined what needed to be done to remedy the situation and provided follow-ups and

ongoing evaluations to the trainee. Finally, the supervisor informed other persons involved in the supervisory system regarding the problems experienced by the trainee and what he/she has done to rectify the situation prior to continuing supervision. By doing so, it makes everyone in the system responsible and accountable for the trainee's future performance.

Based on the information obtained, it is clear that there exists a gap in literature on how to effectively identify, remediate, and dismiss problem trainees within the field. As a result, it is crucial that future research include multiple perspectives from various disciplines. Furthermore, education and training programs should establish clear and concise criteria by which to evaluate trainees, review and/or implement program policies for evaluations and dismissal procedures, match evaluation criteria with types of problems, and provide viable options for remediation (Forrest et al., 1999).

Therefore, the present study seeks to bridge the existing gap by exploring what types of remediation methods are considered most effective in response to the specific types of impairment experienced by trainees within master's and doctoral level Accredited Marriage and Family Therapy graduate training programs. The purpose of the research study is to answer the following questions:

1. What, given a list of impairments and remediation methods, would supervisors and/or professors within MFT graduate training program list as the most effective type of remediation method for a specific type of impairment?

2. Given the initial answers of experts, once they are provided the answers from their colleagues, can they come to a greater consensus about the most effective remediation methods for specific types of impairment?

Chapter III

METHODS

The research design in this study utilizes a modified version of the Delphi method which is considered by many to be the "most clear-cut mixed method" (Sprenkle & Moon, 1996, p. 16). The Delphi method utilizes both quantitative and qualitative methods and methodologies by eliciting responses from a panel of experts to a series of open-ended questions and then analyzing and summarizing these same responses provided by the experts (Sprenkle & Moon, 1996). The philosophical assumption of the Delphi method is based on the saying that "multiple heads are better than one" (Dalkey, 1972). The Delphi method is designed to sample a group of people who are knowledgeable in order to gain a consensus of their opinions on a specific topic. The communication is structured in a way to facilitate a dialogue about ideas (Sprenkle & Moon, 1996) and to tackle complicated problems (Linstone & Turoff, 1975). More specifically, the Delphi method's communication process provides a forum in which experts anonymously express their opinions on a specific topic, gather feedback from other experts about their ideas, access the views of other experts about similar ideas, and then have the opportunity to revise their opinions (Sprenkle & Moon, 1996). By utilizing the Delphi method, the researcher will explore what types of remediation methods are considered most effective for the various types of impairment.

Sample

One of the most critical elements in the Delphi method is panel selection. Dalkey (1969) contended that, when using the Delphi method, the experts' knowledge of the topic of study helps to assure a quality outcome. Therefore, the experts are chosen for

their expertise and not through a process that is random. Using a confidential web-based survey system, an invitation letter, providing an explanation of the research study and objectives, was emailed to all 93 marriage and family therapy training programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The research study solicited participation from the directors, supervisors, and faculty members of graduate level training programs who are most likely to have knowledge of and direct contact and experience in dealing with problem students.

Confidentiality, using the web-based survey system, is ensured by participants submitting data directly to the survey system database. The survey system did track who had responded but only so that reminder notices may be sent to those who have not responded. Furthermore, identifying information was not linked to the responses of participants. The survey system is automatically set up to send information and then purges itself completely of the information once sent. Finally, in order to yield a higher return rate for both questionnaires, a variation of the "tailored design method" developed by Dillman (2000) was employed. After the initial invitation email was sent, follow-up emails, including a reminder notice and URL to link to and complete the questionnaire, were sent to participants every ten days throughout a five-week period of time. Since participation is strictly voluntary, participants were able to withdraw at any point in time. If persons did not wish to participate, a link was provided in the email invitation, as well as any reminder emails, so that participants could click on the link and request that further emails are not sent to them.

Data Collection

When utilizing the Delphi method, data collection typically includes a two- or three-part questionnaire (Sprenkle & Moon, 1996). According to Delphi experts, "a point of diminishing returns is reached after a few rounds. Most commonly, three rounds have proven sufficient to attain stability in the responses; further rounds tended to show little change and excessive repetition was unacceptable to the participants" (Linstone & Turoff, 1975, p. 229). According to Linstone and Turoff (1975), the Delphi method's data collection undergoes four phases. First, an exploration of each participant's opinion about the subject is conducted. Second, the individual information, pertaining to the views of each participant, is compiled and understood. The third phase deals with the possible differing views of the participants. The participants are given an opportunity to review and reevaluate their opinions, as well as the opinions' of other experts. The final phase of the process takes place after the information initially obtained is given back to the participants for their analysis. During this time, the researcher attempts to reach some consensus among the participants with regard to their initial responses (Sprenkle & Moon, 1996). Dalkey (1972) believes that the Delphi method has overcome many specific drawbacks that have presented problems with traditional methods of pooling opinions. As opposed to techniques such as focus groups, the Delphi technique reduces the dominant individual effect by using anonymity, diminishes biased and irrelevant communication by controlling feedback, and decreases the pressure for the group to conform by using statistical procedures.

The Delphi technique in this study was employed with a two-part questionnaire designed by the researcher and emailed to each participant using a web-based survey

system. The initial email, sent to potential research participants, included the Informed Consent Letter (see Appendix A), survey description (see Appendix B) and Delphi Questionnaire I (DQI) (see Appendix C). The DQI consisted of a closed and open-ended form with relevant category headings supplied by the researcher to stimulate and guide the thinking of all participants. The DQI included a number of scenarios (n = 17) relevant to specific types of impairment, and the category heading asked the participants to read each impairment scenario and then place a check mark by one or more of the remediation methods they deemed most effective. If "other" was chosen, the participants were encouraged to indicate the specific type of remediation in the space provided. As stated previously, follow-up emails, including a reminder notice and URL to link to and complete the questionnaire, were sent to participants every ten days during a five-week time frame (See Appendix D).

Once the DQI was completed and returned to the researcher, the researcher compiled the participants' responses and then created the second questionnaire, Delphi Questionnaire II (DQII) (see Appendix E). The DQII included the impairment scenarios from the first questionnaire in addition to a compilation of all the participants' responses. For the DQII, participants were emailed the survey description (see Appendix F) and opening instructions (see Appendix G) and requested to indicate their agreement using the following 7-point scale: 1=Strongly Disagree; 2=Disagree; 3=Somewhat Disagree; 4=Neutral; 5=Somewhat Agree; 6=Agree; and 7=Strongly Agree. Follow-up emails, including a reminder notice and URL to link to and complete the second questionnaire, were sent to participants every ten days for the duration of six weeks (See Appendix H). To express great appreciation to those directors, supervisors, and faculty members from

accredited marriage and family therapy programs who participated in the research study, a complete and final summary of the results were provided.

Data Analysis

Data obtained from using the Delphi method were analyzed by both medians and interquartile ranges (Fish & Busby, 1996). The medians and interquartile ranges were computed to determine the level of consensus for each item. The median, or "50th percentile", is the point below which 50% of the items will fall on a scale, such as the one outlined above. Most often, the median will be near the highest and lowest possible score, as the attempt using the Delphi method is designed to obtain consensus. Therefore, the response distribution is skewed toward the higher or lower ends of the scale. The interquartile range (IQR), on the other hand, indicates the degree to which research participants have reached consensus on a particular item. The interquartile range provides necessary information about data variability, devoid of the effect of extreme scores. In order to calculate the interquartile range, the difference between the 75th percentile and 25th percentile must be determined. A lower IQR results if panelists reach a high level of consensus on a particular item (Fish & Busby, 1996). To insure that the remediation methods chosen by participants and deemed most effective in responding to the corresponding impairment scenario were included in the final profile, the researcher utilized the level of consensus set in accordance by Binning, Cochran, and Donatelli (1972). With this in mind, those remediation methods receiving a median of 6.00 or higher and IQR of 1.50 and lower were included in the final profile. In addition to the presentation of those remediation methods that made the final profile, the results section that follows will also concentrate on data collection and analysis.

Chapter IV

RESULTS

Data Collection and Analysis

As previously mentioned in the methods section, the traditional Delphi method includes a sequence of three questionnaires to which research participants respond (Linstone & Turoff, 1975). Typically, the first questionnaire asks the panel of experts broad, open-ended questions with the goal to solicit their expert opinions on the topic at hand. Once the information is received, it is then consolidated and reported back to the panel of experts in the second questionnaire. The panel of experts is then asked more specific questions, based on the information that was consolidated from the first questionnaire. Finally, the third questionnaire, which replicates the second round, includes statistical data from the entire group in addition to the experts' responses indicated for every item on the second questionnaire. It is during this final round that the panel of experts is asked to re-evaluate their initial reply in response to the statistical data provided by the group (Linstone & Turoff, 1975). Due to the exploratory nature of this research project and to avoid participant fatigue and dropout, the decision was made to omit the third round of questioning based on previous Delphi studies conducted within the field of Marriage and Family Therapy (Godfrey, Haddock, Fisher, & Lund, 2006; Figley & Nelson, 1989; Sori & Sprenkle, 2004; White, Edwards, & Russell, 1997; White & Russell, 1995).

Using a confidential web-based survey system, opinions were elicited and examined from supervisors, directors, and faculty members currently working within accredited master's and doctoral level MFT graduate training programs regarding the

types of remediation methods deemed most effective for the various types of impairment that not only effect graduate students but also graduate trainers. The research study was comprised of two different questionnaires sent to potential participants via a web-based survey system over the course of approximately a four-month period. The first questionnaire, Delphi Questionnaire I (DQI) (see Appendix C), included scenarios developed by the researcher and based on the various remediation methods and specific types of impairment mentioned in the literature as "most troublesome" within graduate training programs (Russell & Peterson, 2003, p. 332**;** Fly et al., 1997; Boxley et al., 1986; Olkin & Gaughen, 1991; and Vacha-Haase, 1995). The email master list, containing names of persons who would be considered "expert" in the field of MFT such as program directors, supervisors, and faculty members, was obtained from the Marriage and Family Therapy Program Director at Kansas State University. Participants were asked to read each scenario and place a check mark by one or more of the remediation methods perceived to be most effective. In addition, participants were afforded the opportunity to check "other" and indicate a different response than those listed as well as to provide further comments about their responses. Participation in the study was done voluntarily and without compensation.

According to the Delphi Questionnaire I (DQI) survey report, of the 239 persons asked to participate in the research study, a total of 46 (n=46) participants completed the survey. A duplicate email accounts for a total of one. A total of 111 persons deleted the invitation email at the onset. Nineteen people opted out after they received the questionnaire. Forty-five people who received the questionnaire started the process but did not complete it. Finally, 17 people left the survey without completing it. Therefore,

the total number of participants who completed the first survey was 46. Both the impairment scenarios and participant responses from the DQI may be viewed (see Appendix C). Those who did not wish to participate were provided a URL to opt out of the survey and discontinue receiving reminder emails.

Once the data was obtained from the DQI, all of the remediation methods indicated and those generated by panelists were compiled in a list. The list was then edited for both redundancy and readability. Using the nonoverlapping responses from participants who completed the first questionnaire, the second questionnaire, Delphi Questionnaire II (DQII), was developed (see Appendix E). Participants who completed the first questionnaire were asked to complete the second survey by rating their agreement on the types of remediation methods chosen and perceived to be most effective by participants in relation to each type of student impairment scenario provided in the first questionnaire. The following scale was used: 1 = strongly disagree; 2 = disagree; 3 = somewhat disagree; 4 = neutral; 5 = somewhat agree; 6 = agree; and 7 = strongly agree. Since the survey system did not track which researchers completed the first survey in order to protect anonymity, the second email was sent out to all potential research participants on the master list. A URL was also provided so that those who did not complete the first questionnaire and those who did not want to complete the second questionnaire would be able to opt out and discontinue receiving reminder emails. After obtaining data from DQII, the data was analyzed by determining both the median and interquartile ranges (IQRs) for each impairment scenario. Both the medians and IQRs are used to establish how high research participants rated each item and the degree they reached consensus (Fish & Busby, 1996).

Based on the statistics from the DQII survey report, a total of 33 persons (n = 33) out of 238 completed the second questionnaire. It is important to note that the number of potential participants was reduced from 239 to 238 due to the deletion of the duplicate email. Of the 238 persons, 135 deleted the invitation email at the onset, 18 opted out, 31 initiated the starting process but did not complete the survey, and 21 left the survey without completing it. Therefore, the total number of participants who completed the second survey was 33. The impairment scenarios and participant responses that made the final profile may be viewed in Table 1, pp. 79-82. Furthermore, while devising the DQII, the survey system automatically included N/R = no response. It was recommended by Tersine and Riggs (1976) that participation of anywhere from 10 to 15 panelists would be acceptable, just as long as the group of panelists is relatively homogeneous. Based on this recommendation, it would seem that the return rate of 46 (n = 46) from the DQI and 33 (n = 33) from the DQII is not only homogeneous due to the criteria for inclusion, but is also suitable for this research study.

Level of consensus among research participants

As mentioned previously, the following research questions were used to help guide the research study:

1. **What, given a list of impairments and remediation methods, would supervisors and/or professors within MFT graduate training program list as the most effective type of remediation method for a specific type of impairment?**

2. **Given the initial answers of experts, once they are provided the answers from their colleagues, can they come to a greater consensus about the types of remediation methods they deem most effective in response to the specific types of impairment?**

Out of a total of 335 chosen remediation methods, including generated responses, identified in DQI to be utilized in DQII, 69 remediation methods from the DQII were

determined to be essential and, therefore, retained in the final results. Those remediation methods with a median of 6.00 or higher and IQR of 1.50 or lower met criteria for consensus, thus, included in the final results (Binning et al., 1972) and presented below. The median measures central tendency. A high median score results when all panelists rate an item highly. The interquartile range (IQR), on the other hand, measures variability by taking the difference between the 75^{th} and 25^{th} percentile. By measuring variability, the IQR provides information without being inordinately affected by extreme scores. A lower IQR results if panelists reach a high level of consensus on a particular item (Fish & Busby, 1996). Although all of the remediation methods did not meet the criteria for consensus, a complete list of all responses (frequencies) from the DQII has been included and may be viewed in Appendix I. The specific types of impairment and various remediation methods, including medians and interquartile ranges, that met criteria for consensus, therefore, deemed most effective by the experts within accredited MFT master's and doctoral level graduate training programs are as follows:

Impairment Scenario 1-Burnout

Mark is a student therapist who is experiencing extreme distress in his life due to an overload of clients, coursework, assistantship, and a part-time job. Not only is Mark consistently late for work and class, he also completes and turns in his assignments late. Mark's professors and employer have noticed him falling asleep in class and emotionally withdrawing from his peers and co-workers. Furthermore, Mark has been requesting more time-off from work and school for medical appointments due to complaints of headaches and gastrointestinal distress.

Based on the data analysis (e.g. median and interquartile ranges), the results indicated that there was a high level of consensus among participants with 4 out of 20 possible remediation methods (see Table 1, p. 79). According to the results, research participants rated one remediation method the highest when responding to a graduate

student who is displaying academic as well as behavioral difficulties due to burnout: (a) “immediate one-on-one consult with student” (median = 7.00; IQR = 0.00). Additional types of remediation methods which were rated highly, therefore, deemed most effective by panelists were as follows: (a) “document problems and course of action” (median = 7.00; IQR = 0.50); (b) make the “decision about alternative options guided by response from one-on-one consult” (median = 6.00; IQR = 1.00); and (c) “mobilize support systems” (median = 6.00; IQR = 1.50).

Table 1

Final Results of DQII (Impairment Methods Deemed Most Appropriate): Median and Interquartile Ranges

Item	Median	IQR
Impairment Scenario 1-Burnout		
Immediate one-on-one consult with student	7.00	0.00
Document problems and course of action	7.00	0.50
Decision about alternative options guided by response from one-to-one consult	6.00	1.00
Mobilization of support systems	6.00	1.50
Impairment Scenario 2-Mental Illness (Depression)		
Immediate one-on-one consult with student	7.00	0.00
Mobilization of support systems	7.00	1.00
Notify significant others; initiate program remediation process	6.00	1.50
Impairment Scenario 3-Unprofessional Behavior		
Address issue in individual supervision	7.00	0.00
Immediate one-on-one consult with student	7.00	0.50
Document problems and course of action	7.00	1.00
Increasing in advising and mentoring	6.00	1.00
Increased supervision	6.00	1.50
Impairment Scenario 4-Personality Disorder		
Document problems and course of action	7.00	0.00
Hold student to program expectations and requirements	7.00	0.00
Immediate one-on-one consult with student	7.00	1.00
Impairment Scenario 5-Ethical Violation		
Immediate one-on-one consult with student	7.00	0.00
Assign structured assignment requiring student therapist to review code of ethics, write about specific ethical code violated, and then conduct discussions with supervisors and faculty to demonstrate an understanding of ethics and laws, including potential harm to client	7.00	1.00
Increased supervision	7.00	1.50

Table 1 Continued

Final Results of DQII (Impairment Methods Deemed Most Appropriate): Median and Interquartile Ranges

Item	Median	IQR
Impairment Scenario 6-Academic Deficiency		
Immediate one-on-one consult with student	7.00	0.00
Advise student therapist of choices, poor grades, and/or academic probation	7.00	0.50
Advise student therapist about academic concerns in each class; reiterate that students must maintain a B average in order to stay in the program, and if student is in danger of getting lower than a B in her course, initiate a formal university warning at mid-semester	7.00	1.00
Determine if student therapist meets the requirements for academic probation	7.00	1.00
Written warning	6.00	1.00
Impairment Scenario 7-Interpersonal Problems		
Immediate one-on-one consult	7.00	1.00
Self-structured behavioral change	6.00	1.00
Impairment Scenario 8-Sexual Contact with Client		
Immediate one-on-one consult with student	7.00	0.00
Conduct review in reference to termination	7.00	0.00
Report ethical violation to state licensing board and university attorney	7.00	0.00
Report ethical violation to AAMFT	7.00	0.50
Leave program	7.00	1.00
Termination	7.00	1.00
Encourage Darren to report to AAMFT Ethics Board	7.00	1.00
Impairment Scenario 9-Physical Illness		
Immediate one-on-one consult	7.00	0.00
Mobilization of support systems	6.00	1.00
Leave of absence	6.00	1.00
Impairment Scenario 10-Supervision Problem		
Immediate one-on-one consult with student	7.00	0.00
Mandate that Susana immediately contact client to verify and establish safety as well as to schedule an appointment as soon as possible to implement safety plan	7.00	0.00
Increased supervision	7.00	0.50
Consult with other supervisors who have worked with Susana	7.00	1.00

Table 1 Continued

Final Results of DQII (Impairment Methods Deemed Most Appropriate): Median and Interquartile Ranges

Item	Median	IQR
Impairment Scenario 11-Job Stress (emotional/physical demands of graduate school)		
Immediate one-on-one consult with student	7.00	0.00
Mobilization of support systems	6.00	1.00
Increased supervision	6.00	1.00
Reduce clinic load	6.00	1.50
Self-structured behavioral change	6.00	1.50
Impairment Scenario 12-Personal Conflict		
Immediate one-on-one consult with student	7.00	0.00
Mobilization of support systems	6.00	1.00
Leave of absence	6.00	1.50
Impairment Scenario 13-Maturity Problem		
Immediate one-on-one consult with student	7.00	1.00
Consult with other faculty	7.00	1.00
Focus on and discuss concern in individual supervision	7.00	1.00
Increased supervision	6.00	0.00
Impairment Scenario 14-Clinical Deficiencies		
This issue becomes a focus for supervision sessions. Could include increased readings, videos, assignments, and observations	7.00	1.00
Increased LIVE supervision	7.00	1.00
Increased supervision	6.00	1.50
Impairment Scenario 15-Chemical Dependency		
Immediate one-on-one consult with student	7.00	0.00
Increased supervision	7.00	1.00
Consider filing ethical complaint if student refuses to address the issue	7.00	1.00
Refer for substance abuse evaluation and treatment	7.00	1.00
Mobilization of support systems	6.00	1.00
Initiate program remediation process	6.00	1.00
If student denies alcohol use, refer to physician to screen for underlying medical illnesses	6.00	1.50

Table 1 Continued

Final Results of DQII (Impairment Methods Deemed Most Appropriate): Median and Interquartile Ranges

Item	Median	IQR
Impairment Scenario 16-Mental Illness (Bipolar II)		
Immediate one-on-one consult	7.00	0.50
Increased supervision	7.00	1.00
Suspension of clinical privileges until situation is addressed	7.00	1.00
Refer to psychiatrist for medication management; contract for medication adherence	7.00	1.00
Impairment Scenario 17-Marital Problems		
Immediate one-one-one consult with student	7.00	1.00
Increased supervision	7.00	1.00
Address issue in individual therapy	7.00	1.00
Confront on isomorphism	7.00	1.00
Individual therapy	6.00	1.50

Impairment Scenario 2-Mental Illness (Depression)

Both peers and professors/supervisors have observed a change in both Dianne's appearance as well as emotional well-being. Dianne appears to be sad most of the time, withdrawn, disheveled appearance, fatigued, and irritable. Also, it was reported that Dianne informed one of her peers that she had been feeling suicidal.

When responding to a student therapist struggling with symptoms of depression, research participants reached a level of consensus with 3 of the possible 19 remediation methods (see Table 1, p. 79). Once again, the remediation method, "immediate one-on-one-consult" was rated the highest (median = 7.00; IQR = 0.00). The additional remediation methods rated highly were the "mobilization of support systems" (median = 7.00; IQR = 1.00) and the "notification of student therapist's significant others and the initiation of the program's remediation process" (median = 6.00; IQR = 1.50).

Impairment Scenario 3-Unprofessional Behavior

While conducting therapy with clients, Maria has been observed wearing revealing clothes (e.g. low-cut blouses, tight trousers, and short skirts) by her primary

supervisor. During one of Maria's individual sessions with a male client, the client appeared to be easily distracted by Maria's low-cut blouse and made several verbal references about how he thought it enhanced her figure.

Five of the 19 possible remediation methods included in response to the above stated impairment scenario were rated highly (see Table 1, p. 79). The impairment method, "address issue in individual supervision", received the highest rating (median = 7.00; IQR = 0.00). There was also a high level of consensus among research participants that the additional remediation methods deemed most effective included "immediate one-on-one consult with student" (median = 7.00; IQR = 0.50), "document problems and course of action" (median = 7.00l; IQR= 1.00), "increase in advising and mentoring" (median = 6.00; IQR = 1.00), and "increased supervision" (median = 6.00; IQR = 1.50).

Impairment Scenario 4-Personality Disorder

The supervisor has noted that Doug seems to lack empathy toward his peers and clients, has a grandiose sense of self, requires admiration from supervisors, peers, and clients, displays arrogance during classroom discussions, and expects favorable treatment by professors by asking them to extend his due dates on assignments.

For the impairment scenario, "personality disorder", the research participants considered 3 of the potential 23 remediation methods essential (see Table 1, p. 79). The research participants reached a strong consensus with two of the three, "document problems and course of action" (median = 7.00; IQR = 0.00) and "hold student to program expectations and requirements" (median = 7.00; IQR = 0.00). As with the previous impairment scenarios, the panelists deemed the remediation method, "immediate one-on-one consult with student" (median = 7.00; IQR = 1.00), a potentially effective way in which to respond to a student therapist struggling with a personality disorder.

Impairment Scenario 5-Ethical Violation

Johnny communicated with his client's attorney and released client information without a release of information signed by his client.

Research participants ranked 3 of the 22 remediation methods as essential (see Table 1, p. 79). The strongest consensus reached pertained to "immediately consulting with student one-on-one" (median = 7.00; IQR = 0.00). A high consensus was also reached on the following remediation methods: (a) "assign structured assignment requiring student therapist to review code of ethics, write about specific ethical code violated, and then conduct discussions with supervisors and faculty to demonstrate an understanding of ethics and laws, including potential harm to client" (median = 7.00; IQR = 1.00) and (b) "increased supervision" (median = 7.00; IQR = 1.50).

Impairment Scenario 6-Academic Deficiency

Although Ana is doing well clinically, she is missing the majority of her semester classes, not turning in required coursework, making substandard grades on exams, and attending classes late and using her clients as an excuse for being tardy.

Regarding the student impairment, "academic deficiency", panelists agreed that 5 of the 21 remediation methods were essential enough to be included in the final results (see Table 1, p. 80). As with numerous other impairment scenarios, research participants strongly agreed that it is vital to "immediately consult with student one-on-one" (median = 7.00; IQR = 0.00). Consensus was also reached on 4 additional remediation methods, such as "advising student therapist of choices, poor grades, and/or academic probation" (median = 7.00; IQR = 0.50), "advising the student therapist about academic concerns in each class; reiterate that students must maintain a B average in order to stay in the program, and if the student is in danger of getting lower than a B in her course, initiate a formal university warning at mid semester" (median = 7.00; IQR = 1.00), "determining if

the student therapist meets the requirements for academic probation" (median = 7.00; IQR = 1.00), and giving the student therapist a "written warning" (median = 6.00; IQR = 1.00).

Impairment Scenario 7-Interpersonal Problems

Kiesha is experiencing problems with getting along well with her peers, professors, and supervisors. During class, it has been observed by Kiesha's professors and peers that she occupies lecture time by asking too many questions that are irrelevant, comments on almost every topic being discussed, and challenges the knowledge of her professors rather than asking questions that will enhance her knowledge base.

Only two of the 16 remediation methods, "immediate one-on-one consult" (median = 7.00; IQR = 1.00) and "self-structured behavioral change" (median = 6.00; IQR = 1.00) were agreed upon as most effective in responding to a student experiencing interpersonal problems (see Table 1, p. 80).

Impairment Scenario 8-Sexual Contact with client

Darren is conducting couples therapy and being supervised live by his primary supervisor. Only the wife attends this particular session. During session, the female client talks to the therapist about their special relationship. After the session, the supervisor immediately asked Darren what was meant by special relationship. The student therapist hesitated, but finally admitted that he had sexual intercourse with the female client during the time he was seeing her for individual therapy.

Research participants strongly agreed that 7 out of 17 remediation methods would be considered important when responding to a student therapist who has had sexual contact with his/her client (see Table 1, p. 80). Of the 7, panelists strongly agreed on a total of three remediation methods. These are as follows: (a) "immediate one-on-one consult with student" (median = 7.00; IQR = 0.00), (b) "conduct review in reference to termination" (median = 7.00; IQR = 0.00), and (c) "report ethical violation to state licensing board and university attorney" (median = 7.00; IQR = 0.00). In addition to reporting the ethical violation to both the state licensing board and university attorney,

the participants agreed that the ethical violation should be reported to AAMFT (median = 7.00; IQR = 0.50). Furthermore, there was a high level of consensus involving the remediation methods, “leave the program” (median = 7.00; IQR = 1.00), “termination” (median = 7.00; IQR = 1.00), and “encourage Darren to report to AAMFT Ethics Board” (median = 7.00; IQR = 1.00).

Impairment Scenario 9-Physical Illness

Javier was recently diagnosed with ulcerative colitis, and his illness is affecting his academic and clinical work. Javier is missing classes, canceling clinic appointments, and failing to turn in coursework.

Consensus was reached on 3 of the 17 remediation methods (see Table 1, p. 80). They are “immediate one-on-one consult with student” (median = 7.00; IQR), “mobilization of support systems” (median = 6.00; IQR = 1.00), and “leave of absence” (median = 6.00; IQR = 1.00).

Impairment Scenario 10-Supervision Problem

Susana was given a directive by her supervisor to devise a No Harm Contract with her client who admitted to current suicidal ideations as well as a previous suicide attempt approximately six months prior to attending appointment with therapist-in-training. Susana failed to comply with her supervisor’s directive by not discussing with the client the rationale and importance of signing the contract and failing to get the client to sign the contract prior to the client’s leaving the clinic office.

In reference to the student impairment, “supervision problem”, 4 of the possible 27 remediation methods were considered essential by research participants (see Table 1, p. 80). Two of the 4 were rated the highest, “immediate one-on-one consult with student” (median = 7.00; IQR = 0.00) and “mandate that Susana immediately contact client to verify and establish safety as well as to schedule an appointment as soon as possible to implement safety plan” (median = 7.00; IQR = 0.00). The second highest score was given to the remediation method, “increased supervision” (median = 7.00; IQR = 0.50). The

remediation method, “consult with other supervisors who have worked with Susana was rated the fourth highest” (median = 7.00; IQR = 1.00).

Impairment Scenario 11- Job Stress (emotional/physical demands of graduate school)

Tamara reported feeling overwhelmed as a result of the demands of coursework, clinic load/administrative duties, and assistantship responsibilities. Due to this stress, she is experiencing difficulties empathizing with her clients. For instance, during one of Tamara’s sessions with a patient who is also experiencing distress at work, rather than empathizing with the patient and providing words of encouragement, Tamara said to her client, “What do you have to complain about? If you only knew what it is like to feel overwhelmed.”

Research participants ranked 5 of the 18 remediation methods as effective ways in which to respond to a student therapist’s experiencing job stress due to the emotional/physical demands of graduate school (see Table 1, p. 81). The highest remediation method ranked was “immediate one-one-one consult with student” (median = 7.00 and IQR = 0.00). The remediation methods immediately following the one-on-one consult with student are “mobilization of support systems” (median = 6.00; IQR = 1.00) and “increased supervision” (median = 6.00; IQR = 1.00). The final two remediation methods ranked, although not as highly, are “reduce clinic load” (median = 6.00; IQR = 1.50) and “self-structured behavioral change” (median = 6.00; IQR = 1.50).

Impairment Scenario 12-Personal Conflict

Since Donna reported to her supervisor that her mother was diagnosed with cancer, both her academic and clinic performance have declined. Donna has been missing the majority of her semester classes including practicum, canceling clinic appointments, requesting extensions for class assignments, and made substandard exam scores.

Only 3 of the 16 remediation methods were deemed essential in responding to a student experiencing personal conflict within the program (see Table 1, p. 81). The highest ranked item is “immediate one-on-one consult with student” (median = 7.00;

IQR= 0.00). The second highest ranked item is “mobilization of support systems” (median = 6.00; IQR = 1.00). The third highest ranked remediation method is “leave of absence” (median = 6.00; IQR = 1.50).

Impairment Scenario 13-Maturity Problem

Michael, a second year student, is unable to receive constructive feedback from supervisors and peers. For example, while discussing one of Michael’s most challenging cases during practicum, Michael began to pout and became defensive when the practicum supervisor provided suggestions and constructive feedback on how he could effectively manage challenging cases in the future.

Of the 20 remediation methods listed and/or generated in DQI, 5 remediation methods were ranked as essential and 3 out of the five were rated higher by research participants (see Table 1, p. 81). Panelists seemed to agree that “immediately consulting with student one-on one” (median = 7.00; IQR = 1.00), “consulting with other faculty” (median = 7.00; IQR = 1.00), and “focusing on and discussing this concern in individual supervision” (median = 7.00; IQR = 1.00) would be most effective in responding to a student therapist who is displaying problems with maturity. Panelists also agreed that “increasing supervision” (median = 6.00; IQR = 0.00) and a “leave of absence” (median = 6.00; IQR = 1.50) would be effective remediation methods.

Impairment Scenario 14-Clinical Deficiencies

Allen, an upper-level first year student, is having difficulties applying systems theory learned in class into practice while conducting therapy. While conducting couples therapy and being supervised live, it was observed that Allen was only focusing on each person’s past rather than how their past experiences may be influencing their lives presently, individually as well as relationally.

Three of the 21 remediation methods were chosen and agreed upon by research participants as most effective (see Table 1, p. 81). Two were ranked the highest. These are “this issue becomes a focus for supervision sessions; could include increased

readings, videos, assignments, and observations" (median = 7.00; IQR = 1.00) and "increased live supervision" (median = 7.00; IQR = 1.00). The next highest ranked remediation method is "increased supervision" (median = 6.00; IQR = 1.50).

Impairment Scenario 15-Chemical Dependency

On several occasions while Amy was present at the clinic conducting therapy with her clients, her supervisor and peers have smelled alcohol on her breath and noticed that her gait was unsteady and she was slurring her speech.

With regard to the impairment scenario, "chemical dependency", 7 of the 21 remediation methods were ranked high enough to be included in the final results (see Table 1, p. 81). Of the 7, the highest ranked remediation method, is "immediate one-on-one consult with student" (median = 7.00; IQR = 0.00). The remediation methods, "increased supervision" (median = 7.00; IQR; 1.00), "consider filing ethical complaint if student refuses to address the issue" (median = 7.00; IQR; 1.00), and "refer for substance abuse evaluation and treatment" (median = 7.00; IQR; 1.00), were rated second to the highest by panelists. The third highest ranking goes to "mobilization of support systems" (median = 6.00; IQR = 1.00) and "initiate program remediation process" (median = 6.00; IQR = 1.00). "If student denies alcohol use, refer to physician to screen for underlying medical illnesses" is the remediation method that received the fourth highest ranking (median = 6.00; IQR = 1.50).

Impairment Scenario 16-Mental Illness (Bipolar II)

Blaine had been diagnosed with Bipolar II and prescribed medication. He made the faculty aware of this. Recently, though, Blaine has not been taking his medication, and it has had an impact on his ability to conduct therapy. For instance, while Blaine was conducting therapy with one of his clients, his primary supervisor observed that his mood was elevated, he talked incessantly and was easily distracted by external stimuli, and commented to the client about how effective and great he thought he was as a therapist in comparison to his peers. Due to questions and growing concerns, the supervisor observed Blaine's follow-up appointment with this

particular client. It was during this session that Blaine seemed to be experiencing a depressive episode in which he appeared depressed, fatigued, indecisive, disinterested, and hypoactive.

In responding to a student therapist displaying clinical difficulties as a result of a mental illness (Bipolar II), the panelists deemed 4 of the 17 remediation methods as most effective and therefore, included in the final results section (see Table 1, p. 82). The strongest level of consensus was granted to "immediate one-on-one consult with student" (median = 7.00; IQR = 0.50). The remaining 3 remediation methods, "increased supervision", "suspension of clinical privileges until situation is addressed", and "refer to psychiatrist for medication management; contract for medication adherence" all received the same medians and IQRs, 7.00 and 1.00, respectively.

Impairment Scenario 17-Marital Problems

While conducting therapy with a female client experiencing marital difficulties due to her spouse's extramarital affair, the supervisor observed Jeanne encouraging the female client to get a divorce. Recently, unbeknownst to Jeanne's professors and peers, she has also filed for divorce as a result of her spouse's extramarital affair.

For the final impairment scenario, marital problems, there was a strong level of consensus among panelists on 5 of the 21 remediation methods (see Table 1, p. 82). The higher ranked items included "immediate one-one-one consult with student" (median = 7.00; IQR = 1.00), "increased supervision" (median = 7.00; IQR= 1.00), "address issue in individual therapy" (median = 7.00; IQR = 1.00), and "confront on isomorphism" (median = 7.00; IQR = 1.00). The remaining method agreed upon is "individual therapy" (median = 6.00; IQR = 1.50).

The results of this study indicate that, given a list of impairments and remediation methods, not only did graduate trainers within master's and doctoral level MFT programs list remediation methods they deemed most effective for each type of impairment

scenario, but when research participants were provided the initial answers from their colleagues, they were able to come to a greater consensus about the types of remediation methods they deemed to be most effective for responding to the various types of impairment. It is in the following section that the results and themes generated from the participants' responses will be discussed in greater detail.

Chapter V

DISCUSSION

While developing the DQII, based on participants' chosen remediation methods and generated responses from DQI, many rich themes emerged that deserve to be mentioned, and therefore, are discussed below. These themes are as follows: (a) multiple ways to peel an apple; (b) no cookie-cutter approach; (c) response to impairment: multi-level process; (d) impairment vs. unethical vs. incompetence; and (e) gatekeeping responsibilities. A complete list of all impairment scenarios and commentaries provided by participants in DQI has been included and may be viewed in Appendix C.

Multiple ways to peel an apple

One could infer from the results that there are multiple types of remediation methods deemed most effective when responding to a particular type of impairment. For instance, there was a high level of consensus among respondents that the most effective ways in which to respond to a student experiencing burnout included the following: (a) "immediate one-on-one consult with student"; (b) "document problems and course of action"; (c) "making a decision about alternative options guided by response from one-on-one consult"; and (d) "mobilization of support systems". The saying, "there are many ways to peel an apple" may be used to better explain and/or understand the research results. Of course, the most obvious way to peel an apple is to use a knife. The question would be whether or not the knife was sharp enough to actually peel the apple. Of course, a dull knife would prove to be less effective than a sharp knife. If a person was desperate and extremely hungry, he/she could even opt to use scissors if a knife was not available. This would not be the most ideal. However, it could also prove to be effective. Whether

or not one uses a knife or scissors to peel an apple, the end result remains the same. The apple is peeled and one has satisfied his/her hunger and/or craving for the apple. With this in mind, let us go back to the burnout scenario. It is apparent by the participants' responses that there are multiple ways in which to respond to students who are experiencing burnout, not just one. The goal is to not only honor gatekeeping responsibilities by responding to the student's impairment but to address the concept of "equifinality" by assisting the student therapist in exploring alternative ways in which he/she may effectively balance and manage the stress experienced within his/her personal and professional life.

No cookie-cutter approach

The second saying, "there is no cookie-cutter approach," may also help to better explain or understand the research results. How graduate trainers choose to respond to student impairment varies from scenario to scenario and also from student to student. For each impairment scenario, research participants chose various types of remediation methods. Let us consider impairment scenario #8, "sexual contact with client." This impairment scenario is what I consider clear-cut with few gray areas. The consensus among research participants was that the most effective ways in which to respond would be to "immediately consult with the student one-on-one" and "conduct a review in reference to termination". The author's interpretation is that these two remediation methods were designed to determine the veracity of the complaint and if there were any extenuating circumstances. The respondents to the survey then listed "report ethical violation to state licensing board and university attorney", "report ethical violation to AAMFT", and "encourage Darren to report ethical violation to AAMFT ethics board".

This demonstrated the respondents' acknowledgement of their duty to report unethical behavior and the need to document potential reasons for dismissal. The respondents to the survey then listed asking the student to "leave the program" and possibly "terminate" student from the program. This would be the ultimate sanction, which could be imposed on a student by a training program.

A less clear-cut situation or impairment scenario that could be considered to be within a gray area includes the impairment scenario in which a student is experiencing interpersonal difficulties with peers, professors, and supervisors (i.e. Impairment Scenario #7-Interpersonal Problems). In this particular case, research participants came to a level of consensus that the way in which to respond, with the exception of one remediation method in particular, "one-on-one consult with student," would be entirely different from the preceding example of a serious ethical violation. In addition to consulting with the student, the respondents seemed to agree that self-structured behavioral change would be necessary. As one participant stated in the first questionnaire, "What is Kiesha's level of self-awareness about these 'interpersonal problems'? I would want to talk to her about them and discuss self-structured behavioral change prior to any other action". Another participant stated that "we would focus on this issue in meetings with the student by professors, her supervisor, and perhaps a joint meeting with the director of the program and faculty if it continued. Our initial purpose of meetings would be to understand what her experience is". It seems evident that, based on the two remediation methods chosen and some of the generated responses, the participants clearly thought about the context in which the impairment scenario occurred and attempted to gain a level of understanding of what the therapist-in-training

experienced within this context prior to implementing certain remediation methods that may be viewed as much more drastic. It appears that they took into consideration the types of remediation methods that would be most effective, given the context and what the therapists-in-training experienced. Consequently, the participants specifically chose remediation methods that they felt fit the impairment.

These statements seem to support the results in which the types of remediation methods chosen and deemed to be most effective by research participants depended upon the impairment scenario. For instance, one research participant generated a response with the impairment scenario pertaining to depression, stating that "as in the first scenario, there are many options that may be helpful but I would want to consult with any student to develop a course of action that seems most appropriate for the student in that particular situation." The work of Richard Schoener (1999) served as a foundation for this generated response. The author contends that, rather than guessing what the therapist-in-training may/may not need in reference to remediation, the needs of the therapist-in-training must be ascertained prior to rehabilitation. In this particular case, the respondent has chosen to consult with the student one-on-one in order to determine what the therapist-in-training's needs are prior to implementing any type of remediation plan.

Therefore, the above stated view seems to be supported by the fact that there is "no cookie-cutter approach" in responding to student impairment. It is important for graduate trainers to be aware that there may be more than one way of responding to student impairment given the type of impairment, context of the situation, individual student therapist, and graduate programs' policies and procedures for responding to student impairment.

Response to impairment: Multi-level process

As mentioned previously, respondents were given an opportunity while completing the DQI to generate a response for each type of impairment. As evidenced by some of the user responses that are rich in content, there appear to be similar themes with regard to responding to impairment. For instance, one theme in particular was recognized not only from the participants' generated responses regarding ways in which to respond to a student who is experiencing burnout but many, if not all, other impairment scenarios as well. This theme pertains to the fact that, in order to be most effective, student remediation should encompass a multi-level process constructed by graduate trainers or "co-constructed" with therapists-in-training. Graduate trainers may begin with consulting with the student one-on-one and if needed, proceed to the next level.

According to some of the research participants, proceeding to the next level may be dependent upon the student therapist's response, verbally as well as behaviorally, to the problem or impairment in question. It is this assumption that impelled numerous respondents to choose to conduct a one-on-one consult with the therapist-in-training. It seems that the respondents wanted to take the opportunity to join with the student therapist while observing the student's response to the type of impairment in question. It is upon the student therapist's response that the respondent will base his/her subsequent level of intervention. One generated response that better exemplifies this multi-level process view is that "one could make the case that any of these could qualify as an 'effective remediation method.' I am approaching each of the scenarios, though, from more of a constructionist perspective in which I would want to initially gather more information before proceeding. Many of the options could be considered, based on

consultation with the student. It may be appropriate to counsel the student out of the program, recommend therapy, reduce clinical load, etc. but I would not presume that course of action until individually consulting with student." According to another research participant, "Decisions are case specific. 'Support' thru burnout is co-constructed between what the student believes he/she needs and what the program believes he/she needs to move through this time with greatest benefit." Based on this information, it is imperative that trainers within graduate training programs view remediation as a multi-level process in which they consult with the student therapist one-on-one in order to gather as much information as possible about the impairment in question, to ascertain the student therapist's needs, and last, to co-construct between the needs of the student therapist as well as the graduate program's needs.

Impairment vs. Unethical vs. Incompetence

The following section will begin by focusing on the impairment scenario, ethical violation, in which Johnny communicated with his client's attorney and released client information without a release of information signed by his client. First, is this a first time error for the student therapist or a pattern of repeated infractions? Although it was not specified whether or not this was the student therapist's first time mistake, several of the respondents seem to share the view that the level of remediation response would be dependent upon if this was the student's first time making a mistake or a pattern of repeated mistakes. For instance, one respondent indicated that "if this is a first time error, then the response would be different- and less- than if it were a repeated error." An additional response is that "the student should be given a second chance. It would be pattern of infractions that would warrant a dismissal from program." Some of the

respondents also seemed to agree that, if this were a repeated behavior, the remediation response would possibly need to be taken to a much higher level. For instance, one research participant stated that “if this is part of an emerging pattern of unethical behavior, a formal letter and meeting would need to occur with the program director and primary supervisor with warning that the next incident of or like it would result in termination.”

Second, what is the level of the student therapist? One respondent indicated that “if this is a beginning student, I would treat this as a learning opportunity. If this is an experienced student and there have been other instances of failure to respect confidentiality or to follow clinic procedures, I would consider more serious action, such as filing an ethics complaint. I think it would also be wise to review the student’s case files for completeness, especially regarding releases and signed informed consents for therapy.” Third, was it a mistake or intentional? One research participant indicated that “response would differ based on the situation. Did he break confidentiality because of lack of knowledge or was he ignoring policy?” With all of this in mind, one research participant eloquently stated that “even in the case of “black and white situation” such as this one, the easiest answer is not always to just terminate at the onset. Initiate the program’s remediation plan. Unless the student could demonstrate total lack of knowledge of appropriate procedures (which would be difficult to do in our program, given the extensive initiation into ethical practice), the student would be on severe probation with substantially increased supervision and accountability, including a mandate to communicate with no one about clients without prior supervisor approval.”

Some of the participants' responses and attempts at remediation seem to be consistent with LeClair Bissell's (1983) work with impaired physicians struggling with alcoholism in which the actual behaviors in question were either defined as "incompetent", "impaired", or "unethical" prior to determining the most appropriate and effective type of remediation method. One may conclude from the participants' responses that, prior to tailoring and implementing a specific type of remediation plan, graduate trainers must take into consideration the level of the student therapist and determine if the impairment in question is a result of incompetence, impairment, or lack of professional ethics. Graduate trainers may draw from LeClair Bissell's work with impaired physicians (1983) to help guide them by distinguishing among the three levels of impairment indicated above and determining which remediation method would be deemed most effective based on the type and level of impairment.

Gatekeeping responsibilities

As mentioned previously, gatekeeping is a process that serves to shield consumers from therapists who may be unskilled, inadequately trained, or just beginning and require assistance during the early stages of the learning process. Not only do trainers have a responsibility to their trainees and to act in a role as gatekeepers, but they must also consider the quality of care given to clients and their ethical responsibilities to the profession and community. Furthermore, it is believed that one of the trainer's responsibilities is to identify trainees who may be impaired and/or incompetent and to remediate them (Storm et al., 2001). For instance, the impairment scenario pertaining to depression provided an excellent example. A couple of research participants mentioned balancing their role as graduate trainer and gatekeeper. For example, one research

participant indicated that “supervision would need to include exploration with Dianne about the impact of her mood/condition on clients and decisions made about how to ensure proper care for her clients. This would be for the well-being of clients, as well as a professional mentoring experience for Dianne.” Furthermore, “again, we would develop a tailored plan that would be worked out with her as well as take steps to insure clients were cared for. We would be sure she was working with a co-therapist on cases where she was strongly connected with clients if she was stable enough to continue seeing clients. No new clients would be assigned, transfers may be explored, and so on, perhaps leading to being asked to leave the program if the distress didn’t decrease with a reasonable length of time.”

An additional response that was generated by a research participant made reference to gatekeeping and pertained to the impairment scenario of “personality disorder”. “If the student lacks the ability to display growth after given feedback and ample opportunity, he poses a public safety concern. In this case, as gatekeepers to licensure and public safety, he is likely to be asked to leave if his behavior is concerning to the degree described.” Two of the respondents indicated that diagnosing student therapists is not a role of graduate trainers. For instance, “diagnosing students is not a part of our role. Nevertheless, we must collect and reflect back to the student data on learning outcomes of the program, including interpersonal skills. Documentation of these skills, or lack thereof, may eventually lead to termination from the program. But it’s likely to be a long process that takes a disproportionate amount of faculty time.” Another participant’s generated response seems to follow the same premise as stated above. “As a systems thinker and social constructionist, I would want to interact with the student about

these observed behaviors, rather than come to a diagnostic conclusion based on my observation. As such, I would provide an immediate consultation and spend some extra time advising/mentoring." According to the respondents, it may also be a lengthy process that requires careful documentation and a significant amount of time on behalf of the faculty to advise/mentor. Although it has been stated in the literature that faculty may not want to interfere except in the most extreme cases because they are aware of the amount of time, effort, and money put forth by students in pursuing their future career (Bemak, Epp, & Keys, 1999), it seems that based on the participant responses throughout, it appears as though the respondents do consider their role as graduate trainers and gatekeepers to be extremely important and that the gatekeeping process is, in fact, a balancing act, in which they must balance the needs of the therapist-in-training, the client, and the graduate program.

In addition to the richly generated responses from respondents, I would also like to further explore and discuss various other themes that have emerged from the responses provided by participants. According to the results, the remediation method, "immediate one-on-one consult", was chosen by participants for 16 of 17 impairment scenarios provided. Why? This remediation method in particular is the purest coping behavior of the group. It is extremely important for supervisors to grant supervisees the benefit-of-the-doubt so that they may be able to tell their "side of the story". Consulting with supervisees one-on-one ensures confidentiality on behalf of the supervisee, fosters emotional and educational support, provides an opportunity for the supervisor to assess what may be occurring, and serves as a strong foundation in which almost all of the other interventions are based. On the other hand, although the review of the literature indicated

that personal therapy was utilized by the majority of graduate training programs to remediate supervisees (Kaczmarek & Conner, 1998; Olkin & Gaughen, 1991; Vacha-Haase, 1995), recommending that the supervisee attend personal therapy was chosen for only 3 of 17 impairment scenarios (e.g. Impairment Scenarios #15-Chemical Dependency, #16-Mental Illness (Bipolar II), and #17-Marital Problems). This seems to further support the fact that "one size doesn't fill all".

During the time that supervisors observe supervisees struggling and possibly "running on empty," such as in Impairment Scenarios #1-Burnout, #2-Depression, #9-Physical Illness, #11-Job Stress (emotional/physical demands of graduate school), #12-Personal Conflict (Illness in the Family), and #15-Chemical Dependency, respondents suggested mobilizing support systems (e.g. other students, family, and/or friends) as an intervention. Likewise, if the supervisors thought that supervisees had "too much on their plate", the respondents suggested various types of remediation methods that could possibly alleviate some of the pressure rather than exacerbating the problem. These included "leave of absence" for impairment scenarios #9-Physical Illness and #12-Personal Conflict, in which the supervisee's family member had been diagnosed with cancer, "reduce clinical load" for job stress, and the "suspension of clinical privileges until situation is addressed" for impairment scenario #16-Mental Illness (Bipolar II).

Other impairment scenarios (e.g. #2-Mental Illness (Depression) and #15-Chemical Dependency), however, triggered an institutional program remediation process. Although the highest ranked remediation method chosen within these two impairment scenarios was "immediate one-on-one consult" with student, it seems that the respondents deemed the remediation method, "initiation of the program's remediation process," a

viable option, especially when a supervisee is displaying major depressive symptoms, including verbal indications of suicidality to a fellow student, and showing up for work and attempting to conduct therapy with clients while displaying signs of intoxication.

Based on the research participants' responses, it appears that the majority of impairments would all require interventions within supervision (e.g. Impairment Scenarios #3-Unprofessional Behavior, #5-Ethical Violation, #16-Supervision Problems, #11-Job Stress, #13 Maturity Problems, #14-Clinical Deficiencies, #15-Chemical Dependency, #16-Mental Illness (Bipolar II), and #17-Marital Problems). Within some of the impairment scenarios, the respondents indicated that the supervisee should be required to have more supervision (e.g. Impairment Scenarios #5-Ethical Violation, #10-Supervision Problem, #11-Job Stress, #13 Maturity Problem, #14-Clinical Deficiencies, #15-Chemical Dependency, #16-Mental Illness (Bipolar II), and #17-Marital Problems) or even an increase in live supervision (e.g. Impairment Scenario #14-Clinical Deficiencies). In 2 of 17 impairment cases (e.g. Impairment Scenarios #3-Unprofessional and #13-Maturity Problem), though, it seems that supervision, rather than many of the other remediation methods, was expected to address the specific problem at hand. It is within supervision that supervisors' decisions about alternative options may be based on supervisees' responses from one-on-one consult (e.g. Impairment Scenario #1-Burnout). In addition, supervision may be a time in which to introduce a self-structured behavioral change program to the supervisee as indicated by respondents for the impairment scenarios dealing with interpersonal problems and job stress and to emphasize and implement the mentoring process, such as in the impairment case in which a supervisee is displaying unprofessional behavior. This supervision process may also be accomplished

either by the individual supervisor or in consultation with other faculty members within the program, especially when responding to a supervisee displaying maturity problems.

When problems surfaced academically, the respondents chose remediation methods that seem to reaffirm the importance of "holding the student to program expectations and requirements" (e.g. Impairment Scenarios #4-Personality Disorder and #6-Academic Deficiency). In some other cases, the respondents seemed to consider it necessary to either assign supplementary assignments (e.g. Impairment Scenarios #5-Ethical Violation and #14-Clinical Deficiencies) or mandate that the student therapist intervene with the client immediately (e.g. Impairment Scenario #10-Supervision Problem). Finally, respondents deemed some of the problems posed in the impairment scenarios specified below as potentially or immediately threatening to both the client and/or program, therefore, requiring that the program document and take legal action (e.g. Impairment Scenarios #1-Burnout, #3-Unprofessional Behavior, #4 Personality Disorder, #6-Academic Deficiency, #8-Sexual Contact with Client, and #15-Chemical Dependency).

Based on the themes and commentaries provided by participants discussed above, it is evident that graduate trainers do seem to view their role as educators and gatekeepers as extremely important and seem to be committed to the professional and personal growth of the therapists-in-training. Furthermore, some of the views and generated responses about the impairment scenarios and possible remediation methods seem to be consistent with various aspects previously covered in the literature about student impairment. This is just the beginning, though, as much more research is needed in this area. Next, the focal point of the following section will be research limitations.

Limitations

Specific reasons that may have accounted for the smaller sample size and cited by potential participants as inhibiting them from participating are discussed further. First, several emails were received from potential participants citing that professional and/or personal time constraints would inhibit them from participating. One potential participant declined to participate entirely as he/she was currently involved in three other dissertation research projects. Second, another potential participant on the email master list indicated that he/she was not a graduate trainer in an accredited master's and doctoral level MFT program but rather in another discipline in the field. In addition, one person stated that he/she was no longer training and, therefore, unable to participate. Third, a potential participant did not participate in this study, citing that he/she was not qualified. Fourth, since the data collection process was conducted during the summer months, many "out-of-the office" replies were sent back in response. Graduate trainers may be typically out of the office more often during the summer months and possibly not teaching and/or supervising as much as if it were during the fall and spring semester. This limitation could have possibly been avoided by delaying the data collection process until the fall semester. The final possible reason for the smaller sample size was that numerous emails were sent back stating "permanent fatal error".

According to the survey reports, there appeared to be a difference in the number of research participants who completed both surveys. For instance, 46 (n=46) research participants completed the DQI, whereas only 33 (n=33) persons completed the DQII. What could possibly account for the difference? The dropout rate was not entirely

unexpected as a result of several challenges and survey system glitches experienced throughout the survey development and data collection process. First, the time required to complete not only one, but two surveys, may have possibly contributed to the difference. It is possible that research participants were given or took on more responsibilities in between the time they completed DQI and then were asked to complete the DQII. Second, during the questionnaire development and data collection process, various problems were encountered while using the web-based survey system, as a result of a personal error in developing the Likert Scale[1] and survey system glitches[2]. It is possible that these errors may have lessened the research participants' interest in completing the second questionnaire (DQII).

Of particular note is that on the DQI, one of the research participants included "no response" as a possible remediation method. There is uncertainty as to whether the research participant was attempting to indicate that he/she did not have a response or suggesting that one does not need to respond to the impairment through the implementation of a particular type of remediation method. Based on the participants' responses in DQII to the remediation options posed in DQI, it appears that research

[1] Another possible reason for the decline in response rate may be due to personal error. The Likert Scale on the DQII was accidentally developed incorrectly. Thankfully, the mistake was caught by some of the participants. Once informed about the mistake, the Likert Scale was modified immediately and then the DQII resent. Once again, the mistake made during the development of the Likert Scale may have diminished the interest of some of the research participants in completing the second questionnaire.

[2] The original offering date was changed in the system in order to complete necessary modifications to the DQI. Although the original offering date was changed to a later date in order to accommodate the need to make edits, a glitch in the system did not prevent the survey from being sent prematurely to potential participants. After consulting with IT at Kansas State University about the survey glitch, I emailed potential participants apologizing profusely for the confusion and then emailed the survey when the modifications were completed.

participants reached a level of consensus that the option, “no response,” would not be the most effective way of responding to student impairment.

An additional limitation that may occur with Delphi studies is that “diversity is sacrificed for consensus” (Fish & Busby, 1996, p. 479). The items selected in the final profile were done so for their small interquartile ranges and high medians so that a level of consensus may be reached. In this study, however, the researcher attempted to minimize this limitation by capturing some degree of diversity through the discussion of participants’ generated responses.

A final limitation of obtaining a sample from experts is that the responses are not representative (Fish & Busby, 1996) of all graduate trainers within master’s and doctoral level MFT programs but just the thoughts and opinions of those who chose to participate in the study. Although the sample size of 46 (n = 46) from the DQI and 33 (n = 33) from the DQII is considered to be homogeneous and suitable for this research study, it is imperative that future studies are conducted so that the voices of professionals within the field of MFT may continue to be heard and make a difference with regard to student impairment and remediation.

Although the results obtained are relevant to MFT master’s and doctoral level graduate training programs, they may possibly be used, in conjunction with other research and literature, as a starting point for other graduate training programs/professions within the mental health field to begin tailoring remediation plans for various types of impairment. This then leads us to the following discussion on suggestions for future research and then finally, implications for practice.

Suggestions for Future Research

Although much research has been conducted in the areas of student impairment, remediation, and dismissal in the fields of medicine and clinical psychology, it is with great hope that the information learned from this research study in particular will encourage others, especially within the field of Marriage and Family Therapy (MFT), to take pertinent information from this research and continue to expand upon it throughout the years to come. For instance, graduate programs may consider tailoring remediation plans with the inclusion of the chosen remediation methods in this research study and conduct future research on the outcomes of these adapted plans. Are these tailored remediation plans effective in helping to remediate students? Do they work better in conjunction with other remediation methods or are they only effective if implemented without the accompaniment of other remediation methods?

The remediation method chosen and deemed most effective by research participants for all but one of the impairment scenarios is “one-on-one consult with student”. It would be interesting for a qualitative study to be conducted on just this remediation method alone. What are the specific reasons research participants considered, more often than not, consulting with students one-on-one first before implementing any other remediation method? What is the primary goal of conducting a “one-on-one consult” with students? Could one possible reason be to show a level of respect by being receptive to hearing the therapist-in-training’s perspective in addition to working with the therapist-in-training in order to determine his/her needs, academically and clinically? Whose responsibility is it to conduct the one-on-one consult and how is this decided? Should all one-on-one discussions be structured similarly or differently? What, if

anything, would the graduate trainers expect to hear or see from the student so that further remediation is not required? For instance, would the therapist-in-training need to express a sense of accountability for what has occurred?

The second remediation method that was chosen more often than not by research participants is “increased supervision”. As part of the remediation process, how much more supervision would be sufficient? How is this determined? Is conducting individual supervision twice a week as opposed to once a week adequate enough in attempting to remediate graduate students? What specifically would be addressed during the multiple supervision sessions? Would the supervision focus primarily on the impairment at hand as well as ways in which the impairment in question may be resolved? Would an increase in supervision sessions pose any potential problems and/or conflicts for the graduate program faculty or therapist-in-training in reference to the time and resources needed? Would this place more stress upon the individual persons involved (e.g. faculty and graduate student) or the system (e.g. graduate program) responsible for effectively educating and training graduate students? What recourse does the graduate program have if the therapist-in-training is noncompliant with attending and engaging in the supervision sessions and making necessary improvements? If there is to be an increase in supervision sessions, what is an appropriate timeframe from beginning to end?

Since the third remediation method, “mobilization support systems”, was chosen for at least 6 of 17 impairment scenarios provided, it, too, deserves further attention and exploration in future research studies. What constitutes a “support system”? Does one’s “support system” involve family members, friends, spouses/significant others? If so, at what point in time is it appropriate to involve the above stated support systems? Would it

be most appropriate to first ask the therapist-in-training if he/she would like their external support systems to be involved or for the graduate program faculty to make this determination? To what extent would the therapist-in-training's support systems be involved and for how long? Would involving outside support systems be considered a breach of confidentiality or an infringement upon the student's rights? From a student's perspective, would involving external support systems be helpful or possibly an embarrassment because their "problem" has been aired to other people?

Last but not least, the results of this study may also be useful for master's and doctoral level students if they wish to pursue this topic for future research, especially to examine the "experience of remediation from the students' perspective" (Russell & Peterson, 2003, p. 336). The perspective of therapists-in-training with regard to remediation is an area of focus that is understudied, and therefore, deserves a great deal of attention in the future.

Implications for Practice

Not only do the current findings serve as a springboard for future research, it also has implications within the realm of practice. According to the literature, it seems that our initial "knee jerk reaction" would be to mandate that the trainee attend individual therapy. However, the results from this research study seem to indicate is that it would be most effective if supervisors were to increase the level of supervision and/or address any problems within the context of supervision. Addressing these concerns in supervision would be a great opportunity for the supervisor to reaffirm the guidelines and expectations discussed during the initial supervision meeting and closely monitor the

trainee as he/she works toward resolving the impairment in question and continues to grow professionally.

No matter what the field of social sciences, it is important for practicing supervisors to first sit down and have a "one-on-one consult" with their trainees when a problem comes to the forefront. It is during this time that the supervisor will be able to (a) hear the trainee's perspective, (b) determine the trainee's needs, and then (c) "co-construct" with the trainee what course of action would be most appropriate.

First, it is extremely important that the supervisor meet with the supervisee "one-on-one" in order to hear his/her perspective about the concern in question. This will allow the supervisor to inquire about what has possibly occurred as well as to make sense of all of the information obtained, especially if the information is coming from several different sources. Furthermore, the supervisee will have the opportunity to share his/her side of the story, clarify and explain any possible misunderstandings, dispel any possible rumors about the situation in question, and express a sense of accountability and a willingness to work toward an appropriate resolution if he/she did indeed make a mistake.

Second, once the supervisor has heard the supervisee's perspective, the next step is to determine what the supervisee may need in order to resolve the matter. The only way this may be done is for the supervisor to simply ask the supervisee what he/she may need. All depending on the concern in question, does the supervisee feel as though he/she may need a reduction in his/her caseload, a temporary leave of absence, an increase in supervision, or an increase in support from internal as well as external support systems? Moreover, if a supervisor suspects or recognizes that a trainee may be experiencing a potential problem that may have a direct affect on his/her work with clients, it may be

very helpful for the supervisor to determine if the trainee has support systems and whether or not the support systems have been mobilized. Based on this discussion, the supervisor may also be able to provide some insight and possible suggestions of what may be helpful.

The third and final step is for the supervisor and supervisee to "co-construct" the most appropriate course of action. The idea is to develop and chose a course of action that closely relates to the problem that requires resolution. This logic is similar to natural and logical consequences. For instance, in the impairment scenario pertaining to an ethical violation, rather than requiring that the supervisee attend individual therapy as a mode of remediation, it would be more natural and logical that the supervisor "assign a structured assignment requiring the student therapist to review the code of ethics, write about specific ethical code violated, and then conduct discussions with supervisors and faculty to demonstrate an understanding of ethics and laws, including potential harm to client". In this case, it would seem that the supervisee would be more inclined to complete this course of action, rather than attend individual therapy, as it closely relates to the problem in question. Furthermore, the supervisee will also learn more about and enhance his/her clinical knowledge and application in the area of ethics.

Finally, it is imperative that supervisors document during the process of supervision, especially if/when remediation is warranted and implemented. It is essential that the supervisor document specifics such as the concern in question, course of action, timeframe in which the course of action must be completed by, and supervisee's progress in completing the remediation plan. Even though the supervisor may document, it is entirely possible, all depending on the type of impairment, that he/she may be faced with

the decision to take legal and/or ethical steps, such as reporting the “ethical violation to the state licensing board, university attorney”, or national association.

Based on the information obtained, it is clear that there exists a gap in literature on how to appropriately and effectively remediate problem trainees within the field of MFT. As a result, it is crucial that future research continue to include multiple perspectives from various disciplines (Forrest et al., 1999) with regard to responding to student impairment while also balancing one’s role as gatekeeper to the public, graduate program, profession, and therapists-in-training (Russell & Peterson, 2003). It is with this research, in addition to future research, that the seriousness of the gatekeeper role will continue to be affirmed and trainers will continue to be guided on how to effectively and appropriately balance this role.

References

Abraham, L. (1995, November 5). Dr. Smith goes to sexual-rehab school. New York Times Magazine, 73, 44-49.

American Association for Marriage and Family Therapy (AAMFT) (2005). Commission on Accreditation for Marriage and Family Therapy Education accreditation standards for graduate and post-graduate Marriage and Family Therapy Programs Version 11.0: Program effectiveness: student performance and faculty accomplishments. Retrieved February 22, 2007 from www.aamft.org/about/COAMFTE/Version%2011%20standards/master_version_11_Accreditation_standards.pdf

American Association for Marriage and Family Therapy (AAMFT) (2004). Marriage and family therapy core competencies. Retrieved February 22, 2007 from http://www.aamft.org/resources/mft_core_competencies/MFT%20Core%20Compentencies_December%202004.pdf

American Association for Marriage and Family Therapy (AAMFT) (2002). Approved supervisor designation standards and responsibilities handbook: Evaluation guidelines. Retrieved February 23, 2007 from http://www.aamft.org/membership/Supervision/Approved%20Supervisor.pdf.

American Counseling Association (1995). Code of ethics and standards of practice. Alexandria, VA: Author.

American Psychiatric Association (1992). The principles of medical ethics with annotations especially applicable to psychiatry. Washington, DC: Author.

American Psychological Association Books Online. Professionals in distress: Issues, syndromes and solutions in psychology. Book description. Retrieved April 17, 2007, from http://books.apa.org/books.cfm?id=4317040.

Asay, T.P., & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), The heart and soul of change: What works in therapy (pp. 23-55). Washington, DC: American Psychological Association. Association for Counselor Education and Supervision (1993). Ethical guidelines for counselor educators and supervisors. Alexandria, VA: Author.

Beck, M., Springen, K., & Foote, D. (1992, April 13). Sex and psychotherapy. Newsweek, 119, 52-57.

Bemak, F., Epp, L. R., & Keys, S. G. (1999). Impaired graduate students: A process model of graduate program monitoring and intervention. International Journal for the Advancement of Counseling, 21, 19-30.

Bennett, G. (1986). Faculty interventions: How far should you go? In C.D. Scott & J.H. Hawk (Eds.), Heal thyself: The health of healthcare professionals (pp. 147-160). New York: Brunner/Mazel.

Bernard, J. L. (1975). Due process in dropping the unsuitable clinical student. Professional Psychology: Research and Practice, 6, 275-278.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E., Bergin (Eds.), Handbook of psychotherapy and behavior change (pp. 257-310). New York: Wiley.

Beutler, L.E., Machado, P.P., & Neufeldt, S.A. (1994). Therapist variables. In A.E. Bergin & S.L. Garfield (Eds.), Handbook of psychotherapy and behavior change (pp. 229-269). New York: Wiley.

Biaggio, M. K., Gasparikova-Krasnec, M., & Bauer, L. (1983). Evaluation of clinical psychology graduate students: The problem of the unsuitable student. Professional Psychology: Research and Practice, 14, 9-20.

Binning, D., Cochran, S., & Donatelli, B. (1972). Delphi panel to explore post-secondary needs in the State of New Hampshire. Manchester, NH: Decision Research.

Bissell, L. (1983). Alcoholism in physicians: Tactics to improve the salvage rate. Postgraduate medicine, 74, 177-230.

Bok, S. (1984). Secrets: On the ethics of concealment and revelation. New York: Vintage Books.

Boxley, R., Drew, C. R., & Rangel, D. M. (1986). Clinical trainee impairement in APA approved internship programs. Clinical Psychologist, 39, 49-52.

Bradey, J., & Post, P. (1991). Impaired students: Do we eliminate them from counselor education programs? Counselor Education and Supervision, 31, 100-108.

Brodsky, A. M. (1986). The distressed psychologists: Sexual intimacies and exploitation. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), Professionals in distress: Issues, syndromes, and solutions in psychology (pp. 153-171). Washington, DC: American Psychological Association.

Brown, L.S. (1997). Remediation, amends, or denial? Professional Psychology: Research and Practice, 13, 153-158.

Chesler, P. (1972). Women and madness. New York: Avon Books.

Chessick, R.D. (1978). The sad soul of the psychiatrist. Bulletin of the Menninger Clinic, 42, 1-9.

Childress, R., & Grills, J. S. (1977). A study of pretherapy role induction as an influence process, Journal of Clinical Psychology, 33, 540-544.

Claiborn, W. (1982). The problem of professional incompetence. Professional Psychology: Research and Practice, 13, 153-158.

Cobia, D.C., & Boes, S.R. (2000). Professional disclosure statements and formal plans for supervision: Two strategies for minimizing the risk of ethical conflicts in post-master's supervision. Journal of Counseling and Development, 78, 293-296.

Committee on Physician Sexual Misconduct (1992). Report prepared for the College of Physicians and Surgeons of British Columbia. Vancouver, British Columbia, Canada: Author.

Corey, G., Corey, M. S., & Callanan, P. (1993). Issues and ethics in the helping professions (4^{th} ed.). Pacific Grove, CA: Brooks/Cole.

Custer, G. (1994, November). Can universities be liable for incompetent grads? APA Monitor, 25(11), 7.

Dalkey, N. (1969). Experimental study of group opinion. Futures, 1, 408-426.

Dalkey, N. (1972). Studies in the quality of life. Lexington, MA: Lexington Books.

Deutsch, C.J. (1984). Self-reported sources of stress among psychotherapists. Professional Psychology: Research and Practice, 15, 833-845.

Deutsch, C.J. (1985). A survey of therapists' personal problems and treatment.

Professional Psychology: Research and Practice, 16, 305-315.

Dillman, D.A. (2000). Mail and internet surveys: The tailored design method. New York: Wiley.

Disney, M.J., & Stephens, A.M. (1994). Legal issues in clinical supervision (ACA Legal Series, Vol. 10). Alexandria, VA: American Counseling Association.

Dixon v. Alabama State Board of Education, 294 F. 2d 150 (5th Cir.), cert. denied, 368 U.S. 930 (1961).

Ellis, A. (1972). Psychotherapy without tears. In A. Burton (Ed.), Twelve therapists (pp. 103-126). San Francisco: Jossey-Bass.

Enochs, W.K. & Etzbach, C.A. (2004). Impaired student counselors: Ethical and legal considerations for the family. The Family Journal, 12, 396-400.

Epstein, R. (1997, July). Why do shrinks have so many problems? Psychology Today, 30, 58-62, 74-76.

Farber, B.A., & Heifetz (1982). The satisfactions and stressors of psychotherapeutic work: A factor analytic study. Professional Psychology: Research and Practice, 12, 621-630.

Figley, C.R., & Nelson, T.S. (1989). Basic family therapy skills: I. Conceptualization and initial findings. Journal of Marital and Family Therapy, 15, 349-365.

Fish, L. S. & Busby, D. M. (1996). The Delphi Method. In D. H. Sprenkle & S. M. Moon (Eds.), Research methods in Family Therapy (pp. 469-482). New York: Guilford Press.

Fly, B. J., van Bark, W. P., Weinman, L., Kitchener, K. S., & Lang, P. R. (1997). Ethical transgressions of psychology graduate students: Critical incidents with implications for training. Professional Psychology: Research and Practice, 28, 492-495.

Folman, R. (1991). Therapist-patient sex: Attraction and boundary problems. Psychotherapy, 28, 168-173.

Ford, J. D. (1979). Research on training counselors and clinicians. Review of Educational Research, 49, 87-130.

Forrest, L., Elman, N., Gizara, S., & Vacha-Haase, T. (1999). Trainee impairment: A review of identification, remediation, dismissal, and legal issues. The Counseling Psychologist, 27, 627-686.

Frame, M. W., & Stevens-Smith, P. (1995). Out of harm's way: Enhancing monitoring and dismissal procedures in counselor education programs. Counselor Education and Supervision, 35, 118-129.

Framo, J. I. (1976). Chronicle of a struggle to establish a family unit within a community mental health center. In P. Guerin (Ed.), Family therapy: Theory and practice. New York: Gardner Press.

Freudenberger, H. J. (1986). Chemical abuse among psychologists: Symptoms, causes, and treatment issues. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), Professionals in distress: Issues, syndromes, and solutions in psychology (pp. 135-152). Washington, DC: American Psychological Association.

Gallessich, J., & Olmstead, K. M. (1987). Training in counseling psychology: Issues and trends in 1986. Counseling Psychologist, 15, 596-600.

Gaubatz, M. D. & Vera, E. M. (2002). Do formalized gatekeeping procedures increase programs' follow-up with deficient trainees? Counselor Education and Supervision, 41, 294-305.

Gelso, C.G. & Fretz, B.R. (1992). Ethical and professional issues. In C.G. Gelso & B.R. Fretz (Eds.), Counseling psychology (pp. 51-82). Fort Worth, TX: Harcourt, Brace, Jovanovich.

Gibbs, P. (1994). Gatekeeping issues in BSW programs. Arete, 19(2), 15-27.

Gizara, S. S. (1997). Supervisor's construction of intern impairment at APA-accredited internship sites. Unpublished doctoral dissertation, Michigan State University, East Lansing.

Goldenson, R. M. (1984). Longman dictionary of psychology and psychiatry. New York: Longman.

Gimmestad, M. J. & Beard, E. G. (1973). Admissions policies for graduate programs in counselor education. Counselor Education and Supervision, 12, 173-177.

Godfrey, K., Haddock, S.A., Fisher, A, & Lund, L. (2006). Essential components of curricula for preparing therapists to work effectively with lesbian, gay, and bisexual clients: A Delphi study. Journal of Marital and Family Therapy, 32, 491-504.

Goldstein, A. P. (1971). Psychotherapeutic attraction. New York: Pergamon.

Gonsiorek, J.C. (1995). Breach of trust: Sexual exploitation by health care professionals and clergy. Thousand Oaks, CA: Sage.

Grayson, H. (1982). Ethical issues in the training of psychotherapists. In M. Rosenbaum (Ed.), Ethics and values in psychotherapy (pp. 51-63). New York: Free Press.

Grunebaum, H. (1995). Helpful and harmful psychotherapy. The Harvard Medical School/Mental Health Letter, 1, 5-6.

Grunebaum, H. (1986). Harmful psychotherapy experiences. American Journal of Psychotherapy, 40, 165-176.

Guy, J.D., Polestra, P.L., & Stark, M.J. (1989). Personal distress and therapeutic effectiveness: National survey of psychologists practicing psychotherapy. Professional Psychology: Research and Practice, 20, 48-50.

Hahn, W. K., & Molnar, S. (1991). Intern evaluation in university counseling centers: Process, problems, and recommendations. Counseling Psychologist, 19, 414-430.

Haley, J. (1975). Why a mental health clinic should avoid doing family therapy. Journal of Marriage and Family Counseling, 1, 3-12.

Harkins, S., & Szymanski, K. (1989). Social loafing and group evaluation. Journal of Personality and Social Psychology, 56, 934-941.

Harris v. Blake and the Board of Trustees of the University of Northern Colorado, 798 F.2d 419 (CO10 1986).

Hassenfeld, I., & Lavigne, G. (1987). Issues raised by troubled residents: Need for psychotherapy. Journal of Medical Education, 62, 608-610.

Heppner, P. P., & Dixon, D. N. (1981). A review of the interpersonal influence process in counseling. The Personnel and Guidance Journal, 55, 542-550.

Heppner, P. P., & Heesacker, M. (1982). Interpersonal influence process in real-life counseling: Investigating client perceptions, counselor experience level, and counselor power over time. Journal of Counseling Psychology, 29, 215-223.

Herman, K.C. (1993). Reassessing predictors of therapist competence. Journal of Counseling and Development, 72, 29-32.

Holloway, E., & Roehlke, H. (1987). Internship: The applied training of a counseling psychologist. The Counseling Psychologist, 15, 205-260.

Jensen, P. S. (1983). Barriers to working with impaired trainees: A resident's viewpoint. Psychiatric Quarterly, 55, 268-271.

Jones, L. K. (1974). Toward more adequate selection criteria: Correlates of empathy, genuineness, and respect. Counselor Education and Supervision, 14, 13-21.

Kaczmarek, M., & Connor, C. (1998, February). A survey of doctoral programs: Remediation. In N. Elman (Chair), Trainee Impairment. Symposium presented at the annual meeting of the Council of Counseling Psychology Training Programs, Scottsdale, AZ.

Kaslow, N. J. & Friedman, D. (1984). The interface of personal treatment and clinical training for psychotherapist trainees. In F. W. Kaslow (Ed.), Psychotherapy with psychotherapists (pp. 33-57). New York: Harworth Press.

Kempthorne, G. (1979). The impaired physician: The role of the state medical society. Wisconsin Medical Journal, 78, 21-23.

Kerr, N. & Brunn, S. (1983). Dispensability of member effort and group motivation losses: Free-rider effects. Journal of Personality and Social Psychology, 44, 78-94.

Kerl, S.B., Garcia, J.L., McCullough, S., & Maxwell, M.E. (2002). Systemic evaluation of professional and performance: Legally supported procedures. Counselor Education and Supervision, 41, 321-334.

Khan, M. (1974). The privacy of the self. New York: International Universities Press.

Kilburg, R. R., Nathan, P. E., & Thoreson, R. W. (Eds.). (1986). Professionals in distress: Issues, syndromes, and solutions in psychology. Washington, DC: American Psychological Association.

Kitchener, K. S. (1984). Intuition, critical evaluation, and ethical principles: The foundation for ethical decisions in counseling psychology. The Counseling Psychologist, 12(3), 43-55.

Kitchener, K. S. (1992). Psychologist as teacher and mentor: Affirming ethical values throughout the curriculum. Professional Psychology: Research and Practice, 23, 190-195.

Knoff, H. M., & Prout, H. T. (1985). Terminating students from professional psychology programs: Criteria, procedures, and legal issues. Professional Psychology: Research and Practice, 16, 789-797.

Laliotis, D. A. & Grayson, J. H. (1985). Psychologist heal thyself: What is available for the impaired psychologist. American Psychologist, 40(1), 84-96.

Lamb, D. (1999). Addressing impairment and its relationship to professional boundary issues: A response to Forrest, Elman, Gizara, and Vacha-Haase. The Counseling Psychologist, 27, 702-711.

Lamb, D. H., Cochran, D. J., & Jackson, V. R. (1991). Training and organizational issues associated with identifying and responding to intern impairment. Professional Psychology: Research and Practice, 22, 291-296.

Lamb, D. H., Presser, N. R., Pfost, K. S., Baum, M. C., Jackson, V. R., & Jarvis, P. A. (1987). Confronting professional impairment during the internship: Identification, due process, and remediation. Professional Psychology: Research and Practice, 18, 597-603.

Latane, B. (1981). The psychology of social impact. American Psychologist, 36, 343-356.

Layman, M.J., & McNamara, J.R. (1997a). Remediation for ethics violations: Focus on psychotherapists' sexual contact with clients. Professional Psychology: Research and Practice, 28, 281-292.

Levy, L. (1983). Evaluation of students in clinical psychology programs. Professional Psychology: Research and Practice, 14, 497-503.

Liddle, H. (1978). The emotional and political hazards of teaching and learning family therapy. Family Therapy, 5, 1-12.

Liddle, H. (1988). Systemic supervision: Conceptual overlays and pragmatic guidelines. In H. Liddle, D. C. Breunlin, & R. C. Schwartz, (Eds.). Handbook of family therapy training and supervision (pp. 153-171). New York: Guilford.

Liddle, H., Breunlin, D. C., & Schwartz, R. C. (Eds.). (1988). Handbook of family therapy training and supervision. New York: Guilford.

Linstone, H.A., & Turoff, M. (1975). The Delphi method: Techniques and applications. Reading, MA: Addison-Wesley.

Maeder, T. (1989, January). Wounded healers. The Atlantic Monthly, 263, 37-47.

Mahoney, M.J. (1997). Psychotherapists' personal problems and self-care patterns. Professional Practice: Research and Practice, 28, 14-16.

Markert, L., & Monke, R. H. (1990). Changes in counselor education admissions criteria. Counselor Education and Supervision, 30, 48-56.

Maslach, C. (1986). Stress, burnout and alcoholism. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), Professionals in distress: Issues, syndromes, and solutions in psychology (pp. 53-76). Washington, DC: American Psychological Association.

McCarthy, P., Sugden, S., Koker, M., Lamendola, F., Maurer, S., & Renninger, S. (1995). A practical guide to informed consent in clinical supervision. Counselor Education and Supervision, 35, 130-138.

McCrady, B.S. (1989). The distressed or impaired professional: From retribution to rehabilitation. The Journal of Drug Issues, 19, 337-349.

Mead, D. (1990). Effective supervision: A task-oriented model for the mental health professions. New York: Brunner/Mazel.

Mearns, J., & Allen, G. J. (1991). Graduate students' experiences in dealing with impaired peers, compared with faculty predictions: An exploratory study. Ethics and Behavior, 1, 191-202.

Milam, S., & Marshall, R. (1987). Impact of regents of the University of Michigan v. Ewing on academic dismissals from graduate and professional schools. Journal of College and University Law, 13, 335-352.

Millon, T., Millon, C., & Antoni, M. (1986). Sources of emotional and mental disorder among psychologists: A career development perspective. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), Professionals in distress: Issues, syndromes, and

solutions in psychology (pp. 119-134). Washington, DC: American Psychological Association.

Nathan, P. E. (1986). Unanswered questions about distressed professionals. In R. R. Kilburg, P. E. Nathan, & R. W. Thoreson (Eds.), Professionals in distress: Issues, syndromes, and solutions in psychology (pp. 27-36). Washington DC: American Psychological Association.

Nagy, T. F. (1989, February). Boundaries of competence: Training and therapist impairment. Paper presented at the California State Psychological Association Annual Convention, San Francisco.

Nugent, C.D. (1996). Prevention and education: Overview. In Nugent, C.D., Gill, J.P., & Plaut, S.M. (Eds.), Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation (pp. 9-10). Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Nugent, C.D. & Schank, J.A. (1996). Public education. In Nugent, C.D., Gill, J.P., & Plaut, S.M. (Eds.), Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation (pp. 21-22). Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Nugent, C. D., Gill, J. P., & Plant, S. M. (Eds.). (1996). Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation. Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Olkin, R., & Gaughen, S. (1991). Evaluation and dismissal of students in master's level clinical programs: Legal parameters and survey results. Counselor Education and Supervision, 30, 276-288.

Openshaw, D. K. (Last updated January 11, 2007). A diagrammatic representation of AAMFT core competencies: Introduction. Retrieved February 22, 2007, from http://www.aamft.org/resources/mft_corecompetencies/btg/implementing_cc_website_conceptual_models.asp

O'Sullivan, M.J., & Gilbert, R.K. (1989). Master's degree programs in marital and family therapy: An evaluation of admission and program requirements. Journal of Marital and Family Therapy, 15, 337-347.

Overholser, J., & Fine, M. (1990). Defining the boundaries of professional competence: Managing subtle cases of clinical incompetence. Professional Psychology: Research and Practice, 21, 462-469.

Plaut, S. M. (1996). Introduction: Scope of the problem. In Nugent, C.D., Gill, J.P., & Plaut, S.M. (Eds.), Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation (pp. 1-8). Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Plaut, S. M. & Mandel, E. (1996). Institutional education and policy. In Nugent, C.D., Gill, J.P., & Plaut, S.M. (Eds.), Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation (pp. 23-26). Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Plaut, S. M. & Schank, J.A. (1996). Professional education. In Nugent, C.D., Gill, J.P., & Plaut, S.M. (Eds.), Sexual exploitation: Strategies for prevention and intervention-report of the Maryland Task Force to study health professional-client sexual exploitation (pp. 11-20). Baltimore, MD: Maryland Department of Health and Mental Hygiene.

Pope, K. (1994). Sexual involvement with therapists: Patient assessment, subsequent therapy, forensics. Washington, DC: American Psychological Association.

Pope, K.S., & Tabachnick, B.G. (1994). Therapists as patients: A national survey of psychologists' experiences, problems, and beliefs. Professional Psychology: Research and Practice, 25, 247-258.

Redfering, D. L. & Biasco, F. (1976). Selection and elimination of candidates in counselor education programs. Counselor Education and Supervision, 15, 298-304.

Robertson, J. (Ed.). (1980). Legal aspects of impairment: In Proceeding of the Fourth AMA Conference on the Impaired Physician: Building well-being (pp. 45-48). Chicago: American Medical Association.

Russell, C.S., & Peterson, C.M. (2003). Student impairment and remediation in accredited marriage and family therapy programs. Journal of Marital and Family Therapy, 29, 329-337.

Russell, C.S., DuPree, W.J., Beggs, M.A., Peterson, C.M., & Anderson, M.P. (2007). Responding to remediation and gatekeeping challenges in supervision. Journal of Marital and Family Therapy, 33, 227-244.

Saba, G. W., & Liddle, H. A. (1986). Perceptions of professional needs, practice patterns, and critical issues facing family therapy trainees and supervisors. American Journal of Family Therapy, 14, 109-122.

Schoener, G. R. (1995). Assessment of professionals who have engaged in boundary violations. Psychiatric Annals, 25, 95-99.

Schoener, G.R. (1995). Employer/supervisor liability and risk management: An administrator's view. In J.C. Gonsiorek (Ed.), The breach of trust: Sexual exploitation by healthcare professionals and clergy, (pp. 300-316). Newbury, CA: Sage.

Schoener, G. R. (1999). Practicing what we preach. Counseling Psychologist, 27, 693-701.

Schoener, G.R., & Gonsiorek, J. (1988). Assessment and development of rehabilitation plans for counselors who have sexually exploited their clients. Journal of Counseling and Development, 67, 227-232.

Schwebel, M., Skorina, J., & Schoener, G. (1988). Assisting impaired psychologists: Program development for state psychological associations. Washington, DC: American Psychological Association.

Shaw, B.F., & Dobson, K.S. (1988). Competency judgments in the training and evaluation of psychotherapists. Journal of Consulting and Clinical Psychology, 56, 666-672.

Sherman, M.D. (1996). Distress and professional impairment due to mental health problems among psychotherapists. Clinical Psychology Review, 16, 299-315.

Sinclair, C., Simon, N., & Pettifor, J. (1996). The history of ethical codes and licensure. In L.J. Bass, S.T. DeMers, J.R. Ogloff, C. Peterson, J.L. Pettifor, R.P. Reaves, T. Retfalvi, N.P. Simon, C. Sinclair, & R.M. Tipton (Eds.), Professional conduct and discipline in psychology (pp. 1-15). Washington, DC: American Psychological Association.

Skorupa, J., & Agresti, A. A. (1993). Ethical beliefs about burnout and continued ethical practice. Professional Psychology: Research and Practice, 24, 281-285.

Slovenko, R. (1980). Legal issues in psychotherapy supervision. In A. Hess (Ed.), Psychotherapy supervision: Theory, Research, and Practice (pp. 453-473). New York: Wiley and Sons.

Smith, D. & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. Professional Psychology: Research and Practice, 26, 499-506.

Sori, C.F., & Sprenkle, D.H. (2004). Training family therapists to work with children and families: A modified Delphi study. Journal of Marital and Family Therapy, 30, 479-496.

Sprenkle, D.H., & Moon, S.M. (Eds.). (1996). Research methods in family therapy. New York: Guilford.

Stadler, H. A., Willing, K. L., Eberhage, M. G., & Ward, W. H. (1988). Impairment: Implications for the counseling profession. Journal of Counseling and Development, 66, 258-260.

Storm, C.L., & Haug, I.E. (1997). Ethical issues: Where do you draw the line? In T.C. Todd & S.L. Storm (Eds.), The complete systemic supervisor: Context, philosophy, and pragmatics (pp. 26-40). Boston: Allyn & Bacon.

Storm, C. L., Todd, T. C., Sprenkle, D. H., & Morgan, M. M. (2001). Gaps between MFT supervision assumptions and common practice: Suggested best practices. Journal of Marital and Family Therapy, 27, 227-241.

Sussman, M. B. (1992). A curious calling: Unconscious motivations for practicing psychotherapy. Northvale, NJ: Jason Aronson.

Tanenbaum, R.L., & Berman, M.A. (1990). Ethical and legal issues in psychotherapy supervision. Psychology in Private Practice, 8, 65-77.

Tedesco, J. F. (1982). Premature termination of psychology interns. Professional Psychology: Research and Practice, 13, 695-698.

Tersine, R. J., & Riggs, W. E. (1976). The Delphi technique: A long-range planning tool. Business Horizons, 19, 51-57.

Thoreson, R., Nathan, P., Skorina, J., & Kilburg, R. (1983). The alcoholic psychologist: Issues, problems, and implications for the profession. Professional Psychology: Research and Practice, 14, 670-684.

U.S. Department of Justice, The Americans with Disabilities Act (1990). Americans with Disabilities Act: Questions and answers. Retrieved April 17, 2007, from http://www.usdoj.gov/crt/ada/q&aeng02.htm.

Vacha-Haase, T. (1995, August). Impaired graduate students in APA-accredited clinical, counseling, and school psychology programs. Unpublished doctoral dissertation, Texas A & M University, College Station, Texas.

Vasquez, M. (1999). Trainee impairment: A response from a feminist/multicultural retired trainer. Counseling Psychologist, 27, 687-692.

Wakefield, J. (1995). Am I my brother's keeper? Impairment in the healing professions. In L.B. Ross & M. Roy (Eds.), Cast the first stone: Ethics in analytic practice (pp. 82-90). Wilmette, IL: Chiron.

Weinstein, H.M (1983). A committee on well-being of medical students and house staff. Journal of Medical Education, 58, 373-381.

Wheeler, S. (1996). The limits of tolerance in assessing the competence of counseling trainees. International Journal for the Advancement of Counseling, 18, 173-188.

White, M.B., Edwards, S.A., & Russell, C.S. (1997). The essential elements of a successful marriage and family therapy: A modified Delphi study. American Journal of Family Therapy, 25, 213-231.

White, M.B., & Russell, C.S. (1995). The essential elements of supervisory systems: A modified Delphi study. Journal of Marital and Family Therapy, 21, 33-53.

White, W. L. (1997). The incestuous workplace: Stress and distress in the organizational family. Center City, MN: Hazelden.

Younes, M. N. (1998). The gatekeeping dilemma in undergraduate social work programs: Collision of ideas and reality. International Social Work, 41, 145-153.

Young, R. B. (1986). An exploratory study of admissions information and success preparation programs for student personnel workers. Journal of College Student Personnel, 27, 131-136.

APPENDIX A: Delphi Questionnaire I
Letter of Consent/Invitation to Participate in Research Study

March 29, 2006

Dear Colleague:

I would like to take this opportunity to introduce myself. My name is Kara McDaniel, and I am currently a doctoral candidate in the Marriage and Family Therapy program at Kansas State University. I am conducting the following dissertation research study under the direction of my major professor, Dr. Tony Jurich. Because of your experience, I would like to ask for your participation in a two round Delphi study that is important and significant to both clinicians and researchers in the field of MFT.

Using a confidential web based survey system, I intend to elicit and examine the opinions of supervisors, directors, and faculty members currently working within graduate training programs. This study will be comprised of two different questionnaires within approximately a two-month period. One questionnaire will be sent via email on two separate occasions and each questionnaire will require approximately 10-15 minutes of your time. The first questionnaire will include scenarios relevant to specific types of impairment. Participants will be asked to read each scenario and place a check mark by one or more of the most effective remediation methods. The second questionnaire will consist of group results from the first questionnaire in which participants will be asked to rate their agreement and indicate what they would do differently. With great appreciation for your participation, a complete and final summary of the results will be sent to you.

This study will utilize a modified version of the Delphi technique. The Delphi technique is widely used to gain group consensus from a panel of knowledgeable experts within a specific field. Compared to other research methods, the Delphi method assures that responses are anonymous, reduces possible pressure to conform to the group, and requires less time from the research participants. Confidentiality using the web based survey system is ensured by directly submitting data to the survey system database. The system does track who has responded but only so that reminder notices can be sent to those who have not responded. Furthermore, identifying information will not be linked to the responses of participants.

Once again, your participation in the present research study will be greatly appreciated as you have valuable information and expertise working with graduate students within the MFT field. Your participation in the study is strictly voluntary and you may withdraw at any point in time. If you would like to participate, just simply complete and submit the first questionnaire using the web based survey system. If you do not wish to participate, a link is provided in the email invitation that you can click on to request that further copies of the study are not sent to you.

If you have any questions or require additional information, either my major professor or I may be contacted. Our contact information is as follows: Kara Z. McDaniel, 11 Dunwoody Park, Suite 150, Dunwoody, Georgia 30338, 404-778-6924 and Anthony P. Jurich, Kansas State University, Department of Human Ecology/Family Studies and Human Services, Campus Creek Complex, Manhattan, Kansas 66506, 785-532-1488.

I look forward to working with you.

Sincerely,

Kara Z. McDaniel, NCC, LPC
Ph.D. Candidate

APPENDIX B: Delphi Questionnaire I
Survey Description

The present research is an exploratory study designed to enhance remediation plans used by graduate training programs through matching specific types of student impairment with specific types of remediation methods. With your assistance, this research study will begin to explore what types of remediation methods are most effective for the various types of impairment that not only effect graduate students but also graduate trainers

APPENDIX C: Delphi Questionnaire I

Below are scenarios describing the different types of student impairment. After reading each scenario, place a check mark by one or more of the most effective remediation methods. If other is chosen, please type the specific remediation method in the space provided. All of the remediation options provided for each scenario are identical.

Question 1

Burnout-Mark is a student therapist who is experiencing extreme distress in his life due to an overload of clients, coursework, assistantship, and a part-time job. Not only is Mark consistently late for work and class, he also completes and turns in his assignments late. Mark's professors and employer have noticed him falling asleep in class and emotionally withdrawing from his peers and co-workers. Furthermore, Mark has been requesting more time-off from work and school for medical appointments due to complaints of headaches and gastrointestinal distress.

- Immediate one-on-one consult with student
- Mobilization of support systems
- Reduce clinic load
- Tutoring
- Increase in advising and mentoring
- Self-structured behavioral change
- Increased supervision
- Leave of absence
- Extra coursework
- Repeat coursework
- Repeat practicum
- Additional field experience
- Second internship
- Personal growth group
- Individual therapy
- Group therapy
- Leave program
- Counseled out of program
- Termination
- Other: _____

Further comments about your response:

Question 2

Mental illness (Depression)-Both peers and professors/supervisors have observed a change in both Dianne's appearance as well as emotional well-being. Dianne appears to be sad most of the time, withdrawn, disheveled appearance, fatigued, and irritable. Also, it was reported that Dianne informed one of her peers that she had been feeling suicidal.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 3

Unprofessional behavior-While conducting therapy with clients, Maria has been observed wearing revealing clothes (e.g. low-cut blouses, tight trousers, and short skirts) by her primary supervisor. During one of Maria's individual sessions with a male client, the client appeared to be easily distracted by Maria's low-cut blouse and made several verbal references about how he thought it enhanced her figure.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 4

Personality Disorder-The supervisor has noted that Doug seems to lack empathy toward his peers and clients, has a grandiose sense of self, requires admiration from supervisors, peers, and clients, displays arrogance during classroom discussions, and expects favorable treatment by professors by asking them to extend his due dates on assignments.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 5

Ethical violation-Johnny communicated with his client's attorney and released client information without a release of information signed by his client.

- Immediate one-on-one consult with student
- Mobilization of support systems
- Reduce clinic load
- Tutoring
- Increase in advising and mentoring
- Self-structured behavioral change
- Increased supervision
- Leave of absence
- Extra coursework
- Repeat coursework
- Repeat practicum
- Additional field experience
- Second internship
- Personal growth group
- Individual therapy
- Group therapy
- Leave program
- Counseled out of program
- Termination
- Other: _____

Further comments about your response:

Question 6

Academic deficiency-Although Ana is doing well clinically, she is missing the majority of her semester classes, not turning in required coursework, making substandard grades on exams, and attending classes late and using her clients as an excuse for being tardy.

- Immediate one-on-one consult with student
- Mobilization of support systems
- Reduce clinic load
- Tutoring
- Increase in advising and mentoring
- Self-structured behavioral change
- Increased supervision
- Leave of absence
- Extra coursework
- Repeat coursework
- Repeat practicum
- Additional field experience
- Second internship
- Personal growth group
- Individual therapy
- Group therapy
- Leave program
- Counseled out of program
- Termination
- Other: _____

Further comments about your response:

Question 7

Interpersonal problems-Kiesha is experiencing problems with getting along well with her peers, professors, and supervisors. During class, it has been observed by Kiesha's professors and peers that she occupies lecture time by asking too many questions that are irrelevant, comments on almost every topic being discussed, and challenges the knowledge of her professors rather than asking questions that will enhance her knowledge base.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 8

Sexual contact with client-Darren is conducting couples therapy and being supervised live by his primary supervisor. Only the wife attends this particular session. During session, the female client talks to the therapist about their special relationship. After the session, the supervisor immediately asked Darren what was meant by special relationship. The student therapist hesitated, but finally admitted that he had sexual intercourse with the female client during the time he was seeing her for individual therapy.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 9

Physical illness-Javier was recently diagnosed with ulcerative colitis, and his illness is affecting his academic and clinical work. Javier is missing classes, canceling clinic appointments, and failing to turn in coursework.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 10

Supervision problem-Susana was given a directive by her supervisor to devise a No Harm Contract with her client who admitted to current suicidal ideations as well as a previous suicide attempt approximately six months prior to attending appointment with therapist-in-training. Susana failed to comply with her supervisor's directive by not discussing with the client the rationale and importance of signing the contract and failing to get the client to sign the contract prior to the client's leaving the clinic office.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 11

Job stress (emotional/physical demands of graduate school)-Tamara reported feeling overwhelmed as a result of the demands of coursework, clinic load/administrative duties, and assistantship responsibilities. Due to this stress, she is experiencing difficulties empathizing with her clients. For instance, during one of Tamara's sessions with a patient who is also experiencing distress at work, rather than empathizing with the patient and providing words of encouragement, Tamara said to her client, "What do you have to complain about? If you only knew what it is like to feel overwhelmed."

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 12

Personal conflict-Since Donna reported to her supervisor that her mother was diagnosed with cancer, both her academic and clinic performance have declined. Donna has been missing the majoring of her semester classes including practicum, canceling clinic appointments, requesting extensions for class assignments, and make substandard exam scores.

- Immediate one-on-one consult with student
- Mobilization of support systems
- Reduce clinic load
- Tutoring
- Increase in advising and mentoring
- Self-structured behavioral change
- Increased supervision
- Leave of absence
- Extra coursework
- Repeat coursework
- Repeat practicum
- Additional field experience
- Second internship
- Personal growth group
- Individual therapy
- Group therapy
- Leave program
- Counseled out of program
- Termination
- Other: _____

Further comments about your response:

Question 13

Maturity problem-Michael, a second year student, is unable to receive constructive feedback from supervisors and peers. For example, while discussing one of Michael's most challenging cases during practicum, Michael began to pout and became defensive when the practicum supervisor provided suggestions and constructive feedback on how he could effectively manage challenging cases in the future.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 14

Clinical deficiencies-Allen, an upper-level first year student, is having difficulties applying systems theory learned in class into practice while conducting therapy. While conducting couples therapy and being supervised live, it was observed that Allen was only focusing on each person's past rather than how their past experiences may be influencing their lives presently, individually as well as relationally.

- Immediate one-on-one consult with student
- Mobilization of support systems
- Reduce clinic load
- Tutoring
- Increase in advising and mentoring
- Self-structured behavioral change
- Increased supervision
- Leave of absence
- Extra coursework
- Repeat coursework
- Repeat practicum
- Additional field experience
- Second internship
- Personal growth group
- Individual therapy
- Group therapy
- Leave program
- Counseled out of program
- Termination
- Other: _____

Further comments about your response:

Question 15

Chemical dependency-On several occasions while Amy was present at the clinic conducting therapy with her clients, her supervisor and peers have smelled alcohol on her breath and noticed that her gait was unsteady and she was slurring her speech.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 16

Mental illness (Bipolar II)-Blaine had been diagnosed with Bipolar II and prescribed medication. He made the faculty aware of this. Recently, though, Blaine has not been taking his medication, and it has had an impact on his ability to conduct therapy. For instance, while Blaine was conducting therapy with one of his clients, his primary supervisor observed that his mood was elevated, he talked incessantly and was easily distracted by external stimuli, and commented to the client about how effective and great he thought he was as a therapist in comparison to his peers. Due to questions and growing concerns, the supervisor observed Blaine's follow-up appointment with this particular client. It was during this session that Blaine seemed to be experiencing a depressive episode in which he appeared depressed, fatigued, indecisive, disinterested, and hypoactive.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

Question 17

Marital problems-While conducting therapy with a female client experiencing marital difficulties due to her spouse's extramarital affair, the supervisor observed Jeanne encouraging the female client to get a divorce. Recently, unbeknownst to Jeanne's professors and peers, she has also filed for divorce as a result of her spouse's extramarital affair.

Immediate one-on-one consult with student
Mobilization of support systems
Reduce clinic load
Tutoring
Increase in advising and mentoring
Self-structured behavioral change
Increased supervision
Leave of absence
Extra coursework
Repeat coursework
Repeat practicum
Additional field experience
Second internship
Personal growth group
Individual therapy
Group therapy
Leave program
Counseled out of program
Termination
Other: _____

Further comments about your response:

APPENDIX D: Delphi Questionnaire I
Reminder Message

Dear Colleague:

Previously, you may remember receiving an email invitation asking for your participation in a two round modified study designed to enhance remediation plans used by graduate training programs through matching specific types of student impairment with specific types of remediation methods.

My records show that you have not completed the survey. Your opinions and expertise within the field are extremely valuable and with your assistance, this research study will begin to explore what types of remediation methods are most effective for the various types of impairment that not only affect graduate students but also graduate trainers.

If you would like to participate, just simply click on the web address (URL) provided below to complete and submit the survey by March 25, 2006.

Your participation is greatly appreciated.

Sincerely,

Kara Z. McDaniel, NCC, LPC
Doctoral Candidate

Please click on the Web address (URL) below to complete and submit
the survey by 03/25/06. All responses are kept confidential.

https://surveys.ksu.edu/TS?key=xxxxxxxxxx

This Survey URL is for your use only. It cannot be used by anyone else.
If you cannot click on the Web address, please copy the underlined
text and paste it into the address field of your Web browser.
If you experience any difficulties please contact Technical Support
at (800) 865-6143 or 532-7722, email: help@surveys.ksu.edu

If you do not want to participate in this survey visit
https://surveys.ksu.edu/TS?key=xxxxxxxxxx&action=optOut to remove your email
address. If you have any questions contact help@surveys.ksu.edu

APPENDIX E: Delphi Questionnaire II

Below are scenarios from the first questionnaire describing different types of student impairment including the types of remediation methods chosen and perceived to be most effective by research participants. Based on the new information provided, please read each scenario and then for each type of remediation method, indicate the degree of agreement it assumes in relation to perceived effectiveness in responding to the specific type of impairment. Please indicate the degree of agreement by selecting the corresponding circle.

Question 1

Burnout-Mark is a student therapist who is experiencing extreme distress in his life due to an overload of clients, coursework, assistantship, and a part-time job. Not only is Mark consistently late for work and class, he also completes and turns in his assignments late. Mark's professors and employer have noticed him falling asleep in class and emotionally withdrawing from his peers and co-workers. Furthermore, Mark has been requesting more time-off from work and school for medical appointments due to complaints of headaches and gastrointestinal distress.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
1.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
1.2 Mobilization of support systems	O	O	O	O	O	O	O
1.3 Increase in advising and mentoring	O	O	O	O	O	O	O
1.4 Self-structured behavioral change	O	O	O	O	O	O	O
1.5 Increased supervision	O	O	O	O	O	O	O
1.6 Leave of absence	O	O	O	O	O	O	O
1.7 Repeat coursework	O	O	O	O	O	O	O
1.8 Repeat practicum	O	O	O	O	O	O	O
1.9 Individual therapy	O	O	O	O	O	O	O
1.10 Group therapy	O	O	O	O	O	O	O
1.11 Leave program	O	O	O	O	O	O	O
1.12 Counseled out of program	O	O	O	O	O	O	O
1.13 No response	O	O	O	O	O	O	O
1.14 Consider co-therapy for some clinic cases	O	O	O	O	O	O	O
1.15 Peer mentoring	O	O	O	O	O	O	O
1.16 Decision about alternative options guided by response from one-to-one consult	O	O	O	O	O	O	O
1.17 Initiate program remediation process	O	O	O	O	O	O	O
1.18 Document problems and course of action	O	O	O	O	O	O	O
1.19 Encourage discussion in group supervision	O	O	O	O	O	O	O
1.20 Quit part-time job	O	O	O	O	O	O	O

Question 2

Mental illness (Depression)-Both peers and professors/supervisors have observed a change in both Dianne's appearance as well as emotional well-being. Dianne appears to be sad most of the time, withdrawn, disheveled appearance, fatigued, and irritable. Also, it was reported that Dianne informed one of her peers that she had been feeling suicidal.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
2.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
2.2 Mobilization of support systems	O	O	O	O	O	O	O
2.3 Reduce clinic load	O	O	O	O	O	O	O
2.4 Increase in advising and mentoring	O	O	O	O	O	O	O
2.5 Self-structured behavioral change	O	O	O	O	O	O	O
2.6 Increased supervision	O	O	O	O	O	O	O
2.7 Leave of absence	O	O	O	O	O	O	O
2.8 Repeat coursework	O	O	O	O	O	O	O
2.9 Repeat practicum	O	O	O	O	O	O	O
2.10 Personal growth group	O	O	O	O	O	O	O
2.11 Individual therapy	O	O	O	O	O	O	O
2.12 Group therapy	O	O	O	O	O	O	O
2.13 Leave program	O	O	O	O	O	O	O
2.14 Counseled out of program	O	O	O	O	O	O	O
2.15 No response	O	O	O	O	O	O	O
2.16 Marital, relational, or family therapy	O	O	O	O	O	O	O
2.17 Notify significant others; initiate program remediation process	O	O	O	O	O	O	O
2.18 Add a co-therapist or team on cases where her leaving could be problematic assuming she was okay to continue to practice with this type of support	O	O	O	O	O	O	O
2.19 Encourage discussion in group supervision	O	O	O	O	O	O	O
2.20 Refer for medication	O	O	O	O	O	O	O

Question 3

Unprofessional behavior-While conducting therapy with clients, Maria has been observed wearing revealing clothes (e.g. low-cut blouses, tight trousers, and short skirts) by her primary supervisor. During one of Maria's individual sessions with a male client, the client appeared to be easily distracted by Maria's low-cut blouse and made several verbal references about how he thought it enhanced her figure.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
3.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
3.2 Mobilization of support systems	O	O	O	O	O	O	O
3.3 Reduce clinic load	O	O	O	O	O	O	O
3.4 Tutoring	O	O	O	O	O	O	O
3.5 Increase in advising and mentoring	O	O	O	O	O	O	O
3.6 Self-structured behavioral change	O	O	O	O	O	O	O
3.7 Increased supervision	O	O	O	O	O	O	O
3.8 Leave of absence	O	O	O	O	O	O	O
3.9 Individual therapy	O	O	O	O	O	O	O
3.10 Counseled out of program	O	O	O	O	O	O	O
3.11 No response	O	O	O	O	O	O	O
3.12 Give student therapist an opportunity to change outfit prior to going in the room with client. If student does not or cannot comply, she would be removed from case immediately. Monitor all interns' dress prior to doing therapy.	O	O	O	O	O	O	O
3.13 If not immediately rectified, give assignment to explore ethics and effects of sexuality in therapy and to conduct structured discussions with program supervisors and faculty	O	O	O	O	O	O	O
3.14 Initiate program remediation process	O	O	O	O	O	O	O
3.15 Address issue in individual supervision	O	O	O	O	O	O	O
3.16 Document problems and course of action	O	O	O	O	O	O	O
3.17 Assign readings on topic of professionalism	O	O	O	O	O	O	O

Question 4

Personality Disorder-The supervisor has noted that Doug seems to lack empathy toward his peers and clients, has a grandiose sense of self, requires admiration from supervisors, peers, and clients, displays arrogance during classroom discussions, and expects favorable treatment by professors by asking them to extend his due dates on assignments.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
4.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
4.2 Mobilization of support systems	O	O	O	O	O	O	O
4.3 Reduce clinic load	O	O	O	O	O	O	O
4.4 Tutoring	O	O	O	O	O	O	O
4.5 Increase in advising and mentoring	O	O	O	O	O	O	O
4.6 Self-structured behavioral change	O	O	O	O	O	O	O
4.7 Increased supervision	O	O	O	O	O	O	O
4.8 Leave of absence	O	O	O	O	O	O	O
4.9 Repeat coursework	O	O	O	O	O	O	O
4.10 Repeat practicum	O	O	O	O	O	O	O
4.11 Individual therapy	O	O	O	O	O	O	O
4.12 Personal growth group	O	O	O	O	O	O	O
4.13 Group therapy	O	O	O	O	O	O	O
4.14 Leave program	O	O	O	O	O	O	O
4.15 Counseled out of program	O	O	O	O	O	O	O
4.16 Termination	O	O	O	O	O	O	O
4.17 Consult with entire clinical faculty	O	O	O	O	O	O	O
4.18 Temporary removal from clinical work	O	O	O	O	O	O	O
4.19 Hold student to program expectations and requirements	O	O	O	O	O	O	O
4.20 Require additional skills training and provide a behavioral contract regarding student's behavior both in class and in the clinic	O	O	O	O	O	O	O
4.21 Initiate program remediation	O	O	O	O	O	O	O
4.22 Conduct meeting with both student and MFT faculty	O	O	O	O	O	O	O
4.23 Document problems and course of action	O	O	O	O	O	O	O
4.24 Encourage discussion in group supervision	O	O	O	O	O	O	O

Question 5

Ethical violation-Johnny communicated with his client's attorney and released client information without a release of information signed by his client.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
5.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
5.2 Mobilization of support systems	O	O	O	O	O	O	O
5.3 Reduce clinic load	O	O	O	O	O	O	O
5.4 Tutoring	O	O	O	O	O	O	O
5.5 Increase in advising and mentoring	O	O	O	O	O	O	O
5.6 Self-structured behavioral change	O	O	O	O	O	O	O
5.7 Increased supervision	O	O	O	O	O	O	O
5.8 Leave of absence	O	O	O	O	O	O	O
5.9 Extra coursework	O	O	O	O	O	O	O
5.10 Repeat coursework	O	O	O	O	O	O	O
5.11 Repeat practicum	O	O	O	O	O	O	O
5.12 Additional field experience	O	O	O	O	O	O	O
5.13 Personal growth group	O	O	O	O	O	O	O
5.14 Individual therapy	O	O	O	O	O	O	O
5.15 Leave program	O	O	O	O	O	O	O
5.16 Counseled out of program	O	O	O	O	O	O	O
5.17 Termination	O	O	O	O	O	O	O
5.18 Assign structured assignment requiring student therapist to review code of ethics, write about specific ethical code violated, and then conduct discussions with supervisors and faculty to demonstrate an understanding of ethics and laws, including potential harm to client	O	O	O	O	O	O	O
5.19 Devise behavioral contract regarding ethics and require a written paper on confidentiality	O	O	O	O	O	O	O
5.20 Initiate program remediation process	O	O	O	O	O	O	O
5.21 Consult University Attorney	O	O	O	O	O	O	O
5.22 Clinical academic probation; repeated incident results in automatic dismissal	O	O	O	O	O	O	O

Question 6

Academic deficiency-Although Ana is doing well clinically, she is missing the majority of her semester classes, not turning in required coursework, making substandard grades on exams, and attending classes late and using her clients as an excuse for being tardy.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
6.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
6.2 Mobilization of support systems	O	O	O	O	O	O	O
6.3 Reduce clinic load	O	O	O	O	O	O	O
6.4 Tutoring	O	O	O	O	O	O	O
6.5 Increase in advising and mentoring	O	O	O	O	O	O	O
6.6 Self-structured behavioral change	O	O	O	O	O	O	O
6.7 Increased supervision	O	O	O	O	O	O	O
6.8 Leave of absence	O	O	O	O	O	O	O
6.9 Extra coursework	O	O	O	O	O	O	O
6.10 Repeat coursework	O	O	O	O	O	O	O
6.11 Individual therapy	O	O	O	O	O	O	O
6.12 Leave program	O	O	O	O	O	O	O
6.13 Counseled out of program	O	O	O	O	O	O	O
6.14 Individual therapy	O	O	O	O	O	O	O
6.15 Termination	O	O	O	O	O	O	O
6.16 Initiate program remediation process	O	O	O	O	O	O	O
6.17 Determine if student therapist meets the requirements for academic probation	O	O	O	O	O	O	O
6.18 Advise student therapist of choices, poor grades and/or academic probation	O	O	O	O	O	O	O
6.19 Arrange for student therapist to be tested for learning difficulties	O	O	O	O	O	O	O
6.20 Advise student therapist about academic concerns in each class. Reiterate that students must maintain a B average in order to stay in the program, and if student is in danger of getting lower than a B in her course, initiate a formal university warning at mid semester	O	O	O	O	O	O	O
6.21 No response	O	O	O	O	O	O	O

Question 7

Interpersonal problems-Kiesha is experiencing problems with getting along well with her peers, professors, and supervisors. During class, it has been observed by Kiesha's professors and peers that she occupies lecture time by asking too many questions that are irrelevant, comments on almost every topic being discussed, and challenges the knowledge of her professors rather than asking questions that will enhance her knowledge base.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
7.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
7.2 Mobilization of support systems	O	O	O	O	O	O	O
7.3 Reduce clinic load	O	O	O	O	O	O	O
7.4 Tutoring	O	O	O	O	O	O	O
7.5 Increase in advising and mentoring	O	O	O	O	O	O	O
7.6 Self-structured behavioral change	O	O	O	O	O	O	O
7.7 Increased supervision	O	O	O	O	O	O	O
7.8 Personal growth group	O	O	O	O	O	O	O
7.9 Individual therapy	O	O	O	O	O	O	O
7.10 Group therapy	O	O	O	O	O	O	O
7.11 Individual therapy	O	O	O	O	O	O	O
7.12 Counseled out of program	O	O	O	O	O	O	O
7.13 Guided discussion among colleagues about the learning community	O	O	O	O	O	O	O
7.14 Initiate program remediation process	O	O	O	O	O	O	O
7.15 No response	O	O	O	O	O	O	O
7.16 Kiesha is a typical African-American name. If she is a person of color, I would be most concerned about her experience of racism in the program from peers or faculty. I would address this with her first, then with faculty and peers according to her desires for such	O	O	O	O	O	O	O

Question 8

Sexual contact with client-Darren is conducting couples therapy and being supervised live by his primary supervisor. Only the wife attends this particular session. During session, the female client talks to the therapist about their special relationship. After the session, the supervisor immediately asked Darren what was meant by special relationship. The student therapist hesitated, but finally admitted that he had sexual intercourse with the female client during the time he was seeing her for individual therapy.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
8.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
8.2 Mobilization of support systems	O	O	O	O	O	O	O
8.3 Reduce clinic load	O	O	O	O	O	O	O
8.4 Increase in advising and mentoring	O	O	O	O	O	O	O
8.5 Increased supervision	O	O	O	O	O	O	O
8.6 Leave of absence	O	O	O	O	O	O	O
8.7 Additional field experience	O	O	O	O	O	O	O
8.8 Individual therapy	O	O	O	O	O	O	O
8.9 Leave program	O	O	O	O	O	O	O
8.10 Counseled out of program	O	O	O	O	O	O	O
8.11 Termination	O	O	O	O	O	O	O
8.12 Conduct review in reference to termination	O	O	O	O	O	O	O
8.13 Report ethical violation to AAMFT	O	O	O	O	O	O	O
8.14 Initiate program remediation process	O	O	O	O	O	O	O
8.15 Ethics education	O	O	O	O	O	O	O
8.16 Encourage Darren to report to AAMFT Ethics Board.	O	O	O	O	O	O	O
8.17 Report ethical violation to state licensing board and university attorney	O	O	O	O	O	O	O

Question 9

Physical illness-Javier was recently diagnosed with ulcerative colitis, and his illness is affecting his academic and clinical work. Javier is missing classes, canceling clinic appointments, and failing to turn in coursework.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
9.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
9.2 Mobilization of support systems	O	O	O	O	O	O	O
9.3 Reduce clinic load	O	O	O	O	O	O	O
9.4 Tutoring	O	O	O	O	O	O	O
9.5 Increase in advising and mentoring	O	O	O	O	O	O	O
9.6 Self-structured behavioral change	O	O	O	O	O	O	O
9.7 Increased supervision	O	O	O	O	O	O	O
9.8 Leave of absence	O	O	O	O	O	O	O
9.9 Repeat coursework	O	O	O	O	O	O	O
9.10 Repeat practicum	O	O	O	O	O	O	O
9.11 Personal growth group	O	O	O	O	O	O	O
9.12 Individual therapy	O	O	O	O	O	O	O
9.13 Group therapy	O	O	O	O	O	O	O
9.14 Offer academic resources	O	O	O	O	O	O	O
9.15 Slow program pace to accommodate the illness	O	O	O	O	O	O	O
9.16 Initiate program remediation process	O	O	O	O	O	O	O
9.17 Encourage discussion in group supervision	O	O	O	O	O	O	O

Question 10

Supervision problem-Susana was given a directive by her supervisor to devise a No Harm Contract with her client who admitted to current suicidal ideations as well as a previous suicide attempt approximately six months prior to attending appointment with therapist-in-training. Susana failed to comply with her supervisor's directive by not discussing with the client the rationale and importance of signing the contract and failing to get the client to sign the contract prior to the client's leaving the clinic office.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
10.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
10.2 Mobilization of support systems	O	O	O	O	O	O	O
10.3 Reduce clinic load	O	O	O	O	O	O	O
10.4 Tutoring	O	O	O	O	O	O	O
10.5 Increase in advising and mentoring	O	O	O	O	O	O	O
10.6 Self-structured behavioral change	O	O	O	O	O	O	O
10.7 Increased supervision	O	O	O	O	O	O	O
10.8 Leave of absence	O	O	O	O	O	O	O
10.9 Extra coursework	O	O	O	O	O	O	O
10.10 Repeat coursework	O	O	O	O	O	O	O
10.11 Repeat practicum	O	O	O	O	O	O	O
10.12 Additional field experience	O	O	O	O	O	O	O
10.13 Second internship	O	O	O	O	O	O	O
10.14 Individual therapy	O	O	O	O	O	O	O
10.15 Leave program	O	O	O	O	O	O	O
10.16 Counseled out of program	O	O	O	O	O	O	O
10.17 Termination	O	O	O	O	O	O	O
10.18 Mandate that Susana immediately contact client to verify and establish safety as well as to schedule an appointment as soon as possible to implement safety plan	O	O	O	O	O	O	O
10.19 Suspension of clinical privileges	O	O	O	O	O	O	O
10.20 Remove from case	O	O	O	O	O	O	O
10.21 Threaten to have to repeat practicum	O	O	O	O	O	O	O
10.22 No response	O	O	O	O	O	O	O
10.23 Termination from practicum site	O	O	O	O	O	O	O
10.24 Written warning	O	O	O	O	O	O	O
10.25 Initiate program remediation process	O	O	O	O	O	O	O
10.26 Consult with other supervisors who have worked with Susana	O	O	O	O	O	O	O
10.27 Meeting with all faculty to discuss issue	O	O	O	O	O	O	O

Question 11

Job stress (emotional/physical demands of graduate school)-Tamara reported feeling overwhelmed as a result of the demands of coursework, clinic load/administrative duties, and assistantship responsibilities. Due to this stress, she is experiencing difficulties empathizing with her clients. For instance, during one of Tamara's sessions with a patient who is also experiencing distress at work, rather than empathizing with the patient and providing words of encouragement, Tamara said to her client, "What do you have to complain about? If you only knew what it is like to feel overwhelmed."

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
11.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
11.2 Mobilization of support systems	O	O	O	O	O	O	O
11.3 Reduce clinic load	O	O	O	O	O	O	O
11.4 Increase in advising and mentoring	O	O	O	O	O	O	O
11.5 Self-structured behavioral change	O	O	O	O	O	O	O
11.6 Increased supervision	O	O	O	O	O	O	O
11.7 Leave of absence	O	O	O	O	O	O	O
11.8 Repeat practicum	O	O	O	O	O	O	O
11.9 Additional field experience	O	O	O	O	O	O	O
11.10 Personal growth group	O	O	O	O	O	O	O
11.11 Individual therapy	O	O	O	O	O	O	O
11.12 Group therapy	O	O	O	O	O	O	O
11.13 Leave program	O	O	O	O	O	O	O
11.14 Counseled out of program	O	O	O	O	O	O	O
11.15 Termination	O	O	O	O	O	O	O
11.16 Discussion with supervisors and faculty about potential harm to clients and then restructuring individual program	O	O	O	O	O	O	O
11.17 No response	O	O	O	O	O	O	O
11.18 Initiate program remediation process	O	O	O	O	O	O	O

Question 12

Personal conflict-Since Donna reported to her supervisor that her mother was diagnosed with cancer, both her academic and clinic performance have declined. Donna has been missing the majoring of her semester classes including practicum, canceling clinic appointments, requesting extensions for class assignments, and make substandard exam scores.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
12.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
12.2 Mobilization of support systems	O	O	O	O	O	O	O
12.3 Reduce clinic load	O	O	O	O	O	O	O
12.4 Increase in advising and mentoring	O	O	O	O	O	O	O
12.5 Self-structured behavioral change	O	O	O	O	O	O	O
12.6 Increased supervision	O	O	O	O	O	O	O
12.7 Leave of absence	O	O	O	O	O	O	O
12.8 Extra coursework	O	O	O	O	O	O	O
12.9 Repeat coursework	O	O	O	O	O	O	O
12.10 Repeat practicum	O	O	O	O	O	O	O
12.11 Personal growth group	O	O	O	O	O	O	O
12.12 Individual therapy	O	O	O	O	O	O	O
12.13 Group therapy	O	O	O	O	O	O	O
12.14 Slow program pace to accommodate the illness	O	O	O	O	O	O	O
12.15 Initiate program remediation process	O	O	O	O	O	O	O
12.16 Encourage discussion in group supervision	O	O	O	O	O	O	O

Question 13

Maturity problem-Michael, a second year student, is unable to receive constructive feedback from supervisors and peers. For example, while discussing one of Michael's most challenging cases during practicum, Michael began to pout and became defensive when the practicum supervisor provided suggestions and constructive feedback on how he could effectively manage challenging cases in the future.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
13.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
13.2 Mobilization of support systems	O	O	O	O	O	O	O
13.3 Reduce clinic load	O	O	O	O	O	O	O
13.4 Tutoring	O	O	O	O	O	O	O
13.5 Increase in advising and mentoring	O	O	O	O	O	O	O
13.6 Self-structured behavioral change	O	O	O	O	O	O	O
13.7 Increased supervision	O	O	O	O	O	O	O
13.8 Leave of absence	O	O	O	O	O	O	O
13.9 Repeat coursework	O	O	O	O	O	O	O
13.10 Repeat practicum	O	O	O	O	O	O	O
13.11 Additional field experience	O	O	O	O	O	O	O
13.12 Second internship	O	O	O	O	O	O	O
13.13 Personal growth group	O	O	O	O	O	O	O
13.14 Individual therapy	O	O	O	O	O	O	O
13.15 Group therapy	O	O	O	O	O	O	O
13.16 Leave program	O	O	O	O	O	O	O
13.17 Counseled out of program	O	O	O	O	O	O	O
13.18 Termination	O	O	O	O	O	O	O
13.19 Initiate program remediation process	O	O	O	O	O	O	O
13.20 Consult with other clinical faculty	O	O	O	O	O	O	O
13.21 Focus on and discuss concern in individual supervision	O	O	O	O	O	O	O

Question 14

Clinical deficiencies-Allen, an upper-level first year student, is having difficulties applying systems theory learned in class into practice while conducting therapy. While conducting couples therapy and being supervised live, it was observed that Allen was only focusing on each person's past rather than how their past experiences may be influencing their lives presently, individually as well as relationally.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
14.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
14.2 Mobilization of support systems	O	O	O	O	O	O	O
14.3 Reduce clinic load	O	O	O	O	O	O	O
14.4 Tutoring	O	O	O	O	O	O	O
14.5 Increase in advising and mentoring	O	O	O	O	O	O	O
14.6 Self-structured behavioral change	O	O	O	O	O	O	O
14.7 Increased supervision	O	O	O	O	O	O	O
14.8 Extra coursework	O	O	O	O	O	O	O
14.9 Repeat coursework	O	O	O	O	O	O	O
14.10 Repeat practicum	O	O	O	O	O	O	O
14.11 Additional field experience	O	O	O	O	O	O	O
14.12 Second internship	O	O	O	O	O	O	O
14.13 Personal growth group	O	O	O	O	O	O	O
14.14 Individual therapy	O	O	O	O	O	O	O
14.15 Group therapy	O	O	O	O	O	O	O
14.16 Counseled out of program	O	O	O	O	O	O	O
14.17 No response	O	O	O	O	O	O	O
14.18 Reinstruction in systems	O	O	O	O	O	O	O
14.19 Often occurs and this issue becomes a focus for supervision sessions. Could include increased readings, videos, assignments, and observations.	O	O	O	O	O	O	O
14.20 Increased LIVE supervision	O	O	O	O	O	O	O
14.21 Discuss in group supervision	O	O	O	O	O	O	O

Question 15

Chemical dependency-On several occasions while Amy was present at the clinic conducting therapy with her clients, her supervisor and peers have smelled alcohol on her breath and noticed that her gait was unsteady and she was slurring her speech.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
15.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
15.2 Mobilization of support systems	O	O	O	O	O	O	O
15.3 Reduce clinic load	O	O	O	O	O	O	O
15.4 Tutoring	O	O	O	O	O	O	O
15.5 Increase in advising and mentoring	O	O	O	O	O	O	O
15.6 Self-structured behavioral change	O	O	O	O	O	O	O
15.7 Increased supervision	O	O	O	O	O	O	O
15.8 Leave of absence	O	O	O	O	O	O	O
15.9 Repeat coursework	O	O	O	O	O	O	O
15.10 Repeat practicum	O	O	O	O	O	O	O
15.11 Personal growth group	O	O	O	O	O	O	O
15.12 Individual therapy	O	O	O	O	O	O	O
15.13 Group therapy	O	O	O	O	O	O	O
15.14 Leave program	O	O	O	O	O	O	O
15.15 Counseled out of program	O	O	O	O	O	O	O
15.16 Termination	O	O	O	O	O	O	O
15.17 Suspension of clinical privileges	O	O	O	O	O	O	O
15.18 Consider filing ethical complaint if student refuses to address the issue	O	O	O	O	O	O	O
15.19 Refer for substance abuse evaluation and treatment	O	O	O	O	O	O	O
15.20 Initiate program remediation process	O	O	O	O	O	O	O
15.21 If student denies alcohol use, refer to physician to screen for underlying medical illnesses	O	O	O	O	O	O	O

Question 16

Mental illness (Bipolar II)-Blaine had been diagnosed with Bipolar II and prescribed medication. He made the faculty aware of this. Recently, though, Blaine has not been taking his medication, and it has had an impact on his ability to conduct therapy. For instance, while Blaine was conducting therapy with one of his clients, his primary supervisor observed that his mood was elevated, he talked incessantly and was easily distracted by external stimuli, and commented to the client about how effective and great he thought he was as a therapist in comparison to his peers. Due to questions and growing concerns, the supervisor observed Blaine's follow-up appointment with this particular client. It was during this session that Blaine seemed to be experiencing a depressive episode in which he appeared depressed, fatigued, indecisive, disinterested, and hypoactive.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
16.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
16.2 Mobilization of support systems	O	O	O	O	O	O	O
16.3 Reduce clinic load	O	O	O	O	O	O	O
16.4 Increase in advising and mentoring	O	O	O	O	O	O	O
16.5 Self-structured behavioral change	O	O	O	O	O	O	O
16.6 Increased supervision	O	O	O	O	O	O	O
16.7 Leave of absence	O	O	O	O	O	O	O
16.8 Extra coursework	O	O	O	O	O	O	O
16.9 Personal growth group	O	O	O	O	O	O	O
16.10 Individual therapy	O	O	O	O	O	O	O
16.11 Group therapy	O	O	O	O	O	O	O
16.12 Leave program	O	O	O	O	O	O	O
16.13 Counseled out of program	O	O	O	O	O	O	O
16.14 Termination	O	O	O	O	O	O	O
16.15 Suspension of clinical privileges until situation is addressed	O	O	O	O	O	O	O
16.16 Refer to psychiatrist for medication management; contract for medication adherence	O	O	O	O	O	O	O
16.17 Initiate program remediation process	O	O	O	O	O	O	O

Question 17

Marital problems-While conducting therapy with a female client experiencing marital difficulties due to her spouse's extramarital affair, the supervisor observed Jeanne encouraging the female client to get a divorce. Recently, unbeknownst to Jeanne's professors and peers, she has also filed for divorce as a result of her spouse's extramarital affair.

1-Strongly Disagree | 2-Disagree | 3-Somewhat Disagree
4-Neutral | 5-Somewhat Agree | 6-Agree | 7-Strongly Agree

	1	**2**	**3**	**4**	**5**	**6**	**7**
17.1 Immediate one-on-one consult with student	O	O	O	O	O	O	O
17.2 Mobilization of support systems	O	O	O	O	O	O	O
17.3 Reduce clinic load	O	O	O	O	O	O	O
17.4 Tutoring	O	O	O	O	O	O	O
17.5 Increase in advising and mentoring	O	O	O	O	O	O	O
17.6 Self-structured behavioral change	O	O	O	O	O	O	O
17.7 Increased supervision	O	O	O	O	O	O	O
17.8 Leave of absence	O	O	O	O	O	O	O
17.9 Extra coursework	O	O	O	O	O	O	O
17.10 Repeat coursework	O	O	O	O	O	O	O
17.11 Repeat practicum	O	O	O	O	O	O	O
17.12 Additional field experience	O	O	O	O	O	O	O
17.13 Personal growth group	O	O	O	O	O	O	O
17.14 Individual therapy	O	O	O	O	O	O	O
17.15 Group therapy	O	O	O	O	O	O	O
17.16 Suspend from all clinical activity	O	O	O	O	O	O	O
17.17 Assign readings	O	O	O	O	O	O	O
17.18 Marital therapy	O	O	O	O	O	O	O
17.19 Address issue in individual supervision	O	O	O	O	O	O	O
17.20 Encourage discussion in group supervision	O	O	O	O	O	O	O
17.21 Confront on isomorphism	O	O	O	O	O	O	O

APPENDIX F: Delphi Questionnaire II
Survey Description

The present research is an exploratory study designed to enhance remediation plans used by graduate training programs through matching specific types of student impairment with specific types of remediation methods. With your assistance, this research study will begin to explore what types of remediation methods are perceived to be most effective for the various types of impairment that not only effect graduate students but also graduate trainers.

APPENDIX G: Delphi Questionnaire II
Opening Instructions

Dear Colleague:

Previously, you may remember receiving an invitation email asking for your participation in completing and submitting the first questionnaire which included scenarios relevant to specific types of impairment. Participants were asked to read each scenario and then place a check mark by one or more of the remediation methods perceived to be most effective.

Included in this email is the second questionnaire that was developed based on responses from participants who completed the first survey. Participants who completed the first survey are being asked to complete the second survey by rating their agreement on the types of remediation methods chosen and perceived to be most effective by participants in relation to each type of student impairment scenario provided in the first questionnaire. To complete and submit the second survey, please click on the link provided. For those participants who did not wish to participate in the first survey and opted out, a link is provided in the email below that you can click on and request that further copies of the second survey are not sent to you.

If you have any questions or require additional information, either my major professor or I may be contacted. Our contact information is as follows: Kara Z. McDaniel, 11 Dunwoody Park, Suite 150, Dunwoody, Georgia 30338, 404-778-6924 and Anthony P. Jurich, Kansas State University, Department of Human Ecology/Family Studies and Human Services, Campus Creek Complex, Manhattan, Kansas 66506, 785-532-1488.

Sincerely,

Kara Z. McDaniel, NCC, LPC
Ph.D. Candidate

APPENDIX H: Delphi Questionnaire II
Reminder Message

Dear Colleague:

Previously, you may remember receiving an email asking for your continued participation in a two round modified Delphi Study designed to enhance remediation plans used by graduate training programs through matching specific types of student impairment with specific types of remediation methods.

My records show that you have not completed the second survey. Your opinions and expertise within the field are extremely valuable and with your assistance, this research study will begin to explore what types of remediation methods are believed to be most effective for the various types of impairment that not only affect graduate students but also graduate trainers.

If you participated by completing the first survey, just simply click on the web address (URL) provided below to complete and submit the second survey by June 16, 2006. For those participants who did not wish to participate in the first survey and opted out, a link is provided in the email below that you can click on and request that further copies of the second survey are not sent to you.

Your participation is greatly appreciated.

Sincerely,

Kara Z. McDaniel, NCC, LPC
Ph.D. Candidate

Please click on the Web address (URL) below to complete and submit
the survey by 06/16/06. All responses are kept confidential.

https://surveys.ksu.edu/TS?key=xxxxxxxxxx

This Survey URL is for your use only. It cannot be used by anyone else.
If you cannot click on the Web address, please copy the underlined
text and paste it into the address field of your Web browser.
If you experience any difficulties please contact Technical Support
at (800) 865-6143 or 532-7722, email: help@surveys.ksu.edu

If you do not want to participate in this survey visit
https://surveys.ksu.edu/TS?key=xxxxxxxxxx&action=optOut to remove your email address. If you have any questions contact help@surveys.ksu.edu

APPENDIX I: Delphi Questionnaire II
Survey Report

Question 1

Burnout-
Mark is a student therapist who is experiencing extreme distress in his life due to an overload of clients, coursework, assistantship, and a part-time job. Not only is Mark consistently late for work and class, he also completes and turns in his assignments late. Mark's professors and employer have noticed him falling asleep in class and emotionally withdrawing from his peers and co-workers. Furthermore, Mark has been requesting more time-off from work and school for medical appointments due to complaints of headaches and gastrointestinal distress.

1.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		6 (18.18%)
Strongly Agree		26 (78.79%)
N/R		0 (0%)

1.2 Mobilization of support systems

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		12 (36.36%)
Strongly Agree		8 (24.24%)

N/R		0 (0%)

1.3 Increase in advising and mentoring

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Agree		8 (24.24%)
Agree		13 (39.39%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

1.4 Self-structured behavioral change

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		5 (15.15%)
Neutral		9 (27.27%)
Somewhat Agree		5 (15.15%)
Agree		8 (24.24%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

1.5 Increased supervision

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)

Neutral		5 (15.15%)
Somewhat Agree		8 (24.24%)
Agree		8 (24.24%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

1.6 Leave of absence

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		9 (27.27%)
Agree		9 (27.27%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

1.7 Repeat coursework

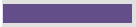
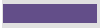
Strongly Disagree		4 (12.12%)
Disagree		6 (18.18%)
Somewhat Disagree		3 (9.09%)
Neutral		12 (36.36%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		1

		(3.03%)
N/R		0 (0%)

1.8 Repeat practicum

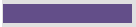
Strongly Disagree		3 (9.09%)
Disagree		4 (12.12%)
Somewhat Disagree		3 (9.09%)
Neutral		15 (45.45%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

1.9 Individual therapy

Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		8 (24.24%)
Somewhat Agree		7 (21.21%)
Agree		7 (21.21%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

1.10 Group therapy

Strongly Disagree		3 (9.09%)

Disagree		5 (15.15%)
Somewhat Disagree		7 (21.21%)
Neutral		12 (36.36%)
Somewhat Agree		5 (15.15%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

1.11 Leave program

Strongly Disagree		9 (27.27%)
Disagree		9 (27.27%)
Somewhat Disagree		5 (15.15%)
Neutral		6 (18.18%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

1.12 Counseled out of program

Strongly Disagree		8 (24.24%)
Disagree		10 (30.3%)
Somewhat Disagree		5 (15.15%)
Neutral		4 (12.12%)
Somewhat Agree		3

		(9.09%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

1.13 No response

Strongly Disagree		27 (81.82%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

1.14 Consider co-therapy for some clinic cases

Strongly Disagree		5 (15.15%)
Disagree		2 (6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		6 (18.18%)
Somewhat Agree		7 (21.21%)
Agree		7 (21.21%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

1.15 Peer mentoring

Strongly Disagree		7

		(21.21%)
Disagree		8 (24.24%)
Somewhat Disagree		7 (21.21%)
Neutral		2 (6.06%)
Somewhat Agree		4 (12.12%)
Agree		2 (6.06%)
Strongly Agree		2 (6.06%)
N/R		1 (3.03%)

1.16 Decision about alternative options guided by response from one-to-one consult

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		4 (12.12%)
Agree		13 (39.39%)
Strongly Agree		11 (33.33%)
N/R		2 (6.06%)

1.17 Initiate program remediation process

Strongly Disagree		3 (9.09%)
Disagree		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Neutral		9 (27.27%)
Somewhat Agree		5

		(15.15%)
Agree		9 (27.27%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

1.18 Document problems and course of action

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Agree		1 (3.03%)
Agree		5 (15.15%)
Strongly Agree		25 (75.76%)
N/R		0 (0%)

1.19 Encourage discussion in group supervision

Strongly Disagree		2 (6.06%)
Disagree		8 (24.24%)
Somewhat Disagree		9 (27.27%)
Neutral		4 (12.12%)
Somewhat Agree		3 (9.09%)
Agree		3 (9.09%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

1.20 Quit part-time job

Strongly Disagree		4 (12.12%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		17 (51.52%)
Somewhat Agree		3 (9.09%)
Agree		4 (12.12%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

Question 2

Mental illness (Depression)-
Both peers and professors/supervisors have observed a change in both Dianne's appearance as well as emotional well-being. Dianne appears to be sad most of the time, withdrawn, disheveled appearance, fatigued, and irritable. Also, it was reported that Dianne informed one of her peers that she had been feeling suicidal

2.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		2 (6.06%)
Strongly Agree		31 (93.94%)
N/R		0 (0%)

2.2 Mobilization of support systems

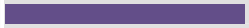
Strongly Disagree		0 (0%)
Disagree		0 (0%)

Somewhat Disagree		1 (3.03%)
Neutral		0 (0%)
Somewhat Agree		3 (9.09%)
Agree		10 (30.3%)
Strongly Agree		19 (57.58%)
N/R		0 (0%)

2.3 Reduce clinic load

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		5 (15.15%)
Somewhat Agree		5 (15.15%)
Agree		6 (18.18%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

2.4 Increase in advising and mentoring

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		7 (21.21%)
Strongly Agree		13 (39.39%)

N/R		0 (0%)

2.5 Self-structured behavioral change

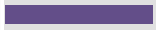
Strongly Disagree		1 (3.03%)
Disagree		2 (6.06%)
Somewhat Disagree		6 (18.18%)
Neutral		10 (30.3%)
Somewhat Agree		4 (12.12%)
Agree		7 (21.21%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

2.6 Increased supervision

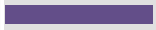
Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		4 (12.12%)
Neutral		2 (6.06%)
Somewhat Agree		6 (18.18%)
Agree		7 (21.21%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

2.7 Leave of absence

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)

Somewhat Disagree		0 (0%)
Neutral		7 (21.21%)
Somewhat Agree		6 (18.18%)
Agree		9 (27.27%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

2.8 Repeat coursework

Strongly Disagree		8 (24.24%)
Disagree		4 (12.12%)
Somewhat Disagree		5 (15.15%)
Neutral		14 (42.42%)
Somewhat Agree		2 (6.06%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

2.9 Repeat practicum

Strongly Disagree		4 (12.12%)
Disagree		5 (15.15%)
Somewhat Disagree		4 (12.12%)
Neutral		14 (42.42%)
Somewhat Agree		5 (15.15%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)

N/R		0 (0%)

2.10 Personal growth group

Strongly Disagree		6 (18.18%)
Disagree		5 (15.15%)
Somewhat Disagree		6 (18.18%)
Neutral		12 (36.36%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

2.11 Individual therapy

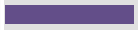
Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		6 (18.18%)
Strongly Agree		17 (51.52%)
N/R		0 (0%)

2.12 Group therapy

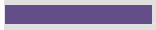
Strongly Disagree		4 (12.12%)
Disagree		2 (6.06%)

Somewhat Disagree		2 (6.06%)
Neutral		11 (33.33%)
Somewhat Agree		8 (24.24%)
Agree		6 (18.18%)
Strongly Agree		0 (0%)
N/R		0 (0%)

2.13 Leave program

Strongly Disagree		7 (21.21%)
Disagree		3 (9.09%)
Somewhat Disagree		6 (18.18%)
Neutral		11 (33.33%)
Somewhat Agree		3 (9.09%)
Agree		1 (3.03%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

2.14 Counseled out of program

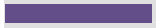
Strongly Disagree		8 (24.24%)
Disagree		5 (15.15%)
Somewhat Disagree		5 (15.15%)
Neutral		10 (30.3%)
Somewhat Agree		2 (6.06%)
Agree		1 (3.03%)

Strongly Agree		2 (6.06%)
N/R		0 (0%)

2.15 No response

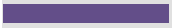
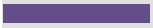
Strongly Disagree		29 (87.88%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		1 (3.03%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

2.16 Marital, relational, or family therapy

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		10 (30.3%)
Somewhat Agree		5 (15.15%)
Agree		9 (27.27%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

2.17 Notify significant others; initiate program remediation process

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)

Neutral		5 (15.15%)
Somewhat Agree		9 (27.27%)
Agree		9 (27.27%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

2.18 Add a co-therapist or team on cases where her leaving could be problematic assuming she was okay to continue to practice with this type of support

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		5 (15.15%)
Neutral		2 (6.06%)
Somewhat Agree		6 (18.18%)
Agree		12 (36.36%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

2.19 Encourage discussion in group supervision

Strongly Disagree		6 (18.18%)
Disagree		5 (15.15%)
Somewhat Disagree		5 (15.15%)
Neutral		8 (24.24%)
Somewhat Agree		6 (18.18%)
Agree		0 (0%)

Strongly Agree		3 (9.09%)
N/R		0 (0%)

2.20 Refer for medication

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		9 (27.27%)
Agree		8 (24.24%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

Question 3

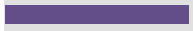
Unprofessional behavior-
While conducting therapy with clients, Maria has been observed wearing revealing clothes (e.g. low-cut blouses, tight trousers, and short skirts) by her primary supervisor. During one of Maria's individual sessions with a male client, the client appeared to be easily distracted by Maria's low-cut blouse and made several verbal references about how he thought it enhanced her figure.

3.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		3 (9.09%)
Agree		4 (12.12%)

Strongly Agree		25 (75.76%)
N/R		0 (0%)

3.2 Mobilization of support systems

Strongly Disagree		10 (30.3%)
Disagree		6 (18.18%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		3 (9.09%)
Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

3.3 Reduce clinic load

Strongly Disagree		12 (36.36%)
Disagree		4 (12.12%)
Somewhat Disagree		6 (18.18%)
Neutral		5 (15.15%)
Somewhat Agree		3 (9.09%)
Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

3.4 Tutoring

Strongly Disagree		11 (33.33%)

Disagree		6 (18.18%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		2 (6.06%)
Agree		5 (15.15%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

3.5 Increase in advising and mentoring

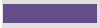
Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		13 (39.39%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

3.6 Self-structured behavioral change

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		5 (15.15%)
Somewhat Agree		9 (27.27%)
Agree		8 (24.24%)

Strongly Agree		9 (27.27%)
N/R		0 (0%)

3.7 Increased supervision

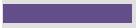
Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		15 (45.45%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

3.8 Leave of absence

Strongly Disagree		15 (45.45%)
Disagree		9 (27.27%)
Somewhat Disagree		4 (12.12%)
Neutral		5 (15.15%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

3.9 Individual therapy

Strongly Disagree		9 (27.27%)
Disagree		7 (21.21%)
Somewhat Disagree		3 (9.09%)

Neutral		5 (15.15%)
Somewhat Agree		7 (21.21%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

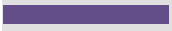
3.10 Counseled out of program

Strongly Disagree		14 (42.42%)
Disagree		8 (24.24%)
Somewhat Disagree		1 (3.03%)
Neutral		10 (30.3%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

3.11 No response

Strongly Disagree		24 (72.73%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		1 (3.03%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

3.12 Give student therapist an opportunity to change outfit prior to going in the room with client. If student does not or cannot comply, she would be removed from case immediately. Monitor all interns' dress prior to doing therapy.

Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		7 (21.21%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

3.13 If not immediately rectified, give assignment to explore ethics and effects of sexuality in therapy and to conduct structured discussions with program supervisors and faculty

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		12 (36.36%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

3.14 Initiate program remediation process

Strongly Disagree		6 (18.18%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		8 (24.24%)
Somewhat Agree		8 (24.24%)
Agree		3 (9.09%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

3.15 Address issue in individual supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		3 (9.09%)
Agree		4 (12.12%)
Strongly Agree		26 (78.79%)
N/R		0 (0%)

3.16 Document problems and course of action

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		2 (6.06%)
Agree		6 (18.18%)
Strongly Agree		24

		(72.73%)
N/R		0 (0%)

3.17 Assign readings on topic of professionalism

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		5 (15.15%)
Somewhat Agree		5 (15.15%)
Agree		9 (27.27%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

Question 4

Personality Disorder-
The supervisor has noted that Doug seems to lack empathy toward his peers and clients, has a grandiose sense of self, requires admiration from supervisors, peers, and clients, displays arrogance during classroom discussions, and expects favorable treatment by professors by asking them to extend his due dates on assignments.

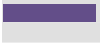
4.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		5 (15.15%)
Strongly Agree		23 (69.7%)
N/R		0 (0%)

4.2 Mobilization of support systems

Strongly Disagree		7 (21.21%)
Disagree		5 (15.15%)
Somewhat Disagree		2 (6.06%)
Neutral		10 (30.3%)
Somewhat Agree		6 (18.18%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

4.3 Reduce clinic load

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		5 (15.15%)
Neutral		7 (21.21%)
Somewhat Agree		11 (33.33%)
Agree		5 (15.15%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

4.4 Tutoring

Strongly Disagree		11 (33.33%)
Disagree		4

		(12.12%)
Somewhat Disagree		4 (12.12%)
Neutral		9 (27.27%)
Somewhat Agree		3 (9.09%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

4.5 Increase in advising and mentoring

Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		12 (36.36%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

4.6 Self-structured behavioral change

Strongly Disagree		6 (18.18%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		7 (21.21%)

Agree		5 (15.15%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

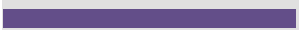
4.7 Increased supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		5 (15.15%)
Agree		8 (24.24%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

4.8 Leave of absence

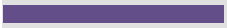
Strongly Disagree		8 (24.24%)
Disagree		4 (12.12%)
Somewhat Disagree		4 (12.12%)
Neutral		9 (27.27%)
Somewhat Agree		2 (6.06%)
Agree		5 (15.15%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

4.9 Repeat coursework

Strongly Disagree		16

		(48.48%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		7 (21.21%)
Somewhat Agree		4 (12.12%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

4.10 Repeat practicum

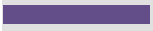
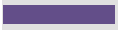
Strongly Disagree		12 (36.36%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		10 (30.3%)
Somewhat Agree		4 (12.12%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

4.11 Individual therapy

Strongly Disagree		1 (3.03%)
Disagree		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		9

		(27.27%)
Agree		4 (12.12%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

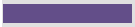
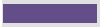
4.12 Personal growth group

Strongly Disagree		3 (9.09%)
Disagree		5 (15.15%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		8 (24.24%)
Agree		4 (12.12%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

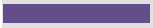
4.13 Group therapy

Strongly Disagree		2 (6.06%)
Disagree		6 (18.18%)
Somewhat Disagree		1 (3.03%)
Neutral		8 (24.24%)
Somewhat Agree		5 (15.15%)
Agree		6 (18.18%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

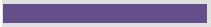
4.14 Leave program

Strongly Disagree		6 (18.18%)
Disagree		4 (12.12%)
Somewhat Disagree		7 (21.21%)
Neutral		5 (15.15%)
Somewhat Agree		5 (15.15%)
Agree		3 (9.09%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

4.15 Counseled out of program

Strongly Disagree		4 (12.12%)
Disagree		6 (18.18%)
Somewhat Disagree		3 (9.09%)
Neutral		5 (15.15%)
Somewhat Agree		8 (24.24%)
Agree		3 (9.09%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

4.16 Termination

Strongly Disagree		11 (33.33%)
Disagree		4

		(12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		8 (24.24%)
Somewhat Agree		3 (9.09%)
Agree		2 (6.06%)
Strongly Agree		2 (6.06%)
N/R		1 (3.03%)

4.17 Consult with entire clinical faculty

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		8 (24.24%)
Agree		5 (15.15%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

4.18 Temporary removal from clinic work

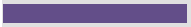
Strongly Disagree		3 (9.09%)
Disagree		4 (12.12%)
Somewhat Disagree		3 (9.09%)
Neutral		7 (21.21%)
Somewhat Agree		8 (24.24%)
Agree		5 (15.15%)

Strongly Agree		3 (9.09%)
N/R		0 (0%)

4.19 Hold student to program expectations and requirements

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		0 (0%)
Agree		4 (12.12%)
Strongly Agree		26 (78.79%)
N/R		1 (3.03%)

4.20 Require additional skills training and provide a behavioral contract regarding student's behavior both in class and in the clinic

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		2 (6.06%)
Somewhat Agree		10 (30.3%)
Agree		7 (21.21%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

4.21 Initiate program remediation

Strongly Disagree		5

		(15.15%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		11 (33.33%)
Agree		5 (15.15%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

4.22 Conduct meeting with both student and MFT faculty

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		2 (6.06%)
Somewhat Agree		9 (27.27%)
Agree		5 (15.15%)
Strongly Agree		12 (36.36%)
N/R		0 (0%)

4.23 Document problems and course of action

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		2 (6.06%)
Strongly Agree		31 (93.94%)

N/R		0 (0%)

4.24 Encourage discussion in group supervision

Strongly Disagree		6 (18.18%)
Disagree		3 (9.09%)
Somewhat Disagree		5 (15.15%)
Neutral		6 (18.18%)
Somewhat Agree		4 (12.12%)
Agree		5 (15.15%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

Question 5

Ethical violation-
Johnny communicated with his client's attorney and released client information without a release of information signed by his client.

5.1 Immediate one-on-one consult with student

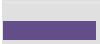
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		30 (90.91%)
N/R		0 (0%)

5.2 Mobilization of support systems

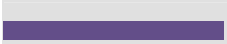
Strongly Disagree		14

		(42.42%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		11 (33.33%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

5.3 Reduce clinic load

Strongly Disagree		11 (33.33%)
Disagree		4 (12.12%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

5.4 Tutoring

Strongly Disagree		12 (36.36%)
Disagree		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		4

		(12.12%)
Agree		7 (21.21%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

5.5 Increase in advising and mentoring

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		2 (6.06%)
Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

5.6 Self-structured behavioral change

Strongly Disagree		4 (12.12%)
Disagree		3 (9.09%)
Somewhat Disagree		0 (0%)
Neutral		8 (24.24%)
Somewhat Agree		7 (21.21%)
Agree		8 (24.24%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

5.7 Increased supervision

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		7 (21.21%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

5.8 Leave of absence

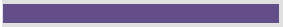
Strongly Disagree		18 (54.55%)
Disagree		6 (18.18%)
Somewhat Disagree		3 (9.09%)
Neutral		4 (12.12%)
Somewhat Agree		1 (3.03%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.9 Extra coursework

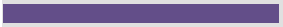
Strongly Disagree		13 (39.39%)
Disagree		5 (15.15%)
Somewhat Disagree		3 (9.09%)
Neutral		3 (9.09%)

Somewhat Agree		4 (12.12%)
Agree		4 (12.12%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

5.10 Repeat coursework

Strongly Disagree		15 (45.45%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.11 Repeat practicum

Strongly Disagree		15 (45.45%)
Disagree		3 (9.09%)
Somewhat Disagree		3 (9.09%)
Neutral		9 (27.27%)
Somewhat Agree		2 (6.06%)
Agree		0 (0%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

5.12 Additional field experience

Strongly Disagree		12 (36.36%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		5 (15.15%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

5.13 Personal growth group

Strongly Disagree		15 (45.45%)
Disagree		5 (15.15%)
Somewhat Disagree		1 (3.03%)
Neutral		10 (30.3%)
Somewhat Agree		2 (6.06%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.14 Individual therapy

Strongly Disagree		13 (39.39%)
Disagree		5 (15.15%)
Somewhat Disagree		2

		(6.06%)
Neutral		12 (36.36%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.15 Leave program

Strongly Disagree		13 (39.39%)
Disagree		7 (21.21%)
Somewhat Disagree		4 (12.12%)
Neutral		8 (24.24%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.16 Counseled out of program

Strongly Disagree		12 (36.36%)
Disagree		7 (21.21%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		2 (6.06%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

5.17
Termination

Strongly Disagree		11 (33.33%)
Disagree		7 (21.21%)
Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Agree		2 (6.06%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

5.18 Assign structured assignment requiring student therapist to review code of ethics, write about specific ethical code violated, and then conduct discussions with supervisors and faculty to demonstrate an understanding of ethics and laws, including potential harm to client

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		4 (12.12%)
Agree		6 (18.18%)
Strongly Agree		22 (66.67%)
N/R		0 (0%)

5.19 Devise behavioral contract regarding ethics and require a written paper on confidentiality

Strongly Disagree		3

		(9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		7 (21.21%)
Agree		5 (15.15%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

5.20 Initiate program remediation process

Strongly Disagree		4 (12.12%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		2 (6.06%)
Somewhat Agree		7 (21.21%)
Agree		10 (30.3%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

5.21 Consult University Attorney

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		4 (12.12%)
Somewhat Agree		4 (12.12%)
Agree		6 (18.18%)

Strongly Agree		16 (48.48%)
N/R		0 (0%)

5.22 Clinical academic probation; repeated incident results in automatic dismissal

Strongly Disagree		2 (6.06%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		8 (24.24%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

Question 6

Academic deficiency-
Although Ana is doing well clinically, she is missing the majority of her semester classes, not turning in required coursework, making substandard grades on exams, and attending classes late and using her clients as an excuse for being tardy.

6.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		1 (3.03%)
Agree		4 (12.12%)
Strongly Agree		27 (81.82%)

N/R		0 (0%)

6.2 Mobilization of support systems

Strongly Disagree		5 (15.15%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		12 (36.36%)
Agree		4 (12.12%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

6.3 Reduce clinic load

Strongly Disagree		5 (15.15%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		7 (21.21%)
Agree		9 (27.27%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

6.4 Tutoring

Strongly Disagree		5 (15.15%)

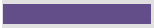
Disagree		4 (12.12%)
Somewhat Disagree		1 (3.03%)
Neutral		9 (27.27%)
Somewhat Agree		6 (18.18%)
Agree		5 (15.15%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

6.5 Increase in advising and mentoring

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		9 (27.27%)
Strongly Agree		12 (36.36%)
N/R		0 (0%)

6.6 Self-structured behavioral change

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		11 (33.33%)
Agree		8 (24.24%)

Strongly Agree		8 (24.24%)
N/R		0 (0%)

6.7 Increased supervision

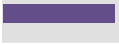
Strongly Disagree		5 (15.15%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		3 (9.09%)
Somewhat Agree		7 (21.21%)
Agree		10 (30.3%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

6.8 Leave of absence

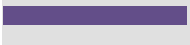
Strongly Disagree		4 (12.12%)
Disagree		5 (15.15%)
Somewhat Disagree		4 (12.12%)
Neutral		11 (33.33%)
Somewhat Agree		6 (18.18%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

6.9 Extra coursework

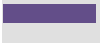
Strongly Disagree		14

		(42.42%)
Disagree		5 (15.15%)
Somewhat Disagree		6 (18.18%)
Neutral		7 (21.21%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

6.10 Repeat coursework

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		1 (3.03%)
Somewhat Agree		10 (30.3%)
Agree		12 (36.36%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

6.11 Individual therapy

Strongly Disagree		5 (15.15%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		12

		(36.36%)
Agree		2 (6.06%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

6.12 Leave program

Strongly Disagree		9 (27.27%)
Disagree		8 (24.24%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		7 (21.21%)
Agree		0 (0%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

6.13 Counseled out of program

Strongly Disagree		9 (27.27%)
Disagree		9 (27.27%)
Somewhat Disagree		1 (3.03%)
Neutral		6 (18.18%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

6.14 Termination

Strongly Disagree		10 (30.3%)
Disagree		10 (30.3%)
Somewhat Disagree		1 (3.03%)
Neutral		8 (24.24%)
Somewhat Agree		4 (12.12%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

6.15 Written warning

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		3 (9.09%)
Agree		16 (48.48%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

6.16 Initiate program remediation process

Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		1

		(3.03%)
Neutral		1 (3.03%)
Somewhat Agree		6 (18.18%)
Agree		11 (33.33%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

6.17 Determine if student therapist meets the requirements for academic probation

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		8 (24.24%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

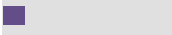
6.18 Advice student therapist of choices, poor grades and/or academic probation

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		25 (75.76%)
N/R		0 (0%)

6.19 Arrange for student therapist to be tested for learning difficulties

Strongly Disagree		4 (12.12%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		10 (30.3%)
Somewhat Agree		4 (12.12%)
Agree		2 (6.06%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

6.20 Advise student therapist about academic concerns in each class. Reiterate that students must maintain a B average in order to stay in the program, and if student is in danger of getting lower than a B in her course, initiate a formal university warning at mid semester

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		1 (3.03%)
Agree		9 (27.27%)
Strongly Agree		21 (63.64%)
N/R		0 (0%)

6.21 No response

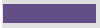
Strongly Disagree		28 (84.85%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)

Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

Question 7

Interpersonal problems-
Kiesha is experiencing problems with getting along well with her peers, professors, and supervisors. During class, it has been observed by Kiesha's professors and peers that she occupies lecture time by asking too many questions that are irrelevant, comments on almost every topic being discussed, and challenges the knowledge of her professors rather than asking questions that will enhance her knowledge base.

7.1 Immediate one-on-one consult with student

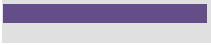
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		10 (30.3%)
Strongly Agree		17 (51.52%)
N/R		0 (0%)

7.2 Mobilization of support systems

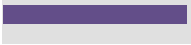
Strongly Disagree		7 (21.21%)
Disagree		4 (12.12%)
Somewhat Disagree		5 (15.15%)
Neutral		10 (30.3%)
Somewhat Agree		4 (12.12%)

Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

7.3 Reduce clinic load

Strongly Disagree		11 (33.33%)
Disagree		9 (27.27%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

7.4 Tutoring

Strongly Disagree		10 (30.3%)
Disagree		9 (27.27%)
Somewhat Disagree		3 (9.09%)
Neutral		5 (15.15%)
Somewhat Agree		2 (6.06%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

7.5 Increase in advising and mentoring

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		8 (24.24%)
Agree		13 (39.39%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

7.6 Self-structured behavioral change

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		11 (33.33%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

7.7 Increased supervision

Strongly Disagree		7 (21.21%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		5 (15.15%)
Somewhat Agree		9 (27.27%)

Agree		4 (12.12%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

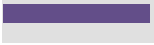
7.8 Personal growth group

Strongly Disagree		4 (12.12%)
Disagree		4 (12.12%)
Somewhat Disagree		1 (3.03%)
Neutral		7 (21.21%)
Somewhat Agree		9 (27.27%)
Agree		3 (9.09%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

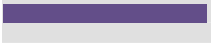
7.9 Individual therapy

Strongly Disagree		8 (24.24%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		5 (15.15%)
Somewhat Agree		11 (33.33%)
Agree		5 (15.15%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

7.10 Group therapy

Strongly Disagree		8 (24.24%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		6 (18.18%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

7.11 Counseled out of program

Strongly Disagree		11 (33.33%)
Disagree		5 (15.15%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		6 (18.18%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

7.12 Termination

Strongly Disagree		17 (51.52%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)

Neutral		7 (21.21%)
Somewhat Agree		3 (9.09%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

7.13 Guided discussion among colleagues about the learning community

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		11 (33.33%)
Agree		7 (21.21%)
Strongly Agree		6 (18.18%)
N/R		1 (3.03%)

7.14 Initiate program remediation process

Strongly Disagree		7 (21.21%)
Disagree		1 (3.03%)
Somewhat Disagree		4 (12.12%)
Neutral		5 (15.15%)
Somewhat Agree		6 (18.18%)
Agree		8 (24.24%)
Strongly Agree		2 (6.06%)

N/R		0 (0%)

7.15 No response

Strongly Disagree		26 (78.79%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		3 (9.09%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

7.16 Kiesha is a typical African-American name. If she is a person of color, I would be most concerned about her experience of racism in the program from peers or faculty. I would address this with her first, then with faculty and peers according to her desires for such

Strongly Disagree		1 (3.03%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		7 (21.21%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

Question 8

Sexual contact with client-
Darren is conducting couples therapy and being supervised live by his primary

supervisor. Only the wife attends this particular session. During session, the female client talks to the therapist about their special relationship. After the session, the supervisor immediately asked Darren what was meant by special relationship. The student therapist hesitated, but finally admitted that he had sexual intercourse with the female client during the time he was seeing her for individual therapy.

8.1 Immediate one-on-one consult with student

Strongly Disagree	0 (0%)
Disagree	0 (0%)
Somewhat Disagree	0 (0%)
Neutral	0 (0%)
Somewhat Agree	0 (0%)
Agree	0 (0%)
Strongly Agree	33 (100%)
N/R	0 (0%)

8.2 Mobilization of support systems

Strongly Disagree	11 (33.33%)
Disagree	4 (12.12%)
Somewhat Disagree	0 (0%)
Neutral	5 (15.15%)
Somewhat Agree	4 (12.12%)
Agree	3 (9.09%)
Strongly Agree	6 (18.18%)
N/R	0 (0%)

8.3 Reduce clinic load

Strongly Disagree	8 (24.24%)
Disagree	0 (0%)
Somewhat Disagree	0 (0%)
Neutral	2

		(6.06%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		22 (66.67%)
N/R		0 (0%)

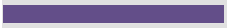
8.4 Increase in advising and mentoring

Strongly Disagree		9 (27.27%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		4 (12.12%)
Somewhat Agree		1 (3.03%)
Agree		3 (9.09%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

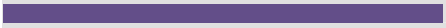
8.5 Increased supervision

Strongly Disagree		8 (24.24%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		21 (63.64%)
N/R		0 (0%)

8.6 Leave of absence

Strongly Disagree		12 (36.36%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		0 (0%)
Agree		5 (15.15%)
Strongly Agree		14 (42.42%)
N/R		0 (0%)

8.7 Additional field experience

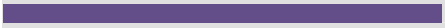
Strongly Disagree		24 (72.73%)
Disagree		4 (12.12%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

8.8 Individual therapy

Strongly Disagree		6 (18.18%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		6 (18.18%)
Somewhat Agree		3 (9.09%)
Agree		2 (6.06%)

Strongly Agree		15 (45.45%)
N/R		0 (0%)

8.9 Leave program

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		3 (9.09%)
Agree		5 (15.15%)
Strongly Agree		24 (72.73%)
N/R		0 (0%)

8.10 Counseled out of program

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		3 (9.09%)
Agree		5 (15.15%)
Strongly Agree		19 (57.58%)
N/R		0 (0%)

8.11 Termination

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		3

		(9.09%)
Agree		6 (18.18%)
Strongly Agree		23 (69.7%)
N/R		0 (0%)

8.12 Conduct review in reference to termination

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		3 (9.09%)
Strongly Agree		27 (81.82%)
N/R		0 (0%)

8.13 Report ethical violation to AAMFT

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		2 (6.06%)
Somewhat Agree		2 (6.06%)
Agree		2 (6.06%)
Strongly Agree		25 (75.76%)
N/R		0 (0%)

8.14 Initiate program remediation process

Strongly Disagree		9 (27.27%)

Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		2 (6.06%)
Somewhat Agree		1 (3.03%)
Agree		3 (9.09%)
Strongly Agree		16 (48.48%)
N/R		0 (0%)

8.15 Ethics education

Strongly Disagree		5 (15.15%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		3 (9.09%)
Agree		4 (12.12%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

8.16 Encourage Darren to report to AAMFT Ethics Board

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		0 (0%)
Somewhat Agree		3 (9.09%)
Agree		3

		(9.09%)
Strongly Agree		24 (72.73%)
N/R		0 (0%)

8.17 Report ethical violation to state licensing board and university attorney

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		4 (12.12%)
Strongly Agree		28 (84.85%)
N/R		0 (0%)

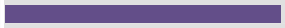
Question 9

Physical illness-
Javier was recently diagnosed with ulcerative colitis, and his illness is affecting his academic and clinical work. Javier is missing classes, canceling clinic appointments, and failing to turn in coursework.

9.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		30 (90.91%)
N/R		0 (0%)

9.2 Mobilization of support systems

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		3 (9.09%)
Agree		11 (33.33%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

9.3 Reduce clinic load

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		9 (27.27%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

9.4 Tutoring

Strongly Disagree		7 (21.21%)
Disagree		3 (9.09%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Agree		4 (12.12%)

Agree		3 (9.09%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

9.5 Increase in advising and mentoring

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		5 (15.15%)
Somewhat Agree		4 (12.12%)
Agree		9 (27.27%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

9.6 Self-structured behavioral change

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		7 (21.21%)
Agree		7 (21.21%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

9.7 Increased supervision

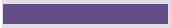
Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		3 (9.09%)
Somewhat Agree		7 (21.21%)
Agree		7 (21.21%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

9.8 Leave of absence

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		11 (33.33%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

9.9 Repeat coursework

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		9 (27.27%)

Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

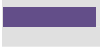
9.10 Repeat practicum

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		7 (21.21%)
Agree		8 (24.24%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

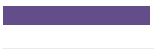
9.11 Personal growth group

Strongly Disagree		7 (21.21%)
Disagree		7 (21.21%)
Somewhat Disagree		6 (18.18%)
Neutral		8 (24.24%)
Somewhat Agree		0 (0%)
Agree		4 (12.12%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

9.12 Individual therapy

Strongly Disagree		3 (9.09%)
Disagree		6 (18.18%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		5 (15.15%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

9.13 Group therapy

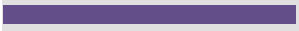
Strongly Disagree		4 (12.12%)
Disagree		6 (18.18%)
Somewhat Disagree		6 (18.18%)
Neutral		8 (24.24%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

9.14 Offer academic resources

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)

Neutral		5 (15.15%)
Somewhat Agree		5 (15.15%)
Agree		9 (27.27%)
Strongly Agree		10 (30.3%)
N/R		1 (3.03%)

9.15 Slow program pace to accommodate the illness

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		5 (15.15%)
Somewhat Agree		5 (15.15%)
Agree		5 (15.15%)
Strongly Agree		16 (48.48%)
N/R		0 (0%)

9.16 Initiate program remediation process

Strongly Disagree		4 (12.12%)
Disagree		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		10 (30.3%)
Agree		8 (24.24%)
Strongly Agree		5

		(15.15%)
N/R		0 (0%)

9.17 Encourage discussion in group supervision

Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		6 (18.18%)
Somewhat Agree		8 (24.24%)
Agree		3 (9.09%)
Strongly Agree		3 (9.09%)
N/R		1 (3.03%)

Question 10

Supervision problem-
Susana was given a directive by her supervisor to devise a No Harm Contract with her client who admitted to current suicidal ideations as well as a previous suicide attempt approximately six months prior to attending appointment with therapist-in-training. Susana failed to comply with her supervisor's directive by not discussing with the client the rationale and importance of signing the contract and failing to get the client to sign the contract prior to the client's leaving the clinic office.

10.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		6

		(18.18%)
Strongly Agree		27 (81.82%)
N/R		0 (0%)

10.2 Mobilization of support systems

Strongly Disagree		10 (30.3%)
Disagree		6 (18.18%)
Somewhat Disagree		4 (12.12%)
Neutral		9 (27.27%)
Somewhat Agree		2 (6.06%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

10.3 Reduce clinic load

Strongly Disagree		3 (9.09%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Agree		10 (30.3%)
Agree		5 (15.15%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

10.4 Tutoring

Strongly Disagree		9

		(27.27%)
Disagree		3 (9.09%)
Somewhat Disagree		5 (15.15%)
Neutral		5 (15.15%)
Somewhat Agree		3 (9.09%)
Agree		5 (15.15%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

10.5 Increase in advising and mentoring

Strongly Disagree		5 (15.15%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		6 (18.18%)
Agree		9 (27.27%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

10.6 Self-structured behavioral change

Strongly Disagree		6 (18.18%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		7 (21.21%)

Somewhat Agree		7 (21.21%)
Agree		10 (30.3%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

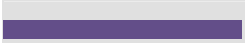
10.7 Increased supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		7 (21.21%)
Strongly Agree		25 (75.76%)
N/R		0 (0%)

10.8 Leave of absence

Strongly Disagree		9 (27.27%)
Disagree		4 (12.12%)
Somewhat Disagree		6 (18.18%)
Neutral		10 (30.3%)
Somewhat Agree		2 (6.06%)
Agree		0 (0%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

10.9 Extra coursework

Strongly Disagree		13 (39.39%)

Disagree		4 (12.12%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		3 (9.09%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

10.10 Repeat coursework

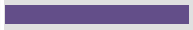
Strongly Disagree		15 (45.45%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Agree		3 (9.09%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

10.11 Repeat practicum

Strongly Disagree		10 (30.3%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		6 (18.18%)
Somewhat Agree		8 (24.24%)
Agree		2

		(6.06%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

10.12 Additional field experience

Strongly Disagree		10 (30.3%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		6 (18.18%)
Agree		5 (15.15%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

10.13 Second internship

Strongly Disagree		10 (30.3%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		5 (15.15%)
Agree		2 (6.06%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

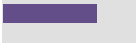
10.14 Individual therapy

Strongly Disagree		6 (18.18%)
Disagree		4 (12.12%)
Somewhat Disagree		3 (9.09%)
Neutral		12 (36.36%)
Somewhat Agree		4 (12.12%)
Agree		1 (3.03%)
Strongly Agree		2 (6.06%)
N/R		1 (3.03%)

10.15 Leave program

Strongly Disagree		10 (30.3%)
Disagree		5 (15.15%)
Somewhat Disagree		5 (15.15%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

10.16 Counseled out of program

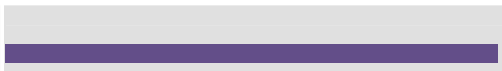
Strongly Disagree		10 (30.3%)
Disagree		4 (12.12%)
Somewhat Disagree		5 (15.15%)
Neutral		7

		(21.21%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

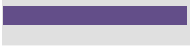
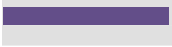
10.17 Termination

Strongly Disagree		12 (36.36%)
Disagree		7 (21.21%)
Somewhat Disagree		2 (6.06%)
Neutral		8 (24.24%)
Somewhat Agree		2 (6.06%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

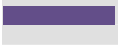
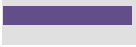
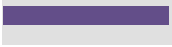
10.18 Mandate that Susana immediately contact client to verify and establish safety as well as to schedule an appointment as soon as possible to implement safety plan

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		0 (0%)
Agree		5 (15.15%)
Strongly Agree		27 (81.82%)
N/R		0 (0%)

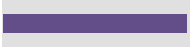
10.19 Suspension of clinical privileges

Strongly Disagree		4 (12.12%)
Disagree		2 (6.06%)
Somewhat Disagree		10 (30.3%)
Neutral		4 (12.12%)
Somewhat Agree		9 (27.27%)
Agree		2 (6.06%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

10.20 Remove from case

Strongly Disagree		6 (18.18%)
Disagree		3 (9.09%)
Somewhat Disagree		7 (21.21%)
Neutral		4 (12.12%)
Somewhat Agree		9 (27.27%)
Agree		4 (12.12%)
Strongly Agree		0 (0%)
N/R		0 (0%)

10.21 Threaten to have to repeat practicum

Strongly Disagree		10 (30.3%)
Disagree		5 (15.15%)
Somewhat Disagree		6

		(18.18%)
Neutral		5 (15.15%)
Somewhat Agree		2 (6.06%)
Agree		3 (9.09%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

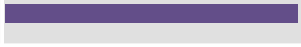
10.22 No response

Strongly Disagree		28 (84.85%)
Disagree		4 (12.12%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		1 (3.03%)

10.23 Termination from practicum site

Strongly Disagree		8 (24.24%)
Disagree		7 (21.21%)
Somewhat Disagree		7 (21.21%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

10.24 Written warning

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		7 (21.21%)
Agree		8 (24.24%)
Strongly Agree		16 (48.48%)
N/R		0 (0%)

10.25 Initiate program remediation process

Strongly Disagree		4 (12.12%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Agree		12 (36.36%)
Agree		10 (30.3%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

10.26 Consult with other supervisors who have worked with Susana

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		4 (12.12%)

Agree		9 (27.27%)
Strongly Agree		18 (54.55%)
N/R		0 (0%)

10.27 Meeting with all faculty to discuss issue

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		2 (6.06%)
Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

Question 11

Job stress (emotional/physical demands of graduate school)-
Tamara reported feeling overwhelmed as a result of the demands of coursework, clinic load/administrative duties, and assistantship responsibilities. Due to this stress, she is experiencing difficulties empathizing with her clients. For instance, during one of Tamara's sessions with a patient who is also experiencing distress at work, rather than empathizing with the patient and providing words of encouragement, Tamara said to her client, "What do you have to complain about? If you only knew what it is like to feel overwhelmed."

11.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		3 (9.09%)
Agree		2

		(6.06%)
Strongly Agree		28 (84.85%)
N/R		0 (0%)

11.2 Mobilization of support systems

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		9 (27.27%)
Agree		12 (36.36%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

11.3 Reduce clinic load

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		11 (33.33%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

11.4 Increase in advising and mentoring

Strongly Disagree		0 (0%)

Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		10 (30.3%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

11.5 Self-structured behavioral change

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		6 (18.18%)
Somewhat Agree		8 (24.24%)
Agree		12 (36.36%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

11.6 Increased supervision

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		4 (12.12%)
Agree		13 (39.39%)
Strongly Agree		15 (45.45%)

N/R		0 (0%)

11.7 Leave of absence

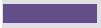
Strongly Disagree		3 (9.09%)
Disagree		4 (12.12%)
Somewhat Disagree		0 (0%)
Neutral		6 (18.18%)
Somewhat Agree		14 (42.42%)
Agree		6 (18.18%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.8 Repeat practicum

Strongly Disagree		7 (21.21%)
Disagree		5 (15.15%)
Somewhat Disagree		2 (6.06%)
Neutral		10 (30.3%)
Somewhat Agree		6 (18.18%)
Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.9 Additional field experience

Strongly Disagree		11 (33.33%)
Disagree		4 (12.12%)
Somewhat Disagree		4 (12.12%)

Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.10 Personal growth group

Strongly Disagree		7 (21.21%)
Disagree		5 (15.15%)
Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Agree		5 (15.15%)
Agree		5 (15.15%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.11 Individual therapy

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		11 (33.33%)
Agree		7 (21.21%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

11.12 Group therapy

Strongly Disagree		4 (12.12%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		8 (24.24%)
Somewhat Agree		10 (30.3%)
Agree		5 (15.15%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

11.13 Leave program

Strongly Disagree		8 (24.24%)
Disagree		7 (21.21%)
Somewhat Disagree		5 (15.15%)
Neutral		8 (24.24%)
Somewhat Agree		5 (15.15%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.14 Counseled out of program

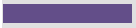
Strongly Disagree		8 (24.24%)
Disagree		8 (24.24%)
Somewhat Disagree		4

		(12.12%)
Neutral		7 (21.21%)
Somewhat Agree		6 (18.18%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.15 Termination

Strongly Disagree		11 (33.33%)
Disagree		10 (30.3%)
Somewhat Disagree		3 (9.09%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

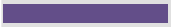
11.16 Discussion with supervisors and faculty about potential harm to clients and then restructuring individual program

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		7 (21.21%)
Agree		9 (27.27%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

11.17 No response

Strongly Disagree		29 (87.88%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		0 (0%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

11.18 Initiate program remediation process

Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		7 (21.21%)
Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

Question 12

Personal conflict-
Since Donna reported to her supervisor that her mother was diagnosed with cancer, both her academic and clinic performance have declined. Donna has been missing the majority of her semester classes including practicum, canceling clinic appointments, requesting extensions for class assignments, and making substandard exam scores.

12.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		2 (6.06%)
Agree		4 (12.12%)
Strongly Agree		27 (81.82%)
N/R		0 (0%)

12.2 Mobilization of support systems

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		18 (54.55%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

12.3 Reduce clinic load

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		7 (21.21%)
Agree		8 (24.24%)
Strongly Agree		16 (48.48%)

N/R		0 (0%)

12.4 Increase in advising and mentoring

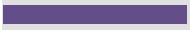
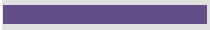
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		10 (30.3%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

12.5 Self-structured behavioral change

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		9 (27.27%)
Somewhat Agree		7 (21.21%)
Agree		10 (30.3%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

12.6 Increased supervision

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1

		(3.03%)
Neutral		4 (12.12%)
Somewhat Agree		10 (30.3%)
Agree		6 (18.18%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

12.7 Leave of absence

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		5 (15.15%)
Agree		12 (36.36%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

12.8 Extra coursework

Strongly Disagree		16 (48.48%)
Disagree		4 (12.12%)
Somewhat Disagree		8 (24.24%)
Neutral		4 (12.12%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

12.9 Repeat coursework

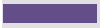
Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		6 (18.18%)
Somewhat Agree		9 (27.27%)
Agree		4 (12.12%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

12.10 Repeat practicum

Strongly Disagree		6 (18.18%)
Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		9 (27.27%)
Somewhat Agree		6 (18.18%)
Agree		5 (15.15%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

12.11 Personal growth group

Strongly Disagree		6 (18.18%)
Disagree		3 (9.09%)
Somewhat Disagree		5 (15.15%)

Neutral		10 (30.3%)
Somewhat Agree		5 (15.15%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

12.12 Individual therapy

Strongly Disagree		1 (3.03%)
Disagree		3 (9.09%)
Somewhat Disagree		1 (3.03%)
Neutral		5 (15.15%)
Somewhat Agree		10 (30.3%)
Agree		9 (27.27%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

12.13 Group therapy

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		8 (24.24%)
Agree		7 (21.21%)
Strongly Agree		3 (9.09%)

N/R		0 (0%)

12.14 Slow program pace to accommodate the illness

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		1 (3.03%)
Somewhat Agree		3 (9.09%)
Agree		9 (27.27%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

12.15 Initiate program remediation process

Strongly Disagree		3 (9.09%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		4 (12.12%)
Somewhat Agree		10 (30.3%)
Agree		8 (24.24%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

12.16 Encourage to discuss in group supervision

Strongly Disagree		1 (3.03%)
Disagree		2

		(6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		5 (15.15%)
Agree		7 (21.21%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

Question 13

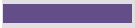
Maturity problem-
Michael, a second year student, is unable to receive constructive feedback from supervisors and peers. For example, while discussing one of Michael's most challenging cases during practicum, Michael began to pout and became defensive when the practicum supervisor provided suggestions and constructive feedback on how he could effectively manage challenging cases in the future.

13.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		5 (15.15%)
Strongly Agree		22 (66.67%)
N/R		0 (0%)

13.2 Mobilization of support systems

Strongly Disagree		5 (15.15%)

Disagree		3 (9.09%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		7 (21.21%)
Agree		4 (12.12%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

13.3 Reduce clinic load

Strongly Disagree		3 (9.09%)
Disagree		2 (6.06%)
Somewhat Disagree		5 (15.15%)
Neutral		5 (15.15%)
Somewhat Agree		10 (30.3%)
Agree		4 (12.12%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

13.4 Tutoring

Strongly Disagree		10 (30.3%)
Disagree		5 (15.15%)
Somewhat Disagree		3 (9.09%)
Neutral		6 (18.18%)
Somewhat Agree		6

		(18.18%)
Agree		1 (3.03%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

13.5 Increase in advising and mentoring

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Agree		11 (33.33%)
Agree		8 (24.24%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

13.6 Self-structured behavioral change

Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		6 (18.18%)
Somewhat Agree		10 (30.3%)
Agree		10 (30.3%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

13.7 Increased supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		4 (12.12%)
Agree		13 (39.39%)
Strongly Agree		14 (42.42%)
N/R		0 (0%)

13.8 Leave of absence

Strongly Disagree		6 (18.18%)
Disagree		7 (21.21%)
Somewhat Disagree		8 (24.24%)
Neutral		4 (12.12%)
Somewhat Agree		6 (18.18%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

13.9 Repeat coursework

Strongly Disagree		11 (33.33%)
Disagree		9 (27.27%)
Somewhat Disagree		5 (15.15%)

Neutral		6 (18.18%)
Somewhat Agree		1 (3.03%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

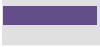
13.10 Repeat practicum

Strongly Disagree		6 (18.18%)
Disagree		5 (15.15%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Agree		5 (15.15%)
Agree		4 (12.12%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.11 Additional field experience

Strongly Disagree		6 (18.18%)
Disagree		5 (15.15%)
Somewhat Disagree		4 (12.12%)
Neutral		7 (21.21%)
Somewhat Agree		6 (18.18%)
Agree		5 (15.15%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.12 Second internship

Strongly Disagree		7 (21.21%)
Disagree		4 (12.12%)
Somewhat Disagree		5 (15.15%)
Neutral		9 (27.27%)
Somewhat Agree		4 (12.12%)
Agree		4 (12.12%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.13 Personal growth group

Strongly Disagree		1 (3.03%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		5 (15.15%)
Somewhat Agree		10 (30.3%)
Agree		12 (36.36%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

13.14 Individual therapy

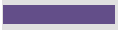
Strongly Disagree		2 (6.06%)
Disagree		3 (9.09%)
Somewhat Disagree		0 (0%)
Neutral		7

		(21.21%)
Somewhat Agree		6 (18.18%)
Agree		10 (30.3%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

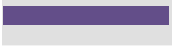
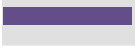
13.15 Group therapy

Strongly Disagree		3 (9.09%)
Disagree		4 (12.12%)
Somewhat Disagree		0 (0%)
Neutral		8 (24.24%)
Somewhat Agree		4 (12.12%)
Agree		11 (33.33%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

13.16 Leave program

Strongly Disagree		6 (18.18%)
Disagree		8 (24.24%)
Somewhat Disagree		11 (33.33%)
Neutral		1 (3.03%)
Somewhat Agree		5 (15.15%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.17 Counseled out of program

Strongly Disagree		4 (12.12%)
Disagree		8 (24.24%)
Somewhat Disagree		9 (27.27%)
Neutral		3 (9.09%)
Somewhat Agree		7 (21.21%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.18 Termination

Strongly Disagree		8 (24.24%)
Disagree		10 (30.3%)
Somewhat Disagree		8 (24.24%)
Neutral		5 (15.15%)
Somewhat Agree		1 (3.03%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

13.19 Initiate program remediation process

Strongly Disagree		3 (9.09%)
Disagree		4 (12.12%)
Somewhat Disagree		3 (9.09%)

Neutral		8 (24.24%)
Somewhat Agree		4 (12.12%)
Agree		8 (24.24%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

13.20 Consult with other clinical faculty

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		1 (3.03%)
Agree		11 (33.33%)
Strongly Agree		20 (60.61%)
N/R		0 (0%)

13.21 Focus on and discuss concern in individual supervision

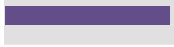
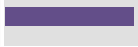
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		8 (24.24%)
Strongly Agree		24 (72.73%)
N/R		0 (0%)

Question 14

Clinical deficiencies-
Allen, an upper-level first year student, is having difficulties applying systems theory

learned in class into practice while conducting therapy. While conducting couples therapy and being supervised live, it was observed that Allen was only focusing on each person's past rather than how their past experiences may be influencing their lives presently, individually as well as relationally.

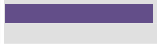
14.1 Immediate one-on-one consult with student

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		4 (12.12%)
Neutral		5 (15.15%)
Somewhat Disagree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

14.2 Mobilization of support systems

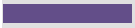
Strongly Disagree		8 (24.24%)
Disagree		8 (24.24%)
Somewhat Disagree		4 (12.12%)
Neutral		10 (30.3%)
Somewhat Disagree		2 (6.06%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.3 Reduce clinic load

Strongly Disagree		8 (24.24%)

Disagree		8 (24.24%)
Somewhat Disagree		7 (21.21%)
Neutral		6 (18.18%)
Somewhat Disagree		4 (12.12%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.4 Tutoring

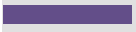
Strongly Disagree		7 (21.21%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Disagree		7 (21.21%)
Agree		6 (18.18%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

14.5 Increase in advising and mentoring

Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Disagree		8 (24.24%)
Agree		6

		(18.18%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

14.6 Self-structured behavioral change

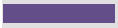
Strongly Disagree		7 (21.21%)
Disagree		4 (12.12%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Disagree		6 (18.18%)
Agree		3 (9.09%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

14.7 Increased supervision

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Disagree		6 (18.18%)
Agree		13 (39.39%)
Strongly Agree		12 (36.36%)
N/R		0 (0%)

14.8 Extra coursework

Strongly Disagree		8 (24.24%)

Disagree		6 (18.18%)
Somewhat Disagree		2 (6.06%)
Neutral		7 (21.21%)
Somewhat Disagree		6 (18.18%)
Agree		4 (12.12%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.9 Repeat coursework

Strongly Disagree		9 (27.27%)
Disagree		6 (18.18%)
Somewhat Disagree		4 (12.12%)
Neutral		5 (15.15%)
Somewhat Disagree		6 (18.18%)
Agree		3 (9.09%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.10 Repeat practicum

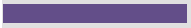
Strongly Disagree		7 (21.21%)
Disagree		4 (12.12%)
Somewhat Disagree		4 (12.12%)
Neutral		6 (18.18%)
Somewhat Disagree		6 (18.18%)

Agree		4 (12.12%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

14.11 Additional field experience

Strongly Disagree		9 (27.27%)
Disagree		3 (9.09%)
Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Disagree		4 (12.12%)
Agree		5 (15.15%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

14.12 Second internship

Strongly Disagree		10 (30.3%)
Disagree		3 (9.09%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Disagree		4 (12.12%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

14.13 Personal growth group

Strongly Disagree		11 (33.33%)
Disagree		8 (24.24%)
Somewhat Disagree		4 (12.12%)
Neutral		8 (24.24%)
Somewhat Disagree		1 (3.03%)
Agree		1 (3.03%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.14 Individual therapy

Strongly Disagree		11 (33.33%)
Disagree		8 (24.24%)
Somewhat Disagree		4 (12.12%)
Neutral		8 (24.24%)
Somewhat Disagree		0 (0%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.15 Group therapy

Strongly Disagree		11 (33.33%)
Disagree		8 (24.24%)
Somewhat Disagree		4 (12.12%)
Neutral		8

		(24.24%)
Somewhat Disagree		0 (0%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.16 Counseled out of program

Strongly Disagree		16 (48.48%)
Disagree		8 (24.24%)
Somewhat Disagree		6 (18.18%)
Neutral		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

14.17 No response

Strongly Disagree		23 (69.7%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

14.18 Reinstruction in systems

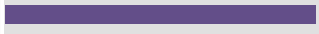
Strongly Disagree		2 (6.06%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Disagree		5 (15.15%)
Agree		13 (39.39%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

14.19 Often occurs and this issue becomes a focus for supervision sessions. Could include increased readings, videos, assignments, and observations

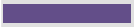
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Disagree		2 (6.06%)
Agree		8 (24.24%)
Strongly Agree		23 (69.7%)
N/R		0 (0%)

14.20 Increased LIVE supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Disagree		2 (6.06%)
Agree		14

		(42.42%)
Strongly Agree		17 (51.52%)
N/R		0 (0%)

14.21 Discuss in group supervision

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		4 (12.12%)
Somewhat Disagree		7 (21.21%)
Agree		12 (36.36%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

Question 15

Chemical dependency-
On several occasions while Amy was present at the clinic conducting therapy with her clients, her supervisor and peers have smelled alcohol on her breath and noticed that her gait was unsteady and she was slurring her speech.

15.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		32 (96.97%)
N/R		0 (0%)

15.2 Mobilization of support systems

Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		6 (18.18%)
Agree		13 (39.39%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

15.3 Reduce clinic load

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		9 (27.27%)
Agree		11 (33.33%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

15.4 Tutoring

Strongly Disagree		13 (39.39%)
Disagree		7 (21.21%)
Somewhat Disagree		0 (0%)
Neutral		7 (21.21%)
Somewhat Agree		0 (0%)
Agree		3

		(9.09%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

15.5 Increase in advising and mentoring

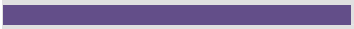
Strongly Disagree		4 (12.12%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

15.6 Self-structured behavioral change

Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		3 (9.09%)
Agree		7 (21.21%)
Strongly Agree		8 (24.24%)
N/R		0 (0%)

15.7 Increased supervision

Strongly Disagree		1 (3.03%)

Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		2 (6.06%)
Agree		8 (24.24%)
Strongly Agree		19 (57.58%)
N/R		0 (0%)

15.8 Leave of absence

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		10 (30.3%)
Agree		5 (15.15%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

15.9 Repeat coursework

Strongly Disagree		9 (27.27%)
Disagree		6 (18.18%)
Somewhat Disagree		1 (3.03%)
Neutral		10 (30.3%)
Somewhat Agree		4

		(12.12%)
Agree		1 (3.03%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

15.10 Repeat practicum

Strongly Disagree		6 (18.18%)
Disagree		4 (12.12%)
Somewhat Disagree		2 (6.06%)
Neutral		4 (12.12%)
Somewhat Agree		10 (30.3%)
Agree		3 (9.09%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

15.11 Personal growth group

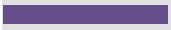
Strongly Disagree		6 (18.18%)
Disagree		2 (6.06%)
Somewhat Disagree		3 (9.09%)
Neutral		9 (27.27%)
Somewhat Agree		6 (18.18%)
Agree		4 (12.12%)

Strongly Agree		3 (9.09%)
N/R		0 (0%)

15.12 Individual therapy

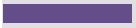
Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		9 (27.27%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

15.13 Group therapy

Strongly Disagree		3 (9.09%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		9 (27.27%)
Agree		7 (21.21%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

15.14 Leave program

Strongly Disagree		1

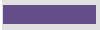
		(3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		7 (21.21%)
Neutral		7 (21.21%)
Somewhat Agree		7 (21.21%)
Agree		3 (9.09%)
Strongly Agree		7 (21.21%)
N/R		0 (0%)

15.15 Counseled out of program

Strongly Disagree		2 (6.06%)
Disagree		2 (6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		8 (24.24%)
Somewhat Agree		6 (18.18%)
Agree		2 (6.06%)
Strongly Agree		9 (27.27%)
N/R		0 (0%)

15.16 Termination

Strongly Disagree		2 (6.06%)
Disagree		3 (9.09%)
Somewhat Disagree		4 (12.12%)
Neutral		9

		(27.27%)
Somewhat Agree		5 (15.15%)
Agree		4 (12.12%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

15.17 Suspension of clinical privileges

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		5 (15.15%)
Agree		10 (30.3%)
Strongly Agree		14 (42.42%)
N/R		0 (0%)

15.18 Consider filing ethical complaint if student refuses to address the issue

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		1 (3.03%)
Neutral		1 (3.03%)
Somewhat Agree		2 (6.06%)
Agree		8 (24.24%)
Strongly Agree		21 (63.64%)
N/R		0 (0%)

15.19 Refer for substance abuse evaluation and treatment

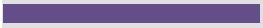
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		2 (6.06%)
Agree		6 (18.18%)
Strongly Agree		22 (66.67%)
N/R		0 (0%)

15.20 Initiate program remediation process

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		4 (12.12%)
Agree		11 (33.33%)
Strongly Agree		15 (45.45%)
N/R		0 (0%)

15.21 If student denies alcohol use, refer to physician to screen for underlying medical illnesses

Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		1 (3.03%)

Somewhat Agree		4 (12.12%)
Agree		11 (33.33%)
Strongly Agree		14 (42.42%)
N/R		0 (0%)

Question 16

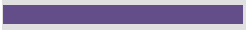
Mental illness (Bipolar II)-
Blaine had been diagnosed with Bipolar II and prescribed medication. He made the faculty aware of this. Recently, though, Blaine has not been taking his medication, and it has had an impact on his ability to conduct therapy. For instance, while Blaine was conducting therapy with one of his clients, his primary supervisor observed that his mood was elevated, he talked incessantly and was easily distracted by external stimuli, and commented to the client about how effective and great he thought he was as a therapist in comparison to his peers. Due to questions and growing concerns, the supervisor observed Blaine's follow-up appointment with this particular client. It was during this session that Blaine seemed to be experiencing a depressive episode in which he appeared depressed, fatigued, indecisive, disinterested, and hypoactive.

16.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		0 (0%)
Agree		1 (3.03%)
Strongly Agree		31 (93.94%)
N/R		0 (0%)

16.2 Mobilization of support systems

Strongly Disagree		1 (3.03%)

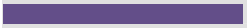
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		4 (12.12%)
Agree		11 (33.33%)
Strongly Agree		13 (39.39%)
N/R		0 (0%)

16.3 Reduce clinic load

Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		7 (21.21%)
Agree		10 (30.3%)
Strongly Agree		12 (36.36%)
N/R		0 (0%)

16.4 Increase in advising and mentoring

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		7 (21.21%)
Agree		3 (9.09%)

Strongly Agree		13 (39.39%)
N/R		0 (0%)

16.5 Self-structured behavioral change

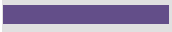
Strongly Disagree		1 (3.03%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		8 (24.24%)
Somewhat Agree		8 (24.24%)
Agree		11 (33.33%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

16.6 Increased supervision

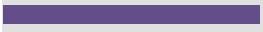
Strongly Disagree		0 (0%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		4 (12.12%)
Agree		8 (24.24%)
Strongly Agree		20 (60.61%)
N/R		0 (0%)

16.7 Leave of absence

Strongly Disagree		1 (3.03%)
Disagree		1 (3.03%)
Somewhat Disagree		2

		(6.06%)
Neutral		6 (18.18%)
Somewhat Agree		9 (27.27%)
Agree		8 (24.24%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

16.8 Extra coursework

Strongly Disagree		14 (42.42%)
Disagree		8 (24.24%)
Somewhat Disagree		6 (18.18%)
Neutral		5 (15.15%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

16.9 Personal growth group

Strongly Disagree		8 (24.24%)
Disagree		7 (21.21%)
Somewhat Disagree		2 (6.06%)
Neutral		8 (24.24%)
Somewhat Agree		4 (12.12%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)

N/R		0 (0%)

16.10 Individual therapy

Strongly Disagree		0 (0%)
Disagree		2 (6.06%)
Somewhat Disagree		1 (3.03%)
Neutral		4 (12.12%)
Somewhat Agree		4 (12.12%)
Agree		8 (24.24%)
Strongly Agree		14 (42.42%)
N/R		0 (0%)

16.11 Group therapy

Strongly Disagree		4 (12.12%)
Disagree		4 (12.12%)
Somewhat Disagree		1 (3.03%)
Neutral		10 (30.3%)
Somewhat Agree		5 (15.15%)
Agree		5 (15.15%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

16.12 Leave program

Strongly Disagree		6 (18.18%)
Disagree		5 (15.15%)

Somewhat Disagree		2 (6.06%)
Neutral		9 (27.27%)
Somewhat Agree		7 (21.21%)
Agree		3 (9.09%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

16.13 Counseled out of program

Strongly Disagree		4 (12.12%)
Disagree		3 (9.09%)
Somewhat Disagree		4 (12.12%)
Neutral		11 (33.33%)
Somewhat Agree		5 (15.15%)
Agree		4 (12.12%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

16.14 Termination

Strongly Disagree		8 (24.24%)
Disagree		5 (15.15%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Agree		1 (3.03%)
Agree		3

		(9.09%)
Strongly Agree		2 (6.06%)
N/R		1 (3.03%)

16.15 Suspension of clinical privileges until situation is addressed

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		2 (6.06%)
Somewhat Agree		4 (12.12%)
Agree		7 (21.21%)
Strongly Agree		20 (60.61%)
N/R		0 (0%)

16.16 Refer to psychiatrist for medication management; contract for medication adherence

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		8 (24.24%)
Strongly Agree		20 (60.61%)
N/R		0 (0%)

16.17 Initiate program remediation process

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		1

		(3.03%)
Neutral		6 (18.18%)
Somewhat Agree		5 (15.15%)
Agree		9 (27.27%)
Strongly Agree		11 (33.33%)
N/R		0 (0%)

Question 17

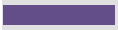
Marital problems-
While conducting therapy with a female client experiencing marital difficulties due to her spouse's extramarital affair, the supervisor observed Jeanne encouraging the female client to get a divorce. Recently, unbeknownst to Jeanne's professors and peers, she has also filed for divorce as a result of her spouse's extramarital affair.

17.1 Immediate one-on-one consult with student

Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		2 (6.06%)
Agree		11 (33.33%)
Strongly Agree		19 (57.58%)
N/R		0 (0%)

17.2 Mobilization of support systems

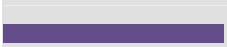
Strongly Disagree		3 (9.09%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		9

		(27.27%)
Somewhat Agree		5 (15.15%)
Agree		8 (24.24%)
Strongly Agree		6 (18.18%)
N/R		0 (0%)

17.3 Reduce clinic load

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		8 (24.24%)
Somewhat Agree		13 (39.39%)
Agree		3 (9.09%)
Strongly Agree		3 (9.09%)
N/R		0 (0%)

17.4 Tutoring

Strongly Disagree		12 (36.36%)
Disagree		8 (24.24%)
Somewhat Disagree		3 (9.09%)
Neutral		6 (18.18%)
Somewhat Agree		1 (3.03%)
Agree		2 (6.06%)
Strongly Agree		1

		(3.03%)
N/R		0 (0%)

17.5 Increase in advising and mentoring

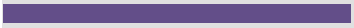
Strongly Disagree		3 (9.09%)
Disagree		0 (0%)
Somewhat Disagree		2 (6.06%)
Neutral		5 (15.15%)
Somewhat Agree		7 (21.21%)
Agree		6 (18.18%)
Strongly Agree		10 (30.3%)
N/R		0 (0%)

17.6 Self-structured behavioral change

Strongly Disagree		6 (18.18%)
Disagree		4 (12.12%)
Somewhat Disagree		1 (3.03%)
Neutral		6 (18.18%)
Somewhat Agree		7 (21.21%)
Agree		4 (12.12%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

17.7 Increased supervision

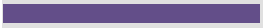
Strongly Disagree		0 (0%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)

Neutral		3 (9.09%)
Somewhat Agree		3 (9.09%)
Agree		8 (24.24%)
Strongly Agree		19 (57.58%)
N/R		0 (0%)

17.8 Leave of absence

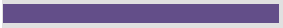
Strongly Disagree		3 (9.09%)
Disagree		3 (9.09%)
Somewhat Disagree		7 (21.21%)
Neutral		9 (27.27%)
Somewhat Agree		6 (18.18%)
Agree		3 (9.09%)
Strongly Agree		2 (6.06%)
N/R		0 (0%)

17.9 Extra coursework

Strongly Disagree		14 (42.42%)
Disagree		10 (30.3%)
Somewhat Disagree		5 (15.15%)
Neutral		4 (12.12%)
Somewhat Agree		0 (0%)
Agree		0 (0%)
Strongly Agree		0 (0%)

N/R		0 (0%)

17.10 Repeat coursework

Strongly Disagree		15 (45.45%)
Disagree		9 (27.27%)
Somewhat Disagree		5 (15.15%)
Neutral		3 (9.09%)
Somewhat Agree		1 (3.03%)
Agree		0 (0%)
Strongly Agree		0 (0%)
N/R		0 (0%)

17.11 Repeat practicum

Strongly Disagree		11 (33.33%)
Disagree		7 (21.21%)
Somewhat Disagree		5 (15.15%)
Neutral		5 (15.15%)
Somewhat Agree		3 (9.09%)
Agree		1 (3.03%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

17.12 Additional field experience

Strongly Disagree		12 (36.36%)
Disagree		5 (15.15%)

Somewhat Disagree		6 (18.18%)
Neutral		7 (21.21%)
Somewhat Agree		0 (0%)
Agree		2 (6.06%)
Strongly Agree		1 (3.03%)
N/R		0 (0%)

17.13 Personal growth group

Strongly Disagree		7 (21.21%)
Disagree		2 (6.06%)
Somewhat Disagree		4 (12.12%)
Neutral		6 (18.18%)
Somewhat Agree		7 (21.21%)
Agree		3 (9.09%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

17.14 Individual therapy

Strongly Disagree		2 (6.06%)
Disagree		1 (3.03%)
Somewhat Disagree		0 (0%)
Neutral		3 (9.09%)
Somewhat Agree		8 (24.24%)
Agree		11 (33.33%)
Strongly Agree		7

		(21.21%)
N/R		1 (3.03%)

17.15 Group therapy

Strongly Disagree		5 (15.15%)
Disagree		2 (6.06%)
Somewhat Disagree		0 (0%)
Neutral		7 (21.21%)
Somewhat Agree		9 (27.27%)
Agree		6 (18.18%)
Strongly Agree		4 (12.12%)
N/R		0 (0%)

17.16 Suspend from all clinical activity

Strongly Disagree		4 (12.12%)
Disagree		9 (27.27%)
Somewhat Disagree		6 (18.18%)
Neutral		6 (18.18%)
Somewhat Agree		6 (18.18%)
Agree		2 (6.06%)
Strongly Agree		0 (0%)
N/R		0 (0%)

17.17 Assign readings

Strongly Disagree		5 (15.15%)
Disagree		1

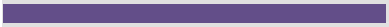
		(3.03%)
Somewhat Disagree		2 (6.06%)
Neutral		10 (30.3%)
Somewhat Agree		7 (21.21%)
Agree		3 (9.09%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

17.18 Marital therapy

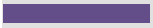
Strongly Disagree		5 (15.15%)
Disagree		1 (3.03%)
Somewhat Disagree		3 (9.09%)
Neutral		10 (30.3%)
Somewhat Agree		1 (3.03%)
Agree		8 (24.24%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

17.19 Address issue in individual supervision

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		0 (0%)
Somewhat Agree		2 (6.06%)
Agree		9 (27.27%)

Strongly Agree		21 (63.64%)
N/R		0 (0%)

17.20 Encourage discussion in group supervision

Strongly Disagree		2 (6.06%)
Disagree		5 (15.15%)
Somewhat Disagree		4 (12.12%)
Neutral		5 (15.15%)
Somewhat Agree		8 (24.24%)
Agree		4 (12.12%)
Strongly Agree		5 (15.15%)
N/R		0 (0%)

17.21 Confront on isomorphism

Strongly Disagree		1 (3.03%)
Disagree		0 (0%)
Somewhat Disagree		0 (0%)
Neutral		1 (3.03%)
Somewhat Agree		4 (12.12%)
Agree		7 (21.21%)
Strongly Agree		19 (57.58%)
N/R		1 (3.03%)

APPENDIX J: Delphi Questionnaire I
Participants' Generated Responses

Question 1

Burnout-Mark is a student therapist who is experiencing extreme distress in his life due to an overload of clients, coursework, assistantship, and a part-time job. Not only is Mark consistently late for work and class, he also completes and turns in his assignments late. Mark's professors and employer have noticed him falling asleep in class and emotionally withdrawing from his peers and co-workers. Furthermore, Mark has been requesting more time-off from work and school for medical appointments due to complaints of headaches and gastrointestinal distress.

- A leave of absence might be negotiated if the problem persists, but I would want that decision to evolve from discussion with the student.

- Mark may need to be advised to extend his time in the program in order to reduce the number of things he is trying to accomplish at the same time, i.e., work, school, clinic and assistantship.

- Students are extensively advised about rigors of program by faculty and senior students. In extreme cases a leave of absence is recommended.

- can't know what to do until you talk to him

- Decisions are case specific. 'support' thru burnout is co-constructed between what the student believes he/she needs and what the program believes he/she needs to move through this time with greatest benefit.

- Until one has consulted with the student the other options are premature.

- It all depends on the exact circumstances.

- The first step would be to talk with Mark. Depending upon the results of this conversation, other interventions would then be considered.

- Any other intervention(s) are contingent upon outcomes of the consultation.

- Everything starts with the one on one consult, with the inquiry as to whether the

situation has reached the level at which a leave should be considered. In any event, individual therapy seems in order. Nothing that adds time to his schedule, other than therapy.

- Make sure students know they can contract for a B in a course to balance their work and home loads better

- Some of the above is dependent on Mark's response. The crux of my response is to provide a relief for Mark as it sounds as if he is juggling to much. There may be other underlying difficulties at the core of his stress which is why the increased mentoring and consultation. May be referred to therapy if deemed appropriate.

- I would use additional methods if the intern didn't respond to those I checked above (which would be my initial actions).

- One could make the case that any of these could qualify as an "effective remediation method." I am approaching each of the scenarios, though, from more of a constructionist perspective in which I would want to initially gather more information before proceeding. Many of the options could be considered based on consultation with the student. It maybe appropriate to counsel the student out of the program, recommend therapy, reduce clinical load, etc. but I would not presume that course of action until individually consulting with the student.

- The first course of action should be out of a direct and clear concern for the student's well-being. Through a one-on-one meeting, a plan of action to ensure the student's success in the program (and life!) should be constructed. Sometimes that includes therapy, leave of absence, reduction of clinical responsibilities, increasing supervision or mentoring, etc.

- We would work with the student to try finding a solution to meeting the expectations of the program that fit for him before moving to items like a temporary leave, withdrawing and repeating the practicum or the class later on or taking an incomplete, and so on. In other words we would tailor the plan with him. We would also wonder if there is a fit with being a therapist or if some of the difficulties were because he wasn't enjoying the work. We would ask about this, not assume anything.

- suggest/recommend therapy - but not require it; mobilization of support systems -

empower student to activate their support systems

Question 2

Mental illness (Depression)-Both peers and professors/supervisors have observed a change in both Dianne's appearance as well as emotional well-being. Dianne appears to be sad most of the time, withdrawn, disheveled appearance, fatigued, and irritable. Also, it was reported that Dianne informed one of her peers that she had been feeling suicidal.

- I would also ask that the student keep the faculty informed regarding her progress in managing her symptoms so that her supervisors know that she is able to manage her caseload. Certain types of cases may need to be directed to other therapists. This amounts to "increase communication" with the student. An agreement regarding open communication should be documented in the student's file.

- Adding to the number of things Dianne needs to do will probably only make things worse. Individual supervision and possibly therapy will help determine the next best step.

- If Dianne is in a relationship then interactional therapy is recommended along with a medical review

- Again, can't know course of action until talk with her.

- Supervision would need to include exploration with Dianne about the impact of her mood/condition on clients and decisions made about how to ensure proper care for her clients. This would be for the well being of clients as well as a professional mentoring experience for Dianne.

- It is interesting that family therapy is not one of the choices.

- As with most of the responses, remediation should employ a staged approach. So, increased supervision may be appropriate as a first step, but eventually the student may need to be counseled out of the program if other steps are not effective.

- Assuming the diagnosis is correct, recommend not working with clients, personal

therapy, and return when ready.

- It all depends on the exact circumstances.
- I would want to consider the possibility of terminating her, but given her current condition, I would wait to see how things developed.
- Again, talk with her first, then consider next options.
- Document problems; Call emergency contact unless she can show proof that she had obtained professional help for suicidal thoughts
- If rumor checks out as true, would stop all cases (transfer to other therapist) and have Dianne seek help.
- The leave program option is one that I would have a hard time selecting without having done the other stuff (such as consulted with student and gotten them to a therapist, etc.)
- I am against mandatory therapy, but would strongly recommend it in this case. Medication might also be in order.
- Would have her stop seeing any clients in practicum until we have a report from her therapist/physician that she is ready to see clients again.
- As in the first scenario, there are many options that may be helpful but I would want to consult with any student to develop a course of action that seems most appropriate for the student in that particular situation.
- Same as above, but with more immediate response and one-on-one attention
- Again, we would develop a tailored plan that would be worked out with her as well as take steps to insure clients were cared for. We would be sure she was working with a co-therapist on cases where she was strongly connected with clients if she was stable enough to continue seeing clients. No new clients would be assigned, transfers may be explored, and so on perhaps leading to being asked to leave the program if the distress didn't decrease with a reasonable length of

time.

- suggest/recommend therapy - but not require it

Question 3

Unprofessional behavior-While conducting therapy with clients, Maria has been observed wearing revealing clothes (e.g. low-cut blouses, tight trousers, and short skirts) by her primary supervisor. During one of Maria's individual sessions with a male client, the client appeared to be easily distracted by Maria's low-cut blouse and made several verbal references about how he thought it enhanced her figure.

- Additional therapy, etc. would only be advisable if Maria does not change. Many of today's young, female therapists appear to be unaware of the potential impact of their dress on their clients. The first step is always to make them aware and then see their response.

- "one on one" consult should include at least one additional supervisor

- Talk to Maria about violation of dress code

- Response to one-to-one consult would guide decisions.

- Talking with her will determine what needs to happen, and talking could be enough.

- Student should be put on notice that should the student's unprofessional behavior continue she will be counseled out of the program.

- Consultation then see where that takes us. Other action is premature.

- might begin remediation plan if other steps are not successful in changing the behavior

- I would consider the possibility of counseling the student out of the program, depending on the student's reaction to the above.

- Same rationale as #1.

- Attempt to assess what this is about. If do not see change in behavior, additional action would need to be taken.

- Again, other things may be needed depending on how the student responded to supervision/consultation.

- The wearing of revealing clothing is only part of a bigger issue, most likely. Supervision would help determine to what extent that might be true.

- Scenario may imply some sexist ideas.

- clinical supervisor would talk with her, explore effects of behavior on clients; supervisor would continue to monitor; would have to change in order to continue to see clients in practicum

- I'm a little bothered by this scenario because it seems a bit sexist -- is there a comparable situation for unprofessional behavior for men? I would have preferred some other gender-neutral scenario that describes unprofessional behavior. For example, you could have developed something about dual relationships. At any rate, the only appropriate course of immediate action would be to consult with the student to discuss behavior. Any other action would seem, as in the other questions, presumptuous.

- We would address and require more professional appearance and dress.

Question 4

Personality Disorder-The supervisor has noted that Doug seems to lack empathy toward his peers and clients, has a grandiose sense of self, requires admiration from supervisors, peers, and clients, displays arrogance during classroom discussions, and expects favorable treatment by professors by asking them to extend his due dates on assignments.

- Diagnosing students is not part of our role. Nevertheless, we must collect and reflect back to the student data on learning outcomes of the program, including interpersonal skills. Documentation of these skills, or lack thereof, may eventually lead to termination from the program. But it's likely to be a long process that takes

a disproportionate amount of faculty time.

- The steps identified above are listed more or less in order of progression. It appears that Doug has a serious problem will should likely result in termination or being counseling out of the program. However, other measures should precede these more drastic measures.

- "one on one consult" should expand to include entire clinical faculty

- If suggestions for change are not followed, student is counseled out of program

- One supervisor's observations would not result in counseling out of program, but a pattern noted by most faculty and supervisors could result in counseling out of program.

- If these methods were not effective, then possibly considering a leave of absence or being counseled out of the program. Unfortunately, this description describes many people in our field already! We don't need more in the profession--ha!

- Counseling out of the program or termination (in that order) would be steps we would take only if other interventions were not successful -- This would be done in a timely manner and other measures would be taken to ensure clients were not harmed by his lack of empathy.

- Again, if increased supervision and advising failed to correct the problem, other approaches including repeated coursework or counseled out of program may be necessary.

- Careful documentation and following of student's progress. If this truly is a personality disorder with no behavioral change then student should be counseled out of the program.

- After consultation consider recommending personal therapy.

- this case would definitely require beginning the remediation plan, which would most likely end in counseling out or termination

- Same rationale as #1.

- In this kind of situation, we usually arrange a meeting of the student with two or three of the faculty and/or supervisory staff, in which the number of different situations in which the behaviors appear is discussed, and alternatives, including those checked, are explored with the student.

- Call a faculty meeting and discuss keeping rules and boundaries firm

- Hard to tell--description does not suggest personality disorder necessarily, however header does. If truly a personality disorder, determine how functional (or disruptive) it is to be able to be a competent therapist. If deemed not possible, counsel to leave the program. If possible with help, then strive for that first.

- If the outcome of the above were poor, I might consult with the faculty and we might agree that he should be counseled out of the program.

- Scenario assumes there is a consensus by respondents on "personality disorder." I personally would not suggest Doug has a personality disorder, although I do agree the behaviors are inappropriate.

- As a systems thinker and social constructionist, I would want to interact with the student about these observed behaviors rather than come to a diagnostic conclusion based on my observation. As such, I would provide an immediate consultation and spend some extra time advising/mentoring.

- If the student lacks the ability to display growth after given feedback and ample opportunity, his poses a public safety concern. In this case, as gatekeepers to licensure and public safety, he is likely to be asked to leave if his behavior is concerning to the degree described.

- Therapy strongly suggested but not required unless there is a direct connection with performance. The lack of a connection with clients would probably lead to problems with maintaining his case load. There would be special attention to establishing relationships with cases in supervision.

- suggest/recommend therapy - but not require it

Question 5

Ethical violation-Johnny communicated with his client's attorney and released client information without a release of information signed by his client.

- In the course of practicum, students do make mistakes. A lot "depends" in this situation. It may have been an honest, but serious mistake. It also could have been intentional. I would need to know more to pursue termination.

- If this is a beginning student, I would treat this as a learning opportunity. If this is an experienced student and there have been other instances of failure to respect confidentiality or to follow clinic procedures, I would consider more serious action, such as filing an ethics complaint. I think it would also be wise to review the student's case files for completeness, especially regarding releases and signed informed consents for therapy.

- If this is a first time error then the response would be different - and less - than if it were a repeated error

- The extra coursework in this situation would consist of additional professional ethics training, perhaps requiring additional reading or attendance at an ethics workshop.

- Response would differ based on the situation. Did he break confidentiality because of lack of knowledge or was he ignoring policy?

- Again, the degree of remedial action would depend on the entire circumstances, the student's response to making the error, ability to demonstrate understanding of potential harm, and so on.

- The student should be given a second chance. It would be a pattern of infractions that would warrant a dismissal from program.

- Initiate the program's remediation plan. Unless student could demonstrate total lack of knowledge of appropriate procedures (which would be difficult to do in our program given the extensive initiation into ethical practice), the student would be on severe probation with substantially increased supervision and accountability, including a mandate to communicate with no one about clients

without prior supervisor approval

- If this is part of an emerging pattern of unethical behavior, a formal letter and meeting would need to occur with the program director and primary supervisor with warning that the next incident of or like it would result in termination.

- The consult should have, as one of its objectives, ascertaining whether this is a widespread pattern of behavior, in which case individual therapy, repetition of an ethics course, would be explored. Depending on the degree of the violation, it might involve termination from the program, though we don't have enough detail in the example to know for sure.

- Document actions; Call Clients and have them talk with student and Supervisor; Call AAMFT attorney; Direct supervisor's license may be on the line and the State Ethics Board may need to be consulted

- Add readings and have Johnny read about ethics, confidentiality, etc. Report on the understanding of readings and do a paper.

- I'm assuming it was an accidental or "rookie" ethical mistake.

- It might be tempting to have Johnny repeat a course on ethics, but I would recommend -- again -- finding out more information from Johnny. What was the context?

- His rationale for the behavior and responses to our concerns would make a big difference. Could lead to termination if he was defiant about it. However, if it was a mistake we would focus on him understanding confidentiality and the consequences of his acts.

Question 6

Academic deficiency-Although Ana is doing well clinically, she is missing the majority of her semester classes, not turning in required coursework, making substandard grades on exams, and attending classes late and using her clients as an excuse for being tardy.

- Is Anna open to changing her behavior, but lacking the means to securing the additional help she needs? What might prevent her from studying? If she refuses

to change, then she should be counseled out of the program, but other options should be pursued first.

- The faculty's focus must be on achievement of learning objectives. I would certainly address the absences late assignments with the student, but these will be reflected in course grades, which may in themselves eventuate in being dismissed from the program for academic reasons.

- Consult should include entire clinical faculty. Repeat coursework should be decided only after the end of the semester results are in

- Result of one-to-one consult would assist in determining outcome.

- Both the instructors and program director would address this concern, highlighting the importance of course content, peer learning, and professional behavior. If too much content was missing, we may require a course repeat or specific additional course related work. We would most likely conduct a group discussion among class/professional colleagues about the impact on the learning community. In the worst scenario she would not be allowed to complete the program.

- Student would be required to repeat coursework if course objectives are not met.

- Consult with the student and attempt to determine what might be getting in the way of her studies. Repeat coursework of deficiencies are too great.

- We have a specific process for addressing deficiencies in student behavior. This "counseling out "process involves a series of steps that would be taken to resolve the deficiency.

- Document problems and actions taken

- Again, further action might need to be taken if the above initial steps were not sufficient.

- If continues, she would eventually be counseled out.

- What circumstances are contributing to Ana's problems in the classroom? As with

the other questions, I would want to know more information before suggesting a course of action. She might need to be counseled out of the program or assigned self-structured behavior change if the coursework is too demanding. If, though, she is experiencing life circumstances that interfere with class attendance and assignments, therapy might be recommended. Again, I would want to know about those options prior to making a recommendation.

- We have a process where we have a conversation with our students and then consider academic, personal, professional, or clinical probation. This would fall under the Academic probation and clear content and process goals are set for continuing in the program.

Question 7

Interpersonal problems-Kiesha is experiencing problems with getting along well with her peers, professors, and supervisors. During class, it has been observed by Kiesha's professors and peers that she occupies lecture time by asking too many questions that are irrelevant, comments on almost every topic being discussed, and challenges the knowledge of her professors rather than asking questions that will enhance her knowledge base.

- Guided discussion among colleagues about the learning community.
- initiate program remediation process
- No Response
- "Kiesha" is a typical African-American name. If she is a person of color, I would be most concerned about her experience of racism in the program, from peers or faculty. I would address this with her first, then with faculty & peers according to her desires for such.
- If Keisha does not respond to some of the less drastic measures--which I would try first, then she may need to be counseled out of the program.
- Consult should include entire clinical faculty.
- Our students have an on-going therapeutic group experience throughout the

program. I would enlist the leader of the group, a faculty member, to assist in the process after a meeting with the student and ALL her instructors.

- Student should be counseled by professors - 1st line of remediation and given a chance to change. At second level the program directors would have to intervene.

- Consult with student, point up problem, help plan strategy for change.

- This seems to be an issue that could be dealt with by the instructor and advisor. If it was made into large concern (larger than the ones listed in this survey) I would be concerned about issues of racism influencing the faculty responses to Keisha's behavior.

- Same rationale as #1.

- Is this a intercultural issue? If yes, have the class co-construct rules about what is helpful and what is not. Maybe everyone needs to stretch a bit.

- If continues, would eventually be terminated

- What is Kiesha's level of self-awareness about these "interpersonal problems?" I would want to talk to her about them and discuss self-structured behavioral change prior to any other action.

- We would focus on this issue in meetings with the student by professors, her supervisor, and perhaps a joint meeting with the director of the program and faculty if it continued. Our initial purpose of meetings would be to understand what her experience is.

Question 8

Sexual contact with client-Darren is conducting couples therapy and being supervised live by his primary supervisor. Only the wife attends this particular session. During session, the female client talks to the therapist about their special relationship. After the session, the supervisor immediately asked Darren what was meant by special relationship. The student therapist hesitated, but finally admitted that he had sexual

intercourse with the female client during the time he was seeing her for individual therapy.

- Consult with student resulting in termination. No intermediate step. This is too serious and an obvious problem.

- Submit formal report to state LMFT ethics committee as well as professional (AAMFT) ethics committee (Not sure I understand the difference between "leave program" and "termination")

- The student has made a serious ethical violation. The immediate concern is reporting the infraction to the ethics board. It is written in student manual that ethical violations result in immediate dismissal from program

- Response would probably be immediate termination.

- It's not clear how "leave program" counseled out of program, and "termination" are different.

- In our program, students sign an agreement - that also serves as a syllabus - to follow the code of ethics and laws. This would be such a severe breach of that contract and a demonstration of such poor judgment that the student would be immediately terminated from the program.

- initiate program remediation process, but this most likely would be pro forma for terminating the student

- refer for ethical violation

- Document problems and actions taken. Call AAMFT attorney and school attorney. Supervisor's license may be at risk. Turn him in to AAMFT ethics board if he is a student member. Document problems and actions taken

- Legal and ethical requirements would require termination from the program.

- In this particular case, I would recommend dismissing the student from the program because of the ethical violation. I would meet individually with the student to encourage him to report the violation to AAMFT and I would want to make sure that support systems were in place to help him. I might also

recommend therapy, but that recommendation would be based on the consultation. Finally, I would report the violation to AAMFT. I would encourage Darren to self-report but I would also follow-up to make sure that it was reported. I would also want to follow-up with the client.

- Immediate dismissal

- No question about this one!

Question 9

Physical illness-Javier was recently diagnosed with ulcerative colitis, and his illness is affecting his academic and clinical work. Javier is missing classes, canceling clinic appointments, and failing to turn in coursework.

- Address therapist self care and ability to manage case load as an ethical issue.

- Work with medical professionals (with Javier's permission) to assess medical prognosis and then tailor academic plan accordingly

- Leave of absence might be best choice, but discussion with student would lead to final decision.

- Above applies if he was in good standing before.

- Same rationale as #1.

- Document problems and actions taken

- This scenario might require the responses checked above, alternately.

- There are many legitimate responses to Javier's problem. As with many of my other responses, I would want to know more information before making recommendations. In some cases, self-structured behavior change might be sufficient while in others it might require a leave of absence or reduction in clinical load. Again, I would want to consult prior to coming to a conclusion about an appropriate response.

- We would explore possibilities for continuation in the program if he wanted to but also explore a leave of absence.

- suggest/recommend therapy - but not require it

Question 10

Supervision problem-Susana was given a directive by her supervisor to devise a No Harm Contract with her client who admitted to current suicidal ideations as well as a previous suicide attempt approximately six months prior to attending appointment with therapist-in-training. Susana failed to comply with her supervisor's directive by not discussing with the client the rationale and importance of signing the contract and failing to get the client to sign the contract prior to the client's leaving the clinic office.

- Termination is not certain here, but it should surely be considered if Susanna does not have a very good reason and is not suitably repentant.

- Find out why the student avoided the contract. Make it clear that a supervisory directive is just that...a directive and not an option. Address supervisory hierarchy.

- I can only assume that since Susana failed to comply with her supervisor's directive, the session was NOT live supervised by the supervisor but it should have been given the seriousness of the situation

- This wouldn't happen in our program since the intern is supervised live. Failing to follow supervisor's directives results in removal from case - without question.

- Result of discussion would help determine outcome.

- Possibly receive a lower practicum grade.

- Again, the level of intervention would depend on the circumstances. If Susana became overwhelmed in session, read the client's situation differently than she explained originally, etc. the supervision intervention would be immediate and remedial - the expectation would include that Susana make immediate contact with the client and follow through. On the other hand, if she simply refused to comply with her supervisor's directive, creating this kind of risk for a client, it is likely she would be counseled out of the program, or in the worst scenario, asked

to leave.

- Intern should be put on probation and be given of list of remediation steps.
- If this is a new student and this is the first error of this type consultation and extra supervision should suffice.
- It depends on why she did it, but this would be viewed as being very serious.
- This also depends upon whether this was a first-time occurrence or there were other such episodes. The need here is to better understand the trainee's reluctance to comply.
- Same rationale as #1.
- If this is an isolated instance, what I've indicated above may be enough. If it's a recurrent problem, a leave of absence or some repetition of coursework or practica may be in order, and termination would have to be considered.
- Document problems and actions taken
- If continued to be problem we would eventually terminate
- Again, it would be tempting to require Susana to repeat an ethics course (or perhaps, she hasn't yet taken it in her program of study) given the seriousness of the situation since this seems to be associated with a "duty to warn" issue. My initial step, as in most other cases, would be to consult with the student and increase advising/mentoring. I would also want to talk to her current and former supervisors to see if this represents some kind of a pattern. The subsequent response should be based on that one-on-one consult.
- Maybe additional work on a suicide crisis line
- This would be addressed in supervision; other supervisors may make suggestions for helping the primary supervisor in this situation. The director may become involved in a meeting if a conflictual supervisory relationship is a part of what is happening. More info is needed to determine why what is happening is

happening.

Question 11

Job stress (emotional/physical demands of graduate school)-Tamara reported feeling overwhelmed as a result of the demands of coursework, clinic load/administrative duties, and assistantship responsibilities. Due to this stress, she is experiencing difficulties empathizing with her clients. For instance, during one of Tamara's sessions with a patient who is also experiencing distress at work, rather than empathizing with the patient and providing words of encouragement, Tamara said to her client, "What do you have to complain about? If you only knew what it is like to feel overwhelmed."

- A leave of absence may be necessary if other measures don't help the problem.
- Address therapist self care as an ethical issue.
- Immediate arrangements to meet with client and have Tamara offer apology - live supervision by supervisor; possibly even in the therapy room
- Result of discussion would determine if leave of absence is appropriate response or counsel out of program.
- other actions determined after meeting with her (including therapy or leave of absence)
- Intern should be put on probation and be given of list of remediation steps.
- Consult with student with eye to helping her balance out her load.
- As with all of the questions, a remediation plan would be developed and if problems persisted the counseling out process may be initiated.
- Consider leave of absence if situation continues and if student was in good clinical and academic standing before.
- Same rationale as #1.
- Document problems and actions taken

- Explore what is at the root of stress and how to relieve--this may include reducing load, or providing feedback of how to work within the context/system.

- We would have her discontinue seeing clients, get into individual therapy. We would require a letter from therapist recommending that she be allowed to see clients again. If problem did not change, we would try to counsel out of program and then terminate

- Again, many of the options seem reasonable (e.g., reduction of clinic load, self-structured behavior change, some for of therapy and perhaps counseling out of the program), but I would need more information about the context.

- Many students need help with the stress of practica. Supervisor would explore ways for supervisee to deal with stress with her.

Question 12

Personal conflict-Since Donna reported to her supervisor that her mother was diagnosed with cancer, both her academic and clinic performance have declined. Donna has been missing the majority of her semester classes including practicum, canceling clinic appointments, requesting extensions for class assignments, and making substandard exam scores.

- I'd like leave of absence to be a joint decision between the faculty and the student.

- Based on outcome of one to one meeting, may suggest self-care activities which may include individual supportive counseling

- Arrange for her clinic cases to be transferred to other therapists after Donna and other therapists conduct transfer sessions with all clients

- Leave of absence probably the best outcome.

- Consult with student and consider together possibility of taking a leave.

- The problem should never get to this point before remediation is addressed. I would have to assume that many attempts had been made to help Donna before it got to this point. If this had been done then discussions about taking a leave of

absence would be initiated.

- Same rationale as #1.

- She definitely needs some setting in which to process the danger to her mother, and some time in which to do it. The options checked above should all be considered, though probably not all of them should be used.

- Document problems and actions taken

- Would encourage her to take a leave

- My somewhat "standard response" although this time a bit more is provided about context. Therapy MIGHT be helpful and perhaps even a leave of absence. I would want to find out even more, though, before developing a response for the student.

- Suggest/recommend therapy - but not require it

Question 13

Maturity problem-Michael, a second year student, is unable to receive constructive feedback from supervisors and peers. For example, while discussing one of Michael's most challenging cases during practicum, Michael began to pout and became defensive when the practicum supervisor provided suggestions and constructive feedback on how he could effectively manage challenging cases in the future.

- Michael will likely need to leave the program, but individual and group therapy should probably be tried first.

- Point pattern out to the student and ask him how he wishes to address it. This could be through therapy or a self change project. The faculty's interest is in the outcome, not how he gets there.

- It is unclear how Michael's "maturity problem" is affecting his clinical work, thus a review of his cases in this regard should be conducted immediately

- This should be discovered long before a student becomes a clinical intern! Programs need to have adequate screening for practicum that eliminates this

occurring.

- Not necessarily repeating practicum, but continuing in practicum beyond the 500 required hours to monitor personal growth.

- Again - interesting that family therapy or self-of the therapist work is not a part of the choice list.

- If situation continues, counsel out of program.

- Same rationale as #1.

- Document problems and actions taken.

- Potentially would recommend therapy or growth group, hard to tell at this point.

- Would be given chance to change. If continued, would be counseled out or terminated.

- Students become defensive. Perhaps therapy would help. I would want to know if this was a pattern, though. How often does this kind of behavior occur? What is Michael's level of self awareness about this.

- Process ability to take a learning position; inability or unwillingness could lead to leaving the program.

Question 14

Clinical deficiencies-Allen, an upper-level first year student, is having difficulties applying systems theory learned in class into practice while conducting therapy. While conducting couples therapy and being supervised live, it was observed that Allen was only focusing on each person's past rather than how their past experiences may be influencing their lives presently, individually as well as relationally.

- Pre internship screening is more productive than discovering this deficit later.

- again, need to consider the individual when determining action from this list.

- See 13 comments above

- This would be addressed in supervision with targeted interventions. He would be a likely candidate for needing extended practicum. In the end, if these interventions failed or his ability to do therapy was so limited that it was clear he would not be able to do effective therapy, he would be counseled out of the program

- Needs more cases, experience.

- Document problems and actions taken in case decide that he does need additional clinical experience due to failing a practicum.

- I would want to carefully find out why he's not using systems ideas. If he has a sound and clear objection to systems ideas, no real defensiveness, and a clear personal theory of change I would respect and work with that.

- It might be helpful to repeat coursework, but I would want to have a better understanding about this particular "deficiency." Many licensed MFT's struggle to think systemically so I think that increased supervision might be a way to help hone clinical skills.

Question 15

Chemical dependency-On several occasions while Amy was present at the clinic conducting therapy with her clients, her supervisor and peers have smelled alcohol on her breath and noticed that her gait was unsteady and she was slurring her speech.

- Amy needs to be suspended from working with clients until her drug/alcohol problem is satisfactorily addressed.

- Determine first the severity of the problems and make appropriate recommendations

- Appropriate referrals given. Submit formal report to the state LMFT ethics committee and the professional (AAMFT) ethics committee

- Leave of absence until chemical dependency is treated.
- Need to understand the situation more before determine therapy, leave of absence, etc.
- If behavior continues, counsel out of program
- She would be asked to leave the program and seek treatment. A decision about her re-entering at some point in the future would depend on her progress in recovery.
- we would immediately initiate our counseling out process.
- If above not successful, student should be asked to leave, or be counseled out of, the program.
- If immediate treatment is refused, then termination should be considered.
- Document problems and actions taken. If she admits to alcohol use, give her a leave of absence for treatment time
- If will not stop after specified time, would be counseled out of the program.
- Would be required to take a leave; upon recommendation of professional that she is able to see clients again, would readmit and give chance. If continued, would terminate
- Since this seems to have occurred on "several occasions," it would suggest a serious problem. I would wonder, though, how the problem had been previously addressed. Had supervisors ignored the problem? Had she been counseled previously? Perhaps Amy needs to be counseled out of the program or perhaps she would benefit from some form of counseling (including a personal growth group) but I would want to meet individually with her to determine helpful courses of action.
- This would be seen as a serious problem. She would be required to have an alcohol assessment and follow-thru with recommendations probably if she wanted

to continue in the future.

- Suggest/recommend therapy;

Question 16

Mental illness (Bipolar II)-Blaine had been diagnosed with Bipolar II and prescribed medication. He made the faculty aware of this. Recently, though, Blaine has not been taking his medication, and it has had an impact on his ability to conduct therapy. For instance, while Blaine was conducting therapy with one of his clients, his primary supervisor observed that his mood was elevated, he talked incessantly and was easily distracted by external stimuli, and commented to the client about how effective and great he thought he was as a therapist in comparison to his peers. Due to questions and growing concerns, the supervisor observed Blaine's follow-up appointment with this particular client. It was during this session that Blaine seemed to be experiencing a depressive episode in which he appeared depressed, fatigued, indecisive, disinterested, and hypoactive.

- If Blaine does not respond positively to an intervention, he should b terminated.

- Sounds like Blane is in no condition to see clients.

- Meet and assess the severity and nature of the problem, to further determine needs

- Consult should include entire clinical faculty. With Blaine's permission, a plan should be developed with Blaine's treatment provider to ensure compliance with treatment - Subsequent assessment will determine continuation in academic program

- Again, if no changes are made, then I would suggest counseling out of program.

- Same as last question. He would need to stop seeing clients and then go through steps to ensure his stability. It may happen in this case that because he was unwilling to take medication and therefore knowingly put himself and clients at risk, he would be counseled out or asked to leave.

- Blaine would need to demonstrate completion of a course of individual therapy to

ascertain the reasons for and work on his reluctance to take his medication.

- If above ineffective, offer leave of absence.
- Same rationale as #1.
- Document problems and actions taken.
- If there were not immediate change related to the first interventions, then the counseling out of the program would occur.
- Medication and systemic therapy would be important.
- Would be asked to stop seeing clients; would be given time to get back on meds and get into therapy; upon recommendation from therapist, could start again. If problems continued, he would be counseled out or terminated.
- It would seem that a self-structured behavioral change along with increased supervision would be required. Therapy of some sort MIGHT be helpful. Other courses of action (e.g., counseling out of program) would need to be based on results of increased supervision.
- All of these would be explored probably simultaneously.

Question 17

Marital problems-While conducting therapy with a female client experiencing marital difficulties due to her spouse's extramarital affair, the supervisor observed Jeanne encouraging the female client to get a divorce. Recently, unbeknownst to Jeanne's professors and peers, she has also filed for divorce as a result of her spouse's extramarital affair.

- The consult would be providing feedback on supervisor's observation that the therapist seems to be "pushing" the divorce option. I might ask the supervisee what factors she sees that might be contributing to that "skew". But if she chooses not to disclose about her personal circumstances, that's her prerogative.
- This comment does not refer specifically to this question, but I find it interesting

that the list of remedial responses does not include marital/family therapy, especially considering that you are an MFT doctoral student.

- If you would like a copy of our remediation process, email me at thorana.nelson@usu.edu

- Check the level of student's ability/willingness to address this personal issue in supervision and examine its impact on her clinical work.

- Same rationale as #1.

- Document problems and actions taken

- If it is not known to supervisor, then I would explore and believe it would just be a focus of therapy about the options for this client and impact of her suggestion.

- Would encourage her to stop seeing clients; get into personal therapy, and return when her therapist recommends she is ready. If pattern doesn't change, would terminate.

- This question seems inappropriate so I am having a hard time responding in a meaningful way. First, how could a supervisor intervene if s/he were unaware that Jeanne was, herself, going through a divorce. Second, it might be a perfectly reasonable recommendation to a client to consider a divorce even if someone is going through the divorce process.

- Initially therapy would be suggested, cases would be followed more closely, cases involving divorce not assigned, a co-therapist perhaps added to existing cases, if problems continued perhaps therapy required.

- Not knowing the parallel in her personal life, I would process Jeanne's encouragement for her client to make a particular decision and explore with her where this recommendation came from.