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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

CLARIFYING THE DEFINITIONAL BOUNDARIES AND ESSENTIAL CHARACTERISTICS OF IMPAIRED COUNSELING STUDENTS: A DELPHI STUDY

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Philosophy

Lisa K. Forbes

College of Education and Behavioral Sciences
Department of Applied Psychology and Counselor Education
Counselor Education and Supervision

December 2014

This Dissertation by: Lisa K. Forbes

Entitled: *Clarifying the Definitional Boundaries and Essential Characteristics of Impaired Counseling Students: A Delphi Study*

has been approved as meeting the requirements for the Degree of Doctor of Philosophy in College of Education and Behavioral Sciences in School of Applied Psychology and Counselor Education, Program of Counselor Education and Supervision

Accepted by the Doctoral Committee

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ABSTRACT

Forbes, Lisa K. *Clarifying the Definitional Boundaries and Essential Characteristics of Impaired Counseling Students: A Delphi Study*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2014.

Impairment is a general term used to identify a wide array of academic, personal, and interpersonal deficiencies leading to diminished ability to be effective with clients. Within the literature, a plethora of definitions of impairment exists; these definitions are often conflicting and lack empiricism and consensus, leading to confusion regarding the identification and remediation of impaired counseling students. In addition, there exists disagreement within the field of counseling and psychology as to the most appropriate term to signify counselor deficiencies as well as which behavioral characteristics indicate impaired performance.

Impairment exists in many forms and is, unfortunately, a common occurrence within counselor training programs. It is the primary responsibility of counselor educators to ensure client welfare; however, counselor educators currently lack a formalized evaluation protocol to adequately identify and remediate impaired behaviors. The lack of evaluation procedures might lead to counselor educators performing subjective, idiosyncratic evaluations of students regarding nonacademic behaviors. Therefore, there is an abundant need to have a formal agreed upon evaluation protocol. However, to obtain such concrete procedures, the profession must first arrive at an agreed upon definition and essential descriptors of counselor impairment. The purpose of the

current study was to create an empirically derived set of descriptors of student impairment that might ultimately lead to a more effective and accurate evaluation protocol.

This investigation utilized the Delphi method, which attempted to create a group communication process for a panel of experts to reach consensus regarding the definition and essential descriptors of impaired behavior. The panel consisted of 11 counselor educators (four males and seven females) who were identified as experts in counselor impairment. Panelists responded to a series of questions investigating the complexity of counselor impairment that spanned over three rounds of inquiry, reaching higher levels of agreement as rounds ensued.

The results demonstrated difficulty among panel members to agree in many areas, which mirrored the current confusion within the field regarding the topic of impairment. Items that did reach consensus generated (a) a continuum of problematic behaviors often identified as impaired ranging from severe to moderate to mild, and (b) lists of problematic behaviors (aligning with counselor competency areas) that were identified as concerning beyond the normal developmental trajectory of a counselor-in-training.

The implications of this study discussed considerations for admissions processes, training master's and doctoral level students, assistance for counselor educators in student evaluations, reconsidering counselor training pedagogy, and an understanding that the confusion and need for additional research was more about protocol and procedure than a term. This study represented an initial attempt to reach expert consensus regarding the definitional boundaries and essential characteristics of counselor impairment. This study generated some consensus regarding various elements of counselor impairment; however,

it was clear that counselor educators must continue to increase their ability to identify and remediate impaired students.

Key words: impairment, problematic student behavior, counselor deficiencies, remediation, gatekeeping.

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supportive way. I wanted these kinds of individuals to be involved in my dissertation process and I am grateful they agreed.

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TABLE OF CONTENTS

CHAPTER I. INTRODUCTION 1

- Educating Counselors 5
- Statement of the Problem 7
- Rationale for the Study 10
- Research Questions 11
- Delimitations 12
- Delphi Methodology 13
- Definition of Terms 13

CHAPTER II. LITERATURE REVIEW 17

- History of Impairment in Counseling and Psychology 18
- Counselor Recruitment and Education 25
- Counselor Education 28
- Student Evaluation 34
- Remediation 40
- Legal Issues 45
- Impairment Definitions 52
- The Problem with Multiple Definitions 56
- Why the Definitions Have Changed Over Time 58
- Inability to Reach a Workable Definition 62
- Relevance of Defining Impairment in Counselor Education 65

CHAPTER III. METHODOLOGY AND RESEARCH PROCEDURES 67

- The Delphi Method 68
- Measures of Rigor 76
- Finding a Sample of Experts 80
- Participants 81
- Procedures 83
- Data Analysis 87

CHAPTER IV. RESULTS 91

- Panelists and Procedures 91
- Personal Communication 94
- Elements of a Definition of Student Impairment 95

Problematic Behaviors 98
Counselor Impairment Continuum of Behaviors 116
Distinguishing Impairment From Other Factors 121
Factors Influencing Assessment of Impairment 127
Influence of Etiology 132
Alternative Terms for Impairment 135
Summary of Findings 136

CHAPTER V. DISCUSSION 137

Complexity of Impairment 137
Differences Among Participants 138
Difficulty Identifying Impairment 142
Disagreement and Lack of Consensus Continues 146
The Definition That Captures the Essence of Impairment 149
Continuum Anchor Points and Behaviors 151
Implications 152
Limitations of the Study 159
Directions for Future Research 168
Conclusion 170

REFERENCES 171

APPENDIX A. ROUND ONE QUESTIONS 188

APPENDIX B. INSTITUTIONAL REVIEW BOARD APPROVAL 192

APPENDIX C. CONSENT FORM FOR PARTICIPATION IN HUMAN RESEARCH 194

APPENDIX D. ROUND TWO QUESTIONS 197

APPENDIX E. ROUND THREE QUESTIONS 203

APPENDIX F. ALL CONTINUUM ITEMS REACHING CONSENSUS AT COMPLETION OF STUDY 210

APPENDIX G. MANUSCRIPT FOR PUBLICATION 218

LIST OF TABLES

1. Definitional Components from Round One and Mean and Interquartile Ranges From Round Two 97

2. Problematic Professional Behaviors: Means and Interquartile Ranges from Rounds Two and Three 100

3. Problematic Relational Behaviors: Means and Interquartile Ranges from Rounds Two and Three 104

4. Problematic Scientific-Application Behaviors: Means and Interquartile Ranges from Rounds Two and Three 108

5. Problematic Supervisory-Based Behaviors: Means and Interquartile Ranges from Rounds Two and Three 111

6. Problematic System-Based Behaviors: Means and Interquartile Ranges from Rounds Two and Three 114

7. Means and Interquartile Ranges From Round Two 119

8. Rating of Statements Determining Impairment from Not Yet Acquired Competence 122

9. Most Frequently Chosen Statements Determining Impairment from Not Yet Acquired Competence 124

10. Rating of Statements Determining Impairment from Performance Associated with Cultural Values 125

11. Most Frequently Chosen Statements Determining Impairment from Performance Associated with Cultural Values 127

12. Intensity of Problematic Behaviors 128

13. Duration of Problematic Behaviors 129

14. Persistence of Problematic Behaviors 131

15. Potential Origins of Impairment 134

16. Alternative Terms to Impairment and Round Three Means and Interquartile Ranges 136

17. Counselor Impairment Continuum 211

18. Problematic Behaviors Reaching Consensus at the Completion of Study 213

19. Behaviors Selected as Unlikely to Remediate 216

20. Most Concerning Problematic Behaviors 217

CHAPTER I

INTRODUCTION

I worked with a supervisee during her first practicum experience; she was intelligent and seemed to quickly form a therapeutic relationship conducive to change. This student's client was making noticeable progress in his journey to increased awareness because, in my opinion, the counselor-in-training had utilized the core counseling skills and created a safe environment for the client to explore her concerns. However, in a supervision session, the student suddenly indicated her desire to use a specific advanced technique with her client. Together we discussed his reasoning for the sudden urge to use an advanced technique, the possible benefits, and potential consequences. Through much discussion, the student was only able to verbalize that she wanted to use this "advanced" technique because she wanted to do more than "just reflect." From my perspective, the student did not have legitimate therapeutic reasons for using this specific technique with her client; rather, it seemed as though she wanted to use this technique to bolster her image in front of her peers.

I could not provide concrete evidence to my supervisor to support my opinion, yet my instincts told me this student was simply being ego-centric in wanting to use an advanced technique for self-gain rather than for the client's benefit. The professor of the course, however, encouraged students to take risks as developing counselors so my supervisee attempted the technique in the following session despite my overt reluctance.

Unsurprisingly, the result was disappointing and appeared to disrupt the previously established flow of sessions. Even the counselor-in-training expressed her discouragement about not achieving her desired result. I believed no real harm was done to the client; therefore, I hoped this experience would result in a valuable learning experience--teaching the supervisee the power of core counseling skills and the therapeutic relationship. I hoped she would learn that the client's needs and progress are paramount and should be the basis of every therapeutic decision.

This student passed practicum because she was an intelligent student who could apply core counseling skills, form a therapeutic relationship with her clients, and who possessed a minimum level of competence required of practicum students. Despite these strengths, my impression of this student was that she was in the counseling profession for the wrong reasons. My instinct told me she desired the power she experienced in the counseling relationship and she cared more about *her* success rather than the client's progress. I was aware these were bold accusations about which I had little to no concrete evidence other than intuition alone. However, this student went on to her internship experience where her site supervisor contacted the faculty of the counseling program with multiple concerns; she did not seem to have learned about the importance of the client's needs. A major concern expressed by her field supervisor was the student's professional behavior. For example, during a group supervision session where this student's role was co-therapist, the other co-therapist reported that this student was disengaged and doing personal work during the counseling session. This action, in addition to many other issues, created enough concern that she was not welcomed back at her internship site; she was eventually counseled out of the counseling program and ultimately the counseling

profession. I had expressed my concerns about this student to my supervising faculty member; yet without a way to clearly identify this student's behavior as impaired, there was no evidence at that time for the faculty member to begin the review and retention process. I wondered and continue to wonder if I had been able to clearly identify this student's behavior in practicum as impaired if there might have been an opportunity to intervene early in this student's counseling program to either remediate problem behaviors or counsel her out of the profession.

Student impairment among counselors-in-training exists in many forms and initially might present as insubstantial or erratic behaviors that could be difficult to identify. At the educational level, faculty serve as gatekeepers to the counseling profession (American Counseling Association [ACA], 2005); thus, it is essential to identify and remediate or dismiss students with personal and professional shortcomings. Graduating only skilled, trained, and competent counselors is vital because a large percentage of Americans utilize mental health services and these individuals are seeking competent mental health care. In fact, The National Institute for Mental Health (NIMH; 2013) reported in 2008, 27.9 million people of the U.S. adult population utilized mental health services and the number of those engaging in mental health services continues to increase each year (NIMH, 2013).

Unfortunately, professional and or personal impairment is a relatively common occurrence in the field of counseling. Guy, Poelstra, and Stark's (1989) study indicated that 75% of responding psychologists reported currently being distressed. Similarly, Cushway and Tyler (1994) found that 75% of responding psychologists reported moderate to high levels of job related stress. Another study (Wood et al., 1985) reported

that 63% of practitioners knew a colleague who struggled with depression or burnout and 38.5% knew a colleague who had a drug or alcohol issue. Wood, Klein, Cross, Lammers, and Elliott (1985) reported that despite the high percentage of practitioners who were aware of potentially impaired colleagues, 92.1% of the participants had never attempted to report or help remediate a colleague's impairment, leading one to wonder about the potential impact on client welfare.

Although these studies were rather dated, recent impairment literature lacked a similar focus related to reporting current data on practitioner impairment. However, the current impairment literature regularly suggested practitioner impairment is, unfortunately, a common occurrence and frequently results in calls for reform to address the issue of practitioner and student impairment (Bemak, Epp, & Keys, 1999; Boxley, Drew, & Rangel, 1986; Elman, Forrest, Vacha-Haase, & Gizara, 1999; Forrest, Elman, Gizara, & Vacha-Haase, 1999; Laliotis & Grayson, 1985; Sherman, 1996). Considering the number of Americans seeking mental health services each year and the unfortunately common occurrence of practitioner impairment, it is vital that counseling programs effectively identify and remediate impaired students who could potentially harm clients as future professional counselors. This study focused on impairment in counseling students because counseling programs are the basis and beginning to a professional's career as a counselor. Faculty members have an ethical obligation to evaluate and remediate potentially impaired individuals from counseling programs (Council for Accreditation of Counseling and Related Programs [CACREP], 2009). In the educational setting, faculty have ample opportunity to evaluate and remediate students earlier in their

professional journey, hopefully reducing the prevalence of impairment within the field of counseling.

This study focused on impairment in terms of impairment that might be the result of intra -or inter-individual behavior rather than the impact of career stressors and also focused on both clinical and academic factors. The term *impairment* is the most frequently used term to identify students and practitioners with problematic behaviors or performance deficiencies (Forrest et al., 1999), yet the impairment literature discussed multiple reasons not to utilize this term. For example, impairment lacks definitional clarity; thus, it is vague and struggles to specifically signify what is concerning about an individual's behavior (Falender, Collins, & Shafranske, 2009). The term impairment is protected under the Americans with Disabilities Act (ADA; 1990). Issues using the term impairment are discussed in depth in Chapter II. Throughout this document, I reluctantly used the term impairment to aid readability. I recognized this term is limited in its capacity to define and identify students with problematic behaviors and performance deficiencies but utilizing multiple terms would create a cumbersome and confusing narrative.

Educating Counselors

The theoretical basis for this study was set in the context of standards for educating counselors, ethical codes, and principles of counselor development. Counselor education is unique from other advanced master's level programs because counselors-in-training must not only demonstrate academic aptitude and success, they must also display adequate nonacademic and professional behaviors related to competence as a counselor. Such nonacademic behaviors include personal and interpersonal characteristics.

Common factors research demonstrated the impact the person-of-the-counselor has on the therapeutic relationship and ultimately the efficacy of treatment (Grencavage & Norcross, 1990; Lambert & Barley, 2001; Norcross, 2002; Wampold, 2001). This research suggests a strong therapeutic relationship is, in large part, responsible for successful treatment outcomes (Grencavage & Norcross, 1990). Thus, the personal characteristics of the counselor play a major role in his or her ability to form a positive relationship with his or her client. Therefore, assessing students' nonacademic ability and personal characteristics is an essential responsibility of counselor educators as gatekeepers into the counseling profession (Ziomek-Daigle & Christense, 2010).

The Counsel for Accreditation of Counseling and Related Educational Programs *Standards* (2009) and The American Counseling Association's *Code of Ethics* (2005) both indicated counselor educator's responsibility to protect the public from harm ,which is partially accomplished when faculty effectively assess for and address potentially impaired counseling students, thus preventing them from entering the professional realm. However, counselor competency is difficult to assess because it is multifaceted (e.g., academic ability, application of counseling skills, appropriate personal and professional behaviors) and evaluative procedures are often vague and subjective in nature (Duba, Paez, & Kindsvatter, 2010). Although the CACREP *Standards* and the ACA *Code of Ethics* provide evaluative requirements, these bodies are often criticized for providing little to no specific guidelines directing faculty in their gatekeeping obligations (Bemak et al., 1999). In addition to the absence of evaluative guidance, assessing nonacademic behaviors is also complex because the term impairment is vaguely defined, thus creating difficulties when attempting to identify problem behavior.

Impairment is a term often used to broadly describe insufficient behavior and diminished clinical performance (American Psychological Association [APA], 2006; Emerson & Markos, 1996; Sheffield, 1998). Within the helping professions literature (i.e., counseling, psychology, medical, nursing), there exists a plethora of definitions and characteristics of practitioner impairment (discussed in detail in Chapter II). However, these definitions are not empirically derived, often conflicted, and lack uniform consensus, which has led to confusion regarding the identification and remediation of impaired students (Sherman, 1996). Absence of a definition limits the ability to establish an efficient, uniform protocol to identify and remediate potentially impaired counseling students (Bradey & Post, 1991; Elman & Forrest, 2007; Huprich & Rudd, 2004; Li, Trusty, Nichter, Serres, & Li, 2007; Schwartz-Mette, 2011).

Statement of the Problem

Counselor impairment is a serious and growing concern within the helping profession and counselor education programs (Bemak et al., 1999; Elman et al., 1999; Forrest et al., 1999; Huprich & Rudd, 2004). Many believe those in the helping profession in particular are more vulnerable to impairment due to the unique stressors and characteristics of the helping role (APA, 2013; Laliotis & Grayson, 1985; O'Connor, 2001; Sherman, 1996). The APA website (2013) identifies many unique job-related stressors impacting psychologists including

> repeated exposure to emotionally difficult material, the need for careful maintenance of boundaries with the client, the need to control one's emotional response in the therapy room, an isolated work environment, and limited control over outcomes. (p. 1)

These stressors, in combination with typical everyday stress, might lead to professional impairment and compromised client care (Orr, 1997; Schwartz-Mette, 2009).

Numerous empirical studies suggested a high number of practicing psychotherapists experience impairment (Laliotis & Grayson, 1985). One study (Guy et al., 1989) investigated the prevalence of distressed psychologists and reported a high number (75%) of practitioners experienced distress. Many of those practitioners (38%) believed their experience of distress had potentially diminished their effectiveness in their work with clients. Another study (Pope, Tabachnick, & Keith-Spiegel, 1987) surveyed distressed practitioners and found 62% reported continuing caring for clients even when their distress levels were too high to work effectively. Obviously, impairment is a concern within the counseling and psychology field; impairment is also a serious issue within counselor education programs (Schwartz-Mette, 2009). Although counselor education programs utilize admissions procedures in an attempt to screen applicants for potential impairment characteristics and behaviors, traditional admissions protocols have been criticized for their ineffectiveness in actually identifying such traits (Brady & Post, 1991). Thus, impaired individuals are frequently admitted to (Bradey & Post, 1991; Markert & Monk, 1990; Young, 1986) and graduate from counselor education programs.

Student impairment can be exacerbated by the stressors one endures in a graduate clinical program such as enduring continuous assessment, long hours, financial difficulties, and stress derived from the counseling role (Schwartz-Mette, 2009). Researchers who studied the prevalence of impairment in counseling programs suggested student impairment is an enormous issue. One group of researchers (Procidano, Busch-Rossnagel, Reznikoff, & Geisinger, 1995) surveyed the occurrence of impairment in psychology doctoral programs. The results indicated 89% of the programs included in the study reported at least one student had been identified with nonacademic deficiencies

within the past five years. Huprich and Rudd (2004) surveyed counseling and school psychology doctoral programs concerning student impairment; the results suggested in the past 10 years 98% of the programs could identify at least one impaired student and 41% of the programs eventually dismissed a student due to impairment issues. Another study (Boxley, Drew, & Rangel, 1986) surveyed APA internship sites and found that 66% of the responding sites had experiences with impaired trainees within the previous five years.

Clearly, impairment exists among practitioners and counselors-in-training. Impairment within the helping profession and counselor education programs raise concerns regarding client welfare, the quality of services being provided, and the integrity of the profession. To protect the public from harm and ultimately reduce the number of impaired psychotherapists, it is essential impairment is identified and remediated in counselor education programs by addressing the issue early. However, identification and remediation of impaired individuals is a complex task because currently there is no agreed upon definition or essential descriptors of what constitutes impairment (Huprich & Rudd, 2004; Laliotis & Grayson, 1985; Wilkerson, 2006). Thus, supervisors and faculty members frequently have difficulty identifying and remediating impaired individuals (Bradey & Post, 1991; Elman & Forrest, 2007; Huprich & Rudd, 2004; Li et al., 2007; Schwartz-Mette, 2011). Without clarity or consensus regarding descriptors of impairment, the issue might continue to persist within counselor education programs and the mental health field, ultimately placing clients at risk.

Rationale for the Study

Many describe impairment as a growing concern within the counseling and psychology fields (Bemak et al., 1999; Elman et al., 1999; Forrest et al., 1999; Huprich & Rudd, 2004) and highlight the necessity of early intervention during counselor education programs (ACA, 2005; Bemak et al, 1999; Schwartz-Mette, 2004) despite the limited conceptual and empirical knowledge available to objectively define student struggles and then implement remediation procedures in graduate programs. The lack of attention to these concerns is curious considering one could safely assume an impaired student with and without remediation would ultimately become an impaired professional counselor (DeVries & Valadez, 2006). A lack of adequate attention to identifying and remediating students who are impaired might only prolong the issue within the counseling field because once an individual is permitted to graduate and enter the professional realm, he or she will participate in considerably lower levels of supervision (Bernard & Goodyear, 2009). Increased independence for practicing counselors might allow impairment issues to escalate and potentially go unaddressed.

Unfortunately, there have been occurrences where counselor educators have allowed impaired students to successfully finish their counselor education program (Bemak et al., 1999)--in some cases due to a lack of formal, concrete evaluation guidelines. In addition to the absence of evaluative protocol, counselor educators might also avoid review and retention due to the additional time requirements or fear of potential litigation resulting in student dismissals (Bemak et al., 1999). An absence of formalized evaluation procedures might inadvertently force counselor educators to

perform vague, subjective evaluations of students' nonacademic behaviors relating to impairment and also lead to fear of student retaliation.

To most effectively address the issue of practitioner impairment, attention must be directed to counselor education programs and the remediation of impaired counselors-in-training. To do this, counselor educators must have formal evaluation procedures to identify and remediate impairment. To develop these evaluations, the profession must first arrive at an agreed upon definition and essential descriptors of impairment. After all, faculty cannot be expected to credibly measure vague, subjective characteristics. Therefore, the purpose of this study was to create an empirically derived set of descriptors of student impairment that might ultimately lead to more effective and accurate evaluation protocol.

Research Questions

In this study, I pursued degrees of agreement and the perspectives of a panel of experts related to the nature, extent, and defining elements of impairment. Thus, the following research questions provided the grand structure and boundaries of this inquiry:

Q1 How do experts in the field of counselor education and psychology define student impairment in terms of behavior, ethical, dispositional, attitudinal, and interpersonal attributes?

Q2 To what degree do experts in the field of counselor education and psychology agree upon the essential descriptors of mental health practitioner impairment?

Q3 What do experts in the field of counselor education and psychology believe are the differences between impairment and issues deriving from not yet attained competence?

Q4 How do experts in the field of counselor education and psychology classify the various levels or categories of impairment?

Delimitations

Panelists included in this study were one of the following: (a) counselor education and psychology faculty members throughout the United States, (b) members of the ACA task force committee and the APA advisory committee, and (c) experts on the topic of impairment in the counseling and psychology fields. I utilized counselor education and psychology faculty members as panelists for this study because these individuals have an ethical obligation to serve as gatekeepers to the counseling profession (ACA, 2005). These individuals also have regular opportunities to train, observe, and evaluate counseling students. With this higher level of observation and obligation to assess students, I assumed these educators had more encounters with impairment, resulting in high levels of knowledge concerning the essential descriptors of the construct due to their consistent engagement with counselors-in-training. I utilized members from the ACA ethical codes board, the ACA task force committee, and the APA advisory committee because of their broader knowledge and experience concerning impairment. I attempted to draw a diverse set of panelists in terms of geographical region, age, and gender; however, the methodology used for this study required a non-random sample of experts (Hasson, Keeney, & McKenna, 2000). Therefore, representational equity of the population was not realistically attainable. For this study, *experts* on impairment were identified by at least one of the following criteria: (a) a faculty member who has been a part of and successful in litigation resulting from dismissing those they determined to be impaired counseling students, (b) a faculty member who has been involved in the review and remediation of at least two counselors-in-training due to perceived impairment, (b) a faculty member who has one or more professional juried publications on impairment, or

(c) members of the ACA ethical codes board, the ACA task force committee, and the APA advisory committee. This study focused on impairment within the counseling student population; thus, the expert panel was primarily faculty members and advisory/board members (ACA ethics committee, ACA task force members, and APA advisory committee members). Field supervisors were not included in the panel of experts because these individuals have a differential responsibility for admission and gatekeeping of students. Field supervisors do not hold the same level of responsibility for gatekeeping as do faculty members.

Delphi Methodology

The Delphi method was utilized for the current study to empirically derive agreement from experts on the essential descriptors of impairment. The Delphi method is a process intended to achieve agreement on a topic where little or no consensus previously existed (Dalkey, 1969b) such as the lack of agreement concerning the definition of impairment. The Delphi method provided the opportunity for a systematic and recursive communication process among experts concerning student impairment that revealed areas of agreement regarding the essential descriptors of impairment. This process was designed to generate categories of impairment to create a classification system, ultimately improving the identification and remediation of impairment.

Definition of Terms

To assist the reader in understanding the terminology used within this study, the following definition of terms is provided.

Academic abilities. Academic abilities refer to intellectual ability often measured by Grade Point Average (GPA), Graduate Record Exam (GRE), classroom assignments, and exams **(**Main-Leverett, 2004).

American Counseling Association (ACA). A "not-for-profit, professional and educational organization that is dedicated to the growth and enhancement of the counseling profession" (ACA, 2014, p.1).

Americans with Disabilities Act (ADA). Provides civil rights protection to people with impairments in the form of disabilities (ADA, 1990)

American Psychological Association (APA). The "largest scientific and professional organization representing psychology in the United States" whose mission is to "advance the creation, communication and application of psychological knowledge to benefit society to improve people's lives" (APA, 2014, p. 1).

Burnout. A state where an individual experiences depleted reserves and physical and mental fatigue (Watkins, 1983).

Competence. Professional expertise or ability to adequately perform the expected duties of any given role (Nelson, 2007).

Council for Accreditation of Counseling and Related Educational Programs (CACREP). An "independent agency recognized by the Council for Higher Education Accreditation" to accredit master's and doctoral degree programs, which provides educational standards for counseling education programs (CACREP, 2014, p. 1).

The Journal of Counselor Education and Supervision (CES). A flagship journal "dedicated to publishing manuscripts with original research, theory development,

or program applications related to counselor education and supervision" (Association for Counselor Education and Supervision, 2013, p. 1).

Delphi method. A group communication process that utilizes a group of expert panelists to contemplate a complex problem in an effort to form a group consensus (Linstone & Turloff, 1975).

Dismissal. A term used when a student's personal, professional, or academic performance is below a minimum standard, leading to removal from the counselor education program (Baldo, Softas-Nall, & Shaw, 1997; Kaslow et al., 2007).

Due process. A citizen's right under the 14th Amendment that states an individual cannot be deprived of liberty or property without appropriate safeguards (Forrest et al., 1999).

Expert. An individual who displays deep knowledge and high levels of experience and ability in any given subject matter (Davis, 1997; Hasson et al., 2000).

Gatekeeping. A term used to signify counselor educators' responsibility to determine which students may graduate and be entrusted to professionally care for clients (McAdams, Foster & Ward, 2007).

Impairment. Signifies behaviors or deficiencies that interfere with professional functioning and compromises service provided to clients or one's ability to perform at a minimum standard in a counselor education program (APA, 2006; Kaslow et al., 2007).

Nonacademic counseling ability. A term that refers to counseling skills, practicum experiences, and other professional behavior (Forrest et al., 1999).

Psychology. The term used in this document to mean applied programs that educate therapists, clinical psychologists, school psychologists, and counseling

psychologists but not experimental, educational, and/or industrial or organizational psychologists.

Remediation. The process of correcting a deficiency (Remediation, 2014) or steps taken to correct insufficient behaviors or skills to exhibit an expected level of competence (Wilkerson, 2006).

Review and retention. The evaluation process counselor educators perform on each student to assess his or her ability to become a counselor (Henderson & Dufrene, 2011).

Screening. The evaluation process within admissions to counselor education programs. Applicants might be evaluated for their potential as a counselor, academic abilities, career goals, and personal characteristics (Bradey & Post, 1991). Screening is also defined as a system for examining and separating into different groups (Screening, 2014).

Wellness. The quality or state of being in good health especially as an actively sought goal (Wellness, 2014). In the counseling profession, wellness is a desired state of optimal functioning in which one maintains physical and mental health (Gross, 1980).

CHAPTER II

LITERATURE REVIEW

This chapter provides an overview and critique of the impairment literature in relation to the fields of psychology, counseling, and counselor education. The term *psychology* is used in this document to mean programs that educate therapists, clinical psychologists, school psychologists, and counseling psychologists but not experimental, educational, and/or industrial or organizational psychologists. The review of impairment literature presents an examination of the multiple issues faced by (a) counselor educators in the assessment and remediation of underperforming or impaired students and (b) members of the psychology and counseling professions who struggle with practitioner impairment. In this review, I specifically discuss the issue of multiple and inconsistent definitions of impairment; the difficulties presented by this lack of consensus are related to identifying, assessing, remediating, and possible termination of students' programs of study. In this dissertation, I reluctantly use the term impairment to improve the readability of the document and recognize it is incomplete and limited in its capacity to define and identify students with problematic behaviors and performance deficiencies (as noted in the Rationale for the Study). Yet, utilizing multiple and often imprecise terms would create a cumbersome and confusing narrative.

An extensive search of impairment literature was conducted in the following databases: EBSCOhost, Academic Premier, LexisNexis Academic, ProQuest Dissertation

& Theses, ScienceDirect, and PsychINFO using the following keywords--counseling student impairment, counselor impairment, impairment, counseling student incompetence, counselor incompetence, professional competence problems, wounded healer, distressed counseling students, distressed counselors, burnout, and wellness. The reader might note the use of dated citations, many 10-15 years old, which reflects the current state of undeveloped knowledge on the subject.

History of Impairment in Counseling and Psychology

Mental health professionals, like many in health care, engage clients in deeply personal and intimate therapeutic conversations to improve the client's wellbeing. Ethical and quality psychotherapy requires counselors to be personally, interpersonally, and technically engaged with clients while simultaneously monitoring their [counselors] areas of strengths and areas of growth. Occasionally, counselors are unable, unwilling, or unaware of behaviors, dispositions, or ways of being that might impair their relationships with clients, colleagues or the profession. In these cases, licensing boards, colleagues, counselor educators, supervisors and professional societies must have procedures aimed at identifying and addressing the impairment by either remediating the issue and returning the counselor to practice or, if necessary, redirecting the counselor to a new career. The process begins with a shared understanding of the nature, definition, or essential characteristics of impairment.

The term *impairment* has been used within medical and mental health professions to describe professionals performing below a standard level of competence (Falender et al., 2009; Forrest et al., 1999). The American Psychological Association (2006) recognized the role of stress, potentially leading to impairment, within the psychology

profession and indicated that the very nature of being a mental health worker created occupational stressors that might amplify personal issues leading to mental health struggles. The authors of the APA policy statement stated psychologists are perhaps prone to impairment due to various factors of the psychologist's role: (a) continually being exposed to highly emotional material, (b) the importance to ensure appropriate boundaries with clients, (c) the need to monitor and control one's emotions within therapeutic relationships, and (d) isolation from colleagues. Many of these factors could eventually result in practitioners' impairment, leading to concern for practitioners, the field, and, most significantly, the practitioners' clients. Although impaired practitioners have existed within mental health professions since its inception, relatively little research and attention has been given to the issue (Hazler & Kottler, 1996; Sherman, 1996).

The history of practitioner impairment in psychology has consisted of an ongoing debate, multiple changes in terminology, and varying goals to better address the issue (O'Connor, 2001). As cited on the American Counseling Association's (2013) website, an informal group called Psychologists Helping Psychologists was formed around 1970 to combat the issue of alcoholism within the profession. The purpose of this group was to provide peer support and promote self-help ideas (Laliotis & Grayson, 1985). More formal attention was given to impairment in the early 1980s when the APA first acknowledged the severity of impairment among practitioners and the need to address behaviors that lead to diminished professional ability (Laliotis & Grayson, 1985; Orr, 1997; Smith & Moss, 2009). In response to identifying increased need to address impairment, the APA (2006) created the Advisory Committee on the Impaired Psychologist (ACIP; Laliotis & Grayson, 1985; Orr, 1997; Smith & Moss, 2009).

Several authors reported varying timeframes regarding the establishment of the ACIP (APA, 2006). Laliotis and Grayson (1985) stated the Advisory Committee on the Impaired Psychologist was created in 1981whereas Smith and Moss (2009) and Orr (1997) each said the ACIP was established in 1986. The conflicting information and a lack of clarity related to the founding date of this group seemed to portend the confusion to come. For example, the purpose of ACIP evolved in an effort to more adequately address impairment by assisting the impaired professional as well as attempting to protect the public from harm. O'Connor (2001) stated the initial approach of the committee was focused on distressed psychologists where the APA recommended procedures that emphasized educative and rehabilitative approaches rather than punitive. Smith and Moss (2009) stated the early goal was on substance use and abuse, which later in the 1990s shifted to education, prevention, and treatment as reflected in its name change to the Advisory Committee on Colleague Assistance (APA, 2006). The apparent shifts in focus and purpose seemed to reflect more than an evolution in the profession's understanding of a construct; one might rightly question the degrees of agreement related to the definition and potential response to impaired colleagues.

Another struggle was reflected in the many name changes to the Advisory Committee. When the committee was focused on distressed practitioners, they found issues with using the term *distressed* psychologist as "every constituency in APA wanted to have special treatment of the ways in which their members were *distressed*" (Schoener, 1999, p. 696). In my opinion, the APA Advisory Committees might have altered the way they approached and defined impairment because the objective was to address impairment while simultaneously traversing a delicate balance of protecting the public

from impaired therapists and presenting an approach to assisting impaired individuals that would not deter them from accepting help.

Thus, in reaction to the special treatment desired by constituent groups, the Board shifted the focus to the *impaired practitioner* (APA, 2006; Laliotis & Grayson, 1985; Orr, 1997; Schoener, 1999), which primarily focused on the more readily identifiable processes of substance use and abuse issues (Smith & Moss, 2009). However, Schoener (1999), a member of the APA advisory committee, indicated once the Board shifted its focus to the *impaired* psychologist, there seemed to be less interest on the issue and less acceptance of responsibility. Schoener did not specifically indicate why this shift in focus led to less accountability; however, I assume the word *impaired* was a more threatening term than *distressed* and perhaps psychotherapists believed, as mental health professionals, they should be in control of their stress before progressing to impairment. This apparent avoidance of taking responsibility for practitioner impairment might have been fueled by the stigma often overshadowing therapists concerning their own mental health (Schoener, 1999); often, habitual helpers have difficulty accepting their own need for mental health services (APA, 2013). This apparent lack of interest and responsibility created a major concern regarding how these attitudes were negatively impacting the clients being served (Schoener, 1999).

In the 1990s, the advisory committee changed its name to the Advisory Committee on Colleague Assistance (ACCA; APA, 2006; O'Connor, 2001) with the intent to exude a more positive and inclusive message (Schoener, 1999). The ACCA members indicated a belief that every therapist might be vulnerable to personal and work related struggles, potentially leading to impairment (APA, 2006). This modification of

the committee's name to Colleague Assistance was intended to reflect a positive image for those suffering with impairments (Schoener, 1999) and to focus on prevention, education, and treatment for impairment (O'Connor, 2001).

Although there is an extensive history of counselors experiencing distress and impairment (ACA, 2013), the counseling field has a relatively stunted history of systematic attention to impairment. In the late 1970s and early 1980s, the literature in the counseling field primarily discussed counselor burnout (Boy & Pine, 1980; Savicki & Cooley, 1980; Warnath, 1979; Watkins, 1983); in the 1990s, it was counselor wellness (Gross, 1980; Myers, 1991, 1992; Romano, 1984). Articles on counselor burnout and counselor wellness acknowledged the unique stressors of those in the counseling profession leading to symptoms of burnout but did not specifically address identification or a response to impaired counseling students. In 1988, Stadler, Willing, Eberhage, and Ward published an article discussing counselor impairment and implications for the counseling profession; they suggested impairment had not been sufficiently discussed in the counseling literature. It was not until 1991 that the American Counseling Association developed the first task force to specifically address impairment (ACA, 2013) of practicing therapists. This task force surveyed ACA members with regard to the issue of impairment. The results indicated approximately 10% (approximately 6,000 ACA members) of the helping profession at any given moment experienced impairment that impacted their work with clients (APA, 2006). This percentage should be viewed with caution because this study included only ACA members and the ACA website did not provide a response rate. However, this percentage (10% experiencing impairment) was similar to other professions' report of impairment, specifically substance abuse.

Baldisseri (2007) found 10-15% of physicians will abuse substances some time in their career.

In 2003, ACA created the second impairment task force, which contacted state licensing boards to understand how various states defined and intervened with impaired counselors (ACA, 2013). The data indicated many states used *impairment* as an umbrella term to encompass many counselor deficiencies. The ACA website (2013) indicated that Virginia, Minnesota, and Michigan defined impairment to be inclusive of many origins and each had established impairment programs. Noting only three states with programs, ACA highlighted the lack of counselor impairment programs in the remaining states. This task force demonstrated the importance of continued attention on counselor impairment and the importance of dedicating resources to the identification and treatment of impaired professionals. This task force raised the following question: why were professional associations and state licensing boards seemingly so disinclined to acknowledge and address counselor impairment?

The ACA task force continued their work in 2004 by surveying ACA members concerning their knowledge and awareness of impairment among counselors and interventions available for those in distress (ACA, 2013). The task force reported the percentages of surveyed members who (a) knew an impaired counselor (63.5%), (b) understood the harm in counseling while impaired (75.7%), and (c) reported uncertainty concerning the existence of an intervention program for impaired counselors in their state (82.7%). From this investigation, ACA (2013) determined a need for three initiatives: (a) preventative education, (b) interventions for impaired counselors, and (c) advocacy to attend to impaired counselors' needs.

Professional literature on impairment within the Counselor Education and Supervision (CES) journal did not seem to surface until the late 1990s and 2000s (Baldo et al., 1997; Bradey & Post, 1991; Frame & Stevens-Smith, 1995; Kress & Protivnak, 2009; McAdams, & Foster, 2007; McAdams et al., 2007; Olkin & Gaughen, 1991; Wilkerson, 2006). Many of these articles were in response to litigation experiences with impaired students. This delay in the CES literature was concerning and curious considering counselor educators are gatekeepers of the counseling profession and certainly have the best opportunity to intervene at the earliest stage of a counselor's career.

This initial focus within the psychology and counseling fields regarding impairment in the 1980s and 1990s seems to have diminished as of late. In the past decade, relatively few impairment articles have been published, which might indicate a current decrease in effort to address the issue (De Vries & Valadez, 2006), difficultly operationalizing the term (Forrest et al., 1999), and reluctance to engage in review and retention that may result in litigation. A review of the literature for the current study demonstrated a relatively limited arsenal of recent articles and a lack of focus on the issue, which is regrettable considering the importance of understanding impairment and its impact on the impaired counselor, client welfare, and the credibility of the profession.

The psychology and counseling literature provided an understanding of the history and prevalence of impairment as well as the struggle the helping profession has had in remediating professional impairment. Many authors suggested the first step in dealing with impairment is clarifying the definition of impairment (Bissell, 1983; Forrest et al., 1999; Huprich & Rudd, 2004; Kaslow et al., 2007; Li, Lampe, Trusty, & Lin, 2009;

Schwartz-Mette, 2011; Smith & Moss, 2009; Stadler et al., 1988). Impairment is not only a major concern within professional practice but also within counselor education programs. Empirical attention focused on counselor education programs is needed to improve identification and remediation practices.

At the educational level, faculty members perform more intensive evaluations of their students because counselor educators have an obligation to be the gatekeepers for the counseling profession. Faculty members are able to spend considerable time with counseling students and closely monitor their development, thus having prime opportunities to identify impairment. With enhanced focus on students' development, behaviors, and skills, it might be more efficient to intercept the problem of impairment in counselor education programs before students become professional counselors who engage in considerably less supervision and thus less opportunity for an outside observer to identify impairment issues.

Counselor Recruitment and Education

Screening and Admission

Screening applicants into counselor education programs is the first step in identifying potentially impaired students and holds high importance (Main-Leverett, 2004). Counselor educators have a duty to select students who will succeed in academics and also the counseling role (Wrenn, 1952). However, screening for impairment in potential counseling students is a complex matter due to the multi-faceted nature of counseling programs. Sternberg (1996) discussed the unique aspects of graduate counseling programs; students must not only possess academic abilities, they must also demonstrate competence in practical and interpersonal skills to become effective

counselors. In addition to the difficulty of screening applicants for potential impairments in multiple areas of competency, currently no universally agreed upon criteria or centralized process for admissions exist in counselor education (Bemak et al., 1999). Without a centralized process or guidance from professional societies, individual program faculty members must decide how and on what criteria they will screen all candidates, specifically potentially impaired individuals. Once identified, faculty members must then engage in some action.

Many programs utilize graduate record examination scores (GRE) and previous grade point averages (GPA) as means to evaluate applicants (Main-Leverett, 2004). Although measuring academic skill is more straightforward, Sternberg (1996) believed academic ability contributes less to counseling effectiveness than practical intelligences (i.e., creativity, interpersonal ability, etc.). In addition to analytic measures (i.e., GRE and GPA), many counseling programs utilize personal interviews, personal written statements, and letters of recommendation (Bradey & Post, 1991; Hill, 1961; Markert & Monke, 1990; Nagpal & Ritchie, 2002; Young, 1986). Personal interviews are intended to identify applicants' personal traits and interpersonal style (Bradey & Post, 1991). Many programs utilize in-person interviews to assess applicants for nonacademic characteristics, such as interpersonal patterns, that would otherwise be difficult to detect (Nagpal & Ritchie, 2002). This process allows counselor educators to observe applicants as they interact with peers in a professional setting, which might signify interpersonal patterns that ultimately develop with future clients. However, too often, the in-person interview is used to screen-out applicants rather than select potentially effective counselors (Nagpal & Ritchie, 2002). Another assessment often utilized is personal

written statements (Perusse, Goodnough, & Noel, 2001) designed to evaluate applicants' writing style, professional goals, motivations for becoming a counselor, and career goals. Letters of recommendation are often included as an admissions assessment to gain insight from previous supervisors or professors concerning applicants' academic ability, work ethic, and personal strengths.

These assessment methods determining admission to psychology and counseling programs have been utilized for virtually 50 years with little variation (Duba et al., 2010; Hill, 1961; Markert & Monke, 1990; Young, 1986). Although most faculty members utilize these methods (i.e., GRE scores, GPA, personal interviews, personal written statements, and letters of recommendation), many counselor educators believe these measures do not accurately gauge counseling and interpersonal ability, thus allowing potentially impaired students to be admitted into counseling programs (Bradey & Post, 1991; Markert & Monke, 1990; Young, 1986). Because these procedures do not guarantee the identification of potentially impaired individuals from counselor education programs, counselor educators have additional responsibilities to assess and identify impaired students in their programs.

Counselor Educator Responsibility

Counselor educators have a responsibility to train and evaluate counselors-in-training (CIT) to assist their development in becoming effective counselors. This responsibility includes identifying and remediating students in a timely manner with due process. Students who demonstrate problematic behaviors and/or competency issues are most commonly referred to as impaired students (Elman & Forrest, 2007; Huprich &

Rudd, 2004). However, identifying and remediating impaired students is at times an exceedingly difficult and complex task counselor educators frequently encounter.

The difficulty and complexity of this task emanates from the very *nature* of counselor education programs, which are multi-faceted, focused on the personhood of the student, and include professional, academic, and interpersonal elements. These evaluations are delivered by faculty members with multiple demands on their time. Further, identifying impaired CITs is fraught with intricacies due to the multiple and intersecting domains of student performance, culture, and assessment (e.g., academic, interpersonal, ethical, and professional). Most significantly, without an agreed upon and operationalized definition of impairment, it is difficult to identify, evaluate, remediate, or remove potentially impaired CITs (Elman & Forrest, 2007). If these difficulties in identifying and remediating impaired students persist, faculty members might unwittingly allow potentially unfit counselors into the profession, ultimately placing clients at risk and might diminish the reputation of the helping profession.

Counselor Education

How Counselors Are Educated

To be licensed as a counselor, school counselor, or marriage and family therapist requires a minimum of a master's degree in counseling. As a program within the graduate school, counselor education programs are similar to other master's degree programs because they have comparable academic requirements of an advanced master's-level education. Counselor education programs are unique in that students are also required to demonstrate nonacademic competency benchmarks such as emotional well-being and effective personal/interpersonal patterns related to their academic knowledge.

Competency in counseling programs is multidimensional; it includes not only academic ability but also applied counseling skills, personal qualities, and emotional wellbeing (Duba et al., 2010; Lumadue & Duffey, 1999; Procidano et al., 1995). The Council for Accreditation of Counseling and Related Programs (2009) provided guidelines for minimum standards for programs, faculty members, and students. With respect to students, CACREP identified specific academic requirements focused on the knowledge and skills successful counseling students should acquire. The 2009 CACREP *Standards* demonstrated the unique nature of counselor education programs by suggesting students should have (a) the potential to form quality therapeutic relationships, (b) the aptitude for graduate level education, and (c) have career goals that match the nature of the counseling program (p. 1.K.).

Perhaps the most distinguishing aspect of a counselor education program is the centrality of the interpersonal skills to effectiveness within the domain. These nonacademic skills are essential as indicated by the link between the person-of-the counselor and effective therapy (Lambert & Barley, 2001; Wampold, 2001). Common factors research indicated the power of the therapeutic relationship on counseling outcomes. Common factors researchers consistently reported the greatest element determining successful psychotherapy is the relationship between the counselor and client (Grencavage & Norcross, 1990; Lambert & Barley, 2001; Norcross, 2002; Wampold, 2001). In fact, Grencavage and Norcross (1990) stated the therapeutic relationship is more important than interventions or techniques; the formation of a strong therapeutic relationship is the context in which techniques work. This indicated the mode of treatment or techniques might not be as effective if the relationship is not initially

established. To build a strong therapeutic relationship, it is helpful for the counselor to have personal characteristics conducive to relationship building. According to Schoener (1999), the work of a counselor depends on who he or she is as a person. Although it is clear the personal characteristics of students are a main contributor to effective treatment, evaluating this nonacademic construct is a major challenge for counselor educators.

Counselor Educators as Gatekeepers

Counselor educators have the ultimate responsibility of educating counselors. They are responsible for students who enter their programs (Wilkerson, 2006), yet the primary responsibility is to protect the public from impaired counselors. Thus, as gatekeepers of the counseling profession, the main responsibility is to insure client welfare. This gatekeeping responsibility is highlighted in the profession's ethical guidelines.

Ethical guidelines provide guidance regarding necessary actions faculty members must take to meet their duties and obligations as counselor educators. The ACA *Code of Ethics* (2005) and the CACREP *Standards* (2009) clearly stated client welfare should be the primary concern of counselor educators; thus, identifying impaired counselors-in-training is a main responsibility of counselor educators. In addition, the ACA *Code of Ethics* and CACREP *Standards* require counselor educators to continuously evaluate student performance to monitor for limitations that might hinder a student's professional work with clients. Upon identification of impairment, counselor educators must intervene by providing remedial assistance or dismissal from the program (ACA, 2005; CACREP, 2009). Although faculty members clearly have gatekeeping responsibilities, ethical codes fail to provide specific guidelines because the guidelines are typically

written to apply broadly (Bemak et al., 1999). Counselor educators gain some guidance from the laws in most states that govern the practice of psychotherapy (e.g., confidentiality, client/therapist amorous relationships, misrepresentation of credentials). Yet, these laws typically focus on post degree practitioners; a violation of this magnitude by a CIT would be significant and worrisome.

As previously stated, the first step in monitoring impaired counseling students is the recruitment and admissions process. Counselor educators typically use the admission process to identify potentially unqualified or potentially impaired applicants (Markert & Monke, 1990). Although the intention of the selection process is to detect impaired individuals and to project success in graduate studies and counseling effectiveness, traditional selection criteria are often insufficient (Markert & Monke, 1990). Thus, many researchers believe impaired individuals frequently gain admittance into counseling programs (Bradey & Post, 1991; Markert & Monke, 1990).

Once students are admitted into counseling programs, counselor educators must attempt to accommodate competing responsibilities. As gatekeepers, counselor educators are responsible to take action when a student lacks the necessary skills, knowledge, or values needed to become a successful counselor (Ziomek-Daigle & Christense, 2010). At the same time, counselor educators are also responsible for students in their program and must attempt to meet each student's rights and needs as developing counselors (Elman & Forrest, 2007; Falender et al., 2009; Forrest et al., 1999). These dual responsibilities create a dynamic challenge as faculty members seek to balance students' rights and needs while protecting the public from potentially harmful counselors. This balancing act becomes tenuous due to the potential existence of legal matters counselor educators

might face from students and clients. For example, if faculty members knowingly allow an impaired student to graduate and the student ultimately harms a client, the counselor educator might be held responsible for client harm (Frame & Stevens-Smith, 1995). On the other hand, if faculty members decide to dismiss a student from their program, they run the risk of the student pursuing legal action by claiming they were not awarded due process. This fear of legal matters could be a challenge counselor educators face, occasionally leading to avoidance of difficult student evaluations (McAdams et al., 2007; Vacha-Haase, Davenport, & Kerewsky, 2004).

Although student evaluations hold high importance, the obligation to evaluate the intersection of students' nonacademic behaviors, attitudes, and skill and their potential professional ability creates yet another challenge. Counselor educators lack an empirically derived or uniform protocol to evaluate students' professional ability (Bemak et al., 1999), potentially leading to claims of inconsistent evaluation criteria and arbitrary and capricious behavior. Additionally, the multi-faceted nature of counseling programs requires faculty members to simultaneously assess students' academic and nonacademic ability (Bradey & Post, 1991). Often, counselor educators hesitate to dismiss students based on mental health or nonacademic, issues alone (Bradey & Post, 1991). Without a concrete or standardized evaluative protocol, assessing non-concrete skills such as interpersonal behaviors or mental health issues become extremely challenging. Yet, as highlighted above, counselor educators have legal and ethical obligations to not only evaluate student academic development and capabilities but also nonacademic behaviors (Corey, Corey, & Callanan, 2011).

In addition to the challenges surrounding the identification of student impairment, faculty members must simultaneously consider the role student development plays in students' behaviors and competence. Bemak et al. (1999) highlighted the importance for faculties to base their counseling program on the belief that students can grow and develop as counselors. Students are not expected to enter counselor education programs as competent, effective counselors. Rather, developmental theorists suggest individuals facing new tasks (e.g., becoming a counselor) go through developmental stages, beginning at a basic level (Ericson, 1963; Loganbill, Hardy, & Delworth, 1982). With the right conditions, students are believed to progress through developmental stages, increasingly gaining confidence and competence. While students are beginning counselors-in-training and reaching new levels of development, it is likely their behavior and skill sets might at times appear as incompetent or impaired. Considering the developmental perspective, faculty members must make difficult decisions regarding students' behaviors and actions and attempt to determine if a student's deficiencies are due to impairment or simply competence yet to be attained (Wilkerson, 2006). Falender et al. (2009) alluded to a similar struggle, suggesting supervisors are faced with the challenge to differentiate between "performance difficulties," e.g., expected developmental struggles; "performance problems," e.g., inability to gain required competence with proper education; and "professional competence problems," e.g., ethical and legal issues (p. 240). Additionally, when a counselor educator determines a student's incompetent behavior or insufficient skill is resulting from not yet attained development, the faculty member must determine what conditions and how much time is adequate for the student to reach the appropriate developmental level required for independent clinical

practice. Considering the issue of development in attaining competence creates challenges in student evaluations, particularly in practicum and internship.

Student Evaluation

Ethical Obligation

Counselor educators may uphold their duty to protect clients from unfit counselors by conducting student evaluations and remediating students demonstrating problematic behaviors. The *Code of Ethics* (ACA, 2005) and accreditation standards (CACREP, 2009) demonstrated the importance of student evaluations. For example, the *Code of Ethics* requires (a) supervisors to provide ongoing "performance appraisal and evaluative feedback…throughout the supervisory relationship" (F.5.a.), and (b) supervisors to identify limitations in supervisees "through ongoing evaluation and appraisal, supervisors are aware of the limitations of supervisees that might impede performance" (F.5.b).

In addition to the above ethical guidelines, the Council for Accreditation of Counseling and Related Programs (2009) provides educational standards for counseling programs that also places responsibility on counselor educators to "conduct a developmental, systematic assessment of each student's progress throughout the program, including consideration of the student's academic performance, professional development, and personal development" (Section 1.P.). Ethical codes and educational standards clearly indicated that student evaluation is for the protection of client welfare and development of the student. Counselor educators' duty to evaluate and monitor their student's progress also benefits the counselors-in-training. For example, students deserve to be evaluated and given feedback in order to grow as counselors and maximize their

development (McAdams et al., 2007). With continual evaluation of counselors-in-training, faculty members will be more likely to identify deficiencies within their students (Hatcher & Lassiter, 2007) and hopefully address them early in the student's education.

Difficulty in Evaluating Students

Several difficulties accompany the responsibility to evaluate students. First, the multi-faceted nature of counseling programs requires students to succeed in multiple domains (Wilkerson, 2006), which include not only academic ability but also clinical skills, personal characteristics, and interpersonal patterns (Duba et al., 2010; Lumadue & Duffey, 1999; Procidano et al., 1995). Developing into an effective counselor requires more than academic success alone (Jordan, 2002). Multiple domains are difficult to evaluate because a single assessment is not effective in measuring clinical, personal, and interpersonal abilities (Neufeld, 1985). Each domain is equally necessary to evaluate in developing counselors (Wilkerson, 2006). A multi-faceted counseling program requires a multi-faceted approach to evaluation; yet, the field currently lacks appropriate assessments to measure each dimension.

Another difficulty in student evaluation is many of the competency areas (e.g., interpersonal pattern) are difficult to concretely measure and thus often subjectively evaluated (Markert & Monke, 1990; Vacha-Haase et al., 2004). Recognizing a student with academic difficulties is more straightforward than identifying deficiencies in clinical or personal domains (Markert & Monke, 1990). Similarly, clear-cut concerns such as ethical and legal violations with potential to harm clients are easier to identify and remediate than vague or subtle issues such as interpersonal deficiencies (Falender et al., 2009). Nonacademic skills, such as interpersonal patterns, are less concrete and thus

difficult to operationalize and measure (Olkin & Gaughen, 1991). Thus, without clear guidelines and assessments for nonacademic skills, counselor educators might frequently evaluate from a subjective position (Vacha-Haase et al., 2004).

Student deficiencies must be evaluated on both functional competence (e.g., conceptualization, supervision, assessment, intervention, etc.) and foundational competence (e.g., self-awareness, relationship patterns, ethics, professionalism, etc.; Kaslow et al., 2007). Faculty members often have difficulty determining the difference between deficiencies resulting from true impairments and deficiencies resulting from a lack of competency. Measuring competency in developing counseling students might be similar to "shooting at a moving target." Evaluating competency in counselors-in-training is especially difficult because students are believed to be at beginning stages of development with the expectation of increasing competency (Schwartz-Mette, 2009). Therefore, counselor educators have a difficult task in determining if students' lack of competence is remediable considering new levels of competency might continue to be reached.

Ethical codes and accreditation standards are clear regarding the obligation and responsibility to evaluate students and supervisees; however, these bodies lack concreteness demonstrating how to uphold this duty (Wilkerson, 2006). Counselor educators lack a uniform way to evaluate counselors-in-training for their fitness for the profession (Bemak et al., 1999). With the requirement to evaluate and the absence of standard evaluative criteria, individual programs are charged with the task of developing their own evaluative methods. Although many programs have developed or borrowed some form of annual evaluation, many programs currently lack procedures to conduct

annual student assessments (Bradey & Post, 1991; Olkin & Gaughen, 1991). Counselor education programs must create evaluative methods that (a) adhere to ethical and accreditation standards and (b) are a systemic, documented way to identify impaired students, ensure readiness for independent clinical work (Jordan, 2002), and are empirically derived.

Current Student Evaluation Models

Although the field of counselor education lacks uniform methods to evaluate students (Bemak et al., 1999), many authors have proposed student evaluation models (Baldo et al., 1997; Bemak et al., 1999; Fouad et al., 2009; Frame & Stevens-Smith, 1995; Lumadue & Duffey, 1999). Many of these authors suggested guidelines for student evaluation developed from their experiences in evaluating, remediating, and handling legal matters with impaired students. Many authors reported their experiences working with impaired students and indicated the necessity of having an evaluation framework that is consistent, fair, and meets ethical and accreditation standards (McAdams et al., 2007).

One review and retention policy presented by Frame and Stevens-Smith (1995) suggested a three-step model to evaluate and potentially dismiss students. The authors completed an extensive review of counseling and psychology literature that discussed impairment and counselor competency. From this analysis, the authors developed The Personal Characteristics Evaluation Form (PCEF) that evaluates students on what they believed to be nine necessary characteristics for effective counselors: being open, flexible, positive, cooperative, hearing and implementing feedback, aware of own influence on others able to manage conflict, accepts personal responsibility, and able to

effectively express feelings. The PCEF utilizes a 5-point Likert scale that assists faculty members in conducting midterm and end-of-the-semester student evaluations. The authors stated this evaluation form provides a concrete assessment to evaluate nonacademic student behaviors.

Baldo et al.'s (1997) evaluative guidelines were developed subsequent to their experience of dismissing a student from their counseling program and resulting court case (*Harris v. Blake and the Board of Trustees of the University of Northern Colorado,* 1986). This review policy differed from others in the literature because their model attempted to not only ensure due process for students but also faculty members. Due process is given to the student through ongoing student evaluations and early notification to the student of faculty concerns and remediation steps taken. Faculty members are given due process because concerns of impaired student behavior are presented to the student from a retention committee instead of the individual faculty member. This team approach includes the entire faculty in the remediation efforts as to not single out individual faculty members. The retention committee also approves the remediation plan and provides the student with a copy of the written plan. The student must sign his or her remediation plan to indicate the student is aware of the parameters of the plan. As an aspect of due process, the student might present his or her experience of the concerns with the faculty.

Bemak et al. (1999) cautioned counseling programs about the dangers of not utilizing evaluation guidelines. The authors warned that without evaluative criteria capable of assessing all domains of counselor education, faculty members might simply rely on academic outcomes to assess students. Although academic performance is one

vital aspect of student success, utilizing this evaluation as a primary assessment is inaccurate in judging counseling competence. Due to the importance of having assessment criteria, Bemak et al. presented a five-step evaluation model: (a) communication about academic and behavioral expectations, (b) acquire student signatures in agreement to uphold expectations, (c) identification of problem behavior through ongoing assessment, (d) informing student of concerns and recommended remediation steps, and (e) monitoring the student's progress and development. This model also utilized ongoing evaluation and feedback that provided students with due process.

Lumadue and Duffey (1999) presented a gatekeeping model that allowed faculty members to systematically evaluate students utilizing the Professional Performance Fitness Evaluation (PPFE). This 4-point rating scale assisted faculty members in assessing students on specific behavioral competencies and was completed on each student in every course. Students were notified of this evaluation process upon admission into the program as well as at the start of each course, demonstrating informed practice and due process. Upon identification of problematic behavior, the concerned faculty member should approach the student to present an opportunity to resolve the issue without official remediation. If a resolution is not found, the faculty member then takes the concern to the department chair and other faculty members to assess the student's previous performance. In this meeting, a course of action and remediation plan is developed and then presented to the student.

Fouad et al. (2009) published competency benchmarks intended to help supervisors understand and measure competence in professional psychology. The

benchmarks described practitioner competence in two categories: foundational and functional. The foundational level consisted of professionalism, relational, and scientific skills and the functional level consisted of application, supervision, and systems. The authors provided examples of competency in each category and level and each from a developmental perspective. Each item was considered from three developmental categories (i.e., readiness for practicum, readiness for internship, and readiness for entry to practice) to exhibit how each area of competence might present differently depending on developmental level.

Overall, similarities among the student evaluation/gatekeeping protocol within the psychology and counseling literature included (a) early communication concerning expectations, (b) an ongoing and systematic evaluation process, (c) steps to undergo once an impaired student is identified, (d) procedures to track and document impaired student's behavior, (e) steps to take to develop a remediation plan, and (f) demonstrated attempts to allow due process for students (Kaslow et al., 2007; Wilkerson, 2006). These student evaluation guidelines, if utilized, might create a more transparent and dependable remediation process. Each evaluation and remediation model presented above provided a concrete, systematic student evaluation process. Yet, one might rightly ask why counselor educators have not adopted an agreed upon review and remediation model; to date, no satisfactory response has been offered.

Remediation

Once problematic behavior is identified, remediation is the most likely course of action. Dufrene and Henderson (2009) defined remediation as "a documented, procedural process that addresses observed inabilities in trainees' performance with the

intent to provide trainees with specific means to remedy their inabilities" (p. 150). Further, remediation is utilized when problematic behaviors are identified and traditional educational techniques and supervision are not enough to remedy the issues (Dufrene & Henderson, 2009). Remediation serves as an additional step that addresses impaired student behaviors with the intention to protect the public from harm (Baldo et al., 1997; Bemak et al., 1999, Frame & Stevens-Smith, 1995; Lumadue & Duffey, 1999; Olkin & Gaughen, 1991). Remediation is an important tool in counselor education; it is implemented prior to the student becoming an independent practitioner where problems might be more likely to go unaddressed (Kaslow et al., 2007). Considering the importance of gatekeeping, Forrest et al. (1999) identified a relatively limited arsenal of literature on remediation plans and a lack of consistency concerning how counseling programs addressed student impairment.

Guidelines to Addressing Problematic Students

The ACA (2005) *Code of* Ethics specifically stated remediation is an ethical standard requiring supervisors to be aware of student impairment and "assist students in securing remedial assistance when needed" (F.9.b). Despite the ethical obligation to engage in remediation efforts, the *Code of Ethics* lacked concrete guidelines concerning how to remediate problematic counseling students (Bemak et al., 1999; Lumadue & Duffey, 1999; Wilkerson, 2006). Considering the lack of guidance from the ethical codes, individual programs must decide how they will execute remediation of impaired students (Wilkerson, 2006).

Many faculty members are often uncertain about when and how to intervene once an impaired student is identified (Lamb, Cochran, & Jackson, 1991). Vacha-Haase et al.

(2004) stated 53% of the programs responding to their study reported lacking guidelines to intervene with impaired student behavior. This lack of protocol is disconcerting considering the frequency with which counseling programs deal with impaired students. For example, Forrest et al. (1999) generalized data from seven studies that investigated the prevalence of student impairment and stated, "We can assume that most training programs in any 3-year period are probably dealing with four to five impaired or possibly impaired trainees" (p. 652). If this is accurate, every counseling program deals with trainee impairment, underscoring the importance of having concrete, proactive guidelines for remediation to address problematic behavior. Recent literature discussed the difficulty that comes with remediation and offered possibilities to approaching remediation plans (Dufrene & Henderson, 2009; Elman & Forrest, 2004; Kress & Protivnak, 2009; McAdams & Foster, 2007).

Several authors presented remediation guidelines their counseling programs utilized (Baldo et al., 1997; Forrest et al., 1999; Lumadue & Duffey, 1999; Olkin & Gaughen, 1991). A review and summary of these authors' guidelines suggested important steps in remediation that encouraged faculty to (a) provide the student with a documented remediation plan (Baldo et al., 1997; Olkin & Gaughen, 1991) with deficiencies related to the programs requirements (Forrest et al., 1999); (b) acquire the student's signature to indicate his or her receipt (Baldo et al., 1997); (c) allow the student an opportunity to present his or her case (Baldo et al., 1997; Lumadue & Duffey, 1999; Olkin & Gaughen, 1991); (d) create a clear, detailed remediation plan reflecting concrete actions for the student to take (Baldo et al., 1997; Forrest et al., 1999), and (e) inform the student of a timeline to achieve goals (Forrest et al., 1999) and state consequences if

deficiencies are not corrected (Olkin & Gaughen, 1991). Given the multiple remediation models with a fair degree of overlapping qualities, it is curious that no organization (i.e., ACA, ACES, or CACREP) has synthesized them into one model of best practices for all programs to utilize.

Remediation Plans

Remediation plans might consist of a wide array of directives depending on individual student problems and individual deficiencies. Although the literature on remediation plans suggested a variety of interventions, this literature rarely discussed matching particular interventions with specific student deficiencies (Vacha-Haase et al., 2004). The most frequently assigned remediation intervention required personal psychotherapy (Bemak et al., 1999; Elman & Forrest, 2007; Forrest et al., 1999; Jordan, 2002; Kress & Protivnak, 2009; Li et al., 2009; Vacha-Haase et al., 2004). This intervention was often suggested to resolve impairment issues by increasing self-awareness and gaining insight about psychological barriers that might be influencing his or her competency (Kaslow et al., 2007).

Although personal psychotherapy has been utilized most frequently as remediation interventions, there are many dangers to this method. Not only does requiring psychotherapy as remediation seem "demanding or unjustifiably intrusive" to students (Bemak et al., 1999, p. 23), this intervention is virtually impossible to measure because therapy often has unclear goals and a vague timeline in addition to being a confidential process (Olkin & Gaughen, 1991). There is a lack of empirical data to support the efficacy of this intervention for correcting impaired student behavior (Kaslow et al., 2007). Not to mention, psychotherapy might not always be an effective

intervention for all sources of impaired student behaviors such as poor grades, clinical skills, etc. (Forrest et al., 1999; Vacha-Haase et al., 2004). The second most recommended course of remedial action is repeating coursework or a practicum experience (Forrest et al., 1999; Li et al., 2009; Olkin & Gaughen, 1991). This remediation intervention supports a developmental perspective, which suggests a student with deficiencies might simply need more time to acquire minimum competence.

Other frequently required interventions include (a) meeting more frequently with an adviser (Kress & Protivnak, 2009), (b) engaging in additional supervision (Forrest et al., 1999; Kress & Protivnak, 2009; Lamb et al., 1991; Li et al., 2009), (c) completing writing assignments or reflective journaling (Jordan, 2002; Kress & Protivnak, 2009), (d) taking a leave of absence from the program (Bemak et al., 1999; Forrest et al., 1999), and (e) completing additional role plays or reviewing clinical tapes (Jordan, 2002).

Once the remediation plan is developed and the student has an opportunity to complete the suggested interventions, a reevaluation of the plan might be conducted to determine possible outcomes. Depending on the student's progress in meeting his or her remediation goals, faculty members might take one of the following actions: (a) student is taken off the remediation plan because he or she has addressed the deficiencies, (b) continuation of an updated remediation plan if the student is progressing but needs more time, (c) counsel the student out of the program, or (d) dismissal from the program (Forrest et al., 1999; Lamb et al., 1987, 1991; Olkin & Gaughen, 1991; Woodyard & Canada, 1992). If a student with problematic behaviors is given opportunities to address his or her deficiencies and is unwilling or unable to meet the faculty's intervention goals,

the next reasonable step is discontinuation of the student's program (Kaslow et al., 2007; Forrest et al., 1999) or counseling out of the program (Kaslow et al., 2007).

Legal Issues

Due Process

Often, counselor educators struggle with the decision to dismiss students from their program. Not only does this process consume considerable faculty time (Olkin & Gaughen, 1991), the decision to dismiss is often paired with fear of student retaliation in the form of litigation (Bradey & Post, 1991; McAdams et al., 2007; Vacha-Haase et al., 2004). Most students dismissed from counseling programs and pursued legal action claimed they were denied due process (Forrest et al., 1999). Due process is a guaranteed right protected under the 14th Amendment, which states citizens cannot be deprived of liberty or property without the benefit of due process (Forrest et al., 1999). In academics, due process must be given in two formats: substantive and procedural. Substantive due process ensures the rules and processes of education programs were applied fairly and consistently to all students (Forrest et al., 1999). Procedural due process ensures students received proper notice of faculty concerns, an opportunity to address their deficiencies, and notice of dismissal steps (Forrest et al., 1999).

Literature on the topic of impairment and student dismissal indicated the steps programs could take to uphold students' right to due process. The first step in due process is defining competencies/expectations and notifying incoming students with a written document communicating these requirements (Bernard, 1975; Forrest et al., 1999; Frame & Stevens-Smith, l995; Lamb et al., 1987). All students must undergo ongoing evaluation (Bernard, 1975; Biaggio, Gasparikova-Kransnec, & Bauer, 1983; Forrest et

al., 1999) and faculty should maintain written and signed records of student evaluations (Baldo et al., 1997; Bemak et al., 1999; Bernard, 1975; Biaggio et al., 1983). If an impaired student is identified through this process, faculty should provide fair warning by developing a remediation plan that (a) identifies the student's deficiencies and faculty concerns, (b) provides prescriptive steps to address deficiencies, and (c) indicates a timeline and consequences for failing to meet the standards of the remediation plan (Bernard, 1975; Biaggio et al., 1983; Forrest et al., 1999). Students should also have an opportunity to provide their perspective as well as appeal a dismissal decision (Bernard, 1975; Forrest et al., 1999). If the faculty members can demonstrate the student was given due process, the court system typically supports the professional opinions of faculty within the program (Bernard, 1975).

Nonacademic Behaviors Resulting in Litigation

Dismissals from clinically-based academic programs such as counseling are taken seriously due to the role the person-of-the-counselor plays within the therapeutic relationship. Common factors research indicated the most influential factor in effective therapy is the therapeutic relationship (Grencavage & Norcross, 1990; Lambert & Barley, 2001; Norcross, 2002; Wampold, 2001). Therefore, the quality of the therapeutic relationship is determined in large part by the counselor's interpersonal skills, personality traits, and his or her ability to form relationships. Yet, as mentioned earlier, counselor educators have no way of consistently or uniformly describing and measuring these constructs. To protect the public from counselors with deficits in interpersonal skills, counselor educators must not only evaluate students' academic performance but also their nonacademic/interpersonal behaviors. However, nonacademic behaviors are less

concrete and more difficult to quantify, which might lead to students disagreeing with faculty subjective evaluations. Nonacademic behaviors that commonly result in litigation might be conflicts between personal beliefs and client welfare (e.g., unwillingness to counsel lesbian-gay-bisexual-transvestite [LGBT] clients), poor interpersonal skills, and impaired mental health.

Examples of nonacademic behaviors resulting in litigation are demonstrated in court cases (highlighted in more depth below) in which students were dismissed from clinically-based education programs. For example, in court cases *Keeton v. Anderson-Wiley* (2011) as well as *Ward v. Wilbanks* (2010), both students were dismissed from their program because they were unwilling, due to their stated religious beliefs, to counsel a client solely because he or she was gay--a violation of the ACA (2005) *Code of Ethics*. In the case of *Butler v. William and Mary* (2005), the student taking legal action was dismissed from her counseling program for various forms of unethical behavior (e.g., lying, being deceitful to clients) and interpersonal concerns such as creating fear in others by stalking and threatening students and professors. Similarly, in *Harris v. Blake* (1986), the student was also dismissed for unethical behavior (e.g., not informing his client of a cancelled session) and an interpersonal inability to create warmth, empathy, and genuineness. *Board of Curators of the University of Missouri v. Horowitz* (1978) involved a student with excellent academic ability but raised faculty concern because of the student's poor personal hygiene and poor clinical skills. Each of these court cases demonstrated nonacademic behaviors commonly resulting in litigation. These behaviors resulted in litigation due to the subjectivity involved in assessing and remediating the issue.

Academic Versus Disciplinary Dismissals

For legal purposes, the court categorizes dismissals from educational programs into two categories: disciplinary and academic (Forrest et al., 1999). Although clinical abilities and interpersonal skills are considered nonacademic behaviors in counselor education, in the court process, personal abilities and traits fall under the category of academic dismissals. On the other hand, disciplinary dismissals include unethical behavior, criminal actions, and breaking rules of conduct, entailing a more rigorous hearing than academic dismissals (Olkin & Gaughen, 1991). Academic dismissals involve indications of incompetence for working in a desired profession including inadequate knowledge, clinical skill, interpersonal ability, and psychological fitness (Forrest et al., 1999; Olkin & Gaughen 1991). In terms of academic dismissals, the faculty and professors must prove they provided fair treatment and ample notice to dismissing the student from the academic program (Forrest et al., 1999). The majority of the court cases reviewed for this study involved academic-based dismissals (*Butler v. Rector and Board of Visitors of the College of William and Mary*, 2005; *Harris v. Blake and the Board of Trustees of the University of Northern Colorado*, 1986; *Board of Curators at the University of Missouri v. Horowitz*, 1978; *Keeton v. Anderson-Wiley*; 2011; *Ward v. Wilbanks*, 2010).

Relevant Court Cases

The following section highlights relevant court cases involving impaired students suing their academic institutions for dismissing them from their educational programs. These students asserted the university failed to provide them proper due process. These cases reflect a sampling of the nonacademic concerns faculty might face. In the court

case *Butler v. Rector and Board of Visitors of the College of William and Mary* (2005), Victoria Butler was enrolled in a counseling practicum course where students must find a practicum site that allowed for direct client hours and videotaping capabilities. Butler informed her program she had secured a site that met the practicum requirements. Butler's site supervisor had concerns regarding Butler's actions and informed Butler's program of various alarming behaviors including Butler lying about her experience as a counselor to gain clients outside of the site without supervision and also being untruthful to clients. Additionally, Butler's site supervisor disclosed to the university that the site did not provide individual counseling and did not allow video-taping, both of which Butler fabricated to the university to secure her internship site.

Butler denied these events took place. Later, faculty met and decided not to allow Butler to continue the practicum. Butler was put on a remediation plan that required she maintain above a certain rating on the program's review form. Butler subsequently received three reviews with scores lower than what was required on her remediation plan. After these reviews, the faculty decided to dismiss Butler from the counseling master's program at the College of William and Mary. Butler proceeded to sue William and Mary stating her dismissal from the program was a violation of procedural and substantive due process and her dismissal was disciplinary in nature. The court ruled in favor of the defendants, stating that Butler was given both forms of due process.

In the case of *Harris v. Blake and the Board of Trustees of the University of Northern Colorado* (1986), Henry Harris was enrolled in a counseling practicum course at the University of Northern Colorado. Due to car troubles, Harris dropped the course after missing a class, which was grounds for failing the course because full attendance

was required due to the applied nature of the course. Harris claimed he left a message for the professor to inform and provide reasoning for his absence. In addition to Harris' absence from class, Margaret Blake, the professor of the course, had additional concerns. First, Blake stated Harris did not come prepared with a volunteer client or a video tape, both requirements of the course. Harris also had difficulty with his client (i.e., lacking warmth, respect, empathy, and genuineness) and did not inform his client of his need to cancel their appointment. Blake wrote a letter to be placed in Harris' student file indicating her belief that Harris should not be allowed to register for the practicum course and that other professors should be aware of his behavior. The school's Advisory Committee discussed Harris' behavior and decided Harris should remain in the program under further review. Harris continued his courses and ultimately received two poor course grades, which made his average drop below the required minimum. At that time, Harris withdrew from the program and sued the professors and the Board of Trustees at the University of Northern Colorado claiming procedural and substantive due process was not given. He also argued that placing Blake's letter in his student file was a disciplinary act rather than academic in nature. The court was in favor of the defendants and stated Harris' procedural and substantive due process rights were upheld.

In the court case of *The Board of Curators at the University of Missouri v. Horowitz* (1978), Charlotte Horowitz was a student in the Missouri-Kansas City Medical School and received excellent marks on her course work and test scores; however, she was dismissed during the last year of her program for failing to meet program standards. Prior to her dismissal, faculty had concerns about Horowitz's hygiene as well as her performance in clinical settings. The faculty placed Horowitz on a remediation plan; yet,

she continued to receive negative clinical evaluations and was dismissed. Horowitz sued the Board of Curators at the University of Missouri, claiming she was not given due process. However, the court ruled otherwise in favor of the defendants.

In the court case of *Keeton v. Anderson-Wiley* (2011), the faculty members in the counseling program at Augusta State University placed Jennifer Keeton on a remediation plan before she began her practicum experience to address Keeton's biases concerning counseling members of the gay-lesbian-bisexual-transvestite (GLBT) community. In previous courses, Keeton had voiced her disagreement with the GLBT lifestyle, expressed her interest in using the dangerous conversion therapy with clients from the GLBT community, and was reported attempting to get other students to adopt her belief system. Faculty members informed Keeton she could enroll in the practicum course as long as she continued working on her remediation plan of learning not to impose her beliefs on clients. Four days after this meeting, Keeton withdrew from the counseling program because she would not agree to follow her remediation plan if she encountered a GLBT client. Keeton filed a complaint against the university, claiming that the remediation plan discriminated against her religious beliefs and violated her free speech. The court ruled the school had not violated Keeton and the remediation plan was in fact fair.

Similarly, in the case of *Ward v. Wilbanks* (2010), the professors at Eastern Michigan University (EMU) became concerned about Julea Ward's ethical behavior after she refused to counsel a homosexual client because she did not agree with homosexual behavior. The professor indicated Ward could no longer be assigned practicum clients and must meet with her advisor for an informal review for violating the ACA (2005)

Code of Ethics of not discriminating against a client based on his or her sexual orientation. Previously, Ward had disclosed her beliefs in classes and wrote a paper admitting she would be unable to work with a client from the GLBT community and would refer the client to another counselor. At the conclusion of Ward's informal review with her advisor, she rejected her opportunity to complete a remediation plan, which led to her dismissal from the program. Ward sued the university and claimed the university discriminated against her beliefs, her religion, and violated her right to free speech. The court ruled in favor of the university and indicated the university clearly stated the expectations that students adhere to the ACA *Code of Ethics* (which Ward was in violation of) as an academic requirement.

Each of these court cases involving student dismissals from clinically-based educational programs included students suing their academic institutions, claiming they were not given proper due process. The student behaviors causing concern and ultimately leading to dismissal from the program were overwhelmingly nonacademic behaviors. In each case, the concerning student behaviors that indicated impairment included a range of issues: personal hygiene, clinical deficiencies, interpersonal problems, ethical violations, and academic failures. Perhaps the universities could have avoided litigation if a more concrete, succinct definition of impairment was provided.

Impairment Definitions

The difficulty of identifying and responding to student impairment at the educational level might result from a lack of definitional clarity of the term *impairment* and more legislation, which constrains the utility of the terminology even further. Dating back to the initial focus on the issue within the mental health profession, Laliotis and

Grayson (1985) reported only a few definitions existed within the literature on psychologist impairment. Over 10 years later, Emerson and Markos (1996) stated there were several definitions referring to many different types of impairment within the medical, psychology, and counseling literature. In 2006, the American Psychological Association also reported an existence of numerous descriptions of impairment "according to various states' laws, regulations, or state psychological associations" (Smith & Moss, 2009, p. 2). To add to the issue of multiple definitions, other authors have utilized many other terms to describe impairment in an attempt to create clarity (Biaggio et al., 1983; Bradey & Post, 1991; Elman & Forrest, 2007; Frame & Stevens-Smith, 1995; Overholser & Fine, 1990; Procidano et al., 1995; Vacha-Haase et al., 2004); however, adding new terms simply created additional confusion (Wilkerson, 2006). To date, a literature review for the current study resulted in a plethora of competing definitions of the impairment term.

A review and comparison of the existing definitions of impairment from the medical, psychology, and counseling literature demonstrated three types of impairment definitions: (a) generally stated definitions with limited clarity, (b) definitions recognizing diminished performance linked with possible causes, and (c) definitions attempting to describe categories or themes of impairment. The broadly stated definitions were general in nature and provided little definitional clarity. For example, in discussing counselor impairment, Emerson and Markos (1996) stated, "Impairment means inability to perform one's professional responsibilities appropriately" (p. 117). Orr (1997) wrote psychologist "impairment is the presence of an illness or illnesses that render or are very likely to render the professional incapable of maintaining acceptable

practice standards" (p. 293). Sheffield (1998) presented the following definition: "Counselor impairment is a condition that compromises and reduces the quality of counseling received by clients" (p. 97). The APA (2006) website defined psychologist impairment as "an objective change in the individual's professional functioning manifested by a marked diminished quality in work related performance" (p. 1). This set of definitions recognized the issue of diminished performance but was stated too broadly to be descriptive.

Other authors attempted to define impairment by first acknowledging diminished ability and then attempted to link various behavioral issues potentially defining the etiology of the individual's impairment. For example, Kempthorn (1979) identified impairment in physicians as "the inability to deliver competent patient care resulting from alcoholism, chemical dependency, or mental illness" (p. 24). Similarly, Laliotis and Grayson (1985) described psychologist impairment as "interference in professional functioning due to chemical dependency, mental illness, or personal conflict" (p. 84). After a review of impairment literature for their article, Forrest et al. (1999) summarized the existing impairment definitions in the field of psychology: "diminished professional functioning attributable to personal distress, burnout, and/or substance abuse, and ….unethical and incompetent professional behavior" (pp. 631- 632). Duba et al. (2010) defined impairment in counseling students as: "any emotional, physical, or educational condition that interferes with the quality of one's professional performance" (p. 155). Each of these definitions attempted to expand and contextualize the definition of impairment more broadly by describing a professional with diminished ability and added possible causes of impairment. This second set of definitions demonstrated an

understanding of the complexity of impairment indicated by the attempt to provide various causes of impairment. However, none of these definitions has wide acceptance.

It seemed this last category of definitions might have been generated in an effort to further define the complexity of defining impairment. The following set of definitions attempted to provide themes or categories that impairment can represent. A frequently referenced categorical system of impairment came from Bissell (1983) who categorized impaired physicians as (a) incompetent, (b) unethical, or (c) impaired. Bissell might have attempted to clarify the various gradations of practitioner impairment resulting in diminished functioning. Another author who attempted to classify problematic behaviors in psychotherapists was Sherman (1996) who presented three categories of impairment: (a) substance abuse issues, (b) client-therapist sexual violations, and (c) personal mental health issues. Gizara and Forrest (2004) conducted a study on supervisors who had experience working with impaired psychologist trainees and the results created a definition signifying three common themes: (a) impaired supervisees were harmful to clients or lacking in skill, (b) concerning actions became a pattern, and (c) behavior did not change. Lamb et al. (1987) added a categorical definition of impairment focusing specifically on counselors-in-training:

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

These thematic definitions of impairment attempted to categorize impaired counselors' behavior, which provided supervisors and counselor educators with important

indicators of impaired behavior. However, the variation of these definitions along with the plethora of other existing definitions created confusion and a lack of clarity of what impairment really is and how it manifests. Thus, within the literature, impairment seemed to be used as an umbrella construct to represent a magnitude of issues, behaviors, and processes experienced by a student that might prohibit his or her ability to provide quality counseling. Utilizing the term impairment might draw attention to the counselor's personality or issues underlying problematic behavior rather than his or her professional conduct concerning his or her counseling skills, knowledge, or values (Falender et al., 2009). In an attempt to be inclusive, the definition of impairment seemed to have lost its definitional boundaries and thus has created confusion and increased the complexity of dealing with the issue.

The Problem with Multiple Definitions

Although the competing definitions have overlapping qualities, the existence of multiple definitions is problematic for counselor educators. Having numerous definitions of impairment not only created confusion when understanding impairment (Sherman, 1996), it also created difficulty for faculty members and students in identifying impaired individuals and implementing appropriate remedial actions (Bradey & Post, 1991; Elman & Forrest, 2007; Huprich & Rudd, 2004; Li et al., 2007; Schwartz-Mette, 2011). Competing definitions creates trouble for faculty because it might cloud or impede the identification and remediation of impaired students. Varying definitions of impairment is an issue for students because evaluation standards, which assess their scholastic and counseling abilities, might not be clear. Diminished functioning and a reduction in effectiveness might arise from a number of sources such as current personal stress, not

yet attained development, and/or an inability or unwillingness to learn necessary skills (Gizara & Forrest, 2004). With conflicting definitions of impairment, counselor educators might experience confusion when evaluating and remediating impairment (Elman & Forrest, 2007; Schwartz-Mette, 2011), might under-identify potentially harmful student behaviors/dispositions, or over-identify idiosyncratic but not harmful behaviors/dispositions. The presence of multiple conflicting definitions produces difficulty in establishing a uniform standard from which to evaluate students (Bemak et al., 1999; Schwartz-Mette, 2011). Without consensus or an empirically derived process to indicate behavioral and process markers of impairment, arriving at an agreed upon protocol for review and retention has been problematic. If confusion and difficulty exist regarding the identification and remediation of impaired counselors, the ultimate concern is the quality of care the public is receiving.

Bradey and Post (1991) surveyed master's-level counseling programs about their screening procedures for impaired students. The results indicated that only 65% of the programs had ongoing screening protocols--some formal and others informal. When it came to due process and dismissal procedures of impaired students, even fewer programs had protocols in place. For example, Forrest et al. (1999) highlighted a review of studies reporting counseling programs with due process procedures and indicated programs varied greatly from 24% in one study (Boxley et al., 1986) to 62% in another (Biaggio et al., 1983). Perhaps many counseling programs did not have formal evaluation and or due process procedures because of the difficulty defining and identifying impairment with any degree of reliability. These findings were surprising considering the frequency of

impairment in counseling programs (e.g., Forrest et al., 1999; Olkin & Gaughen, 1991) and the extensive time spent dealing with impaired students (Olkin & Gaughen, 1991).

In the absence of an agreed upon definition of impairment, counselor educators might more often use subjective evaluations to identify impairment (Procidano et al., 1995), often resulting in inaccuracies. Bennett (1986) suggested faculty reluctance to dismiss an impaired counseling student might be due to the difficulty proving student impairment when the individual earns high academic marks. A clearer definition might create a more concrete evaluation system to monitor nonacademic indicators of impairment. Forrest et al. (1999) suggested the need for differentiation between incompetent, unethical, and impaired counselors in order to develop accurate evaluations, appropriate remediation plans, and concrete reasons to dismiss impaired students.

In addition to issues with faculty identifying impaired students, the lack of a shared understanding of impairment could also cause confusion for peers of impaired students who could potentially assist faculty in identifying impairment (Elman & Forrest, 2007). Students spend extended amounts of time interacting with one another so this peer interaction could provide additional opportunities to detect student impairment. However, without a clear understanding of impairment, students might feel insufficient in their evaluative ability, thus refraining from reporting concerning peer behavior.

Why the Definitions Have Changed Over Time

In 1981, when the American Psychological Association (2006) created the advisory committee on impaired psychologists, the impairment construct was predominantly used. At that time, *impairment* reflected practitioners' substance abuse issues that affected their work with clients (APA, 2006; Elman & Forrest, 2007). As

APA's advisory committee continued working with practitioner impairment, they began to understand impairment could reflect a range of other factors in addition to substance abuse. The advisory committee then broadened the impairment construct to also include other, more encompassing behavioral issues such as incompetence, diminished professional functioning, violations of ethics, and personal distress (Forrest et al., 1999).

The construct has undergone changes within counselor education as well. Impairment is frequently used in the counseling and psychology literature to define troubled or struggling counseling students; yet, much of the literature discussed reasons to no longer use this construct (Schwartz-Mette, 2011). Falender et al. (2009) warned the usage of impairment to communicate competence issues could be problematic because the term is vague and does not concretely signify what is concerning. Despite the overall consensus to use alternative verbiage for problematic behavior, *impairment* is most frequently used within the literature (Forrest et al., 1999; Schwartz-Mette, 2011; Wilkerson, 2006) perhaps due to the lack of an alternative option. As a result, many definitions have been created in attempts to identify various types of behaviors and issues (Sherman, 1996). Yet without a systematic investigation, these attempts have resulted in confusing, competing, and incomplete definitions.

One reason so many definitions exist might be due to multiple etiologies of impairment. Because so many behaviors can reflect impairment, identification of an impaired individual is often centered on subjective evaluations (Sherman, 1996) of students or practitioners based on discrepancies between their behaviors and standards of practice. What constitutes impairment to one professional might not be considered impairment by another regarding the nature, degree, or intensity. Assessing impairment

becomes subjective in nature not only because being a successful counselor-in-training requires appropriate functioning in both academic and interpersonal domains but also due to the lack of agreement on the construct (Sherman, 1996).

American with Disabilities Act

Perhaps the most important reason *impairment* might not be an appropriate term is because, as it is used in the mental health literature, it overlaps with its use in the American with Disabilities Act (ADA, 1990; Elman & Forrest, 2007). As cited in Elman and Forrest (2007), the use of the construct impairment might cause legal issues when considering the ADA defines a disability as "a physical or mental impairment that substantially limits one or more major life activities" (p. 501); the ADA guards against individuals with disabilities to be discriminated against and requires accommodations be made by the individual's employer (Falender, Collins, & Shafranske, 2005). Elman and Forrest (2007) warned that the term impairment could become a legal issue. If impairment is used to describe issues with counseling abilities and the individual actually has a disability covered under ADA and has not disclosed this information to their supervisor, it is illegal for the supervisor to discuss the issue of impairment with the individual. The ADA prohibits discrimination of an individual that is either reality or even a perceived disability or impairment (Falender et al., 2005, 2009). Thus, utilizing the term impairment creates possible legal issues and potential protection from the ADA. Individuals who have informed their program or supervisor about their disability are entitled to reasonable accommodations as long as their disability does not prohibit "essential functions of the profession" (Elman et al., 1999, p. 714). In addition, Falender et al. (2009) cautioned using impairment can imply disability, thus shifting focus away

from specific areas of deficiencies related to program requirements. Such broad labeling of student behavior might shift supervisors' focus to one of diagnosis of the issue rather than remediating deficiencies (Falender et al., 2009). Li et al. (2007) suggested the term impairment should not be used loosely by counselor education faculty members because of the severity and multiple meanings of the term. It is curious, however, that this term is the most frequently used word to describe students with personal or clinical deficiencies.

Used as a Catch-All

There are many reasons why using the impairment construct has become problematic (Elman & Forrest, 2007; Sherman, 1996). One reason might be the difficulty in defining impairment. This difficulty is reflected in the existence of many definitions and behavioral indicators encompassing impairment. Attempting to define many types of issues has led to *impairment* being used as an umbrella term to indicate a plethora of possible issues (Forrest et al., 1999; Schwartz-Mette, 2011). These issues range from physical handicaps to incompetence (diminished competence or never achieved) to mental health issues and ethical concerns (Forrest et al., 1999; Schwartz-Mette, 2011; Sherman, 1996). Elman and Forrest (2007) implied the concern of using impairment as a catch-all word was that it "(a) merges description of behavior with character and (b) co-mingles descriptions of behavior with causes of the behavior, thus making it difficult to distinguish whether the behavior is incompetent, diminished, unethical, or even illegal" (p. 503). Thus, despite the overuse of *impairment,* the catch-all nature of this construct simply creates confusion within the field (Forrest et al., 1999).

Lack of Definitional Clarity

Another reason why the impairment construct has been criticized is because it has definitional issues (Elman & Forrest, 2007; Forrest et al., 1999). Forrest et al. (1999) suggested the definition lacks clarity and is not used consistently within the field. Elman and Forrest (2007) described how the construct impairment is used to indicate issues with professional behaviors and level of functioning as well as being used to refer to diagnosable disorders within the therapist. Schwartz-Mette (2011) viewed competency problems in two distinct categories: "legally defined disabilities" and "non-disability problems" (p. 432). The latter could represent a plethora of issues including personal problems, situational problems, developmental problems, behavioral problems, and psychological problems (Schwartz-Mette, 2011). Forrest et al. (1999) recognized the multiple types of problem behaviors that are often included under the broad construct of impairment and suggested this indicates there is more need for additional literature on the subject to clarify the confusion.

Inability to Reach a Workable Definition

The definition of impairment has gone through multiple permutations. The literature suggested the fields of psychology and counseling have long struggled with defining impairment and currently do not have an agreed upon definition (Huprich & Rudd, 2004; Laliotis & Grayson, 1985; Wilkerson, 2006). The extent of this struggle indicates defining student/practitioner impairment is a difficult undertaking (Li et al., 2009). Some reasons why agreeing on a definition is so difficult is because (a) there are many different types of impairment (Bradey & Post, 1991; Sherman, 1996), (b)

evaluating impairment is highly subjective (Sherman, 1996), and (c) the human experience is vastly complex and unique (Smith & Moss, 2009).

A review of the medical, psychology and counseling literature demonstrated countless forms of impairment. Impairment has been identified as substance abuse (APA, 2006; Emerson & Markos, 1996; Forrest et al., 1999; Kempthorne, 1979; Laliotis & Grayson, 1985; Orr, 1997; Sherman, 1996), sexual misconduct (Emerson & Markos, 1996; Li et al., 2009; Sherman, 1996), boundary violations (Li et al., 2009), other unethical behaviors (APA, 2006; Bissell, 1983; Forrest et al., 1999; Li et al., 2009; Orr, 1997), burnout/personal stress (Bemak et al., 1999; Emerson & Markos, 1996; Forrest et al., 1999; Laliotis & Grayson, 1985; Lamb et al., 1987; Stadler et al., 1988), emotional problems (Duba et al., 2010; Emerson & Markos, 1996; Kempthorn, 1979; Laliotis & Grayson, 1985; Lamb et al., 1987; Orr, 1997; Sherman, 1996), issues with professional competence (Bemak et al., 1999; Bissell, 1983; Elman & Forrest, 2007; Lamb et al., 1987), issues with self-awareness (Elman & Forrest, 2007; Witmer & Young, 1996), physical conditions (Duba et al., 2010; Sheffield, 1998), and educational conditions (Duba et al., 2010). Existence of this wide range of behaviors suggests impairment creates difficulty in agreeing on a single definition. Such broad usage of *impairment* creates confusion for counselor educators when evaluating, identifying, and remediating impaired students (Schwartz-Mette, 2011).

Additionally, an agreed upon or empirically derived definition has yet to be established because evaluating impairment can be highly subjective. For example, more concrete, identifiable behaviors such as substance abuse, clear psychotic disturbances, and violations of ethical codes could be objectively and clearly evaluated as impairment

(Laliotis & Grayson, 1985). However, many indicators of an impaired counselor are less concrete, thus subjectively evaluated. Sherman (1996) believed evaluators often differed in their perceptions of others' behaviors and competence, which made the evaluation process highly subjective in nature. In counseling programs, perceptions of impairment might vary considerably across faculty members (Greenwald, 1975). In addition to the subjective nature of evaluating impairment, counselor educators must evaluate multiple and intersecting domains of student development (i.e., academic, professional, interpersonal, etc.). Identification of academic difficulties is considerably less difficult and less subjective, whereas evaluating mental health or interpersonal issues is less concrete and becomes a matter of perception (Markert & Monke, 1990). Not only are there multiple types of impairment, each type of impairment has the potential to be evaluated differently depending on the evaluator.

Lastly, the human experience varies greatly, which only compounds the issue of creating an agreed upon definition of impairment. Variance in human experiences and culture makes it difficult to pinpoint a single definition considering the existence of wide ranges of issues and also varying degrees of frequency each issue might take (Forrest et al., 1999). This might be a reason why professionals in the field have long struggled to agree on a definition of impairment. Perhaps many existing definitions are stated too rigidly and do not allow consideration for such complex and unique human experiences (Smith & Moss, 2009). Each of these reasons might partially explain why an agreed upon definition of impairment is yet to exist.

Relevance of Defining Impairment in Counselor Education

This study utilized medical, psychology, and counseling literature as a basis for an understanding of the history and current state of the impairment construct. It is clear impairment has been an ongoing issue within these helping fields and yet intervening with impairment remains a difficult, time consuming, and inconsistent task (Kaslow et al., 2007; Olkin & Gaughen, 1991; Vacha-Haase et al., 2004; Wilkerson, 2006). A plethora of literature discussed the importance of clarifying the definition of impairment as the first step to more effectively identify and remediate the issue (Bissell, 1983; Forrest et al., 2009; Huprich & Rudd, 2004; Kaslow et al., 2007; Li et al., 2009; Schwartz-Mette, 2011; Smith & Moss, 2009; Stadler et al., 1988). Although impairment exists in professional practice as well as academic programs, this study concentrated efforts on clarifying the definitional boundaries of impairment in all its forms within counselor education programs. In counseling programs, students, by definition, are at a development level that naturally requires increased levels of observation, greater accountability, and additional supervision. With this magnified focus on students' abilities, skills, behaviors, and competence, problematic behaviors might be identified and addressed earlier than individuals already practicing independently who are believed to require lower levels of supervision.

However, the ability to more effectively identify problematic behaviors cannot exist until a clarified definition of impairment exists. Progress toward definitional clarity and behavioral indicators of potentially impaired students would allow counselor educators (a) to have a better understanding of impairment and all of its forms (Elman & Forrest, 2007), (b) to clearly communicate program expectations and guidelines to

students (Li et al., 2007), (c) to more formally and effectively evaluate students (Huprich & Rudd, 2004; Li et al., 2007), (d) to more efficiently and effectively identify problematic students (Elman & Forrest, 2007; Li et al., 2007), and (e) to be preventative in addressing and managing problematic behaviors with specific, concrete remediation plans (Elman & Forrest, 2007; Elman et al., 1999; Huprich & Rudd, 2004; Li et al., 2007; Schwartz-Mette, 2009, 2011).

CHAPTER III

METHODOLOGY AND RESEARCH PROCEDURES

The purpose of this research study was to increase clarity concerning the term *impairment*, to identify markers indicating essential descriptors of student impairment, and determine and refine the degree of agreement by a panel of experts through an empirically derived and recursive process. This chapter highlights the methods and procedures used. This chapter begins with an overview of the Delphi method and follows with the recruitment criteria and strategies to gain participants, survey rounds, data collection, and data analysis procedures.

The Delphi method is a multi-round process that surveys experts with the intent of developing a group consensus or high level of agreement concerning a topic (Dalkey, 1969a; Okoli & Pawlowski, 2004) previously lacking consensus such as the lack of agreement on essential descriptors of impairment within the counseling field. The Delphi method was chosen for the current research project because this methodology allowed for a group communication process leading toward group consensus on a topic where little or no agreement previously existed (Dalkey, 1969b). The Delphi method allowed for a communication process among the expert panel concerning student impairment that identified areas of agreement regarding the essential descriptors of impairment, which led to a clarified understanding of impairment. This process also created a spectrum or

categories of impairment, allowing for the creation of a classification system, ultimately improving the identification and the remediation process of impaired counseling students.

The Delphi Method

History

The Delphi method was developed in the 1950s by Norman Dalkey, Olaf Helmer, Ted Gordon, and their associates at the Rand Corporation as a way to gather and organize opinions of experts about intricate problems (Hasson et al., 2000; Linstone & Turoff, 2011). Originally, the Delphi method was created to understand possible outcomes of nuclear warfare (Misiner, Watkins, & Ossege, 1994). The Rand Corporation also conducted a series of Delphi studies to determine the effectiveness of the approach (Landeta, 2006). The results from this series of tests demonstrated that Delphi studies (a) gather a vast amount of information, (b) contain multiple rounds where feedback is given to panelists from previous rounds, (c) allow a collective group response to become more precise and narrowed as rounds continue, and (d) allow for anonymity which creates a more accurate group consensus (Dalkey, 1969b).

In the 1960s, the Delphi method expanded beyond Rand Corporation use. The Delphi method became more popular and was recognized and utilized as an instrument that could assist decision making and aid in the assessment of difficult, multi-faceted social problems (Landeta, 2006). Over the years, researchers have used modified formats of the Delphi to fit specific situations or research needs (Keeney, Hasson, & McKenna, 2006; Proctor & Hunt, 1994). It is difficult to concretely indicate how each modified form of the Delphi differs from another because each form of the Delphi allows for a wide range of applications (Hasson & Keeney, 2011). For example, varying formats of

modified Delphi studies might include individual interviews, focus groups, or a first round solely researcher-developed (Hasson & Keeney, 2011). Modified Delphi procedures could also differ regarding key characteristics such as sampling approaches, number of rounds, criteria determining consensus, levels of anonymity, and/or types of feedback given to panelists (Hasson & Keeney, 2011).

The original Delphi study, however, was a classic Delphi that had the intent of gathering opinions and creating a group consensus (Hasson & Keeney, 2011). The first round of the classical Delphi was open-ended to elicit qualitative data from panelists to formulate feedback used in the development of successive round's questionnaires where panelists were asked to rate and rank their level of agreement on each item (Linstone & Turloff, 1975). Some other popular forms of the Delphi method were the argument or policy Delphi and the forecasting Delphi (Hasson & Keeney, 2011). The argument Delphi was modified to elicit opposing arguments from experts to better understand the issue and the underlying reasons for each opinion (Hasson & Keeney, 2011). This format was not intended to arrive at a group consensus or create decision-making policies; rather, this format used a group of experts to "present all the options and supporting evidence for his or her consideration" (Linstone & Turloff, 1975, p. 84).

The purpose of the forecasting Delphi was to utilize a panel of experts to predict a future event within a given topic or domain (Hasson & Keeney, 2011). For example, Liu (1988) used the forecasting Delphi to predict Hawaii tourism in the year 2000. The first round of this study provided panelists with a summary of statistics regarding Hawaii and tourism projections; panelists were asked to provide their opinions about the projections and whether or not they believed those projections could be reached by the year 2000.

The results provided a future forecast regarding the number and type of visitors to Hawaii.

Overall, the modified Delphi differs from the classical Delphi in that the first round is typically controlled by the researcher rather than by the panelists--the experts are asked to consider and evaluate researcher-selected data (Hasson & Keeney, 2011). For example, Froud et al. (2011) used a modified Delphi format to investigate "reporting outcomes of back pain trials" (p. 1068). The first round was modified by providing panelists with a summary of a recent qualitative study regarding clinicians' views "on the reporting of back pain trials" and asking the panelists to answer questions about the reporting methods as well as the appropriateness of the study (p. 1069).

The above examples demonstrated the variety and range of applications modified Delphi studies can take. These examples were intended to provide the reader with an idea of how the Delphi method could be modified to fit individual researcher needs. By no means were the above examples representative of the particular modified format (e.g., forecasting Delphi). In other words, there might be multiple studies utilizing a forecasting Delphi but each might conduct their study in a different manner (i.e., number of rounds, open-ended vs. researcher-selected information, first round, etc.). There are wide ranges of variance in the way researchers choose to apply and design their Delphi study; therefore it is difficult to concretely identify key characteristics of each modified version (Hasson & Keeney, 2011). Each of the modified forms of the Delphi (i.e., discussed above) had a specific desired outcome (i.e., forecast the future, understand opposing arguments), yet the characteristics (e.g., number of rounds, data analysis, how

the researcher determines consensus, etc.) might vary widely depending on the research problem under investigation.

The various modifications of the Delphi method were created to target slightly different outcomes depending on the needs of the research project. Despite the modifications to the Delphi, this method continues to be used as an opinion gathering and consensus forming research tool (Landeta, 2006). The current study utilized a classical Delphi method because the goal of the study was to gather expert opinions in order to gain consensus regarding the essential descriptors of counselor impairment, which created a clarified and more empirically derived understanding of impairment. To develop an inclusive, non-biased list of essential descriptors, a classical Delphi format with an open-ended first round was necessary to acquire panelists' opinions and to diminish the risk of panelist foreclosing on a researcher-generated list.

Purpose of a Delphi Study

There are two main reasons one might utilize the Delphi method for conducting research: (a) when there is incomplete knowledge concerning the topic at hand (Dalkey, 1969b; Skulmoski, Hartman, & Krahn, 2007) and (b) when the research problem lends itself to group involvement and views from a collective experience (Hasson et al., 2000; Linstone & Turloff, 1975; West, 2011). The Delphi method is an effective research tool when the problem lacks exact knowledge within the literature because this method can assist researchers in exploring what does not exist by creating a process where a group of experts funnel their knowledge into a collective consensus (Skulmoski et al., 2007).

Some might argue that many other research methodologies are effective in examining what is not yet known (Hasson et al., 2000); however, Hasson et al. (2000)

recommended use of this method when the research questions are best answered by subjective judgments from a group of experts. For example, some research problems cannot be answered by quantitative techniques because those methods lack descriptive information (Hasson et al., 2000). On the other hand, some research problems cannot be answered by purely qualitative approaches because traditional qualitative techniques do not typically result in a group consensus (Hasson et al., 2000). The Delphi method has the ability to take a group's collective intelligence concerning the issue under investigation and through successive rounds of inquiry refine expert opinions and knowledge to inform decision-making, theory, and practice (Linstone & Turloff, 1975; Skulmoski et al., 2007).

This group communication process is effective because it utilizes the age-old adage of "two heads are better than one" (Dalkey, 1969b, p. 408). A group of experts will reach a "better" result than an individual would on their own (Linstone & Turloff, 2011, p. 1713) due to a synthesis of multiple perspectives, thereby reducing the potential for individual bias. Although most research utilizes a group of participants greater than one, the Delphi method allows group communication through an anonymous process where panelists present their opinions and are provided with feedback concerning the group's current opinion on the subject (Dalkey, 1969b). This process allows experts to provide their viewpoint and also understand the collective view to potentially reconsider their initial standpoint, ultimately leading to group agreement (Hasson et al., 2000). A group consensus or agreement from a panel of experts would not be achieved with another research approach (Hasson et al., 2000). Thus, the results from the Delphi method answer research questions that are otherwise difficult to quantify (Helmer, 1983).

Delphi Study Strengths

The Delphi method has multiple strengths and is often chosen as research methodology because it provides (a) flexibility, (b) anonymity, (c) feedback to panelists, (d) multiple rounds, and (e) expert consensus. Flexibility is one reason many researchers find the Delphi approach appealing (Hasson et al., 2000). As indicated above, the Delphi literature did not suggest a one-size-fits-all protocol of Delphi studies. Because multiple forms of the Delphi method exist, researchers design their Delphi study to fit with the research questions (Davis, 1997).

An important strength of the Delphi method is the anonymity between panelists (Vazquez-Ramos, Leahy, & Hernandez, 2007; West, 2011). Anonymity is important in a Delphi study because panelists can provide their opinions and do so in a non-adversarial way (Hasson et al., 2000). Often, within group settings, dominant personalities might influence other members' opinions and responses. In Delphi studies, however, anonymity might reduce confrontations (Vazquez-Ramos et al., 2007) and decrease the phenomena of 'jumping on the band wagon' (Skulmoski et al., 2007). A sub-strength of anonymity is the advantage of location. Survey methodology such as the Delphi allows the researcher to select experts from a wide range of geographic locations (Ziglio, 1996). Diverse groups of experts can participate and form a group consensus without having to physically gather (Hasson et al., 2000; Ziglio, 1996).

In addition, the Delphi method goes beyond a simple one-time or point-in-time survey method as it utilizes multiple rounds of questionnaires and also provides feedback on each round regarding the group's collective opinion. Several rounds of surveys allow the researcher to organize and refine the group's opinions as well as provide the panelists

time to reflect on their initial opinion (Ziglio, 1996). In each round, the researcher provides feedback to panelists concerning the current state of the group's collective opinion. This process offers panelists an opportunity to read and consider the collective opinions of the group (West, 2011; Ziglio, 1996) and potentially reconsider their initial opinions. This process ultimately leads to group consensus (Hasson et al., 2000).

The Delphi method is often used to investigate gaps in the literature or issues involving contradictory information (Dalkey, 1969a; Hasson et al., 2000). The Delphi permits experts to unite their knowledge and opinions; with the assistance of the researcher, the group communication process can synchronize knowledge to make decisions and create theory (Dalkey, 1969a). Whereas the Delphi method provides a structured and systematic technique to create group consensus, expert consensus might not be reached with other methodology other than a subjective approach (Reid, 1988).

Delphi Study Limitations

Although the Delphi method has multiple strengths, it is not without its limitations: (a) minimal guidance and direction in the literature demonstrating how to conduct a Delphi study; (b) requires considerable time to complete and produces a plethora of information, thus leading to potential researcher fatigue and low participant response rate; (c) the method is criticized for forcing consensus among group members; and (d) potential investigator bias and issues with reliability and validity.

Landeta (2006) warned researchers about utilizing the Delphi without the necessary knowledge concerning the method and stated a potential downfall in doing so was disappointment in the results. Despite this caution, the literature lacked direction informing researchers how best to conduct Delphi research (West, 2011). For example,

researchers were not provided with advice about (a) how to determine an *expert* for the study (Hasson & Keeney, 2011; Linstone & Turloff, 1975), (b) designing surveys (Hasson et al., 2000), (c) organizing expert responses (Hasson & Keeney, 2011), (d) analyzing data (Hasson et al., 2000; Keeney et al., 2001), and (e) defining and determining a threshold for group consensus (Graham, Regehr, & Wright, 2003; Hasson et al., 2000; Keeney et al., 2001).

Another aspect of the Delphi method often considered a limitation is this method creates a plethora of information and takes considerable time on the part of the researcher and expert panelists. Typical Delphi studies consist of two to four rounds of surveys varying in length (Procter & Hunt, 1994), which requires panelists to commit a sizeable amount of time participating in the study (Adler & Ziglio, 1996). As successive rounds ensue, response rates from panelists typically begin to suffer, especially in the final rounds of the study (Keeney et al., 2001; Skulmoski et al., 2007). In addition to large time commitments required of panelists, the Delphi method also requires significant time on the part of the researcher. An open-ended first round that collects massive amounts of qualitative data ultimately leads to time-consuming qualitative data analysis (Skulmoski et al., 2007).

A defining characteristic and arguably a strength of the Delphi method is consensus-forming results. However, forming consensus has also been noted as a limitation of the Delphi because some believe this method might force the group of experts to agree on a final consensus without an opportunity to fully discuss the problem at hand (Hasson et al., 2000). In addition, regression toward the mean could suggest once panelists were provided with feedback from a previous round, they might reconsider their

answers to better fit the overall view of the group (Vazquez-Ramos et al., 2007). Thus, it has been criticized that acquiring a true group consensus might not be realistic. Rather, the data might be a result of the group-think phenomenon instead of true consensus. Hasson and Keeney (2011) suggested the results might be more accurately labeled as expert opinion for the current group of panelists rather than true consensus.

The Delphi method is also criticized for the potential of researcher bias. Information provided to the panelists is partially controlled by the researcher (Pill, 1971). The results might then be subject to the researcher's biases, which might potentially create distorted findings (Graham et al., 2003; Pill, 1971). Thus, if the researcher does not attempt to manage his or her biases, the group consensus might develop through a limited scope of understanding (Graham et al., 2003). One way to decrease researcher bias is to allow for an open initial round where panelists are generating information to be judged in previous rounds (Okoli & Pawlowski, 2004). An added concern of the Delphi method is the validity and reliability of the findings (Hasson & Keeney, 2011). Although this method might create unique results not available from other methodologies, Dalkey and Helmer (1963) admitted difficulty in verifying the accuracy and consistency of the Delphi results.

Measures of Rigor

Reliability

As cited in Hasson and Keeney (2011), reliability refers to the consistency of achieving similar results with the same measurement. In the case of a Delphi study, reliability would be demonstrated as acquiring similar results if the same study was conducted using two separate panels of experts. The Delphi literature consisted of

opposing beliefs about the Delphi method's reliability. For example, many authors stated no current evidence to suggest the Delphi method is capable of reliability (Dalkey, 1969b; Hasson & Keeney, 2011; Keeney et al., 2001). The concerns regarding reliability question (a) whether two separate panels would arrive at similar results if they were given the same questionnaires and (b) if two different researchers conducting the same Delphi study would arrive at similar results (Dalkey, 1969a).

However, Ziglio (1996) stated the opposite and claimed the Delphi method might actually demonstrate reliability because of the use of expert-derived consensus. Some argued the Delphi method demonstrated reliability because this method utilizes experts to acquire information for the results (Baker, Lovell, & Harris, 2006), which suggested expert opinion was more reliable than randomly choosing participants because experts are often defined as having high levels of knowledge in their domain. The assertion was also made that group consensus is more reliable than a single person's knowledge and opinions on any given topic (Dalkey, 1969a).

If this assertion is accurate, increased group size would also contribute to increased reliability (Ziglio, 1996). In fact, Dalkey's (1969a) article discussing the results from the studies the Rand Corporation conducted on the Delphi method indicated that when group sizes increased, the reliability of the group's overall responses increased. However, Woudenberg (1991) contradicted this point by stating a larger group only leads to increased dissimilarity among panelist responses, thus reducing the reliability of the results. Wide variations might very well exist among a panel of experts; however, the combination of the expert panel and the group communication process is thought to

eventually lead to group consensus, which may ultimately enhance reliability (Ziglio, 1996).

Validity

As cited in Hasson and Keeney (2011), research validity refers to the accuracy of the study's findings. One argument supporting the validity of the Delphi method is if expert panelists are representative of the knowledgebase on the issue at hand, the researcher can believe content validity exists (Reid, 1988). Similar to reliability, expert-group opinion maintains more validity than simply acquiring a single person's opinion (Reid, 1988). The classical Delphi method demonstrates validity through the open nature of the first round. If panelists are free to respond with limited constraints to generate the parameters they will then judge in subsequent rounds, researcher bias might be reduced and, in turn, increase the validity of the findings (Okoli & Pawlowski, 2004; Reid, 1988). There are, however, multiple threats to validity of the Delphi method due to the low response rates as rounds continue, low accountability of panelist responses, and the potential for panelists' views influencing one another (Simoens, 2006).

Qualitative Measures of Rigor

The Delphi method shares characteristics of both qualitative and quantitative ideas (Hasson & Keeney, 2011). From a quantitative approach, there are many criticisms concerning the validity and reliability of the Delphi method. Yet, many of these criticisms might be resolved from a qualitative lens (Keeney et al., 2001). Evaluating the Delphi study for credibility, dependability, confirmability, and transferability might be more appropriate standards of rigor or trustworthiness (Keeney et al., 2001).

Trustworthiness of a qualitative study is comprised of the study's credibility, dependability, confirmability, and transferability (Cornick, 2006). Credibility is the believability of the study's results (Cornick, 2006). Keeney et al. (2001) suggested with the existence of multiple modifications of the Delphi study, there is a potential threat to the credibility of the Delphi. However, to increase the credibility of a Delphi study, the researcher must effectively identify and use the highest possible level experts on the topic at hand (Baker et al., 2006). In addition, credibility increases with the use of multiple rounds that include feedback to panelists (Engles & Kennedy, 2007). This increases credibility because the final consensus has been fully considered by each participant. Dependability refers to the strength of the results and whether those results could be found again using the same study and information (Cornick, 2006). The Delphi literature suggested the dependability of the Delphi method is not currently known. However, Cornick (2006) believed it might be enhanced by using a representative set of experts.

Confirmability suggests the researcher(s) have remained objective throughout their study (Cornick, 2006). This can be achieved by maintaining a written record of steps taken to conduct the Delphi study or an audit trail (Cornick, 2006). Last, transferability is the capability of the findings to be generalized to other settings (Cornick, 2006). Although generalizability is not the purpose of qualitative research (Creswell, 2007), the ability to transfer results might be increased by including participants who share similar traits and backgrounds (Cornick, 2006) such as a panel of counselor educator and psychology faculty members teaching in counselor education programs who frequently encounter student impairment. Therefore, the results might be useful to other individuals with the same characteristics.

Finding a Sample of Experts

Identifying an expert panel is the first step in a Delphi study (Keeney et al., 2001). This step is vital because poor selection of experts is often a cause for methodological problems (Keeney et al., 2001). The Delphi method utilizes a group of experts to "formulate factual judgments" (Dalkey, 1969b, p. 411). Therefore, this group of experts should consist of individuals who display expertise and deep knowledge concerning the issue under investigation (Davis, 1997; Hasson et al., 2000). However, there is much debate regarding what constitutes an *expert* and how to determine the minimum standards for inclusion in a Delphi study (Hasson et al., 2000; Keeney et al., 2001).

Many authors established potential criteria to identify experts in their Delphi studies (Adler & Ziglio, 1996; Graham et al., 2003; Henderson & Dufrene, 2011; Wester & Borders, 2014). Adler and Ziglio (1996) reported four criteria that would identify an expert for their social policy and public health study: (a) expertise and knowledge in the subject, (b) ability and desire to contribute, (c) ample time to participate, and (d) communicative ability. In the Graham et al. (2003) article studying epidemiology, the authors suggested researchers identify experts by ensuring they are either leaders at a national organization level within the field or they have more than one publication on the issue.

More specifically to the counseling field, Henderson and Dufrene (2011) conducted a Delphi study on emerging ethical issues in counseling and provided criteria for selecting the expert panel for their study. This list of requirements included individuals who (a) took part on a ACA Ethical Code revision board, (b) served as chair of the ACA Ethics Committee, or (c) published an ethics textbook or had a record of

publications in the field. Last, Wester and Borders (2014) attempted to acquire a comprehensive set of researcher competencies for the field of counseling. For their study, they identified experts as individuals who

> had conducted research using qualitative and quantitative methodologies; who had knowledge of data analysis, methodology, and instrument development and assessment; and selected panelists who varied in their concentration, including foci on clinical mental health, school, college, and couple and family concentrations. (Wester & Borders, 2014, Abstract)

In addition to the various criteria reported as requirements of experts within the Delphi literature, Anders Ericsson and his colleagues (Ericsson, Charness, Feltovich, & Hoffman, 2006; Ericsson & Kintsch, 1995; Ericsson, Krampe, & Tesch-Romer, 1993; Ericsson, Roring, & Nandagopal, 2007) conducted extensive research on the factors contributing to the development of expertise. Their findings suggested the following factors consistently identified an expert in any given domain: (a) domain-specific talent, (b) deep knowledge in the field, (c) persistence, (d) motivation and passion, (e) adequate memory, and (f) intelligence. Although defining and identifying what characteristics constitute an expert for inclusion in a Delphi study is ambiguous and often an area of criticism, the above criteria of expertise aided in the decision-making concerning the present study's selection of experts.

Participants

For a Delphi method, between 10-18 expert panelists are recommended to achieve sufficient results (Okoli & Pawlowski, 2004; Skulmoski et al., 2007). Skulmoski et al. (2007) reviewed 14 published Delphi studies where the number of panelists ranged from 4-171 participants with a median of 12 participants. Considering the above information, for this study, I maintained a minimum threshold of 15 panelists and attempted to recruit

18-30 participants to anticipate for attrition. The final number of participants was determined by how many individuals met the criteria of an expert for my study and how many of those individuals agreed to participate.

Criteria for determining an expert for this study were consistent with previous Delphi studies that included individuals with deep knowledge, capacity to communicate, and experience with the domain (Adler & Ziglio, 1996; Davis, 1997; Hasson et al., 2000). Panelists for this study consisted of counselor education and psychology faculty members from master's and doctoral counseling and psychology programs across the nation. Further, *experts* were determined by at least one or more of the following: (a) a faculty member with one or more professional juried publications on impairment, (b) a faculty member who has been involved in the review and remediation of at least two counselors-in-training due to impairment reasons, (c) committee members from either the ACA task force or APA advisory committee, or (d) a faculty member who has been a part of and successful in litigation resulting from dismissing an impaired counseling student.

The Delphi method does not utilize a random sampling technique because of the intentional use of experts as panelists (Hasson et al., 2000). Rather, this technique operates from a non-probability sampling procedure where each participant is selected specifically for their knowledge and expertise on the subject under investigation (Hasson et al., 2000). Therefore, it is not assumed that the sample of panelists is representative of any population (Hasson et al., 2000; Keeney et al., 2001; Okoli & Pawlowski, 2004). For the current study, I created a list of potential panelists from three sources: (a) authors of impairment literature identified from an extensive literature search, (b) a review of relevant court cases to identify faculty members who had been involved and successful in

litigation resulting from student dismissal, (c) members of the ACA task force committee and the APA advisory committee, and (d) utilization of snowball sampling (Creswell, 2007). Faculty members from the same counseling program could be independently invited to participate in this study due to their involvement in a remediation case. After compiling a list of potential expert panelists, I individually contacted each faculty member by e-mail, described in more detail below.

Procedures

Prior to beginning my study, I piloted the process with counselor education doctoral students for readability of round one questions (see Appendix A) and to test my data collection and organizational processes. I recruited five counselor education and supervision doctoral students from the University of Northern Colorado student listserv. The pilot study generated ideas regarding necessary changes to the study's round one questions, procedures, and protocol prior to administering questionnaires to the expert panel. Specifically, this pilot process asked participants to indicate unclear questions, which were adjusted prior to administering the questions with the panel of experts. The pilot also provided an opportunity to organize and analyze the large amount of data returned from round one.

After Institutional Review Board (IRB) approval (see Appendix B) was granted, I recruited potential participants for my study via two methods: an e-mail invitation to specific individuals who met the criteria for inclusion (i.e., 92 individuals) and a snowball sampling procedure of participants who agreed to participate in my study. The initial email consisted of a brief description of the topic and purpose of my study, the procedures of the Delphi method, approximate amount of time required to participate,

and the informed consent (see Appendix C). After a participant consented to participation and returned a signed informed consent, a link to the first round survey was emailed.

The first round questions were refined and guided by the APA competency benchmarks in professional psychology (Fouad et al., 2009). The APA competency benchmarks discussed expected skill and knowledge necessary for competence at both the foundational (i.e., professionalism, relational, scientific) and functional levels (i.e., application, education, systems). This document addressed the multi-faceted nature and complexity of practitioner competency in both the foundational and functional domains, each broken down into smaller components. The APA benchmarks also considered the nuances of practitioner development by demonstrating how skills and knowledge in each category might present differently depending on the developmental level of the practitioner (i.e., readiness for practicum, readiness for internship, readiness for entry to practice). However, the APA competency benchmarks were cumbersome and the examples provided were vague and broadly stated (Fouad et al., 2009). This document focused on practitioner competence rather than practitioner impairment so it did not provide examples of problem behaviors individuals might experience at each developmental level. This document provided a theoretical framework for the development of the first round questions but could not stand alone as a helpful tool to identify and remediate impairment.

The first round consisted of asking the panelists open-ended questions: (a) create a list of student behaviors or characteristics (e.g., behavior, ethical, dispositional, attitudinal, and interpersonal attributes) inconsistent with an expected developmental

trajectory that would raise concerns related to their appropriateness or effectiveness and/or typically lead to student review and retention and possibly dismissal; (b) identify which behaviors or characteristics (e.g., behavior, ethical, dispositional, attitudinal, and interpersonal attributes) are remediable and which are non-remediable; (c) in what manner the above described elements differed from not yet acquired competence; and (d) given the dimensions provided (e.g., behavior, ethical, dispositional, attitudinal, and interpersonal attributes) what role did duration, persistence, and intensity of the concerning behavior play in your view of it being impairment? A complete list of the questions for the first round can be found in Appendix A.

Panelists were asked to list as many ideas as possible for each question and were invited to include explanations for their opinions or simply provide a list (Henderson & Dufrene, 2011). Once each participant completed and returned the round one questionnaire, I eliminated duplicate opinions and then organized the remainder into themes and categories using content analysis (Creswell, 2007; Okoli & Pawlowski, 2004; West, 2011). The themes and categories were returned to panelists in a second round questionnaire.

The second round of questionnaires (see Appendix D) was intended to narrow the information gathered in round one (Okoli & Pawlowski, 2004). Panelists were sent the list of the categories or themes derived from the initial round with the purpose of allowing the participants to verify the accuracy of my interpretation of the initial round's information and also begin to identify the most important factors and descriptors (Okoli & Pawlowski, 2004). I remained mindful of Elman and Forrest's (2007) caution about not merging the description of behavior with character or co-mingling descriptions of

behavior with causes of the behavior. Panelists were asked to review and rank each item in terms of their agreement utilizing a 7-point Likert scale (Vazquez-Ramos et al., 2007). Panelists were also invited to include commentary regarding their reasoning for the level of agreement as well as an opportunity to edit or add items to the list (Okoli & Pawlowski, 2004). Once panelists returned their questionnaires, descriptive statistics (mean, interquartile range [IQR]) were employed to analyze the data to create the third round questionnaire. A more detailed description of data analysis is provided below.

Similarly to the previous round, the third round questionnaire (see Appendix E) was developed from the results of round two (Hasson et al., 2000). Panelists received the list of themes and categories of the impairment descriptors, statistical information concerning the group's level of agreement on each item, and a copy of their individual responses (Vazquez-Ramos et al., 2007). After considering the group's responses, panelists then utilized a 7-point Likert scale (i.e., from s*trongly agree* to *strongly disagree*) to rate their level of agreement concerning each item from the previous round (Skulmoski et al., 2007). Once each panelist returned the questionnaire, descriptive statistics were utilized to analyze the data to determine if consensus among the group had been achieved (i.e., IQR <= 1). Linstone and Turoff (1975) stated three rounds were sufficient to reach consensus and any additional rounds typically provided insignificant changes in the level of consensus. For this study, I utilized a total of three rounds. I determined the necessary number of rounds by considering the development of consensus after each round (described in more detail below). I was continuously aware of the delicate balance between the number of rounds and panelist fatigue, potentially leading to

high dropout rates since it was suggested that Delphi researchers do not prolong the rounds unnecessarily due to the potential for panelist attrition (Hasson et al., 2000).

Data Analysis

Data analysis occurred between each round of questionnaires because the development of each survey depended on the data from the previous round (West, 2011). Data analysis following the first round in a classical Delphi study differs from subsequent rounds because the initial round is intended to brainstorm a topic that returns large amounts of qualitative data (Hasson et al., 2000). Therefore, data generated from the first questionnaire were analyzed using content analysis that included breaking down the data into smaller units of data or information, which were then assigned themes and categories to create groups of descriptions (Hasson et al., 2000). Because the first round returned a plethora of information, it was important to reduce the data to a manageable amount to create efficient questionnaires in subsequent rounds (Henderson & Dufrene, 2011). As stated above, in order to organize and refine panelists' opinions from the first round, identical responses were omitted (Okoli & Pawlowski, 2004) and then created into groups of similar items (Hasson et al., 2000). To develop the second questionnaire, I generated categories including smaller themes to make the data manageable for the panelists to review and reconsider. The list of categories and themes were returned to the panelists for further consideration in the second round (Okoli & Pawlowski, 2004).

In subsequent rounds, panelists indicated their level of agreement for each item utilizing a 7-point Likert scale. Therefore, the data analysis for rounds after the initial questionnaire included calculating (a) the means for each item and (b) interquartile ranges. These statistics were used to determine consensus and also as feedback presented

to panelists as information concerning the group's current opinion on the matter (Hasson et al., 2000). Each round returned the statistical data and a new questionnaire to the panelists for further consideration to attempt to reach consensus (Hasson et al., 2000).

Determining what constitutes group consensus is an ambiguous task and must be predetermined by the researcher because "a universally agreed proportion does not exist for the Delphi" (Hasson et al., 2000, p. 1011). Graham et al. (2003) reported consensus might be achieved when there is homogeneity or consistency among the panel of experts. This might be accomplished by developing statistical summaries for items on the questionnaire (Hasson et al., 2000). Various authors indicated multiple ways to determine the level of consensus by using statistical summaries (Graham et al., 2003; Hasson et al., 2000; Okoli & Pawlowski, 2004). Graham et al. and Okoli and Pawlowski (2004) both discussed statistical indexes they used to determine expert consensus. Graham et al. drew on the work of Bland and Altman (1997) who reported using Chronbach's alpha. In this process when expert responses become highly correlated, they are considered homogeneous and have reached consensus. Okoli and Pawlowski reported utilizing Kendall's *W* to determine consensus among experts. Kendall's *W* creates values for each item between 0 and 1 where 0.7 is considered a satisfactory agreement among experts on the item.

Another approach taken to determine consensus is utilizing agreement percentiles based on measures of central tendency. Hasson et al. (2000) determined their agreement percentage by reviewing other studies utilizing percentiles to determine group consensus with the Delphi approach. As cited in Hasson et al. (2000), McKenna (1994) determined consensus when agreement rates reached 51%, Sumison (1988) recommended utilizing a

70% agreement rate, and Green, Jones, Hughes, & Williams (1999) suggested an even higher 80% agreement rate among experts. After reviewing these suggested percentiles, Hasson et al. opted to utilize a 70% agreement rate to maintain the rigor of their study.

Yet other authors utilized measures of statistical dispersion to establish consensus. West (2011) used measures of standard deviation to determine levels of consensus. For example, items with a standard deviation of less than 1.5 were considered to have reached consensus. Whereas, Wester and Borders (2014) utilized medians and interquartile ranges (IQR) to indicate levels of agreement. In Wester and Borders' study, the smaller the IQR value the greater the level of agreement among experts. Considering the above information, the current study utilized the mean and IQR to determine when agreement had been reached. The mean was used to determine the midpoint of a frequency distribution and the IQR was used to identify consensus, indicate the middle 50% of the panelists' opinions, and to omit outliers. A smaller IQR value indicated less dispersion of expert responses, which implied high levels of agreement among the expert panelists. Consensus for the current study consisted of an IQR value of 1.0 or lower (Wester & Borders, 2014).

Reducing the number of impaired psychotherapists and counselors-in-training is a vital task to ensure the welfare of the clients served. This is a difficult undertaking considering there is no current agreed upon definition or characteristics of impairment that guide counselor educators' and supervisors' evaluation protocol. With a better understanding of what constitutes impairment, counselor educators can begin to develop sounder procedures for evaluating, identifying, and remediating problematic student

behavior. The results from this study provided such knowledge and direction for better intervening with impairment.

CHAPTER IV

RESULTS

This chapter presents the results from the current study. Using a Delphi study methodology, I sought to clarify the definitional boundaries and essential descriptors of counselor impairment by gathering experts' opinions and beliefs regarding the definition and characteristics of impaired counselors-in-training. Open coding was utilized for the qualitative portions of data analysis whereas median scores and interquartile ranges (IQR) provided medians to analyze the quantitative data to determine consensus (i.e., IQR $\leq$ 1). The results of the three rounds of data collection are reported within each primary structural category. The terms *expert panel*, *panel members*, and *panelists* are used interchangeably to describe the participants of this study as suggested by the Delphi study literature.

Panelists and Procedures

The expert panel was selected based on the criteria developed for this study: (a) a faculty member with one or more professional juried publications on impairment, (b) a faculty member who has been involved in the review and remediation of at least two counselors-in-training due to impairment reasons, (c) committee members from either the ACA task force or APA advisory committee, or (d) a faculty member who has been a part of and successful in litigation resulting from dismissing an impaired counseling student. The criteria revealed that nationwide 92 experts were eligible and invited to participate;

21 agreed to participate for a response rate of 22.8%. Eight of the 21 panelists dropped out during the first round, one panelist withdrew during round two, and one panelist withdrew during round three. Five of the 10 panelists who withdrew did so due to perceived time to compete multiple rounds of data collection. The other 5 of the 10 panelists failed to complete the questionnaire and did not respond after multiple reminders; therefore, it was assumed these panelists needed to withdraw from the study. The final expert panel was comprised of 12 counselor educators; four identified as male and seven identified as female.

Data were collected over a period of 12 weeks. Members of the expert panel took 29 days to respond to the first round of questions. The data collected were subjected to a content analysis, which included reducing the text into smaller units of (e.g., words, phrases, sentence fragments). The smaller units formed the basis of the categories of descriptions. Once assembled, the categories were organized and presented in the next round. Expert panel members completed the second round of inquiry in 22 days and the third and final round in 17 days. In the second and third rounds, members of the expert panel were asked to rate and rank order items derived from the first round on a given dimension (e.g., importance, relevance, agreement, etc.). Data analysis for both the second and third round data included calculating the medians and interquartile ranges (IQR) for each item. Interquartile ranges were computed using the Excel formula. This formula identified the first and third quartile to determine the difference between them, which accounted for outliers and identified the spread or dispersion among the expert panels' data.

These statistics were utilized to determine the level of consensus. Items with interquartile ranges of $\leq$ 1indicated consensus (i.e., limited variance in opinion). Items that reached consensus were noted and not included in subsequent rounds. Items with interquartile ranges > 1 indicated consensus was not reached; therefore, those items were incorporated in the subsequent round following minor modifications for clarity. For example, the expert panel was asked to what degree they believed various statements should be included in a definition of student impairment. The panel reached consensus, indicating that "personal and or professional behaviors that interfere with the student's ability to provide competent client care" should be included in a definition. However, no other element for this question achieved consensus. Therefore, in the following round, panelists were presented with the remaining statements (i.e., ordered by median scores highest to lowest from the previous round) and were asked to rate to what degree they believed the statements were in the correct order in terms of importance to the development of a definition of student impairment.

Alternatively, other questions with elements where panelists failed to reach consensus were asked in a different way. In these cases, either the interquartile ranges were relatively high or in reviewing the previous round question, the lack of consensus may have been a result of vague or poorly worded questions. For example, a series of questions asked the expert panel to consider a continuum of counselor impairment with anchors of severe/major, moderate, and mild problematic behaviors. The questions in this series asked panelists to rate their level of agreement that each element belonged on the designated continuum (i.e., severe/major, moderate, mild). While there was relatively high agreement (i.e., IQR $\leq$ 1) regarding the elements on the severe/major continuum

(i.e., 15 out of 23 items), there was extremely low consensus regarding the other two continua. For the moderate continuum, the expert panel only reached consensus on one item out of eight. For the mild continuum, the expert panel did not reach consensus on any item (i.e., 21 items total). Instead of asking this series of questions in the same fashion for the subsequent round, each problem behavior was individually listed and panelists were asked to determine if that trait or behavior should be categorized in the severe/major, moderate, mild category or if the trait or behavior did not indicate any impairment. By asking this series of questions in a different manner than the previous round, the expert panel was able to reach consensus on almost every item (i.e., reached consensus on 47 out of 52 traits and behaviors; see Appendix F).

The data were further reduced and focused through a process of synthesis including combining similar terms, removing previously agreed upon or irrelevant elements, and restructuring or refining items that had yet to reach consensus. However, upon the completion of the third and final round, 71 out of 174 items (i.e., 41%) lacked expert consensus. The results are examined further below by focusing on each primary structural category.

Personal Communication

During the recruitment stage of this study, I received numerous emails regarding potential panelists' concern about my use of the term impairment. Many individuals sent me multiple articles that highlighted the limitations of the term impairment. Each article had previously contributed to the literature review for the current study so I was aware of the limitations and concerns regarding the term impairment yet understood the

individuals' concerns. However, I chose to utilize the term impairment for this study for multiple reasons.

First, although many authors identified limitations of the term impairment within counselor education, this term continues to be used, perhaps because of its simplicity or because of the confusion and disagreement within the field regarding problematic student behaviors. For the current study, impairment served as a term that was familiar, identifiable, and less cumbersome than other potential terms. The main purpose for using the term impairment was to aid in the readability of the document. In addition, the central purpose of this study was to clarify the definitional boundaries and essential characteristics of impaired counseling students. As discussed in the literature review, the field currently lacks an agreed upon definition and deep understanding of the phenomenon. Therefore, I utilized the term most frequently used within the literature in order to create a communication process among experts on the topic with intentions of developing an agreed upon term that was more appropriate.

Despite providing explanations regarding my use of impairment for this study, two individuals stated they believed in the importance of my study but were unwilling to participate due to my use of the term impairment. Two individuals who shared similar concerns agreed to participate in my study regardless of my usage of the term impairment and indicated their desire to advocate for their beliefs on the issue.

Elements of a Definition of Student Impairment

Definitional Components

In the initial round, panelists provided individual definitions of counselor impairment. These statements were subjected to a content analysis and various terms and

sentence fragments (e.g., descriptors of counselor impairment) were categorized and presented in the second round. The sentence fragments were grouped according to similarity. A total of five definitional statements were presented to panelists in the second round. In the second round, the panelists rated to what degree they believed each item should be included in such a definition. The only element panelists reached consensus on was "personal and or professional behaviors that interfere with the student's ability to provide competent client care" (IQR =1.00; *Mdn* = 7.00). The remaining elements yielded relatively large interquartile ranges (IQR > 1.00), indicating low agreement or consensus regarding the inclusion of those elements in a definition (see Table 1).

Items on which panelists did not reach consensus were organized according to median scores, ordered from most important to least important, and presented to the expert panel in the third round. In the third round, panel members rated their level of agreement with the order of items described above. Similar to the second round, the third round results indicated high interquartile ranges (IQR > 1.00) suggesting low levels of agreement among the panel. At the conclusion of the final round, the expert panel agreed "personal and or professional behaviors that interfere with the student's ability to provide competent client care" was the most important element to include in a definition.

Table 1

Definitional Components from Round One and Median and Interquartile Ranges From Round Two

Definitional Components	Median	IQR
Personal and or professional behaviors that interfere with the student's ability to provide competent client care.	7.00	1.00*
Behavior that interferes with personal life.	2.00	2.00
Events or behaviors that compromise the student's previously acquired level of competence.	5.00	1.75
Student is simultaneously engaged in: concerning behaviors, displaying poor or limited insight related to these behaviors and an inability or unwillingness to change.	6.00	2.00
Inadequate or insufficient behaviors that are readily measured through academic (e.g., retention and integration of knowledge or skills) or clinical/performance measures.	5.50	3.00

*Note. * Reached consensus*

Individual Basis of the Definition

In the first round, the expert panel provided qualitative responses regarding the bases for their definition of counselor impairment. These responses were subjected to a content analysis, which generated five categories on which panelists based their definition of impairment (i.e., "experience," "professional literature," "theories", "consultation with colleagues," and "general criteria for personality disorders in the DSM-V"). In the second round, the panelists rank ordered the above elements in terms of their level of contribution to the definition of impairment. The panel reached consensus that "experience addressing the issue" (IQR= 1.00; *Mdn* = 1.00) contributed the most to

their definition of counselor impairment. The panel also reached consensus that "general criteria for personality disorders as described in the DSM-V" (IQR=1.00; *Mdn* = 6.00) was least influential in the basis of their definition of counselor impairment. At the conclusion of the study, the panel failed to reach consensus (IQR > 1.00) regarding the remaining items (i.e., "experience as a clinician," "professional literature," "theories," and "consultation with colleagues").

Problematic Behaviors

Potential problematic student behaviors that might contribute to student impairment clustered into five categories (i.e., problematic professional, relational, scientific-application, supervisory, and system-based behaviors), which were based off of the APA competency benchmarks (Fouad et al., 2009). In the current study, each category was examined separately to clarify the multifaceted aspect of problematic students in counselor education programs. Within each category, panel members were presented the following tasks for each item: (a) indicate to what degree you agree these behaviors are problematic (7-point Likert scale), (b) select the behaviors that are so significant or egregious they are unlikely to respond to remediation regardless of the quality or duration of the remediation, and (c) rank order the behaviors from most concerning to least concerning.

Problematic Professional Behaviors

Level of agreement. In round one, panel members were asked to identify problematic professional behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. A content analysis of the first round data yielded 15 problematic professional behaviors. These behaviors were included in the second round

where panel members indicated to what degree they believed the behaviors were problematic on a 7-point Likert scale. Ten out of 15 problematic professional behaviors demonstrated interquartile ranges less than 1, indicating consensus. Since panel members rated to what degree the behaviors were problematic on a 7-point Likert scale, items ranked between 5.6 and 7 indicated the panel agreed the behavior was problematic, items ranked between 2.6 and 5.5 were considered moderately problematic, and items ranked between 1 and 2.5 were considered not problematic. Of the 10 items that yielded interquartile ranges less than 1, nine of the behaviors had median scores ranging from 5.58 to 6.83, indicating the expert panel believed these to be problematic. However, one behavior (i.e., "lacks cognitive complexity necessary to demonstrate core skills and understanding") that reached consensus (IQR = 1.00) had a median of 5.00, indicating panelists agreed this behavior was moderately problematic. The remaining five items yielded interquartile ranges greater than 1; therefore, they were included in the third round for further consideration.

In the third round, panel members indicated to what degree they believed the remaining five professional behaviors were problematic. The results indicated panel members reached consensus on two of the five behaviors (i.e., "rigid and uninformed patterns of belief" and "unable or unwilling to examine the impact of one's behavior"). Both items had median scores above the determined threshold (i.e., *Mdn* = 6.00 and *Mdn* = 7.00, respectively), indicating panelists agreed each item was a problematic professional behavior (see Table 2).

Table 2

Problematic Professional Behaviors: Medians and Interquartile Ranges from Rounds Two and Three

Problematic Professional Behaviors	Round Two		Round Three	
	Median	IQR	Median	IQR
Desire to be something other than professional counselor.	7.00	0.00*	-	-
Unprofessional behavior (e.g., texting in class/clinic, consistently late, late paperwork, unprofessional social media).	7.00	0.00*	-	-
Imposition of prejudicial beliefs/values.	6.50	1.00*	-	-
Failure to follow ethical standards.	6.00	1.00*	-	-
Unable or unwilling to engage in appropriate self-care (e.g., personal counseling).	6.50	1.00*	-	-
Unable or unwilling to take the perspective of another.	6.00	1.00*	-	-
Psychological problems – personality disorders (e.g., patterns of lying, attention getting, addictive behavior, suicidal ideation/attempts).	6.00	1.00*	-	-
Lacks cognitive complexity necessary to demonstrate core skills and understanding.	5.00	1.00*	-	-
Inability to respond flexibly to complex and or unexpected supervisory or clinical situation.	7.00	1.00*	-	-
Deficits in decision-making.	6.50	1.00*	-	-
Rigid and uninformed patterns of belief.	5.00	2.00	6.00	1.00*
Unable or unwilling to examine the impact of one's behavior.	5.00	2.75	7.00	1.00*
Cultural incompetence	7.00	1.75	6.00	3.00
Behaviors of superiority (e.g., dogmatism, entitlement, above pitfalls of being human).	6.00	1.75	6.00	2.00
Lack of ego strength or helplessness.	6.00	1.75	5.00	2.00

Note. * Reached consensus
- Not included in next round

Unable to remediate. Within the category of problematic professional behaviors, panelists indicated behaviors so significant or egregious they were unlikely to respond to remediation regardless of the quality or duration of the remediation. The behaviors most frequently selected were (a) “imposition of prejudicial beliefs and or values” (chosen by 4 of 13 panelists), (b) “failure to follow ethical standards” (chosen by 4 of 13 panelists), (c) “unable or unwilling to engage in appropriate self-care” (personal counseling; chosen by 5 of 13 panelists), and (d) “inability to respond flexibly to complex and or unexpected supervisory or clinical situations” (chosen by 6 of 13 panelists). The results from this question identified the most frequently selected items, indicating which behaviors might be unlikely to respond to remediation regardless of training and remediation techniques.

Rank order. In the second round, panel members rank ordered the problematic professional behaviors from most concerning to least concerning. Members of the expert panel were unable to reach consensus as demonstrated by interquartile ranges that were greater than 1 (IQR = 2.00 to 9.00). In an attempt to reduce the number of behaviors presented in this question, the number of elements was reduced in the third round. This process consisted of identifying the 10 elements that yielded the lowest median scores from round two (i.e., indicating most concerning elements), which were then included in the third round where panel members were asked to indicate the five most concerning professional behaviors.

The five most problematic professional behaviors chosen most frequently were (a) “failure to follow ethical standards” (chosen by 11 of 12 panelists), (b) “imposition of prejudicial beliefs and or values” (chosen by 10 of 12 panelists), (c) “rigid and uninformed patterns of belief” (chosen by 10 of 12 panelists), (d) “behaviors of

superiority" (dogmatism, entitlement, above pitfalls of being human; chosen by 9 of 12 panelists), and (e) "cultural incompetence" (chosen by 6 of 12 panelists). Panelists were asked to provide rationale to support each choice, which indicated the panel believed (a) the behaviors were the most difficult for supervisory or experiential change, (b) the behaviors demonstrated incompetence due to impairment or mental conditions, (c) the behaviors demonstrated unethical issues and cultural incompetence, (d) the behaviors identified a lack of willingness to hold clients' needs above their own, and (e) the behaviors had the potential to harm clients.

Problematic Relational Behaviors

Level of agreement. In the first round, panel members provided problematic relational behaviors they believed were inconsistent with the expected developmental trajectory of a counselor-in-training. Through the process of content analysis, a list of 17 problematic relational behaviors emerged. These relational behaviors were generally described as interpersonal deficits, lack of awareness regarding affect and cultural issues, defensive and or guarded, etc. In the second round, panelists indicated to what degree they believed the relational behaviors were problematic. Panelists reached consensus regarding 9 of the 17 behaviors after the second round. Eight of the nine behaviors that reached consensus with interquartile ranges less than 1 had median scores ranging from 6.00 to 7.00, indicating the panel agreed these behaviors were problematic. One behavior that reached consensus (i.e., "demonstrates extreme hyperactivity"; IQR = 1.00) had a median score of 5.50, indicating the panel agreed this relational behavior was moderately problematic. The remaining eight problematic relational behaviors yielding interquartile ranges greater than 1 were included in the third round for further consideration. With a

reduced list of problematic relational behaviors, panel members indicated to what degree the behaviors were problematic on a 7-point Likert scale. The third round results indicated panel members reached consensus on three of eight problematic relational behaviors with interquartile ranges less than 1. However, these three behaviors where panelists reached consensus, each had a median score of 5.00, indicating the panel agreed these behaviors (i.e., “difficulty with affect,” “difficulty understanding the role of the counselor,” and “excessive intellectualization”) were only moderately problematic relational behaviors. The panelists failed to reach consensus on the five remaining problematic relational behaviors (see Table 3), indicating the expert panel did not agree to what degree each behavior was problematic.

Table 3

Problematic Relational Behaviors: Medians and Interquartile Ranges from Rounds Two and Three

Problematic Relational Behaviors	Round Two		Round Three	
	Median	IQR	Median	IQR
Defensiveness or interpersonally guarded (e.g., does not take responsibility, inability or resistance to compromise).	7.00	0.75*	-	-
Interpersonal deficits leading to difficulty forming and maintaining rapport (e.g., poor basic social skills, lack of authenticity, inability to manage a conversation, uncooperative, dominates interpersonal interactions, etc.).	6.50	1.00*	-	-
Inability to demonstrate a minimum level of empathy.	6.00	1.00*	-	-
Lack of compassion.	7.00	1.00*	-	-
Engages in triangulation.	6.00	1.00*	-	-
Difficulty with interpersonal boundaries (e.g., invades others' space, inappropriate touch or relationships with clients, shares too much personal information).	6.50	1.00*	-	-
Intense criticism of others.	6.00	1.00*	-	-
Fails to demonstrate culturally sensitive approaches.	6.00	1.00*	-	-
Demonstrates extreme hyperactivity.	5.50	1.00*	-	-
Difficulty with affect (e.g., inability to manage affect, limited affective vocabulary, resistance to experience and identify a variety of emotions).	6.00	1.75	5.00	1.00*
Excessive intellectualization.	5.50	1.75	5.00	1.00*
Difficulty understanding the role of the counselor (e.g., friend vs. counselor, asking too many unnecessary closed questions, giving advice, too much self-focus).	5.50	2.00	5.00	1.00*
Unaware of countertransference (e.g., over-identification, unable to separate own issues).	6.00	2.00	5.00	3.00
Appears generally aloof.	5.00	2.00	5.00	2.00
Lack of tolerance of ambiguity.	5.83	1.75	5.00	2.00
Intolerant and avoidant of conflict and distress/discomfort in others or self.	5.83	1.75	6.00	3.00
Lack of insight/awareness (e.g., inability to understand how one's behaviors impact others).	6.25	1.75	6.00	2.00

Note. *Reached consensus

- Not included in next round

Unable to remediate. Within the category of problematic relational behaviors in the second round, panel members identified the behaviors so significant or egregious they were unlikely to respond to remediation regardless of the quality or duration of the remediation. The most frequently selected behaviors were (a) "interpersonal deficits leading to difficulty forming and maintaining rapport" (chosen by 4 of 13 panelists), (b) "defensiveness or interpersonally guarded" (chosen by 4 of 13 panelists), (c) "lack of insight and or awareness" (chosen by 4 of 13 panelists), and (d) "lack of compassion" (chosen by 5 of 13 panelists). The results from this question identified the most frequently selected items, indicating which behaviors might be unlikely to respond to remediation regardless of training and remediation techniques.

Rank order. In the second round, panel members rank ordered the problematic relational behaviors identified in round one from most concerning to least concerning. Similarly to the rank order question for problematic professional behaviors, the second round results indicated high levels of disagreement among the expert panel members. Panelists were only able to reach consensus regarding two problematic relational behaviors. The first, "excessive intellectualization" (IQR = 1.00), had a median of 15, indicating the behavior was the 15^{th} most concerning relational behavior out of 17. The second, "demonstrates extreme hyperactivity" (IQR = 1.00), had a median score of 16.00, indicating the panel agreed this behavior was one of the least concerning relational behaviors. The panelists failed to reach consensus regarding the remaining 15 problematic relational behaviors. In fact, these behaviors yielded high interquartile ranges (IQR = 3.00 to 9.00), which indicated high levels of disagreement among the panelists. In an attempt to reduce the amount of data for a finer consideration in the third

round, only the top 10 most problematic relational behaviors (i.e., according to median scores) were included.

Of the behaviors listed, panel members chose the most concerning relational behaviors: (a) “defensiveness or interpersonally guarded” (chosen by 9 of 12 panelists), b) “interpersonal deficits associated with difficulties in forming and maintaining rapport” (chosen by 7 of 12 panelists), c) “difficulty with interpersonal boundaries” (chosen by 7 of 12 panelists), d) “inability to demonstrate a minimum level of empathy” (chosen by 7 of 12 panelists), and e) “lack of insight and or awareness” (chosen by 5 of 12 panelists). Panelists provided commentary regarding a rationale in support of their selection of the five behaviors. Panelist’s rationales were subjected to a content analysis and the following themes emerged: (a) the behaviors might indicate personality disorders that are difficult to address in academia, (b) the behaviors are directly related to forming a strong relationship--a critical aspect of being a counselor, (c) the behaviors indicate a lack of self-awareness that inhibits growth, and (d) the behaviors indicate potential projection and blame on clients, putting clients at risk.

Problematic Scientific-Application Behaviors

Level of agreement. Panel members were asked to indicate problematic scientific-application behaviors inconsistent with an expected developmental trajectory of a counselor-in-training. Content analysis of these responses yielded 13 problematic scientific-application behaviors. These behaviors were generally described as deficiencies in managing crises, an inability to understand how to apply scientific information, lacking conceptualization skills, lacking capacity to evaluate scholarly literature, etc. Expert panel members reached consensus regarding 6 of the 13 behaviors

(IQR < = 1.00) and four of the six had median scores ranging from 6.00 to 7.00, indicating the expert panel agreed these behaviors (i.e., “lack of conceptualization and diagnosis skills”; “no use of ASCA National Model, ACA Standards and or Code of Ethics, unfamiliar with the DSM”; “does not know what steps to take in the event of a crisis”; and “lacks the capacity to develop research studies”) were problematic. The remaining two problematic scientific-application behaviors where the panel reached consensus each yielded a median score of 5.00, indicating the expert panel agreed these behaviors (i.e., “does not know how to advocate for clients in need,” and “inability to link client behaviors to previously described behaviors from coursework”) were only moderately problematic.

Panelists were unable to reach consensus on the remaining seven problematic scientific-application behaviors that did not reach consensus in the second round so they were included in the next round for further consideration. In the third round, panel members indicated on a 7-point Likert scale the degree to which they believed the remaining seven scientific-application behaviors were problematic. The results demonstrated that panelists reached consensus on only one out of the seven behaviors. Panel members agreed that “lying in research” (IQR = 1.00; *Mdn* = 7.00) is a problematic scientific-application behavior. However, panelists failed to reach consensus (IQR > 1.00) regarding the remaining six items (i.e., “inability to utilize appropriate interventions,” “dismisses or refuses to use commonly accepted techniques and evidence based theory,” “incapability to recognize the importance of evidence to support assertions,” “use of only scientific information and not considering useful theories with

less empirical support," "does not consider the uniqueness of the client before applying scientific information," and "lacks the capacity to develop research studies"; see Table 4).

Table 4

Problematic Scientific-Application Behaviors: Medians and Interquartile Ranges from Rounds Two and Three

Problematic Scientific-Application Behaviors	Round Two		Round Three	
	Median	IQR	Median	IQR
Does not know what steps to take in the event of a crisis.	6.00	1.00*	-	-
Does not know how to advocate for clients in need.	5.00	1.00*	-	-
Lack of conceptualization and diagnosis skills (e.g., difficulties with diagnosis with or without supervisory support and training, inability to create appropriate treatment plan).	6.00	1.00*	-	-
No use of ASCA National Model, ACA Standards/Ethics, unfamiliar with DSM.	6.50	1.00*	-	-
Inability to link client behaviors to previously described behaviors from coursework.	5.00	1.00*	-	-
Lacks the capacity to evaluate scholarly literature (e.g., failure to understand basic statistical concepts commonly used in assessments and tests).	5.00	1.00*	-	-
Lying in research (e.g., manipulating systems to meet research needs).	4.50	2.50	7.00	1.00*
Incapable of recognizing the importance of evidence to support assertions.	6.00	1.75	6.00	2.00
Inability to utilize appropriate interventions.	5.50	2.00	5.00	2.00
Dismisses or refuses to use commonly accepted techniques and evidence-based theory.	6.00	2.00	6.00	3.00
Using only scientific information, not considering useful theories with less empirical support.	5.00	2.00	5.00	2.00
Does not consider the uniqueness of the client before applying scientific information.	5.50	2.00	6.00	2.00
Lacks the capacity to develop research studies that build on previous research, inability to build research questions, inability to understand the relationships between methods used and conclusions that can be drawn.	7.00	2.50	**	**

*Note. * Reached consensus*
- Not included in next round
***Due to technical error, this item was not included in subsequent rounds.*

Unable to remediate. Within the category of problematic scientific-application behaviors, panel members identified behaviors so significant or egregious they were unlikely to respond to remediation regardless of the quality or duration of the remediation. The behaviors selected most frequently were (a) "lacks the capacity to develop research studies that build on previous research and inability to understand the relationship between methods used and conclusions that can be drawn" (chosen by 6 of 13 panelists) and (b) "dismisses or refuses to use commonly accepted techniques and evidence-based theory" (chosen by 4 of 13 panelists). The results from this question identified the most frequently selected items, indicating which behaviors might be unlikely to respond to remediation regardless of training and remediation techniques.

Rank order. In the second round, panel members rank ordered the problematic scientific-application behaviors from most concerning to least concerning. The results indicated low levels of agreement with interquartile ranges from 1.50 to 9.75. In an attempt to reduce the amount of data for a finer consideration in the third round, only the top 10 most problematic scientific-application behaviors (i.e., according to median scores) were included. Of the behaviors listed, panel members chose the top five most concerning scientific-application behaviors: (a) "does not consider the uniqueness of the client before applying scientific information" (chosen by 10 of 12 panelists), (b) "dismisses or refuses to use commonly accepted techniques and evidence-based theory" (chosen by 9 of 12 panelists), (c) "lack of conceptualization and diagnosis skills" (chosen by 7 of 12 panelists), (d) "inability to utilize appropriate interventions" (chosen by 6 of 12 panelists), and (e) "does not know what steps to take in the event of a crisis" (chosen by 6 of 12 panelists). Panelists were asked to provide a rationale for the selection of the

five most concerning behaviors. Panelist's rationales were subjected to a content analysis and the following themes emerged: (a) the behaviors indicate an inability to apply the scientist-practitioner model, (b) the behaviors would cause client harm whereas being ineffective is less of a problem, (c) the behaviors affect a student's ability to connect and understand the client, and (d) because the relationship is a significant factor for client success, students must understand standardized models.

Problematic Supervisory Relationship Behaviors

Level of agreement. Content analysis from the first round data yielded 11 problematic supervisory behaviors the expert panel believed were inconsistent with the expected developmental trajectory of a counselor-in-training. In the second round, panel members indicated to what degree they believed the behaviors were problematic. The results indicated panel members reached consensus (IQR $\leq$ 1.00) regarding 8 of the 11 problematic supervisory behaviors. All eight behaviors with interquartile ranges less than 1 had median scores ranging from 6.00 to 7.00, indicating panel members agreed these behaviors (i.e., "inability to receive and integrate feedback," "poor insight and or awareness;" "inability to risk trying reasonable new behaviors as instructed by supervisor," "rigid or inflexible interpersonal processes," "not asking for supervision on difficult cases," "lack of conscientiousness of time," "inability to regulate own emotions within supervision," and "a pattern of difficulties in supervision across supervisors") were problematic. The panel did not reach consensus regarding the remaining three problematic supervisory behaviors, which were presented in the final round. In the third round, panelists indicated to what degree they believed the remaining supervisory behaviors were problematic. Panelist reached consensus on one behavior (IQR = 1.00)

with a median score of 4.00, indicating the expert panel agreed "over-reliance on a supervisor" was only moderately problematic. They were unable to reach consensus on the remaining two behaviors: "uninterested and or unable to demonstrate growth" and "does not understand the complimentary roles of trainee and supervisor" (IQR = 1.00; see Table 5).

Table 5

Problematic Supervisory-Based Behaviors: Medians and Interquartile Ranges from Rounds Two and Three

Problematic Supervisory-Based Behaviors	Round Two		Round Three	
	Median	IQR	Median	IQR
Not asking for supervision on difficult cases.	6.00	0.75*	-	-
Lack of conscientiousness (e.g., failure to arrive on time, etc.).	6.00	0.75*	-	-
Inability to receive and integrate feedback in supervision (e.g., closed off to supervision, argumentative with feedback, unopened to processing difficult feedback).	7.00	1.00*	-	-
Poor insight/awareness (e.g., poor general awareness, unable to see impact on others).	6.50	1.00*	-	-
Inability to risk trying reasonable new behaviors as instructed by supervisor.	6.00	1.00*	-	-
Rigid or inflexible interpersonal processes (e.g., dogmatic in approach to supervisor, frequent use of defense mechanisms, refusal to discontinue rude/cruel interpersonal behaviors).	7.00	1.00*	-	-
Inability to regulate own emotions within supervision.	6.00	1.00*	-	-
A pattern of difficulties in supervision across supervisors.	6.50	1.00*	-	-
Over-reliance on supervisor.	5.00	1.75	4.00	1.00*
Does not understand the complimentary roles of trainee and supervisor.	5.00	1.50	4.00	2.00
Uninterested and or unable to demonstrate growth (e.g., does not pursue professional growth activities, lack of growth from supervision, is not goal oriented, lack of a sense of growing confidence and competence).	6.00	2.00	5.00	2.00

Note. * Reached consensus
- Not included in next round

Unable to remediate. In the second round, panel members indicated problematic supervisory behaviors they believed were so significant or egregious they are unlikely to respond to remediation regardless of the quality or duration of the remediation. The behaviors selected most frequently were (a) "inability to receive and integrate feedback in supervision" (chosen by 7 of 13 panelists), (b) "rigid or inflexible interpersonal processes" (chosen by 6 of 13 panelists), (c) "uninterested and or unable to demonstrate growth" (chosen by 5 of 13 panelists), and (d) "a pattern of difficulties in supervision across supervisors" (chosen by 5 of 13 panelists). The results from this question identified the most frequently selected items, indicating which behaviors might be unlikely to respond to remediation regardless of training and remediation techniques.

Rank order. In the second round, panel members rank ordered the problematic supervisory behaviors from most concerning to least concerning. The results indicated panelists' lack of consensus (IQR = 2.00 to 8.00) regarding the rank order of problematic supervisory behaviors. In an attempt to reduce the amount of data for a finer consideration in the third round, only the top 10 most problematic supervisory behaviors (i.e., according to median scores) were included. Of the behaviors listed, panel members chose the most concerning supervisory behaviors: (a) "inability to receive and integrate feedback in supervision" (chosen by 11 of 12 panelists), (b) "rigid or inflexible interpersonal processes" (chosen by 11 of 12 panelists), (c) "poor insight and or awareness" (chosen by 9 of 12 panelists), (d) "uninterested and or unable to demonstrate growth" (i.e., chosen by 7 of 12 panelists), and (e) "a pattern of difficulties in supervision across supervisors" (chosen by 6 of 12 panelists). Panelists provided rationales for why they chose the behaviors, those rationales were subjected to a content analysis, and the

following themes emerged: (a) the behaviors suggest problematic defensiveness and rigidity, (b) the behaviors indicate resistance to integrate supervisory feedback, (c) the behaviors indicate problems with self-reflection and an inability to ask for help and continue to grow, and (d) the behaviors have the ability to put clients at risk.

Problematic System-Based Behaviors

Level of agreement. Content analysis from the initial survey's data yielded seven problematic system-based behaviors the expert panel believed were inconsistent with the expected developmental trajectory of a counselor-in-training. In the second round, panel members indicated to what degree they believed the behaviors were problematic. The panel reached consensus regarding four of the seven problematic system-based behaviors with interquartile ranges less than 1. Each behavior where panelists reached consensus had a median score of 7.00, indicating the expert panel agreed these system-based behaviors (i.e., "inappropriate or disrespectful interactions with peers," "professors and or clients," "does not respond to or follow direction," "inability to negotiate and or compromise," and "failing grades especially in skills courses") were problematic. The panel failed to reach consensus (IQR > 1.00) regarding the remaining three problematic system-based behaviors (i.e., "frequently unable to conduct themselves in a timely manner," "unwilling to share responsibility," and "difficulty with systems"; see Table 6). The remaining problematic system-based behaviors that failed to reach panel consensus were included in the final round. In the third round, panel members indicated to what degree they believed these behaviors were problematic. The results indicated the expert panel did not reach consensus on any of the problematic system-based behaviors included in the final round.

Table 6

Problematic System-Based Behaviors: Medians and Interquartile Ranges from Rounds Two and Three

Problematic System-Based Behaviors	Round Two		Round Three	
	Median	IQR	Median	IQR
Inappropriate or disrespectful interactions with peers/professors/clients (e.g., involved in harassment, stalking, violence, and or threats, argumentativeness, hostility, not committed to building productive relationships).	7.00	0.00*	-	-
Does not respond to or follow directions (e.g., unwilling to listen).	7.00	0.75*	-	-
Inability to negotiate and or compromise.	7.00	1.00*	-	-
Failing grades especially in skills courses.	7.00	1.00*	-	-
Difficulty with systems (e.g., does not understand how systems work, monopolizes cooperative activities, difficulty cooperating with others in task completion and common goals, ignorance of the importance of a team approach).	6.00	1.75	6.00	2.00
Frequently unable to conduct themselves in a timely manner (e.g., paperwork, arriving late, disregard for others' time).	6.00	2.00	5.00	2.00
Unwilling to share responsibility.	6.00	2.00	5.00	3.00

Note. * Reached consensus
- Not included in next round

Unable to remediate. Within the category of problematic system-based behaviors, panel members indicated the behaviors so significant or egregious they are unlikely to respond to remediation regardless of the quality or duration of the remediation: (a) "inappropriate or disrespectful interactions with peers, professors and or

clients" (chosen by 6 of 13 panelists) and (b) "failing grades especially in skills courses" (chosen by 5 of 13 panelists). The results from this question identified the most frequently selected items, indicating which behaviors might be unlikely to respond to remediation regardless of training and remediation techniques.

Rank order. In the second round, panel members rank ordered the problematic system-based behaviors from most concerning to least concerning. The expert panel reached consensus (IQR = 0.25) that "inappropriate or disrespectful interactions with peers, professors and or clients" was the most concerning problematic system-based behavior. However, the panel failed to reach consensus regarding the remaining six problematic system-based behaviors. In the following round, panel members indicated the most problematic system-based behaviors: (a) "inappropriate or disrespectful interactions with peers, professors and or clients" (chosen by 11 of 12 panelists), (b) "failing grades especially in skills courses" (chosen by 9 of 12 panelists), (c) "does not respond to or follow direction" (chosen by 9 of 12 panelists), (d) "inability to negotiate and or compromise" (chosen by 7 of 12 panelists), and (e) "difficulty with systems" (chosen by 7 of 12 panelists). Panelists provided rationales for why they chose the behaviors, those rationales were subjected to a content analysis, and the following themes emerged: (a) the behaviors suggest a lack of respect and or competency, (b) the behaviors suggest a lack of conscientiousness or agreeableness, (c) the behaviors indicate poor interpersonal skills that are necessary to work with clients, (d) the behaviors suggest the client is unopened to learning, and (e) the behaviors would have potential to harm clients.

Counselor Impairment Continuum of Behaviors

In the first round, panel members indicated their belief that counselor impairment behaviors existed on a continuum. In addition, those who agreed these behaviors existed on a continuum indicated specific anchor points with behavioral characteristics along the continuum (i.e., severe, moderate, mild). The panel suggested 23 problematic behaviors that existed on the severe category, eight problematic behaviors were suggested to exist on the moderate category, and 21 problematic behaviors were suggested to exist on the mild category of the counselor impairment continuum. In the second round, panel members rated their level of agreement that each element belonged on the respective category of the continuum.

Severe Category

On the severe category, panelists reached consensus regarding 15 of the 23 problematic behaviors with interquartile ranges less than 1. Of the behaviors where panelists reached consensus, 14 of the 15 problematic behaviors had median scores ranging from 6.50 to 7.00, indicating the expert panel agreed these behaviors belonged on the severe continuum. One problematic behavior where panelists reached consensus had a median score of 5.50, indicating the expert panel agreed this behavior only moderately belonged on the severe portion of the counselor impairment continuum. Panelists were unable to reach consensus on the remaining eight items (IQR = 1.50 to 2.00) in round two; these items were included in round three for further examination.

In the third round, the remaining items were presented and the panel members indicated on which section of the counselor impairment continuum (i.e., severe, moderate, mild, or does not demonstrate impairment) they believed each behavior or

action belonged. For analysis purposes, the titles (i.e., severe, moderate, mild, or does not demonstrate impairment) were labeled with one, two, three, and four, respectively. Each behavior originally listed on the severe category reached panel consensus with interquartile ranges less than 1. Median scores indicated what category the expert panel agreed the behavior or action should exist. A complete list of all consensus-reaching behaviors along the anchor points of the continuum after the third round is presented in Appendix F.

Moderate Category

The results of the second round demonstrated that panelists agreed to describe one out of the eight problematic behaviors as moderate. The only item that reached consensus ("turning in late work") had an interquartile range of 1 and a median score of 5.00, indicating that the expert panel agreed this behavior only somewhat belonged in the moderate category. The panel failed to reach consensus regarding the remaining problematic behaviors. In the third round, the remaining items were included and the panel members indicated in which section of the counselor impairment continuum they believed each behavior or action belonged (i.e., severe, moderate, mild, or does not demonstrate impairment). Similar to the severe category, the panel reached consensus (IQR $\leq$ 1.00) on each item. Median scores indicated the particular category the expert panel agreed the behavior or action should be placed. A complete list of all consensus-reaching behaviors along the anchor points of the continuum after the third round is presented in Appendix F.

Mild Category

The second round results indicated the expert panel did not agree that any of the behaviors listed should be included in the mild category of the counselor impairment continuum. The interquartile ranges were relatively high, spanning from 2 to 4.75 (see Table 7). Since no consensus was reached for this question, each item was included in the final round where panel members indicated which section of the counselor impairment continuum they believed each behavior or action belonged (i.e., severe, moderate, mild, or does not demonstrate impairment). The third round results indicated more agreement with panel members reaching consensus (IQR $\leq$ 1.00) on 16 out of 21 items. Median scores specified in which category the expert panel agreed the behavior or action should exist. A complete list of all consensus-reaching behaviors along the anchor points of the continuum after the third round is presented in Appendix F.

Table 7

Medians and Interquartile Ranges From Round Two

Anchor Points	Median	IQR
Severe		
Initiates inappropriate relationships with clients (e.g., sexual, romantic, or financial).	7.00	0.00*
Lies.	7.00	0.75*
Boundary violations.	7.00	0.75*
Does not listen, argues, and blames others.	7.00	0.75*
Cannot create/maintain therapeutic relationship with any client.	7.00	1.00*
The behavior consistently and negatively impacts relationships.	7.00	1.00*
Refusal to accept feedback.	7.00	1.00*
Denial of responsibility.	7.00	1.00*
Unwilling to work on the problem causing deficiencies.	7.00	1.00*
Behavior or trait stems from an ingrained characterological trait or difficult to treat mental illness.	7.00	1.00*
Depression, anxiety, bipolar disorder.	5.50	1.00*
Intolerant of diverse viewpoints and or people.	6.50	1.00*
Ethical violations.	7.00	1.00*
Problem behavior or trait is present and apparent in the majority of academic and clinical work.	6.50	1.00*
Failure to attend class or counseling sessions.	7.00	1.00*
Is not curious.	5.00	1.50
Problem behavior or trait is consistent and present with or without stress.	6.00	1.50
Substance abuse issues.	7.00	1.75
Cognitive rigidity, emotional dysregulation, and or use of defense mechanisms concurrent with poor insight.	6.00	1.75
Misdiagnosing.	5.00	1.75
Applying the wrong treatment.	5.50	1.75
Failure to complete internship tasks or coursework.	6.00	1.75
Lacks awareness and insight.	6.00	2.00
Moderate		
Turning in late work.	5.00	1.00*
Cannot create and or maintain therapeutic relationship with most clients.	6.50	2.00
The problem behavior or trait impacts the student's relationship with peers and faculty.	7.00	2.00
The behavior or trait is present and consistent with or without stress.	6.00	2.00
Deficiencies present in at least half of the student's academic and or clinical work.	6.00	2.00
Clinical work suffers as a result of deficiencies.	6.00	4.00
Questionable ethical behavior.	6.00	4.25
Minor		
No real harm to clients.	6.00	2.00
Behavior and or trait problems are transient and may only be present with stress.	5.50	2.00
Developmentally normative anxiety with willingness to address.	7.00	2.00
Deficiency stems from lack of awareness and or knowledge.	6.00	2.00
Showing up late.	5.00	2.50
Behaviors that mildly impacts social functioning.	5.00	2.75
Lack of cooperation.	5.00	2.75
Accepts being mediocre.	5.50	2.75
Late academic work and or late case notes.	5.00	2.75
Lack of self-care.	5.00	3.00
Does not aspire to be better.	5.00	3.00
Being snippy and irritable with peers and or faculty.	5.00	3.50
Just meets minimal professional standards.	5.00	3.75
Problem is present in some academic and or clinical work.	5.00	3.75
Difficulties with skill development (e.g., reflecting, active listening, etc.).	5.00	3.75
Lack of ability to accept and or incorporate feedback.	5.00	3.75
Does not accept responsibility.	4.50	4.00
Individual is aware, reflective, and knows when to withdraw or seek help.	6.50	4.25
Willing to work to solve the problem.	6.50	4.25
Disrespectful toward peers and or faculty.	5.50	4.50
Does not follow directions.	5.50	4.75

Note. * Reached consensus

Additional Continua

In addition to the continuum counselor impairment ranging from severe to mild, panelists suggested additional continua they considered useful when evaluating student impairment. These additional continua presented alternative criteria that might assist counselor educators in the identification or remediation of problematic students. These continua varied by their focus (i.e., on the client, on personal referrals, and student's level of awareness). For example, one panel member indicated viewing problematic behaviors on a continuum of potential damage to clients ranging from high potential to harm clients to minor potential to harm. Another panel member suggested a continuum that indicated the likelihood of the evaluator to suggest the student's therapeutic services to a family member or friend in need of professional help. The anchor points of this continuum were "absolutely," "maybe," and "absolutely not." Last, another panel member indicated a helpful tool to identify and consider the intensity of the student's behavior was considering a continuum regarding the student's level of insight or awareness concerning the problematic behavior. The anchor points ranged from the student's lack of awareness to having awareness.

These alternative continua were included in the second round and the panelists rank ordered the continuum scales from most to least useful in their evaluation of impairment. The expert panel reached consensus on each continuum (IQR $\leq$ 1.00). Median scores indicated that panel members ordered the scales from most useful to least useful in the following order: (a) potential damage to clients (IQR = 1.00; *Mdn* = 1.00), (b) level of insight and or awareness of the student regarding the problem (IQR = 0.75;

Mdn = 2.00), and (c) potential to refer a family or friend to the student (IQR = 0.75; *Mdn* = 3.00).

Distinguishing Impairment From Other Factors

Impairment from Not Yet Acquired Competence

Counselor impairment is a complex, multifaceted concept. As counselors-in-training progress along the developmental continuum of competence, they might exhibit various behaviors or actions that mimic impairment. However, these behaviors, due to not yet acquired competence, might not necessarily be true impairment. It is important to differentiate between the two in order to understand how to accurately identify impairment from not yet acquired competence.

In the first round, panel members identified statements that assisted them in distinguishing impairment from not yet acquired competence. The responses were analyzed with a content analysis, which generated 12 statements that allowed panelists to differentiate impairment from not yet acquired competence. In the second round, panel members rated to what degree each of these statements distinguished impairment from not yet acquired competence. The results indicated the panel reached consensus regarding two statements: (a) “the severity of inappropriate behavior” (IQR = 1.00; *Mdn* = 7.00) and (b) “the level of behavior change overtime” (IQR =1.00; *Mdn* = 6.50). The results suggested these two statements assisted panel members in distinguishing between impairment and not yet acquired competence. However, the panelists failed to reach consensus (IQR > 1.00) regarding the remaining statements (see Table 8).

Table 8

Rating of Statements Determining Impairment from Not Yet Acquired Competence

Rating of Statement	Median	IQR
The severity of inappropriate behavior.	7.00	1.00*
The level of behavior change overtime.	6.50	1.00*
The origin of the behavior.	5.00	3.75
If the problem is internal or external to the student (e.g., personality disorder--internal, not yet introduced to material--external).	6.50	2.75
If the student is simply struggling with learning or if they are justifying their behavior and attitudes.	5.50	2.00
The level of defensiveness on the part of the student and resistance to change.	6.50	2.00
The level of willingness of the student to discuss the issue and assume appropriate responsibility for correction.	6.50	2.00
If a level of competence had previously been acquired and then diminished.	5.50	2.00
If the problem occurs as a pattern and is pathological in nature.	7.00	1.75
If struggles exist despite competent and appropriate education.	6.50	2.00
If peers at the same developmental level have been able to master the skill and or behavior.	5.50	2.50
Evaluations based on the expected acquired competencies for the developmental level.	5.50	2.75

Note. * Reached consensus

In addition to rating the degree to which each statement distinguished impairment from not yet acquired competence, panel members were asked in round two to indicate

the five most useful statements that assisted them in differentiating between impairment and not yet acquired competence. The results indicated the most useful statements were (a) "the level of defensiveness on the part of the student and resistance to change" (chosen by 8 of 13 panelists), (b) "the problem occurs as a pattern and is pathological in nature" (chosen by 8 of 13 panelists), (c) "the severity of inappropriate behavior" (chosen by 7 of 13 panelists), (d) "the level of willingness of the student to discuss the issue and assume appropriate responsibility for correction" (chosen by 5 of 13 panelists), and (e) "if struggles exist despite competent and appropriate education" (chosen by 5 of 13 panelists).

In the third round, panel members were presented with the five statements most often chosen that distinguished impairment from not yet acquired competence and were asked to rate each statement's level of usefulness in assisting them in distinguishing impairment from not yet acquired competence (see Table 9). Panelists reached consensus (IQR <=1.00) regarding two statements: (a) "the problem occurs as a pattern and is pathological in nature" (IQR = 1.00; *Mdn* = 7.00) and (b) "the level of willingness of the student to discuss the issue and assume appropriate responsibility for correction" (IQR = 1.00; *Mdn* = 7.00). Median scores for each of the statements suggested the expert panel agreed the statements were useful in differentiating between impairment and not yet acquired competence. The panelists failed to reach consensus regarding the remaining items: i.e., "the level of defensiveness of the student" (IQR =2.00), "the severity of inappropriate behavior" (IQR = 2.00), and "if struggles exist despite competent and appropriate education" (IQR = 2.00).

Table 9

Most Frequently Chosen Statements Determining Impairment from Not Yet Acquired Competence

Statements	Median	IQR
The level of defensiveness on the part of the student and resistance to change.	7.00	2.00
The problem occurs as a pattern and is pathological in nature.	7.00	1.00*
The severity of inappropriate behavior.	7.00	2.00
The level of willingness of the student to discuss the issue and assume appropriate responsibility for correction.	7.00	1.00*
If struggles exist despite competent and appropriate education.	6.00	2.00

Note. * Reached consensus

Impairment from Cultural Values

Similar to differentiating impairment from not yet acquired competence, identifying impairment from performance related to cultural values is important to better understand the concept of impairment. Various cultural values might generate behavior that appears as impaired (e.g., lack of eye contact, religious values that conflict with the counseling profession, etc.). Yet, the behaviors might be a result of individual cultural values rather than true impairment.

In the first round, panel members responded to open-ended questions regarding how they distinguished impaired performance from performance associated with cultural values. These responses were subjected to a content analysis and the results generated seven statements that assisted panelists in distinguishing impairment from performance

associated with cultural values (see Table 10). In the second round, panel members were presented with the seven statements and were asked to rate to what degree each statement distinguished impaired performance from performance associated with cultural values. Panel members failed to reach consensus on any of the seven statements (IQR > 1.00), indicating disagreement regarding a single statement or combination of statements aiding them in differentiating impairment from cultural values.

Table 10

Rating of Statements Determining Impairment from Performance Associated with Cultural Values

Rating of Statement	Median	IQR
Student demonstrates beliefs or behaviors inconsistent to other students of similar cultural backgrounds/experiences.	4.50	3.50
Student fails to recognize and or discuss the impact of his/her cultural values on others.	5.50	3.00
Student demonstrates a lack of consideration and or respect for the cultural contexts of others.	6.50	1.75
Student refuses to manage personal cultural values that contradict with the expectations of the profession.	7.00	2.75
Prior to any determination of impairment a discussion is required with the student.	7.00	1.75
Student consistently refuses to suspend cultural values in order to meet the needs of the client.	6.50	2.75
Impaired performance and performance associated with cultural values are largely distinct--only connected to a limited extent where extreme prejudice could be considered impairment.	5.50	3.00

In addition to rating to what degree (i.e., on 7-point Likert scale) each statement distinguished impaired performance from performance associated with cultural values, panel members were also asked to identify the most useful statements that allowed them to differentiate between impaired performance and performance associated with cultural values. The results indicated four of the seven statements were identified as the most useful: (a) "student refuses to manage personal cultural values that contradict with the expectations of the profession" (chosen by 8 of 13 panelists), (b) "the student fails to recognize and or discuss the impact of his or her cultural values on others" (chosen by 7 of 13 panelists), (c) "the student demonstrates a lack of consideration and or respect for the cultural contexts of others" (chosen by 7 of 13 panelists), and (d) "the student consistently refuses to suspend cultural values in order to meet the needs of the client" (chosen by 7 of 13 panelists).

In the final round, panel members were presented with four statements most frequently chosen as useful. They were asked to rate their level of agreement on a 7-point Likert scale regarding each statements' level of usefulness in distinguishing impairment from cultural values. The results indicated a lack of consensus on each item (IQR $\geq$ 3.00), indicating panel members' inability to agree on the usefulness of the statements (see Table 11).

Table 11

Most Frequently Chosen Statements Determining Impairment from Performance Associated with Cultural Values

Most Frequently Chosen Statements	Median	IQR
Student refuses to manage personal cultural values that contradict with the expectations of the profession.	6.00	3.00
The student fails to recognize and or discuss the impact of his or her cultural values on others.	7.00	3.00
The student demonstrates a lack of consideration and or respect for the cultural contexts of others.	6.00	3.00
The student consistently refuses to suspend cultural values in order to meet the needs of the client.	7.00	3.00

Factors Influencing Assessment of Impairment

In the first round, panel members responded to a series of questions regarding various factors (i.e., intensity, duration, and persistence) potentially influencing an assessment of problematic behaviors as impaired. Each factor is discussed separately below.

Intensity of Problematic Behaviors

The content analysis of the first round responses yielded three statements regarding how the intensity of a behavior or trait influenced an evaluation of it as impaired. In the second round, panelist rated their level of agreement with each statement. The results indicated panelists reached consensus regarding the following statement: “the intensity of a behavior or trait determines the urgency of a required intervention” (IQR = 0.75; *Mdn* = 7.00). The median score indicated the panel agreed the greater the intensity of a problematic behavior, the more urgent the need for remediation.

The panelists failed to reach consensus regarding the remaining two statements: “the intensity of a behavior is directly related to the likelihood of it being a deficiency and the need to remediate” (IQR = 1.75; *Mdn* = 7.00) and “the intensity is less important than the awareness on the part of the student” (IQR = 2.00; *Mdn* = 6.00; See Table 12).

Table 12

Intensity of Problematic Behaviors

Most Frequently Chosen Statements	Median	IQR
The intensity of a behavior or trait determines the urgency of a required intervention.	7.00	0.75*
The intensity of a behavior or trait is directly related to the likelihood of it being a deficiency and the need to remediate.	7.00	1.75
The intensity is less important than the awareness on the part of the student. Those who are impaired lack the insight and remorse to know they need to withdraw or attend to the problem.	6.00	2.00

Note. * Reached consensus

Duration of Problematic Behaviors

The content analysis of the first round responses yielded four statements regarding how the duration of a behavior or trait influenced an evaluation of it as impaired. In the second round, panel members rated their level of agreement with each statement. The results indicated consensus was reached regarding two statements: (a) “a single incident is enough to start a conversation with a student but if the duration of a behavior increases, the concern increases” (IQR = 1.00; *Mdn* = 7.00) and (b) “if there is not response to remediation and the duration of the behavior is prolonged then the

behavior might be considered impaired and in need of remediation" (IQR = 1.00; *Mdn* = 6.50). However, panelists failed to reach consensus regarding the remaining statements: "if the student has been made aware of a less serious behavior and no change is evidenced, the student is likely presenting a deficiency needing remediation" (IQR = 1.75; *Mdn* = 7.00) and "duration is less important than insight of the student" (IQR = 1.75; *Mdn* = 6.50). The two statements where panelists failed to reach consensus were included in the third round; however, consensus was never reached for either statement after the third round (IQRs = 2.00, 3.00; *Mdns* = 6.00, 5.00; see Table 13).

Table 13

Duration of Problematic Behaviors

Ratings of Duration Statements	Median	IQR
A single incident is enough to start a conversation with a student but if the duration of a behavior increases, the concern increases.	7.00	1.00*
If there is no response to remediation and the duration of the behavior is prolonged then the behavior might be considered impaired and in need of remediation.	6.50	1.00*
Some on-time behaviors are indicative of impairment because they are serious violations. If the student has been made aware of a less serious behavior and no change is evidenced, the student is likely presenting a deficiency needing remediation.	7.00	1.75
Duration is less important than insight of the student. If awareness is present, then the student must be asked what he/she has done or is doing to deal with the impairment. If awareness is lacking, the duration of the concern is less problematic than creating awareness and addressing the potential defensiveness of the student to remediate the problem.	6.50	1.75

Note. * Reached consensus

Persistence of Problematic Behaviors

The content analysis of the first round responses yielded five statements regarding how the persistence of a behavior or trait influenced an evaluation of it as impaired. In the second round, panel members rated their level of agreement with each statement. The results indicated consensus was reached regarding three statements: (a) "if the behavior persists, I become more aware of the student deficiency and need to remediate" (IQR = 1.00; *Mdn* = 7.00), (b) "if the behavior persists even after intervention I would characterize it as a persistent problem where a more serious action is required" (IQR = 1.00; *Mdn* = 7.00), and (c) "even a student deficiency that is minor in its impact can have a cumulative quality that increases the impact over time" (IQR = 1.00; *Mdn* = 5.50). The median scores indicated the expert panel agreed the more persistent the behavior, the more likely remediation should occur; the increased need for a more serious action; and even minor issues could have a cumulative quality over time. The panel failed to reach consensus regarding the remaining items: "the more persistent a behavior, the more likely it is entrenched and in need of remediation" (IQR = 1.75; *Mdn* = 7.00) and "persistence of a behavior is less important than the level of insight the student has and how willing they are to change" (IQR = 2.50; *Mdn* = 5.50; see Table 14).

Table 14

Persistence of Problematic Behaviors

Most Frequently Chosen Statements	Median	IQR
If the behavior or trait persists, I become more aware of the student deficiency and need to remediate.	7.00	1.00*
If the behavior persists even after intervention I would characterize it as a persistent problem where a more serious action is required.	7.00	1.00*
Even a student deficiency that is minor in its impact can have a cumulative quality that increases the impact over time.	5.50	1.00*
The more persistent a behavior or trait, the more likely it is entrenched and in need of remediation.	7.00	1.75
Persistence of a behavior is less important than the level of insight the student has and how willing they are to change.	5.50	2.50

Note. * Reached consensus

The two statements that did not reach panel consensus were included in the final round where panel members rated their level of agreement with each statement. The results indicated the expert panel reached consensus, indicating "the more persistent a behavior, the more likely it is entrenched and in need of remediation" (IQR = 1.00). However; the median score (*Mdn* = 6.00) suggested the level of agreement with this statement was not as strong as the two statements that previously reached consensus in the second round. At the end of the third round, panel members failed to reach consensus regarding the remaining statement: "persistence of a behavior is less important than the level of insight the student has and how willing they are to change" (IQR = 2.00; *Mdn* = 5.00).

Influence of Etiology

In the first round, panel members responded to open-ended questions regarding the etiology of counselor impairment. More specifically, panelists were asked to identify potential origins of impairment as well as statements regarding how etiology might influence a decision to identify a behavior as impairment.

Potential Origins of Impairment

The results from the first round were subjected to a content analysis and the results yielded 18 potential origins of counselor impairment. In the second round, panel members rated their level of agreement that each statement was an origin of impairment. The results indicated no consensus (IQR > 1.00). In addition to panel members rating the level of agreement that each statement was an origin of impairment, panelists indicated the most concerning potential origins of impairment. The results demonstrated four statements that were most frequently chosen as the most concerning potential origins of impairment: (a) “mental health issues” (chosen by 7 of 13 panelists), (b) “personality traits and intrinsic personality characteristics” (chosen by 6 of 13 panelists), (c) “lack of commitment to change” (chosen by 5 of 13 panelists), and (d) “family systems and attachment insecurity” (chosen by 5 of 13 panelists).

In the third round, the initial list of 18 potential origins of impairment was reduced to nine items. In an attempt to reduce the data for a finer examination, the items from the second round that yielded a median of less than 5.50 were removed for the third round (see Table 15). The remaining nine potential origins with median scores equal to or greater than 5.50 were included in the third round. Panel members indicated five statements they most agreed with regarding how the etiology of a behavior might

influence their decision to identify a behavior as impairment: (a) “the student’s degrees of insight and willingness to take ownership of the problem carry more weight than etiology” (chosen by 8 of 12 panelists), (b) “impairment is impairment regardless of etiology” (chosen by 8 of 12 panelists), (c) “etiology is less important than its behavioral manifestations” (chosen by 7 of 12 panelists), (d) “impairment seems more probable for those struggling with anything described in the DSM-5” (chosen by 7 of 12 panelists), and (e) “opportunities for remediation should be provided because stable personality traits outside the student’s awareness will persist beyond remediation and will be more difficult to remediate” (chosen by 7 of 12 panelists).

Also in the third round, panel members were presented with the most frequently selected statements concerning origins of impairment from the previous round. Panelists rated their level of agreement regarding the level of concern of each potential origin. The results indicated consensus was reached regarding two statements. One origin that reached consensus (i.e., “mental health issues”; IQR = 1.00) yielded a median score of 6.00, indicating the expert panel agreed this origin of impairment was of great concern. However, the other origin that reached consensus (i.e., “family systems and attachment insecurity”; IQR = 1.00) yielded a median of 5.00, indicating the expert panel agreed this potential origin might not hold great concern regarding impairment. The panel did not reach consensus regarding the remaining two items: “personality traits and intrinsic personality characteristics” (IQR = 2.00; *Mdn* = 6.00) and “lack of commitment to change” (IQR = 3.00; *Mdn* = 5.00).

Table 15

Potential Origins of Impairment

Statements	Median	IQR
Personality traits, intrinsic personality characteristics (e.g., low self-esteem, immaturity).	7.00^	2.00
Mental health issues (e.g., PD, severe mood disorders, substance abuse, eating disorders, anxiety, depression, etc.).	6.00^	2.00
Traumatic history and or past experiences.	6.00^	1.75
Family systems and attachment insecurity (e.g., distorted working models of self and others).	6.50^	2.00
Neuropsychological problems (e.g., dementia or serious head trauma).	6.00^	2.00
Lack of self-awareness and self-knowledge.	6.50^	2.00
Lack of commitment to change.	5.50^	2.00
Interpersonal deficits.	5.00^	2.75
Previously held prejudices.	6.00^	2.50
Personal issues, environmental factors, limited resources (e.g., situational stressors, burnout).	5.00	1.75
Cultural or religious values.	5.00	1.75
Privilege.	5.00	2.75
Learned behaviors.	4.50	2.50
A cultural that promotes student deficient behaviors or traits (e.g., student's cohort or wider professional network).	4.50	2.75
Poor fit between student's goals/personal traits and the mission and expectations of the program/profession.	5.00	2.75
Limited life experience.	4.50	1.75
Lack of or poor education or training.	4.50	2.75
Poor modeling by other counselors whom the student had been exposed to.	4.00	2.75

Note. ^ median score $\geq$ 5.5 = included in the third round

Alternative Terms for Impairment

Much of the current student impairment literature suggested the term impairment should no longer be utilized to identify problematic student behaviors (Elman & Forrest, 2007; Kaslow et al., 2007; Schwartz-Mette, 2011). Despite this suggestion, the term impairment continues to be utilized frequently within the literature as well as counselor education programs. Panel members were asked to provide an alternative term to impairment that they believed better captured the phenomenon of counselor deficiencies. The qualitative results indicated the expert panel was divided in their belief regarding the use of the term impairment. Four panel members' qualitative responses demonstrated agreement that the term impairment was an appropriate term to use. Five panel members suggested a term related to competence such as "problems in professional competence" or "incompetence." Two panel members suggested "problematic student behaviors including skills and dispositions." One expert suggested "a counselor who is unsafe to practice".

In the third round, panelists were presented with the alternative terms (see table 16) suggested by panel members from the previous round. Panelists rated their level of agreement regarding the appropriateness of using each term the panel suggested in round two. The expert panel did not reach consensus (IQR > 1.00) regarding the use of any one term. Those panelists who did not believe the term impairment should be used provided a description of the limitations or issues of utilizing the term impairment. The results indicated *impairment* as a term to identify problematic student behavior that might harm clients should not be used because (a) the term overlaps with the term as it is used in the American's with Disabilities Act (ADA); (b) the term creates legal risk for counseling

programs; (c) the term intermingles etiology with observable professional behaviors creating more confusion for students and faculty; and (d) the term suggests a medical model or deficiency of personality where it might have more to do with skills and dispositions of the student.

Table 16

Alternative Terms to Impairment and Round Three Medians and Interquartile Ranges

Alternative Terms	Median	IQR
Problems in professional competence.	6.00	2.00
Problematic student behaviors.	5.00	3.00
Impairment.	5.00	5.00
A counselor who is unsafe to practice	5.00	5.00

Summary of Findings

Although not all items reached consensus after the third round, there were many significant findings from this research study. The most salient results from this research were (a) an agreed upon aspect of the definition of counselor impairment (b) a list of problematic behaviors regarding the areas of counselor competency suggested by Fouad et al. (2009); (c) potentially non-remediable behaviors regardless of the extent and quality of training, supervision, and or experience; (d) a continuum of counselor impairment with identified categories including behaviors in each category; and (e), identification of alternative terms to impairment although consensus was not reached.

CHAPTER V

DISCUSSION

This study sought to clarify the definitional boundaries and essential descriptors of counselor impairment through the Delphi process. In this chapter, I discuss the major findings, their congruence with the professional literature, and the utility of Delphi methodology in counselor education including the consensus building process and the benefits and limitations. The chapter concludes with the limitations of the study, implications for counselor education, and directions for future research.

Complexity of Impairment

The literature on counselor impairment suggests an immediate need for increased ability to identify and remediate impaired counselors-in-training (Bemak et al., 1999; Boxley et al., 1986; Elman et al., 1999; Forrest et al., 1999). However, much disagreement exists regarding what constitutes impairment, which ultimately decreases counselor educators' ability to deal with individuals displaying deficiencies. Impairment is a complex phenomenon because of the multifaceted nature of counselor competency and because of vague evaluative procedures (Duba et al., 2010).

Differences Among Participants

A Tale of Two Professional Perspectives

As mentioned, many individuals recruited for this study contacted me outside of the study to communicate their beliefs or concerns regarding impairment. In some cases, panelists agreed to participate in my study and indicated their excitement related to my research topic as they believed there was a great need for clarifying the boundaries and descriptors of impairment. However, other potential panelists responded to my recruitment email merely to communicate their concern regarding my use of the term impairment. For example, one potential panelist stated, "I am interested in your study but concerned because the term impairment is no longer used. We now speak in terms of problems of professional competence." Another potential panelist stated a similar concern by stating, "My guess is that you are referring to problematic students and or a lack of competencies in professional behavior, unless you really are looking at those characteristics that fall under the ADA definition." Both of these individuals chose not to participate in my study. Neither overtly indicated whether their decision was because of my use of the term impairment or for another reason (e.g., too busy), which led me to believe they strongly disagreed with my use of the term to the point of being unwilling to participate.

Although some individuals might not have participated because of my use of the impairment term, another potential panelist also indicated concerns regarding the term impairment but agreed to participate. This individual stated she would participate and informed me that the psychology field had moved away from using the term impairment and was using "problems of professional competence." This panelist continued:

> At least within professional psychology (perhaps not so true in the counseling literature) using the term impairment may make it look like you haven't read the recent literature on the topic. In fact, you may have experts who decide not to participate because of your use of the term impairment because it conveys something about the quality of your work. If your experts do decide to participate, it is possible that using the term impairment might actually affect the data they provide--that is it might create some unnecessary noise in your data.

Each personal communication I received (i.e., either excitement or criticism) demonstrated the amount of investment and dedication many had regarding the topic of student impairment. These comments might indicate a difference between counseling psychology and counselor education professionals in terms of the development and understanding of the term. For example, after reviewing the various sources of the personal communications (i.e., individual with psychology or counseling background) and reviewing the psychology versus counseling literature, it appeared as though individuals with a psychology background were more avid in their beliefs regarding the term impairment. For example, the above comments during the recruitment stage regarding the use of the term impairment came from concerned individuals who all had psychology backgrounds. The lack of similar feedback from individuals from the counseling profession sparked my curiosity, leading me to reexamine the impairment literature by focusing on a possible difference between counseling psychology and counselor education.

Upon taking a closer look at the impairment literature, it became apparent that the psychology profession began discussing the issue of impairment sooner and had overall more attention to impairment in the literature (i.e., 26 psychology impairment articles vs. 16 counseling impairment articles). The psychology literature was also more direct about no longer using the term impairment. It appeared that in 2007, many professionals within

the psychology profession made a statement regarding the use of the term impairment; multiple articles were published identifying issues with the term impairment and specifically advocated for no longer using the term (Elman & Forrest, 2007; Falender et al., 2009; Kaslow et al., 2007; Schwartz-Mette, 2011).

A similar review of the counseling impairment literature indicated that fewer impairment articles were published over a shorter time period. The overall trends in the counseling literature, however, seemed to follow psychology; after psychology's 2007 call to discontinue impairment, the counseling literature demonstrated less use of the term impairment and began using alternative terms (i.e., unfit for practice, professional performance deficiencies, problematic behavior, trainee competence, counselor competency). However, despite a reduction in the use of the term impairment since 2007, some authors continued to use the term impairment (APA, 2014; Duba et al., 2010; Williams, Pomerantz, Segrist, & Pettibone, 2010).

Results Mirroring Psychology and Counseling Differences

Not only did the personal communication and review of the literature demonstrate differences between the psychology and counseling professional perspectives regarding impairment, the results of the current study exhibited similar differences. Two areas within the study that displayed a difference among panelists were questions relating to (a) the terminology used to describe student deficiencies and (b) the likelihood of remediating such issues.

The terminology question stated that the literature suggested some individuals do not believe the term impairment should be utilized to refer to student deficiencies in training programs. Panel members were asked to suggest an alternative term they

believed was more appropriate and to also provide an explanation as to why impairment should no longer be used. The expert panel did not reach consensus regarding the most appropriate alternative term and further, some individuals believed impairment remains the most appropriate term for the phenomenon. More specifically, 71% of the counseling panelists suggested an alternative term as compared to 80% of the psychology panelists, meaning 29% of counseling panelists and 20% of psychology panelists believed impairment was an appropriate term.

The difference between professions became apparent upon examining their explanations as to why impairment should no longer be used. These responses mirrored a similar state of the impairment literature; 50% (i.e., 2 out of 4) of psychologists provided detailed explanations indicating issues with the term impairment as compared to 17% (i.e., 1 out of 6) of counseling panelists. These results suggested the psychology panelists were more frequently providing detailed explanations.

An additional difference between professional perspectives was related to the questions regarding panelists' beliefs regarding the likelihood of various impairment behaviors being remediated. This series of questions presented panel members with multiple problematic behaviors and/or actions and asked panelists to indicate which items they believed were irremediable. An examination of the results demonstrated a difference between counselors and psychologists--counselors chose fewer items as irremediable when compared to psychologists. On average, counseling panelists chose 8.8 items out of 63 to be non-remediable whereas psychologists chose 13.7 items out of 63 to be non-remediable. This might indicate that counseling panelists were less willing

to identify items as non-remediable, perhaps reflecting the counseling profession's focus on human growth and development.

Difficulty Identifying Impairment

Both the literature in counselor education and participants in this study articulated difficulty, reluctance, complexity, and-or dis-ease when attempting to define impairment or professional incompetence in counselor trainees (Bradey & Post, 1991; Frame & Stevens-Smith, 1995; McAdams et al., 2007; Wilkerson, 2006). One possible explanation for this hesitation was the intimate, personal, and often times critical nature of the evaluation of trainees' non-academic ways of being. For example, Bemak et al. (1999) underscored the importance of counseling programs and student evaluations being based on the belief that given the appropriate knowledge and environment, students can grow and develop as counselors. Students are not expected to enter a training program as competent because a developmental approach would suggest beginning counselors might often exhibit behaviors or skills that appear as impaired; however, they are a result of not yet acquired competence (Ericson, 1963; Loganbill et al., 1982). Therefore, the typical developmental approach many counselor educators hold regarding human potential and growth might create hesitancy in identifying impairment. A judgment might result in sanctions or other accountability measures (e.g., program termination), which belie counselor educators' inherent belief in the individual's capacity for growth, improvement, and change.

Identifying impairment was also difficult due to the lack of a professionally agreed upon process, structure, and protocol for the identification and evaluation of impairment behaviors. The ACA (2005) *Code of Ethics* clearly states the evaluative

requirements to be performed by counselor educators but the document lacked specific guidelines and direction to meet such requirements (Elman & Forrest, 2007). Without specific, objective, and agreed upon professional standards, counselor education faculty members are left to their idiosyncratic, subjective, and potentially arbitrary judgments (Duba et al., 2010). Many behaviors and/or dispositions indicative of impairment are often multifaceted, fluctuating in intensity and presentation, or might be concealed by the student leaving faculty and supervisors to rely on their professional judgment, experience, and/or instinct to raise concerns about a particular student.

Last, identifying impairment increases in difficulty due to the potential for legal actions related to the identification and dismissal of impaired students (McAdams et al., 2007; Vacha-Haase et al., 2004). The lack of agreed upon or empirically based professional standards for identification, evaluation, and remediation provides a potential basis for identified impaired students to contest their remediation or dismissal. The absence of a uniform protocol to identify and remediate impaired students leaves potential for claims of inconsistent evaluations and unwarranted dismissals (Bemak et al., 1999).

Perhaps, the problem stems from the difficulty in describing and measuring characteristics of an effective counselor. If counselor educators were able to concretely identify the behaviors and dispositions of an effective counselor, then identifying impairment (or ineffectiveness not due to a lack of training or skill) might be easier. This struggle to specify, identify, and evaluate effective and desired counselor behaviors and dispositions has been an ongoing and difficult problem to solve (Bemak et al., 1999).

I believe there is an added struggle when attempting to evaluate impaired personal and interpersonal behaviors throughout the didactic portion of students' training. Throughout coursework, identifying academic difficulties is more straightforward than identifying personal or interpersonal deficiencies (Markert & Monke, 1990). It is my belief that didactic coursework can often lead to passivity in students, i.e., less interaction and/or revealing oneself, decreasing the ability and opportunities for counselor educators to observe possible problematic interpersonal patterns. However, once students enter the clinical portion of their training (i.e., practicum and internship), the faculty and supervisors' ability to identify impaired behaviors might increase. This increased ability might be due to the nature of clinically-based practice where trainees are (a) interacting with clients and peers rather than sitting passively in class, (b) experiencing high levels of stress and anxiety with regard to being observed and evaluated (e.g., for programs utilizing live supervision), and (c) spending increased time in direct supervision. Therefore, counselor educators might be more likely to identify impairment (Hatcher & Lassiter, 2007). Each of these variables allows the potential for increased exposure of problematic behaviors as well as additional opportunities to observe a student's interpersonal abilities and patterns.

This study, perhaps, called into question the very way we train. A standard approach to training counselors results in two to three years to complete the master's program where the majority of that time students are learning in a didactic and somewhat passive manner (i.e., reading, PowerPoint, and lectures), which allows for the possibility that non-academic problematic behaviors might be masked or concealed. Some forms of instruction have little interaction with the faculty member and or peers; thus, all students

and, in particular, potentially impaired students have fewer opportunities to exhibit impaired or maladaptive interpersonal behaviors. Because the didactic requirements of training programs are great (often to meet accreditation requirements), there are less opportunities for clinically-focused experiences (i.e., practicum and internship). During students' clinical training, students are observed in a more intimate manner and evaluated in a more multifaceted approach.

Impairment identified later in one's program might not allow ample time to implement a remediation plan and provide due process for the student to attempt to meet remediation requirements. Therefore, early identification might provide faculty members with increased opportunities to identify impairment and students adequate time to address faculty concerns (Olkin & Gaughen, 1991). It seems our current training model (e.g., clinical training and multifaceted evaluations occurring only in the latter stages of one's program) is not conducive to identifying impairment early, which potentially increases legal risk.

Authors have long noted that identifying academic struggles is inherently more straightforward than recognizing difficulties in clinical or personal domains (Markert & Monke, 1990). Legal and ethical violations potentially harmful to clients are easier to identify than vague problems such as interpersonal deficiencies (Falender et al., 2009). Panel members in this study seemed to grapple with defining the vague and complex nature of nonacademic skills (i.e., interpersonal patterns) related to impairment, which as Olkin and Gaughen (1991) noted, made vague behaviors more difficult to identify and measure. In addition, evaluation of students is a complex undertaking because it requires assessment on both a functional competence level (e.g., conceptualization, supervision,

intervention, etc.) as well as a foundational competence level (e.g., professionalism, self-awareness, relationship patterns, ethics, etc.; Kaslow et al., 2007). The inherent difficulty to identify interpersonal characteristics within counselor education might have led the panel to fail to reach consensus in some areas.

Disagreement and Lack of Consensus Continues

Disagreement and lack of consensus existed in the literature regarding impairment. Whereas many in the field of psychology and counseling agree that there is difficulty in identifying impairment and implementing appropriate remediation strategies (Bradey & Post, 1991; Elman & Forrest, 2007; Huprich & Rudd, 2004; Li et al., 2007; Schwartz-Mette, 2011), there continues to be a lack of consensus and clarity regarding definitional boundaries, processes of remediation, and even the term we use to describe deficiencies (Elman & Forrest, 2007; Falender et al., 2009; Kaslow et al., 2007; Schwartz-Mette, 2011). This disagreement was also reflected in the panelists' responses in this study. The lack of an empirically based and professionally consistent definition and protocol was concerning considering the ethical and professional responsibilities counselor educators and psychologist have related to accurate student evaluations and client welfare.

Issues with Etiology

Although some definitions of impairment within the literature co-mingled the origin and behavioral descriptors indicating impairment (Kempthorn, 1979; Laliotis & Grayson, 1985), authors offered caution in defining impairment because co-mingling increased the difficulty in "distinguishing whether the behavior is incompetent, diminished, unethical, or even illegal" (Elman & Forrest, 2007, p. 503). Despite this

caution, I created questions regarding etiology because it was my belief that to not ask about etiology of impaired behaviors went against our nature as counselors. From a counseling perspective, when we work with clients regarding increasing awareness and insight in their lives in order to lead to productive changes, we often ask about etiology to gain an understanding of factors that influence and perpetuate the behavior.

Therefore, in the first round, panel members listed the potential origins of impairment behaviors or traits as well as provided opinions regarding how the etiology of a behavior or trait influenced their decision to identify that behavior as impaired. From the opinions presented from these questions, in the second round panel members (a) rated their level of agreement that each statement was a potential origin of impairment, (b) indicated the top five origins that were most concerning, and (c) rated their level of agreement regarding various statements regarding how the etiology of a behavior might influence a decision to identify that behavior as impaired. Panel members failed to reach consensus regarding these questions.

Some comments from panel members indicated their belief that etiology should be separate from the identification of impairment because, as one person stated: "impairment is impairment regardless of etiology." Another panelist provided feedback regarding the issue of co-mingling origin and behavior and reported difficulty answering many sections within my questionnaires because I had intermixed causes and actual observable behaviors. This panelist stated that etiology is always a guess unless counselor educators complete a full psychological assessment on the student displaying deficiencies, which would then create a dual role for faculty. This individual warned that faculty must tread lightly when talking about potential causes of the problems with

professional competence; until the field can clearly separate and understand the differences between causes (e.g., personality disorders) from observable behaviors during training, then the field will continue to muddle through this mess.

Other panelists indicated that the etiology of an impaired behavior might assist them in the development of a remediation plan. Perhaps the lack of agreement was based on an individual's theoretical beliefs regarding change. Individuals stemming from a cognitive behavioral theoretical orientation might have believed the etiology of impairment behaviors was irrelevant, whereas those with theoretical approaches such as psychoanalytic, Adlerian, etc. might have believed etiology was important to guide their understanding of the problem and to generate remediation requirements to remedy the issue.

Moderate to Mild Characteristics

Another set of questions yielding low consensus were items regarding mild to moderate problematic behaviors. Alternatively, questions yielding high consensus were items regarding severe behaviors and characteristics. In line with Olkin and Gaughen's (1991) beliefs, the results indicated the more serious or egregious a behavior, the more identifiable it became; the panel demonstrated more difficulty in reaching consensus the more ambiguous the behavior. For example, in the first round, panel members were asked to identify problematic behaviors along a continuum of counselor impairment ranging from severe to mild. In sequential rounds, panel members were asked to indicate their level of agreement that each item belonged in its respective category (i.e., severe, moderate, mild). The panel overwhelmingly agreed (i.e., 15 out of 23 items) that the elements on the severe anchor were indicative of impairment but the panel struggled to

reach consensus regarding the other two categories--the panel only reached consensus on one of eight items in the moderate category and did not reach consensus on any item (i.e., out of 21 total) in the mild category. These results mirrored the current literature on counselor impairment--the more flagrant a concerning behavior, the more identifiable it became. However, many behaviors and/or characteristics potentially leading to counselor impairment were less concrete and thus more difficult to identify (Vacha-Haase et al., 2004). The difficulty in identifying the moderate, mild, vague, and dynamic problematic behaviors creates challenges to our ability to accurately and adequately identify impairment, which was also described within the literature.

The Definition That Captures the Essence of Impairment

There is a challenge in defining impairment with any certainty, which was reflected by the difficulty the panel demonstrated in agreeing on a single or set of terms. When asked to identify an alternative term in place of impairment, the panel generated four terms or phrases: (a) impairment, (b) problems in professional competence, (c) a counselor who is unsafe to practice, and (d) problematic student behaviors. The mere results from this question, even prior to panelists rating their level of agreement, suggested immediate disagreement among the panel regarding the appropriateness of the term impairment. Many panel members (i.e., 4 out of 13) indicated they did not share the belief that impairment is an inappropriate term and at the conclusion of the study, the panel failed to reach consensus on a single term.

An initial goal of this research was to reach consensus on a set of alternative terms; however, in all reality, this was not realistic. The inability for counselor educators to agree on a term that identified student deficiencies has been a documented struggle

within the literature for 15 years (Elman & Forrest, 2007; Falender et al., 2005, 2009; Forrest et al., 1999; Li et al., 2007; Schwartz-Mette, 2011; Wilkerson, 2006). Agreement on a single term might not be possible; instead, a more feasible solution might come from the development of a uniform protocol and process for addressing impairment behaviors that would include (a) an empirically derived set of problematic behaviors and dispositions not likely to be influenced by feedback or intervention; (b) a spectrum to assist counselor educators in identifying the severity, intensity, and longevity of student behaviors; and (c) and the potential risk to clients if these behaviors and dispositions are not remediated.

Perhaps the disagreement regarding the appropriateness of the term impairment was in part because of the difference between the usability versus legality of the term. Many warned against using the word impairment because it overlaps with its use in the Americans with Disability Act (ADA, 1990), thus creating legal risk for those who use the term (Elman & Forrest, 2007). Using this term becomes an issue if the identified student actually has an impairment protected under ADA; it is then illegal for a faculty member to discuss the student's impairment because it can imply disability (Falender et al., 2005).

However, despite these warnings, the term impairment continues to be frequently used in the literature to discuss problematic student behavior (Schwartz-Mette, 2011; Smith & Moss, 2009; Williams et al., 2010). Possible reasons for the term's continued use despite many warnings might be due to familiarity and usability. Use of the term impairment dates back to the 1980s when the American Psychological Association implemented the Advisory Committee on the Impaired Psychologist (ACA, 2013).

Impairment has been a long-standing term within the helping literature; therefore, professionals might be using an historic term. Impairment might serve as a functional term because it is succinct and instantly identifiable but has limitations; whereas an alternative term such as “problems with professional competence” might be technically correct but is cumbersome.

Further, the struggle to reach consensus on a single term is most likely reflective of the complexity involved in the identification and remediation process. Smith and Moss (2009) believed the problem might be based in the rigidity of the term and/or definition, which does not allow for finer consideration of such complex and unique human experiences such as the levels of student behavior (i.e., academic, practical, personal, interpersonal, etc.). There seems to be a lack of agreement within both the counseling and psychology professions on what constitutes impairment (e.g., behaviors, psychological disorders, personality disorders) and whether the severity, intensity, duration, and/or nature of the impairment is most important. Future focus regarding this issue might be better spent on pinpointing a protocol and threshold where the problematic behaviors are situationally-based (i.e., potentially more remediable) or more ingrained (i.e., potentially irremediable).

Continuum Anchor Points and Behaviors

Within the impairment literature, there is a lack of discussion regarding a continuum of behaviors constituting an impaired student. However, the results from this study promoted the utility of an agreed upon continuum generated from the expert panel. This continuum had three anchor points or categories (i.e., severe, moderate, mild), each containing various problematic behaviors. The continuum with lists of behaviors

associated with each anchor might provide guidance and support for counselor educators' identification and remediation decisions for problematic students. The severe category consisted of not only more severe, persistent behaviors but also seemed to be focused on the potential of the behavior to harm clients. In addition to the potential harm to clients, the panel identified behaviors for the severe category that demonstrated the individual's lack of awareness and/or accountability. The behaviors within the moderate category varied slightly from the severe category and still demonstrated the potential for harm. The mild category consisted of behaviors considered problematic warranting additional attention and remediation efforts but were more minor in their presence and generally not harmful to clients. The findings from this study provided insight into possible directions or suggestions for the field of counselor education.

Implications

The results of this study identified multiple implications for the field of counselor education. The need exists for an empirically-derived description of problematic behaviors and dispositions associated with each counselor competency (Fouad et al., 2009). These behaviors and dispositions could be classified along a continuum of counselor impairment that addresses potential levels of interventions based on the nature, intensity, presentation, and duration of the behaviors or dispositions. A well-conceived protocol to identify and assess impaired students would assist counselor educators in training the next generation of master's and doctoral students; supplement recruitment, admissions, and retention procedures; and provide more structure to identify problematic or impaired student behaviors. Further, devising a profession-wide protocol might call into question the very format and methods used to educate and train counselors. It is long

past time for the field of counselor education to invest in objective, accountable measures for trainee and practitioner performance; our ethical code calls for nothing less (e.g., client welfare; ACA, 2005).

Considerations for Admission Process

By having an empirically derived set of descriptors set along a continuum with some predictive validity, counselor educators might be able to screen for some of the potential indicators of disturbance or disruption at the recruitment and admission stage. The mere presence of a behavior does not mean it will be acted upon or would be problematic but there is a need to more readily screen the fitness of potential applicants so they do not begin a program from which they might be terminated or enter a profession with an increased likelihood of harming a client.

Current pre-admission requirements commonly include (a) bachelor level grade point average (GPA), (b) Graduate Record Examination (GRE) scores, (c) personal statements, (d) letters of recommendation, and, in some cases, (e) personal interviews. These methods of assessment have been utilized within counselor education programs with virtually no variance since the inception of the counseling profession (Duba et al., 2010; Gimmestad & Goldsmith, 1973; Hill, 1961; Markert & Monke, 1990; Walton & Sweeney, 1969; Wellman, 1955; Young, 1986). Therefore, it seems counselor education programs are due for an overhaul of its admissions procedures.

The results from this study suggested the importance of personal interviews within the admissions process. Not all counselor education programs conduct in-person interviews for applicants but this process might provide an opportunity to evaluate non-academic characteristics prior to a student's acceptance into a counseling program. It

should be noted that with an in-person interview, there is an increased possibility of biased evaluations if a faculty member holds a certain prejudice. Such biased evaluations might be reduced if faculty build in a multiple-rater evaluation system and group discussions regarding each candidate. This type of pre-admission requirement might be more important for identifying possible impairment than other academic-related components (i.e., GPA, GRE) and more effective than other pre-admission requirements attempting to acquire information regarding applicants' interpersonal characteristics (i.e., personal statements, letters of recommendation).

In-person interviews might assist counselor educators in the early identification of potential student impairment. The results from this study might also suggest a need for applicants to understand counselor competencies and the reality and possibility of impairment. Pre-admissions procedures might be supplemented by the opportunity for individuals to learn about typical counselor characteristics and standards as well as concerning behaviors often identified as impairment leading to requirements of remediation and/or dismissal from counseling programs. This type of information not only jumpstarts applicants' understanding of counselor competencies, it also provides individuals with an opportunity to determine if the counseling profession is appropriate for them. Since the primary responsibility of counselor educators is to protect the wellbeing and welfare of clients served (Bernard & Goodyear, 2009), the inclusion of alternative admissions procedures might be a beneficial addition in the admissions process.

Training Master's and Counselor Education and Supervision Doctoral Students

An implication from this study was the need for more training for master's and Counselor Education and Supervision (CES) doctoral students around the topics of counselor success, impairment, remediation, and gatekeeping. Many CES doctoral programs include education and discussion on the literature on remediation and gatekeeping, yet the depth and complexity of these discussions is unknown and potentially questionable considering the lack of understanding of identifying and remediating impaired behavior. In addition, this area of education must be more than conversations regarding gatekeeping; it must also be about knowledge regarding what a developmentally healthy student looks like. Without an understanding of outcomes and characteristics of the necessary skills needed for counseling students, identifying an impaired student will continue to remain a struggle. This area of education must also include understanding procedures and protocol to support students either through a remediation process or selecting a more appropriate career if they are unable to demonstrate appropriate counseling skills and dispositions. If we fail to have conversations with the next generation of counselor educators, then we are perhaps perpetuating the lack of clarity, lack of accountability, and hesitancy in addressing impairment concerns, possibly leading to higher rates of graduating impaired counselors who might potentially increase the instance of client harm.

In addition to additional training for CES doctoral students, a similar understanding might be beneficial for master's counseling students. It is important for master's counseling students to know the hallmarks of impairment because most master's

students might work alongside colleagues who exhibit impairment behaviors. Education regarding counselor impairment might increase the likelihood of colleague assistance and identification of impaired counselors needing help. Not to mention, many master's level counselors serve in supervisory roles at some point throughout their career. Therefore, knowledge of indicators of impairment and appropriate remedial protocol might prove to be invaluable to reduce impairment within the counseling profession, thus decreasing potential harm to clients.

Assistance for Counselor Educators

The results from this study might provide assistance or a protocol for counselor educators to assess and address students who demonstrate impaired behaviors or dispositions. Much of the struggle related to identifying and creating a remediation plan is the absence of concrete measures to identify often vague and subjective personal and interpersonal behaviors. A student who is struggling within their academic work is not only identified earlier within their program but faculty members often have more confidence in addressing the issue because the problem behavior itself is concrete (Olkin & Gaughen, 1991).

The results from this study suggested many problematic student behaviors containing the highest potential for client harm are less substantial (e.g., interpersonal deficiencies). Since such behaviors are not academically related, they might be more likely to go unnoticed until clinical work often at the end of a program, if they are noticed at all. In addition, personal and interpersonal behaviors might prove to be difficult for faculty to identify with any certainty and decrease the confidence and ability to address them (Bradey & Post, 1991). Much of the struggle comes from not only an inability to

verbalize an intuitive evaluation of a student but also the lack of guidance and support in the literature regarding personal and interpersonally based behaviors. Often times, counselor educators believe unless they can concretely identify the problematic behavior, they are unable to address the student's problematic behaviors, which occasionally leads to avoidance of evaluations (McAdams et al., 2007; Vacha-Haase et al., 2004). The results from this study might provide empirically supported documents (i.e., lists of problematic behaviors associated with each counselor competency area and a continuum of impairment behaviors) that can aid in faculty discussions and confidence in addressing even vague and subjective behaviors.

Reconsideration of Pedagogy

An initial indication of this study was a need for a variety of forms of evaluation to assess student performance. Counselor training programs are unlike bachelor's degrees and even other master's degree programs since students are working with people and not objects. Thus, a student's way of being and interpersonal patterns are a potentially more important aspect of evaluation than grades within coursework. Although grades are a necessary aspect of training, especially to uphold the CACREP (2009) standards and student learning outcomes, the field must consider the apparent imbalance between and focus on objective grades versus subjective evaluations within supervision and the amount of supervision provided. Student evaluation should be less about grades for courses and more about having multiple measures of evaluation that are objective and transparent. This issue is about a pedagogy that would require the observation of specific counselor behaviors and dispositions with clients and their peers over time (i.e., from the beginning of the program to its completion) with ample and

recursive feedback and correction. In this way, if the student consistently fails to meet the standards or has an egregious violation, he or she could be removed or remediated.

More Than a Term

Many authors have advocated the field to discontinue the use of impairment for multiple reasons (Falender et al., 2005; Forrest et al., 1999; Schwartz-Mette, 2011; Wilkerson, 2006). Despite this, impairment continues to be used within the literature, not only in conceptual and research articles (Schwartz-Mette, 2011; Smith & Moss, 2009; Williams et al., 2010) but also in the 2014 ACA *Code of Ethical Standards*: "Students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or providing professional services when such impairment is likely to harm a client or others" (F.5.b).

My beliefs regarding the appropriateness of the term impairment mirrored the struggle reflected in the literature and the results of this study. On one hand, I view impairment as the most realistic, functional term because it has a long history of being used in the context of problematic counseling students and, therefore, counselor educators immediately recognize the meaning of the word. In addition, other terms present as too cumbersome; thus, the term impairment provides an easy and efficient word to signify concerning student behaviors. On the other hand, the term is broad and can lead to confusion and difficulty pinpointing the exact form of problematic behavior. Most importantly, impairment is a protected word under ADA (1990) and creates legal risk for counselor educators who choose to use it to create conversations with their students (Elman & Forrest, 2007).

The results indicated an ongoing debate regarding the most appropriate term to denote various student deficiencies, yet the findings also suggested the issue is more than agreement on a term. The results might spark a discussion that could result in a protocol for identification, assessment, and remediation of impaired counselors. The protocol must be sensitive to ADA (1990) and other concerns while being utilitarian enough for counselor educators to more readily use.

Limitations of the Study

Methodological Inadequacies in Reducing a Complex Issue

The Delphi method allows for a group communication process that can empirically derive consensus among experts (Dalkey, 1969b). However, a review of the literature for the current study indicated this method is underutilized, perhaps due to the absence of structure or function regarding the methodology of the Delphi process. A limitation of the Delphi method is the lack of direction regarding how to effectively conduct Delphi research (West, 2011). The literature surrounding this methodology suggested researchers are not provided with guidance regarding (a) how to determine an expert (Hasson & Keeney, 2011; Linstone & Turloff, 1975), (b) survey design (Hasson et al., 2000), (c) organizing and analyzing expert responses (Hasson & Keeney, 2011; Hasson et al., 2000; Keeney et al., 2001), and (d) determining a threshold for consensus (Graham et al., 2003; Hasson et al., 2000; Keeney et al., 2001). These limitations regarding structure and functionality of the Delphi method are consistent across disciplines. For this study, 31 articles concerning the Delphi study were reviewed and only three of the articles were specifically within the counselor education field.

The current study was conducive to a Delphi study because there is (a) limited information currently available regarding impaired counseling students and (b) a lack of current consensus regarding the definition and characteristics of impairment. Regardless of the appropriateness of the methodology for this research, the panel struggled to reach agreement in some areas. Upon conducting this study, I realized the Delphi method as currently described had limitations regarding the group communication process for a topic this complex and might be suited for a face-to-face methodology, allowing the expert panel to interact in real time. Some of the struggles I experienced utilizing the Delphi method for this study were (a) a lack of direction from the Delphi literature, (b) difficulty reducing a complex topic into question format, (c) the lack of opportunity for real time interaction among panel members, and (d) the impact of strongly held beliefs.

Lack of direction designing surveys. In the current study, the survey and question development was the most difficult area of conducting a Delphi study. In my opinion, one strength of the Delphi method is the flexibility the researcher has to design each survey depending on the specific needs of the study. However, this flexibility inherently lacks guidance, potentially leading to researcher struggles in survey and question development. For example, I experienced difficulty in reducing a multifaceted and dynamic problem (i.e., counselor competency and impairment) into succinct sentences or questions; therefore, the questions and items offered were lengthy. The results indicated complex questions and large numbers of items to consider within each question were troublesome for panelists. For example, questions within the study asked panel members to rank order the behaviors from most concerning to least concerning--there were anywhere from 7 to 17 behaviors and/or actions to rank order. Those

questions with over 10 items (i.e., 4 of the 8 questions) might have proven to be too cumbersome for panel members to track and accurately rank order a large number of items.

Perhaps if the amount of items presented was fewer, the results would have proven to be more accurate (i.e., reached consensus). Unfortunately, reducing the complexity and number of items would also have reduced my ability to acquire an in-depth evaluation of a complex and multifaceted issue such as counselor impairment. It became apparent that to adequately capture the complexity of impairment and gather useful data, the sheer number of questions required might have become cumbersome, thus increasing potential fatigue encountered by participants as successive rounds of inquiry were used.

Due to a lack of valid pre-constructed surveys, there was a potential for poorly worded or confusing questions. I attempted to reduce this limitation by piloting the first round questions with the intent to acquire feedback regarding the wording, nature, and understandability of the questions. Although this pilot process provided valuable feedback and generated multiple wording changes within the first round of survey questions, the pilot process could not benefit the successive rounds because each Delphi study is different depending on the responses from the unique set of panelists. If a pilot process had been conducted for all three rounds of the study, the pilot panelists, who differed from the actual panelists, would have provided different responses, thus requiring an alternative form of survey for following rounds.

Some potential issues regarding the wording of the questions could have been confusing wording, complexity of questions, and including multiple behaviors within a

single question. For example, a series of questions asked panelists to identify problematic professional behaviors. Feedback from a panel member indicated confusion with the wording of this question because she believed problematic and professional contradicted each other, leaving her unsure of how to answer this question. Other panel members did not have the same issue understanding this question yet alternative wording could have asked panel members to identify problematic behaviors related to being a professional counselor.

Another potential issue with questioning could have been the complexity. The first round of data collection yielded a lot of data that needed to be analyzed and summarized into successive round questions for panel members to rate and rank their agreement. The large amount of data collected for each question created complex questions. For example, in one series of questioning, panel members were asked to rank order the elements from most concerning to least concerning. Panel members had to sort through up to 17 elements. Feedback from one panel member indicated this task was tedious and daunting, which could have impacted the accuracy of these results.

Last was the use of multiple behaviors and/or actions within a single question. The first round data analysis required content analysis and coding of qualitative data for themes. Many of the elements fit under an overall theme but I listed multiple related behaviors for each theme in an effort to be descriptive about what the theme included. The inclusion of multiple behaviors under each theme might have created inaccurate results because if each behavior was listed separately instead of under a theme, the panelists might have rated each behavior with a different number than they did when rating their level agreement with the overall theme. For example, one element within a

question where the panel rated their level of agreement was “difficulty with interpersonal boundaries (e.g., invades others' space, inappropriate touch or relationships with clients, shares too much personal information).” In this case, the overall theme was “difficulty with interpersonal boundaries” and the multiple behaviors linked under the theme were “invades others' space, inappropriate touch or relationships with clients, shares too much personal information.” While each of these concerning behaviors represented difficulty with interpersonal boundaries, panelists were forced to rate their level of agreement regarding all three behaviors under one theme. The responses might have varied if each behavior was listed as a separate element to be considered individually. However, in an effort to reduce and organize the data in each round, the identification of themes was necessary.

Analyzing data and determining a threshold for group consensus. Some authors believed forming consensus among Delphi panelists was simply forcing a group of experts to agree on a final consensus, disallowing for the opportunity to discuss the subtleties of the topic (Hasson et al., 2000). Thus, this criticism suggested that reaching a true consensus might not be realistic. Rather, the data might be a result of a groupthink phenomenon or the researcher’s subjective evaluation of consensus instead of true consensus. Hasson and Keeney (2011) suggested the results might be more accurately labeled as expert opinion for the current group of panelists rather than true consensus.

In the present study, I did not experience expert panelists being forced into consensus. With a lack of opportunity to engage in real-time discussions regarding the topic, it seemed that panel members actually resisted converging. One example was demonstrated in the question inquiring about an alternative term experts believed should

be used instead of impairment. Panelists suggested four terms to identify student problematic behavior (i.e., problems in professional competence, problematic student behaviors, impairment, and a counselor who is unsafe to practice). At the conclusion of the study, consensus was not reached regarding the appropriateness for a single alternative term. The potential lack of clarity or succinctness in the original inquiry sentences as well as the likely inflexibility of some participants' perceptions might have contributed to difficulties this panel had in arriving at consensus rather than forcing consensus.

Difficulty reducing a complex topic. Perhaps there are methodological inadequacies within research that limit the ability to acquire an in-depth evaluation of a complex and multifaceted issue such as counselor impairment. I experienced difficulty in reducing a multifaceted and dynamic problem (i.e., counselor competency and impairment) into succinct sentences or questions. To adequately capture the complexity of impairment and gather useful data, the sheer number of questions required might have become cumbersome, thus increasing potential fatigue encountered by participants as successive rounds of inquiry were used. The potential lack of clarity or succinctness in the inquiry sentences might have contributed to difficulties this panel had in arriving at consensus in some areas.

Large number of items to consider. An additional issue within the construction of questions could have been the number of items to consider. An investigation of a complex phenomenon (i.e., counselor impairment) naturally creates intricate questions and numerous items. For example, for the questions asking panel members to rank order the listed behaviors from most concerning to least concerning, there was anywhere from

7 to 17 behaviors to rank order. The questions with items over 10 (i.e., 4 out of 8 questions) might have proven to be too cumbersome for panel members to track and accurately rank order a large number of items. Perhaps if the number of items presented was fewer, the results might have demonstrated higher levels of consensus. However, if the number of items presented was reduced, it would also reduce the ability to adequately investigate this complex issue. Unfortunately, the Delphi literature lacked suggestions regarding survey and question development (Hasson et al., 2000).

Difficulty rank ordering numerous items. The second round included eight rank ordered questions. Of those rank ordered questions, there was a total of 77 items and the expert panel reached consensus on only 10 of those items (i.e., 0.13% consensus). One panel member commented on the overwhelming nature of the rank ordered questions, more specifically, she struggled to keep the large number of items organized in her mind. Although the rank ordered questions yielded a low level of panel consensus, I believe the type of question (i.e., rank ordering numerous items) created the lack of consensus rather than an actual disagreement among the expert panel, thus demonstrating possible methodological inadequacies inherent with the Delphi method.

Lack of opportunity for real time interaction. The Delphi method is often utilized because it allows the researcher to create anonymous group communication, ultimately leading to consensus (Dalkey, 1969b). This process allows for panel members to present their opinions and then receive feedback regarding the collective viewpoint in order to potentially reconsider their initial thoughts by funneling individual knowledge into collective agreement (Hasson et al., 2000; Skulmoski e al., 2007). Despite the reported ability of the Delphi method to create a group communication process that

allows experts to clarify a complex problem, I believe the expert communication in this study had limited impact on the results. There were multiple questions where panel members' opinions did not change from round to round. A potential reason for this absence of convergence might have been the lack of an in-depth communication process among panelists. The complexity of counselor impairment was not only difficult to adequately represent in question format but it might have been difficult for panel members to adequately describe all its nuances in the communication format they were given. Therefore, if panel members were unable to fully describe and discuss their views on counselor impairment, the results would lack enough description to adequately produce a group communication process. Without an adequate group communication process, the ability to reach group consensus is limited.

Perhaps a complex, multifaceted problem such as counselor impairment requires a real-time communication process. Future researchers might consider this real-time communication process by utilizing a modified Delphi method. Authors writing about the Delphi method indicated high levels of flexibility with the Delphi methodology where researchers could uniquely design their study to fit the problem they were investigating as well as the research questions (Davis, 1997). Modified Delphi studies might include individual interviews and/or focus groups (Hasson & Keeney, 2011) to gather more descriptive data. Conceivably, a possible way to increase the ability of a group communication process to reach consensus regarding a complex problem might be through a modified Delphi study that utilizes expert panel focus groups.

Impact of strongly held beliefs. One purpose of the Delphi method is for a panel of experts to revise and reconsider their original opinion each round as they learn the

group's overall opinions, ultimately leading to consensus (Hasson et al., 2000). The Delphi literature lacked a discussion regarding the potential impact of strongly held beliefs on the ability of the expert panel to reach consensus. The only study within the Delphi literature regarding reaching consensus was discussion of a common criticism that the Delphi method forces group consensus because the expert panel lacks opportunities to fully discuss their opinions (Hasson et al., 2000). In addition to limited communication among panelists, forced consensus might result from regression toward the mean, i.e., once panel members saw the collective viewpoint, they might then reconsider their opinions to align with the group (Vazquez-Ramons et al., 2007).

In this study, I do not believe consensus was forced; instead, consensus might have been lacking in multiple areas, perhaps due to strongly held beliefs panelists were unwilling to alter. The high level of investment and dedication the panel members expressed regarding the topic of impairment suggested the presence of strong opinions and beliefs, which might have created difficulty in shifting their perspectives despite the input of others. Therefore, there might have been an unwillingness to alter one's original opinion due to firm beliefs and past experiences dealing with the issue and/or simply no opportunity to fully discuss the controversial aspects.

Researcher's Oversight

A unique limitation of this study was the errors I made in failing to include various elements and questions in a successive round. For example, after the second round, interquartile ranges (IQR) were calculated for each item. Upon creating the third round survey, I made a coding error and failed to include an item that lacked consensus in the previous round. This item yielded an IQR of 2.5 and the panel was not able to

reconsider this item to create consensus. An additional researcher error was the failure to include various questions in the third round. A series of questions in the second round asked panel members to rate their level of agreement with statements regarding how (a) intensity, (b) duration, and (c) persistence influenced their evaluation of a behavior as impaired. In the third round, I failed to include the question regarding the intensity of behaviors even though only one item out of three reached consensus after the second round. Although these errors did not affect the other data collected, the panel was unable to give each of these items full consideration of three rounds.

Directions for Future Research

This investigation, which attempted to clarify the definitional boundaries and essential descriptors of counselor impairment, has identified future research needs and opportunities. First, the current study identified lists of problematic behaviors regarding each counselor competency area and a continuum of problematic behaviors ranging in severity. These empirically derived, agreed upon lists could provide support for further development of concrete evaluation measures. If counselor educators were able to have lists of problematic behaviors and concrete forms that indicated a need for a remediation plan, a protocol could be developed that could provide more confidence in a more objective process. In addition, the counselor impairment continuum and lists of problematic behaviors might provide research opportunities to create a coinciding list of remediation techniques and/or activities that might be warranted for various behaviors or severity of behaviors.

There is an ongoing need for research that would create a deeper, more concrete understanding of counselor impairment as well as clarify the definitional boundaries and

appropriate term to use in identifying problematic behavior. A concern within the field has been a lack of understanding of impairment and the inconsistent nature with which we refer to problematic student behaviors (Forrest et al., 1999). This disagreement and inconsistency were demonstrated in the results of the current study; thus, additional attention to the issue is warranted. After all, confusion and disagreement among counselor educators only decreases the ability to effectively identify and remediate impaired students, thus increasing the potential harm to clients.

The first line of defense to decrease impairment within counseling programs is to increase our ability to identify impairment within the admissions process. Therefore, future research is needed to identify which admissions requirements and procedures increase counselor educators' ability to identify impairment prior to admission. If a deep understanding of impairment and agreement regarding the characteristics of impairment is an unrealistic task, then the ability to identify potential impairment upon admission is vital.

Creation of a task force might be an important next step considering the need to formalize a decision-making process that would allow for a more effective and efficient identification and remediation protocol of impaired counseling students. The development of a task force and, ultimately, a formalized process or protocol might increase counselor educators' confidence and ability to accurately identify problematic student behaviors and create appropriate remediation plans. Upon completion of a formalized document, the task force could present the protocol to the CACREP (2009) board (for example) for adoption and then dissemination to counseling programs for suggested use. This process might provide much needed assistance to counselor

educators who would then be able to increase their ability to protect the public from impaired counselors.

Conclusion

This research represents an initial attempt to reach expert consensus regarding the definitional boundaries and characteristics of counselor impairment. Although complete consensus was not achieved for each area of inquiry for this study, the items that did reach expert agreement generated lists of problematic behaviors as well as a continuum of deficiencies from severe to mild. The protocol might provide much needed guidance and empirical support to begin to more effectively and efficiently identify problematic student behaviors. It is vital that counselor educators continue to increase their ability, confidence, and competence in identifying and requiring appropriate remediation plans for impaired students. With the presence of hesitancy or uncertainty in identifying personal or interpersonal behaviors as impairment, we run the risk of knowingly graduating an impaired individual who has great potential to harm clients. This type of oversight must be addressed for the overall welfare of clients and the credibility of the counseling profession.

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APPENDIX A

ROUND ONE QUESTIONS

Round One Questions

1) Please provide your definition of student impairment

   1a) Describe the basis of your definition (e.g., theories, experiences, professional literature, etc.).

2) List professional behaviors or traits (i.e., values/attitudes, professional identity, individual/cultural diversity, legal/ethical standards decision making, reflective practice/ self-care) that are inconsistent with the expected developmental trajectory of a counselor-in-training.

   2a) Of the behaviors or traits listed in question 2, list the ones you consider to be remediable given adequate experience, education and or supervision.

   2b) Of the behaviors or traits listed in question 2 that you considered remediable, suggest possible educational activities, timelines for completion and type of supervision required to remediate.

3) List relational-based behaviors or traits (i.e., interpersonal ability, affect skills, expressive skills) that are inconsistent with the expected developmental trajectory of a counselor-in-training.

   3a) Of the behaviors or traits you suggested in question 3, list the ones you considered to be remediable with experience, education and or supervision.

   3b) Of the behaviors or traits listed in question 3 that you considered remediable, suggest possible educational activities, timelines for completion and type of supervision required to remediate.

4) List scientific-application behaviors or traits (i.e., methods, scientific knowledge, scientific foundation and professional practice, application of evidence-based practice,

assessment/diagnosis, intervention planning) that are inconsistent with the expected developmental trajectory of a counselor-in-training.

4a) Of the behaviors or traits you suggested in question 4, list the ones you consider to be remediable with experience, education and or supervision.

4b) Of the behaviors or traits listed in question 4 that you considered remediable, suggest possible educational activities, timelines for completion and type of supervision required to remediate.

5) List supervision based behaviors or traits (i.e., knowledge of supervision process, open to supervision, integrates supervisor feedback) that are inconsistent with the expected developmental trajectory of a counselor-in-training.

5a) Of the behaviors or traits you suggested in question 5, list the ones you consider to be remediable with experience, education and or supervision.

5b) Of the behaviors or traits listed in question 5 that you considered remediable, suggest possible educational activities, timelines for completion and type of supervision required to remediate.

6) List system-based behaviors or traits (i.e., cooperates with others in task completion, willingness to listen, respectful and productive relationships within a system, responds to direction, completes assignments in a timely manner) that are inconsistent with the expected developmental trajectory of a counselor-in-training.

6a) Of the behaviors or traits you suggested in question 6, list the ones you consider to be remediable with experience, education and or supervision.

6b) Of the behaviors or traits listed in question 6 that you considered remediable, suggest possible educational activities, timelines for completion and type of supervision required to remediate.

7) Some believe counselor impairment exists on a continuum from minor to severe behaviors and traits. If you agree, how would you describe the major segments of this continuum and the behaviors or traits associated with each segment? If you do not view impairment on a continuum, please describe how you perceive impairment to exist.

8) How do you distinguish between impairment from not yet acquired competence?

9) What indicators distinguish impaired performance from performance associated with cultural values?

10) Describe how/if the intensity of a behavior or trait influences your evaluation of it as impaired.

11) Describe how/if the duration of a behavior or trait influences your evaluation of it as impaired.

12) Describe how/if the persistence of a behavior or trait influences your evaluation of it as impaired.

13) List the potential origins of impairment behaviors or traits.

14) Given the list of potential origins of impaired behaviors or traits suggested in the previous question, how might the etiology of a behavior or trait influence your decision to identify that behavior as impaired?

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL

UNIVERSITY of NORTHERN COLORADO

Institutional Review Board

DATE:	January 16, 2014
TO:	Lisa Forbes, M.A.
FROM:	University of Northern Colorado (UNCO) IRB
PROJECT TITLE:	[541073-3] Clarifying the Definitional Boundaries and Essential Characteristics of Impaired Counseling Students: A Delphi Study
SUBMISSION TYPE:	Amendment/Modification
ACTION: STATUS	APPROVAL/VERIFICATION OF EXEMPT
DECISION DATE:	January 16, 2014

Thank you for your submission of Amendment/Modification materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or Sherry.May@unco.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

APPENDIX C

CONSENT FORM FOR PARTICIPATION IN HUMAN RESEARCH

UNIVERSITY of NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH
University of Northern Colorado

Project Title: Clarifying the Definitional Boundaries and Essential Characteristics of Impaired Counseling Students: A Delphi Study

Principal Researcher: Lisa K. Forbes, M.A., NCC
Phone: (303) 669-1131
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Email: linda.black@unco.edu

The primary purpose of this research project is to understand and clarify the essential descriptors of counselor-in-training impairment. The Delphi method, consisting of three to four rounds of surveys, will be utilized to gather expert opinions regarding impairment. The final number of survey rounds will depend on reaching a minimum threshold of the group's level of agreement. The first round may take 20-30 minutes to complete and rounds 2-4 may take 10-15 minutes to complete. I expect the study's 3-4 rounds may be conducted over a period of two to three months. This research method will allow the principal investigator to gradually refine the group's expert opinion into a high level of agreement concerning the essential descriptors of counselor-in-training impairment. Surveys will be distributed via e-mail and collected electronically via Qualtrics software. The principal investigator will collect and analyze the data received from each round of surveys. The initial round of surveys will yield qualitative responses therefore, data analysis will consist of content analysis. Subsequent surveys after the first round will consist of primarily quantitative data resulting from Likert scaling. Therefore, data analysis from rounds 2-4 will consist of using medians and interquartile ranges to evaluate the group's responses for the level of agreement.

I do not foresee risks to you. The results from your participation will be held in strict confidence. I will take reasonable precautions to ensure the confidentiality of your survey responses. A common procedure of the Delphi method provides participants' anonymity in relation to other panelists yet the identity of each participant are known to the researcher. In each round, your individual responses and the group's current level of agreement for each item will be returned to you in addition to the subsequent round survey with the purpose of allowing you to reconsider your initial opinion. Therefore, your identity, in connection with your survey responses, will be known to the principal researcher but will not be disclosed to other participants. Data will be stored in a password-activated computer that only the principle investigator will have access.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you have the right to withdraw at any time. Those who participate to the conclusion of the study will be entered into a drawing to win one of four $50 Amazon gift cards. Having read the above and having had an opportunity to ask any questions, if you are at least 18 years of age please type your name and return this document to the principle investigator via e-mail if you would like to participate in this research. A copy of this form will be retained for a period of three years by my research advisor. A copy can be provided upon request.

_____

Signature Date

_____

Researcher as Witness Date

If you have any concerns about your selection or treatment as a research participant, please contact the Office of Sponsored Programs, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-2161.

APPENDIX D

ROUND TWO QUESTIONS

Round Two Questions

1. The expert panel identified the following potential elements of a definition of student impairment. Please indicate to what degree you believe each item should be included in such a definition.
2. Please rank the level of importance that each of the elements below holds in the development of the definition of impairment.
3. The expert panel identified the following as the basis for their definition of impairment. Please rank order each item in terms of the magnitude of its contribution to your definition of impairment. To change the rank of each element please click and drag to the desired rank.
4. The expert panel identified problematic professional behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. Please indicate to what degree you agree that these behaviors are problematic.
5. Assuming you agree that each element is a professional behavior inconsistent with the expected developmental trajectory of a counselor-in-training, please rank order the following elements from most concerning to least concerning.
6. Of the behaviors listed below, select those that are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation.
7. The expert panel identified problematic relationship-based behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. Please indicate to what degree you agree that these behaviors are problematic.

8. Assuming you agree that each element is a relationship-based behavior inconsistent with the expected developmental trajectory of a counselor-in-training, please rank order the following elements from most concerning to least concerning.
9. Of the behaviors listed below, select those that are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation.
10. The expert panel identified problematic scientific-application behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. Please indicate to what degree you agree that these behaviors are problematic.
11. Assuming you agree that each element is a scientific-application behavior inconsistent with the expected developmental trajectory of a counselor-in-training, please rank order the following elements from most concerning to least concerning.
12. Of the behaviors listed below, select those that are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation.
13. The expert panel identified problematic supervisory-based behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. Please indicate to what degree you agree that these behaviors are problematic.
14. Assuming you agree that each element is a supervisory-based behavior inconsistent with the expected developmental trajectory of a counselor-in-training, please rank order the following elements from most concerning to least concerning.

15. Of the behaviors listed below, select those that are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation.
16. The expert panel identified problematic system-based behaviors inconsistent with the expected developmental trajectory of a counselor-in-training. Please indicate to what degree you agree that these behaviors are problematic.
17. Assuming you agree that each element is a system-based behavior inconsistent with the expected developmental trajectory of a counselor-in-training, please rank order the following elements from most concerning to least concerning.
18. Of the behaviors listed below, select those that are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation.
19. The expert panel agreed that impairment exists on a continuum. The below elements were identified as examples of behaviors, traits, or actions that may exist on the “severe/major” end of the impairment continuum. Please rate your level of agreement that each element belongs in the “severe/major” segment.
20. The below elements were identified as examples of behaviors, traits, or actions that exist on the “moderate” segment of the impairment continuum. Please rate your level of agreement that each element belongs in the “moderate” segment.
21. The below elements were identified as examples of behaviors, traits, or actions that exist on the “minor” end of the impairment continuum. Please rate your level of agreement that each element belongs in the “minor” segment.

22. In addition to the continuum suggested in the previous questions, panel members also provided the following scales they use to measure impairment. Please rank order the following scales in the usefulness in your evaluation of impairment.
23. The expert panel indicated the following statements distinguish impairment from not yet acquired competence. Please rate to what degree each statement distinguishes impairment from not yet acquired competence.
24. Please indicate the top five, or five most useful, statements that assist you in determining impairment from not yet acquired competencies.
25. The expert panel indicated the following statements distinguish impairment performance from performance associated with cultural values. Please rate to what degree each statement distinguishes impaired performance from performance associated with cultural values.
26. Please indicate the top five, or five most useful, statements that assist you in determining impaired performance from performance associated with cultural values.
27. The expert panel generated statements regarding how the intensity of a behavior or trait influences an evaluation of it as impaired. Please rate your level of agreement with each statement.
28. The expert panel generated statements regarding how the duration of a behavior or trait influences an evaluation of it as impaired. Please rate your level of agreement with each statement.

29. The expert panel generated statements regarding how the persistence of a behavior or trait influences an evaluation of it as impaired. Please rate your level of agreement with each statement.
30. The expert panel generated a list of potential origins of impairment behaviors or traits. Please rate your level of agreement that each statement is an origin of impairment.
31. Of the potential origins of impaired behavior and traits, please indicate the five origins that are most concerning to you in your evaluation of it as impaired.
32. The expert panel suggested various statements regarding how the etiology of a behavior or trait might influence a decision to identify that behavior as impaired. Please rate your level of agreement with each statement below.
33. Many in the field believe that the term impairment is an inappropriate and incomplete term to identify this phenomenon. Please provide an alternative term that you believe better captures the phenomenon.

APPENDIX E

ROUND THREE QUESTIONS

Round Three Questions

1. The expert panel agreed that “personal and or professional behaviors that interfere with the student’s ability to provide competent client care” is the most important statement to be included in a definition of impairment. The expert panel did not reach consensus regarding the remaining statements. The following statements are ranked in order of their mean scores. Please rate your level of agreement that the following statements are in order of importance in developing a definition of impairment.
2. The expert panel acknowledged that professional experience addressing impairment contributed the most to the development of a definition of impairment and that the criteria for personality disorders as described in the DSM-V contributed the least. However, the expert panel did not reach consensus regarding the remaining items. The following statements are ranked in order of their mean scores. Please indicate to what degree you agree with the ranking of the following elements.
3. The expert panel reached consensus regarding many problematic professional behaviors that are inconsistent with the expected developmental trajectory of a counselor-in-training. The expert panel did not reach consensus regarding the behaviors listed below. Of the problematic behaviors listed, please indicate to what degree these behaviors are problematic.
4. The expert panel indicated that the following elements are the 10 most concerning problematic professional behaviors. Of the list below, please choose the top 5 most concerning behaviors.

5. Please provide a brief rationale to support the choice of the 5 most concerning behaviors.
6. Members of the expert panel indicated that the following problematic professional behaviors are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation. Please rate how likely each behavior is to respond to remediation.
7. The expert panel reached consensus regarding many problematic relational behaviors that are inconsistent with the expected developmental trajectory of a counselor-in-training. The expert panel did not reach consensus regarding the behaviors listed below. Of the problematic behaviors listed, please indicate to what degree these behaviors are problematic.
8. The expert panel indicated that the following elements are the 10 most concerning problematic relational behaviors. Please choose the top 5 most concerning behaviors.
9. Members of the expert panel indicated the following problematic relational behaviors are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation. Please rate how likely each behavior is to respond to remediation.
10. The expert panel reached consensus regarding many problematic scientific-application behaviors that are inconsistent with the expected developmental trajectory of a counselor-in-training. The expert panel did not reach consensus regarding the behaviors listed below. Of the problematic behaviors listed, please indicate to what degree these behaviors are problematic.

11. The expert panel indicated that the following elements are the 10 most concerning problematic scientific-application behaviors. Please choose the top 5 most concerning behaviors.
12. Members of the expert panel indicated the following problematic scientific-application behaviors are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation. Please rate how likely each behavior is to respond to remediation.
13. The expert panel reached consensus regarding many problematic supervisory-based behaviors that are inconsistent with the expected developmental trajectory of a counselor-in-training. The expert panel did not reach consensus regarding the behaviors listed below. Of the problematic behaviors listed, please indicate to what degree these behaviors are problematic.
14. The expert panel indicated that the following elements are the 10 most concerning problematic supervisory-based behaviors. Please choose the top 5 most concerning behaviors.
15. Members of the expert panel indicated the following problematic supervisory-based behaviors are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation. Please rate how likely each behavior is to respond to remediation.
16. The expert panel reached consensus regarding many problematic system-based behaviors that are inconsistent with the expected developmental trajectory of a counselor-in-training. The expert panel did not reach consensus regarding the

behaviors listed below. Of the problematic behaviors listed, please indicate to what degree these behaviors are problematic.

17. The expert panel indicated that the following elements are the 10 most concerning problematic system-based behaviors. Please choose the top 5 most concerning behaviors.
18. Members of the expert panel indicated the following problematic system-based behaviors are so significant or egregious that they are unlikely to respond to remediation regardless of the quality or duration of the remediation. Please rate how likely each behavior is to respond to remediation.
19. The expert panel reached consensus regarding many problematic behaviors that belong on the "severe/major" section of the counselor impairment continuum. However, the expert panel did not agree that the following behaviors belong on the "severe/major" section of the continuum. Please indicate which section of the counselor impairment continuum you believe each behavior or action belongs.
20. The expert panel did not agree that the following behaviors belong on the "moderate" section of the counselor impairment continuum. Please indicate which section of the continuum you believe each behavior or action belongs.
21. The expert panel did not agree that the following behaviors belong on the "mild" section of the counselor impairment continuum. Please indicate which section of the continuum you believe each behavior or action belongs.
22. When asked to indicate the top five most useful statements that assist you in determining impairment from not yet acquired competence the most frequently selected statements are listed below. Please rate your level of agreement with each

statement concerning its level of usefulness in assisting you in distinguishing impairment from not yet acquired competence.

23. When asked to indicate the top five most useful statements that assist you in determining impaired performance from performance associated with cultural values, the most frequently selected statements are listed below. Please rate your level of agreement with each statement concerning its level of usefulness in assisting you in distinguishing impairment from cultural values.
24. The expert panel did not reach consensus concerning the following statements regarding how the duration of a behavior or trait influences an evaluation of it as impaired. Please rate your level of agreement with each statement.
25. The expert panel did not reach consensus concerning the following statements regarding how the persistence of a behavior or trait influences an evaluation of it as impaired. Please rate your level of agreement with each statement.
26. The most frequently selected statements regarding the most concerning origins of impairment are listed. Please rate your level of agreement regarding how the level of concern of each potential origin.
27. Of the statements below, please choose the 5 statements you agree with most regarding how the etiology of a behavior or trait might influence your decision to identify a behavior as impaired.
28. The expert panel did not reach consensus regarding the appropriateness of the term impairment. Four panel members agreed the term impairment should be used. Five panel members suggested a term related to competence such as: “problems in professional competence” or “incompetence.” Two panel members suggested

“problematic student behaviors (skills and dispositions).” One expert suggested “a counselor who is unsafe to practice.” Please rate your level of agreement with each term

APPENDIX F

ALL CONTINUUM ITEMS REACHING CONSENSUS AT COMPLETION OF STUDY

Table 17

Counselor Impairment Continuum

	Median	IQR
Severe Category of Counselor Impairment Continuum		
Initiates inappropriate relationships with clients (e.g., sexual, romantic, or financial).	7.00 (7)	0.00
Does not listen, argues, and blames others.	7.00 (7)	0.75
Refusal to accept feedback.	7.00 (7)	1.00
Boundary violations.	7.00 (7)	0.75
The behavior consistently and negatively impacts relationships.	7.00 (7)	1.00
Lying.	7.00 (7)	1.00
Cannot create/maintain therapeutic relationship with any client.	7.00 (7)	1.00
Ethical violations.	7.00 (7)	1.00
Denial of responsibility.	7.00 (7)	1.00
Unwilling to work on the problem causing the deficiencies.	7.00 (7)	1.00
Behavior or trait stems from an ingrained characterological trait or difficult to treat mental illness.	7.00 (7)	1.00
Intolerant of diverse viewpoints and or people.	6.50 (7)	1.00
Failure to attend class or counseling sessions.	7.00 (7)	1.00
Problem behavior or trait is present and apparent in the majority of academic and clinical work.	6.50 (7)	1.00
Depression, anxiety, bipolar disorder.	5.50 (7)	1.00
Cognitive rigidity, emotional dysregulation, and or use of defense mechanisms concurrent with poor insight.	1.00 (4)	1.00
The problematic behavior or trait is present and consistent with or without stress.	1.00 (4)	1.00
Moderate Category of Counselor Impairment Continuum		
Turning in late work	5.00 (7)	1.00
Misdiagnosing.	2.00 (4)	1.00
Difficulties with skill development (e.g., reflecting, active listening, etc.).	2.00 (4)	1.00
Applying wrong treatment.	2.00 (4)	1.00
Does not follow directions.	2.00 (4)	1.00
Lacks awareness and insight.	2.00 (4)	0.00
Failure to complete internship tasks or coursework.	2.00 (4)	1.00
Does not accept responsibility.	2.00 (4)	1.00
Behavior or trait that negatively impacts social functioning.	2.00 (4)	1.00
Deficiencies are present in at least half of the student's academic and or clinical work.	2.00 (4)	1.00
Substance abuse issues.	2.00 (4)	1.00

Problem behavior or trait is consistent and present with or without stress.	2.00 (4)	1.00
Clinical work suffers as a result of deficiencies.	2.00 (4)	1.00
The problematic behavior or trait impacts the student's relationships with peers and faculty.	2.00 (4)	1.00
Questionable ethical behavior	2.00 (4)	1.00
Mild Category of Counselor Impairment Continuum		
Deficiency stems from lack of awareness and or knowledge.	3.00 (4)	1.00
Just meets minimal professional standards.	3.00 (4)	1.00
Accepts being mediocre.	3.00 (4)	1.00
Behaviors that mildly impacts social functioning.	3.00 (4)	1.00
Behavior and or trait are transient and may only be present with stress.	3.00 (4)	1.00
Is not curious	3.00 (4)	1.00
Being snippy and irritable with peers and or faculty.	3.00 (4)	1.00
Showing up late.	3.00 (4)	0.00
Late academic work and or late case notes.	3.00 (4)	1.00
The problem is present in some academic and or clinical work.	3.00 (4)	1.00

x.xx (7) indicates the median is based on a 7-point Likert scale
x.xx (4) indicates the median is based on a 4-point Likert scale 1 = severe, 2 = moderate, 3 = mild, 4 = not impairment

Table 18

Problematic Behaviors Reaching Consensus at the Completion of Study

		Median	IQR
	Problematic Professional Behaviors		
Problematic	Unprofessional behavior (e.g., texting in class/clinic, consistently late, late paperwork, unprofessional social media).	7.00	0.00
	Desire to be inconsistent with what is expected of a professional counselor.	7.00	0.00
	Inability to respond flexibly to complex and or unexpected supervisory or clinical situations.	7.00	1.00
	Unable or unwilling to examine the impact of one's behavior.	7.00	1.00
	Unable or unwilling to engage in appropriate self-care (e.g., personal counseling).	6.50	1.00
	Deficits in decision-making.	6.50	1.00
	Imposition of prejudice beliefs/values.	6.50	1.00
	Failure to follow ethical standards.	6.00	1.00
	Psychological problems, personality disorders (e.g., pattern of lying, attention getting, addictive behavior, suicidal ideation/attempts.	6.00	1.00
	Unable or unwilling to take the perspective of another.	6.00	1.00
	Rigid and uninformed patterns of beliefs.	6.00	1.00
Moderately Problematic	Lacks cognitive complexity necessary to demonstrate core skills and understanding.	5.00	1.00
	Problematic Relational Behaviors		
Problematic	Defensiveness or interpersonally guarded (e.g., does not take responsibility, inability or resistance to compromise).	7.00	0.75
	Lack of compassion.	7.00	1.00
	Interpersonal deficits associated with difficulties in forming and maintaining rapport (e.g., poor basic social skills, lack of authenticity, inability to manage a conversation, uncooperative, dominates interpersonal interactions, etc.)	6.50	1.00
	Difficulty with interpersonal boundaries (e.g., invades others' space, inappropriate touch or relationships with clients, shares too much personal information).	6.50	1.00
	Inability to demonstrate a minimum level of empathy.	6.00	1.00
	Engages in triangulation.	6.00	1.00
	Intense criticism of others.	6.00	1.00
	Fails to demonstrate culturally sensitive approaches.	6.00	1.00
Moderately Problematic	Demonstrates extreme hyperactivity.	5.50	1.00
	Difficulty with affect (e.g., inability to manage affect, limited affective vocabulary, resistance to experience and identify a variety of emotions).	5.00	1.00

	Difficulty understanding the role of the counselor (e.g., friend vs. counselor, asking too many unnecessary closed questions, giving advice, too much self-focus).	5.00	1.00
	Excessive intellectualization.	5.00	1.00
	Problematic Scientific-Application Behaviors		
Problematic	Lying in research (e.g., manipulating systems to meet research needs).	7.00	1.00
	No use of ASCA National Model, ACA Standards/Ethics, unfamiliar with DSM.	6.50	1.00
	Lack of conceptualization and diagnosis skills (e.g., difficulties with diagnosis with or without supervisory support and training, inability to create appropriate treatment plan).	6.00	1.00
	Does not know what steps to take in the event of a crisis.	6.00	1.00
Moderately Problematic	Inability to link client behaviors to previously described behaviors from coursework.	5.00	1.00
	Does not know how to advocate for clients in need.	5.00	1.00
	Lacks the capacity to evaluate scholarly literature (e.g., failure to understand basic statistical concepts commonly used in assessments and tests).	5.00	1.00
	Problematic Supervisory Behaviors		
Problematic	Inability to receive and integrate feedback in supervision (e.g., closed off to supervision, argumentative with feedback, unopened to processing difficult feedback).	7.00	1.00
	Rigid or inflexible interpersonal processes (e.g., dogmatic in approach to supervisor, frequent use of defense mechanisms, refusal to discontinue rude/cruel interpersonal behaviors).	7.00	1.00
	Poor insight/awareness (e.g., poor general awareness, unable to see impact on others).	6.50	1.00
	A pattern of difficulties in supervision across supervisors.	6.50	1.00
	Not asking for supervision on difficult cases.	6.00	1.00
	Lack of conscientiousness (e.g., failure to arrive on time).	6.00	1.00
	Inability to risk trying reasonable new behaviors as instructed by supervisor.	6.00	1.00
	Inability to regulate own emotions within supervision	6.00	1.00
Moderately Problematic	Over-reliance on supervisor.	4.00	1.00
	Problematic System-Based Behaviors		
Problematic	Inappropriate or disrespectful interactions with peers/professors/clients (e.g., involved in harassment, stalking, violence, and or treats, argumentativeness, hostility, not committed to building productive relationships).	7.00	0.00

Does not respond to or follow direction (e.g., unwilling to listen).	7.00	0.75
Failing grades especially in skills courses.	7.00	1.00
Inability to negotiate or compromise.	7.00	1.00

Table 19

*Behaviors Selected as Unlikely to Remediate**

	Times Chosen
Problematic Professional	
Imposition of prejudicial beliefs and values.	4 of 13 panelists
Failure to follow ethical standards.	4 of 13 panelists
Unable or unwilling to engage in appropriate self-care.	5 of 13 panelists
Inability to respond flexibly to complex and or unexpected supervisory or clinical situations.	6 of 13 panelists
Problematic Relational	
Interpersonal deficits leading to difficulty forming and maintaining rapport.	4 of 13 panelists
Defensiveness or interpersonally guarded.	4 of 13 panelists
Lack of insight and or awareness.	4 of 13 panelists
Lack of compassion.	5 of 13 panelists
Problematic Scientific-Application	
Lacks the capacity to develop research studies that build on previous research and inability to understand the relationship between methods used and conclusions that can be drawn.	6 of 13 panelists
Dismisses or refuses to use commonly accepted techniques and evidence-based theory.	4 of 13 panelists
Problematic Supervisory-Based	
Inability to receive and integrate feedback in supervision.	7 of 13 panelists
Rigid or inflexible interpersonal processes.	6 of 13 panelists
Uninterested and or unable to demonstrate growth.	5 of 13 panelists
A pattern of difficulties in supervision across supervisors.	5 of 13 panelists
Problematic System-Based	
Inappropriate or disrespectful interactions with peers, professors, and or clients.	6 of 13 panelists
Failing grades especially in skills courses.	5 of 13 panelists

*These behaviors selected as unlikely to remediate did not necessarily reach panel consensus as there were many panel members refrained from choosing various behaviors perhaps because of the belief that all behaviors are remediable. The chosen behaviors above simply indicate which behaviors some panelists believe are so serious or egregious that they are unlikely to remediate.

Table 20

Most Concerning Problematic Behaviors

	Times Chosen
Five Most Concerning Problematic Professional	
Failure to follow ethical standards.	11 of 12 panelists
Imposition of prejudicial beliefs/values.	10 of 12 panelists
Behaviors of superiority (e.g., dogmatism, entitlement, above pitfalls of being human).	10 of 12 panelists
Deficits in decision-making.	9 of 12 panelists
Cultural incompetence.	6 of 12 panelists
Five Most Concerning Problematic Relational	
Defensiveness or interpersonally guarded.	9 of 12 panelists
Interpersonal deficits associated with difficulties in forming and maintaining rapport.	7 of 12 panelists
Difficulty with interpersonal boundaries.	7 of 12 panelists
Inability to demonstrate a minimum level of empathy.	7 of 12 panelists
Lack of insight and or awareness.	5 of 12 panelists
Five Most Concerning Problematic Scientific-Application	
Does not consider the uniqueness of the client before applying scientific information.	10 of 12 panelists
Dismisses or refuses to use commonly accepted techniques and evidence-based theory.	9 of 12 panelists
Lack of conceptualization and diagnosis skills.	7 of 12 panelists
Inability to utilize appropriate interventions.	6 of 12 panelists
Does not know what steps to take in the event of a crisis.	6 of 12 panelists
Five Most Concerning Problematic Supervisory-Based	
Inability to receive and integrate feedback in supervision.	11 of 12 panelists
Rigid or inflexible interpersonal processes.	11 of 12 panelists
Poor insight and or awareness.	9 of 12 panelists
Uninterested and or unable to demonstrate growth.	7 of 12 panelists
A pattern of difficulties in supervision across supervisors.	6 of 12 panelists
Five Most Concerning Problematic Systems-Based	
Inappropriate or disrespectful interactions with peers, professors, and or clients.	11 of 12 panelists
Failing grades especially in skills courses.	9 of 12 panelists
Does not respond to or follow direction.	9 of 12 panelists
Inability to negotiate and or compromise.	7 of 12 panelists
Difficulty with systems (e.g., does not understand how systems work, monopolizes cooperative activities, difficulty cooperating with others in task completion and common goals, ignorance of the importance of a team approach).	7 of 12 panelists

APPENDIX G

MANUSCRIPT FOR PUBLICATION

Clarifying the Definitional Boundaries and Essential Descriptors of Counselor Impairment: A Delphi Study

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CLARIFYING THE DEFINITIONAL BOUNDARIES AND ESSENTIAL DESCRIPTORS OF COUNSELOR IMPAIRMENT: A DELPHI STUDY

Mental health professionals routinely engage clients in intimate and personal therapeutic relationships intended to increase the wellbeing of clients. Counselors must be engaged interpersonally and technically, all while monitoring their impact on and reactions to their client. Occasionally, counselors may become unwilling or unable to understand or evaluate how their way of being may negatively impact their relationship with their client. These counselor deficiencies cause great concern regarding the potential harm to clients and the integrity of the counseling profession.

Counselor impairment is a term frequently used to broadly describe problematic or insufficient behavior (American Psychological Association [APA], 2006; Emerson & Markos, 1996; Sheffield, 1998). However, many have indicated using the term impairment is problematic (Elman & Forrest, 2007; Sherman, 1996). These individuals argue the term is insufficient to describe problematic behavior because (a) impairment is used as an umbrella term to indicate many possible issues (Forrest, Elman, Gizara, & Vacha-Haase, 1999; Schwartz-Mette, 2011), (b) the term lacks definitional clarity and is not used consistently in the field (Elman & Forrest, 2007; Forrest et al., 1999), and (c) the term overlaps with its use in the Americans with Disabilities Act (ADA; 1990); therefore, its use could result in legal action (Elman & Forrest, 2007). Although much of the literature discusses reasons to no longer use impairment to identify problematic behavior, this term continues to be frequently used within the literature as well as the 2014 American Counseling Association (ACA; 2005) *Code of Ethics*.

While the ongoing debate and disagreement regarding identifying an appropriate term to capture problematic behavior continues, student impairment within training programs continues to be recognized as a serious and growing problem in counselor education (Bemak, Epp, & Keys, 1999; Boxley, Drew, & Rangel, 1986; Forrest et al., 1999; Sherman, 1996). Procidano, Busch-Rossnagel, Reznikoff, and Geisinge (1995) were interested in the prevalence of impaired students in psychology doctoral programs; the results indicated that 89% of programs participating in the study reported one or more students identified as being impaired within the past five years. Similarly, Huprich and Rudd (2004) found in the past 10 years, 98% of the counseling and school psychology doctoral programs included in the study identified at least one impaired student where 41% of these occurrences led to dismissal of the student from their program. In a different study, Boxley et al. (1986) reported that 66% of responding APA internship sites experienced impaired trainees within the last five years.

Although these studies are relatively dated, the recent impairment literature lacks similar studies reporting the occurrence of impairment. The literature does suggest impairment is a common and growing occurrence and indicates the importance of increasing the effectiveness of identifying and remediating impairment from counseling programs (Bemak et al., 1999; Elman et al., 1999; Sherman, 1996). It can be assumed that unless impairment is remediated in training programs, these individuals will then graduate and become impaired professional counselors, which increases the risk of potential client harm.

Therefore, reducing the existence of impaired individuals within training programs and the counseling field is vital because millions of Americans engage in

counseling services and expect competent mental health care. In fact, in 2008, 27.9 million U.S. adults utilized mental health services and this number continues to increase each year (National Institute for Mental Health [NIMH], 2013). Considering the prevalence of student impairment within counselor training programs and the great number of individuals utilizing mental health services each year, it is vital for counselor educators to efficiently and effectively identify and remediate impairment.

However, identifying and remediating impairment is a difficult task because determining counselor competency is multifaceted (e.g., interpersonal behaviors, academic ability, application of clinical skills, etc.) and because the current evaluative procedures are vague and subjective in nature (Duba, Paez, & Kindsvatter, 2010). Within the helping professions literature (i.e., counseling, psychology, medical, nursing), there are a plethora of definitions and characteristics of practitioner impairment. Yet these definitions lack consensus and clarity, thereby creating confusion regarding the identification and remediation of impaired students (Sherman, 1996).

The difficulties regarding the identification and remediation of impairment is problematic for counselor educators because they have an obligation to act as gatekeepers to the counseling profession and adequately identify and remediate impaired students from entering the counseling profession (ACA, 2005; Council for Accreditation of Counseling and Related Programs [CACREP], 2009). The current disagreement and lack of consensus within the field regarding the definitional boundaries and essential descriptors of impairment, unfortunately, limit counselor educators' ability to develop a protocol to effectively perform their gatekeeping duties (Bissell, 1983; Forrest et al., 1999; Huprich & Rudd, 2004; Kaslow et al., 2007; Li, Lampe, Trusty, & Lin, 2009;

Schwartz-Mette, 2011). Without a universal understanding of impairment and effective protocol to identify and assist remediation efforts, impairment within counselor education programs might go unidentified and not addressed, which ultimately increases the prevalence of impairment among professional counselors (DeVries & Valadez, 2006). The first step to more effectively identify and remediate problematic behavior is to clarify the definitional boundaries of impairment (Elman & Forrest, 2007; Elman et al., 1999; Huprich & Rudd, 2004; Li, Trusty, Nichter, Serres, & Lin, 2007; Schwartz-Mette, 2009, 2011). Therefore, the purpose of this study was to create consensus regarding the definitional boundaries and a set of descriptors of student impairment that might increase the clarity regarding impairment and ultimately lead to a more effective and accurate evaluation protocol.

Method

The Delphi method is multi-round process that surveys a panel of experts with the intent to reach consensus regarding a particular problem (Dalkey, 1969; Okoli & Pawlowski, 2004). This approach is commonly utilized when (a) there is incomplete knowledge regarding an area of research (Dalkey, 1969), and (b) when the problem best lends itself to group discussion and involvement (Hasson, Keeney, & McKenna, 2000; Linstone & Turloff, 1975). The expert panel was carefully selected by pre-determined criteria (discussed below) and the results were analyzed after each round of data collection. Consistent with the Delphi literature, the terms “expert panel,” “panel members,” and “panelists” were utilized in this document to indicate the study’s participants.

Sample

There is much discussion regarding how to determine expertise for a Delphi study (Hasson et al., 2000; Keeney, Hasson, & McKenna, 2001). However, it is generally agreed that an expert is an individual with deep knowledge and experience in the domain (Adler & Ziglio, 1996; Davis, 1997). For the current study, panel members were selected by at least one or more of the following criteria: (a) a faculty member who has one or more professional juried publications on impairment, (b) a faculty member who has been involved in the review and remediation of at least two counselors-in-training due to impairment reasons, (c) committee members from either the ACA task force or APA advisory committee, or (d) a faculty member who has been a part of and successful in litigation resulting from dismissing whom they determined to be an impaired counseling student. These criteria revealed 92 eligible experts who were individually invited to participate in the current study; 21 agreed to participate yielding a response rate of 22.8%. During the first round, eight individuals withdrew; in the second round, one individual withdrew; and in the third round, one individual withdrew. The final expert panel consisted of 11 nation-wide counselor educators (i.e., four males and seven females).

Data Collection and Analysis

In the current study, three rounds of data collection were used. Once each panel member returned a signed informed consent, they were emailed a link to the first round survey using Qualtrics software. Panel members took 29 days to respond to the first round questionnaire, which asked open-ended questions regarding the definition and characteristics of impairment. First round responses consisted of qualitative data, which

were analyzed through content analysis. This process involved reducing the text into smaller units of data in order to create categories of behaviors or descriptions to be used in the following rounds where panelists were asked to rate and rank their levels of agreement on each item.

The second round (i.e., lasting 22 days) and third round (i.e., lasting 17 days) surveys included the categories of behaviors and/or characteristics from the previous round's analysis. Panel members were asked to rate and rank their level of agreement on a 7-point Likert scale (1 = *strongly disagree to* 7 = *strongly agree*) with each statement. In addition, panelists were invited to provide feedback regarding each question or statement. The responses in the second and third round were primarily quantitative; therefore, the data analysis consisted of calculating the medians and interquartile ranges (IQR) for each item. The medians were used as a measure of central tendency and interquartile ranges determined the level of consensus among the expert panel. As suggested in Wester and Borders' article (2014), an IQR ≤ 1 denoted consensus had been achieved. A smaller IQR indicated less spread or dispersion among panel responses, therefore greater consensus. Once consensus was reached, that item was identified and removed from the following round. Those items failing to reach panel consensus were included in the following round for further consideration.

Results

Elements of a Definition

Definitional components. Panel members were asked two questions regarding elements of a definition of student impairment. In the primary round, the first question asked panel members to indicate their definition of student impairment. These responses

were coded using content analysis and five categories of definitions were created. In the second round, panel members rated their level of agreement with each of the five definitional statements and the results indicated that the panel reached consensus regarding only one item: “personal and professional behaviors that interfere with a student’s ability to provide competent client care” (i.e., IQR = 1.00; *Mdn* = 7.00). The remaining four items were ordered (i.e., according to median scores) from most to least important in the development of a definition of student impairment and presented in round three. In the third round, panel members rated their level of agreement with the ranking of importance of each. However, the results indicated the panel failed to reach consensus on any item. At the conclusion of three rounds, the panel agreed that “personal and professional behaviors that interfere with a student’s ability to provide competent client care” was the most important statement to be included in the definition of student impairment.

Individual basis of the definition. The second question regarding elements of a definition of student impairment asked panel members to identify the various bases for their definition of student impairment. The results from content analysis performed from the responses of the first round generated five bases for the panel’s definition: (a) “experience dealing with impairment”, (b) “professional literature”, (c) “theories”, (d) “consultation with colleagues”, and (e) “general criteria for personality disorders in the DSM-V.” In the second round, panel members rank ordered each item in terms of the level of contribution each item has in their definition of impairment. The expert panel reached consensus regarding two of the five items (i.e., “experience” IQR = 1.00, *Mdn* = 7.00; and “general criteria for personality disorders in DSM-V” IQR = 1.00, *M* = 6.00).

Median scores indicated that the panel agreed “experience dealing with impairment” contributes the most to their definition of impairment while “general criteria for personality disorders in DSM-V” contributes the least to their definition of impairment. In the third round panel members were asked to rank order the remaining three items in terms of its level of contribution to the definition of impairment yet the panel was unable to reach consensus on any of the remaining elements.

Problematic Behaviors

Problematic behaviors were clustered into five categories based on the Fouad et al. (2009) competency benchmarks (i.e., problematic professional, relational, scientific-application, supervisory, and systematic-based behaviors). Each category was examined separately in order to focus and refine our understanding of the complexity of counselor impairment. Within each category, panel members were given instructions to (a) rate the degree to which they believed each behavior was a problematic behavior, (b) identify which behaviors were so significant they were unlikely to respond to remediation efforts, and (c) rank order each behavior from most concerning to least. The results from each question are presented separately below.

Degree each behavior is problematic. In the first round, panel members were asked to identify problematic behaviors for each competency area (i.e., professional, relational, scientific-application, supervisory-based, and systems-based) that were inconsistent with the expected developmental trajectory of a counselor-in-training. Content analysis of the first round results generated 15 problematic professional behaviors, 17 problematic relational behaviors, 13 problematic scientific-application behaviors, 11 supervisory-based behaviors, and seven systems-based behaviors (i.e., a

total of 63 problem behaviors). In the second round, panel members rated to what degree they believed each behavior within the different categories was problematic.

In the second round, panel members were presented with the lists of behaviors and asked to rate to what degree they believed each behavior was problematic. The results of the second round indicated panel members reached consensus on 37 items (i.e., 10 professional behaviors, 9 relational behaviors, 6 scientific-application behaviors, 8 supervisory-based behaviors, and 4 systemic-based behaviors). Of the remaining items in each category from round two that did not reach consensus, panel members were asked in the third round to rate to what degree they believed each behavior was problematic. The results indicated the panel reached consensus on seven additional behaviors (i.e., two professional behaviors, three relational behaviors, one scientific-application behavior, one supervisory-based behavior, and zero systemic-based behaviors), increasing the total number of consensus reaching behaviors to 44 items (i.e., out of 63).

The 44 item that reached panel consensus yielded median scores ranging from 4.00 to 7.00, indicating consensus regarding varying degrees of severity. Panel members rated the degree to which they believed each behavior was problematic on a 7-point Likert scale. To assign meaning to the varying medians for the problematic behaviors, the Likert scale was labeled as follows for the current study: medians ranging from 1.00 to 3.00 indicated the panel did not believe these behaviors were problematic; medians ranging from 3.50 to 5.50 indicated the panel believed these behaviors were moderately problematic; and medians ranging from 6.00 to 7.00 indicated the panel believed these behaviors were problematic. Of the 44 behaviors where panel members reached

consensus, 35 behaviors were considered problematic and nine behaviors were considered moderately problematic (see Table 1).

Table 1

Problematic Behaviors Reaching Consensus at the Completion of Study

		Median	IQR
	Problematic Professional Behaviors		
Problematic	Unprofessional behavior (e.g., texting in class/clinic, consistently late, late paperwork, unprofessional social media).	7.00	0.00
	Desire to be inconsistent with what is expected of a professional counselor.	7.00	0.00
	Inability to respond flexibly to complex and or unexpected supervisory or clinical situations.	7.00	1.00
	Unable or unwilling to examine the impact of one's behavior.	7.00	1.00
	Unable or unwilling to engage in appropriate self-care (e.g., personal counseling).	6.50	1.00
	Deficits in decision-making.	6.50	1.00
	Imposition of prejudice beliefs/values.	6.50	1.00
	Failure to follow ethical standards.	6.00	1.00
	Psychological problems, personality disorders (e.g., pattern of lying, attention getting, addictive behavior, suicidal ideation/attempts.	6.00	1.00
	Unable or unwilling to take the perspective of another.	6.00	1.00
	Rigid and uninformed patterns of beliefs.	6.00	1.00
Moderately Problematic	Lacks cognitive complexity necessary to demonstrate core skills and understanding.	5.00	1.00
	Problematic Relational Behaviors		
Problematic	Defensiveness or interpersonally guarded (e.g., does not take responsibility, inability or resistance to compromise).	7.00	0.75
	Lack of compassion.	7.00	1.00
	Interpersonal deficits associated with difficulties in forming and maintaining rapport (e.g., poor basic social skills, lack of authenticity, inability to manage a conversation, uncooperative, dominates interpersonal interactions, etc.)	6.50	1.00
	Difficulty with interpersonal boundaries (e.g., invades others' space, inappropriate touch or relationships with clients, shares too much personal information).	6.50	1.00
	Inability to demonstrate a minimum level of empathy.	6.00	1.00
	Engages in triangulation.	6.00	1.00
	Intense criticism of others.	6.00	1.00
	Fails to demonstrate culturally sensitive approaches.	6.00	1.00
Moderately Problematic	Demonstrates extreme hyperactivity.	5.50	1.00
	Difficulty with affect (e.g., inability to manage affect, limited affective vocabulary, resistance to experience and identify a variety of emotions).	5.00	1.00
	Difficulty understanding the role of the counselor (e.g., friend vs. counselor, asking too many unnecessary closed questions, giving advice, too much self-focus).	5.00	1.00
	Excessive intellectualization.	5.00	1.00
	Problematic Scientific-Application Behaviors		
Problematic	Lying in research (e.g., manipulating systems to meet research needs).	7.00	1.00
	No use of ASCA National Model, ACA Standards/Ethics, unfamiliar with DSM.	6.50	1.00
	Lack of conceptualization and diagnosis skills (e.g., difficulties with diagnosis with or without supervisory support and training, inability to create appropriate treatment plan).	6.00	1.00
	Does not know what steps to take in the event of a crisis.	6.00	1.00

Table continues

		Median	IQR
Moderately Problematic	Inability to link client behaviors to previously described behaviors from coursework.	5.00	1.00
	Does not know how to advocate for clients in need.	5.00	1.00
	Lacks the capacity to evaluate scholarly literature (e.g., failure to understand basic statistical concepts commonly used in assessments and tests).	5.00	1.00
	Problematic Supervisory Behaviors		
Problematic	Inability to receive and integrate feedback in supervision (e.g., closed off to supervision, argumentative with feedback, unopened to processing difficult feedback).	7.00	1.00
	Rigid or inflexible interpersonal processes (e.g., dogmatic in approach to supervisor, frequent use of defense mechanisms, refusal to discontinue rude/cruel interpersonal behaviors).	7.00	1.00
	Poor insight/awareness (e.g., poor general awareness, unable to see impact on others).	6.50	1.00
	A pattern of difficulties in supervision across supervisors.	6.50	1.00
	Not asking for supervision on difficult cases.	6.00	1.00
	Lack of conscientiousness (e.g., failure to arrive on time).	6.00	1.00
	Inability to risk trying reasonable new behaviors as instructed by supervisor.	6.00	1.00
	Inability to regulate own emotions within supervision.	6.00	1.00
Moderately Problematic	Over-reliance on supervisor.	4.00	1.00
	Problematic System-Based Behaviors		
Problematic	Inappropriate or disrespectful interactions with peers/professors/clients (e.g., involved in harassment, stalking, violence, and or treats, argumentativeness, hostility, not committed to building productive relationships).	7.00	0.00
	Does not respond to or follow direction (e.g., unwilling to listen).	7.00	0.75
	Failing grades especially in skills courses.	7.00	1.00
	Inability to negotiate or compromise.	7.00	1.00

Unlikely to respond to remediation. Of the 63 problematic behaviors generated from the first round, panel members were asked which of the behaviors were so significant or egregious they were unlikely to respond to remediation. The results from the second round indicated 16 problematic behaviors (i.e., four professional, four relational, two scientific-application, four supervisory, and two systemic-based) that were unlikely to respond to remediation (see Table 2). However, these 16 behaviors yielded low percentages of panelists that selected each item (i.e., 30%-54%). Therefore, these results did not necessarily represent group consensus yet they did identify which items

some panelists believed to be unlikely to respond to remediation. However, the results indicated many panel members did not select any items, indicating the belief that all listed problem behaviors might be remediated.

Table 2

Behaviors Selected as Unlikely to Remediate

	Times Chosen
Problematic Professional	
Imposition of prejudicial beliefs and values.	4 of 13 panelists
Failure to follow ethical standards.	4 of 13 panelists
Unable or unwilling to engage in appropriate self-care.	5 of 13 panelists
Inability to respond flexibly to complex and or unexpected supervisory or clinical situations.	6 of 13 panelists
Problematic Relational	
Interpersonal deficits leading to difficulty forming and maintaining rapport.	4 of 13 panelists
Defensiveness or interpersonally guarded.	4 of 13 panelists
Lack of insight and or awareness.	4 of 13 panelists
Lack of compassion.	5 of 13 panelists
Problematic Scientific-Application	
Lacks the capacity to develop research studies that build on previous research and inability to understand the relationship between methods used and conclusions that can be drawn.	6 of 13 panelists
Dismisses or refuses to use commonly accepted techniques and evidence-based theory.	4 of 13 panelists
Problematic Supervisory-Based	
Inability to receive and integrate feedback in supervision.	7 of 13 panelists
Rigid or inflexible interpersonal processes.	6 of 13 panelists
Uninterested and or unable to demonstrate growth.	5 of 13 panelists
A pattern of difficulties in supervision across supervisors.	5 of 13 panelists
Problematic System-Based	
Inappropriate or disrespectful interactions with peers, professors, and or clients.	6 of 13 panelists
Failing grades especially in skills courses.	5 of 13 panelists

Rank ordering problematic behaviors. As indicated above, the results from the first round generated lists of problematic behaviors regarding each counselor competency category. In the second round, panel members were asked to rank order each list from most concerning to least concerning. However, the behaviors in each competency category yielded low panel consensus regarding their rank ordering. Of the 63 problematic behaviors generated in round one, the panel members were only able to reach consensus regarding the rank ordering of two items. Due to the extremely low consensus reached for each ranking question, the behaviors in each category were reduced and the question was asked in a different fashion in the final round.

Each competency category was reduced to 10 items for a finer consideration of the data in the following round. For each category, the ten behaviors were selected based on the behaviors that yielded the lowest median scores (i.e., indicating most concerning behaviors). In the third round, instead of rank ordering a lengthy list of behaviors, panel members were presented with the reduced lists of problematic behaviors and asked to choose the top five most concerning behaviors. The results from the third round identified the top five most chosen behaviors for each category (i.e., indicating the top five most concerning behaviors; see Table 3). These results also yielded higher consensus among the panel as evidenced by an average of 8 out of 12 panelists (i.e., 67%) choosing each item with a range of 5 to 11 panelists out of 12 choosing each item.

Table 3

Most Concerning Problematic Behaviors

	Times Chosen
Five Most Concerning Problematic Professional	
Failure to follow ethical standards.	11 of 12 panelists
Imposition of prejudicial beliefs/values.	10 of 12 panelists
Behaviors of superiority (e.g., dogmatism, entitlement, above pitfalls of being human).	10 of 12 panelists
Deficits in decision-making.	9 of 12 panelists
Cultural incompetence.	6 of 12 panelists
Five Most Concerning Problematic Relational	
Defensiveness or interpersonally guarded.	9 of 12 panelists
Interpersonal deficits associated with difficulties in forming and maintaining rapport.	7 of 12 panelists
Difficulty with interpersonal boundaries.	7 of 12 panelists
Inability to demonstrate a minimum level of empathy.	7 of 12 panelists
Lack of insight and or awareness.	5 of 12 panelists
Five Most Concerning Problematic Scientific-Application	
Does not consider the uniqueness of the client before applying scientific information.	10 of 12 panelists
Dismisses or refuses to use commonly accepted techniques and evidence-based theory.	9 of 12 panelists
Lack of conceptualization and diagnosis skills.	7 of 12 panelists
Inability to utilize appropriate interventions.	6 of 12 panelists
Does not know what steps to take in the event of a crisis.	6 of 12 panelists
Five Most Concerning Problematic Supervisory-Based	
Inability to receive and integrate feedback in supervision.	11 of 12 panelists
Rigid or inflexible interpersonal processes.	11 of 12 panelists
Poor insight and or awareness.	9 of 12 panelists
Uninterested and or unable to demonstrate growth.	7 of 12 panelists
A pattern of difficulties in supervision across supervisors.	6 of 12 panelists
Five Most Concerning Problematic Systems-Based	
Inappropriate or disrespectful interactions with peers, professors, and or clients.	11 of 12 panelists
Failing grades especially in skills courses.	9 of 12 panelists
Does not respond to or follow direction.	9 of 12 panelists
Inability to negotiate and or compromise.	7 of 12 panelists
Difficulty with systems (e.g., does not understand how systems work, monopolizes cooperative activities, difficulty cooperating with others in task completion and common goals, ignorance of the importance of a team approach).	7 of 12 panelists

Counselor Impairment Continuum of Behaviors

In the first round, panel members indicated their belief that impaired behaviors existed on a continuum of severity. Panelists provided specific problematic behaviors they believed to exist at each anchor point (i.e., severe, moderate, mild) along the continuum. The first round responses were coded using content analysis and the results demonstrated the panel identified 23 behaviors on the severe section, 8 behaviors on the moderate section, and 21 behaviors on the mild section. In the second round, the lists of behaviors for each anchor point were presented and panel members were asked to rate their level of agreement that each behavior should exist on the section of the continuum where it was currently placed. The results of the second round demonstrated that panelists reached consensus on 15 of the 23 behaviors on the severe category, 1 of the 8 behaviors on the moderate category, and 0 of the 21 behaviors on the mild category. With considerably low levels of consensus for this series of questions, an alternative format of this question was asked in the final round.

In the final round, the behaviors that failed to reach panel consensus were presented again; however, in this round, panelists were asked to indicate which section of the continuum they believed the behavior to exist (i.e., severe, moderate, mild, or does not demonstrate impairment). For analysis purposes, each of the anchor points was labeled with a 1, 2, 3, and 4, respectively. Panel members reached consensus on all behaviors included on the severe and moderate lists (i.e., 8/8 behaviors and 7/7 behaviors) and reached consensus on 16 of 21 behaviors on the mild list. For the items reaching consensus (i.e., 31 out of 36), median scores were used to identify which

category the expert panel agreed the behavior existed (see complete list of continuum behaviors on Table 4).

Table 4

All Continuum Items Reaching Consensus at the Completion Study

	Median	IQR
Severe Category of Counselor Impairment Continuum		
Initiates inappropriate relationships with clients (e.g., sexual, romantic, or financial).	7.00 (7)	0.00
Does not listen, argues, and blames others.	7.00 (7)	0.75
Refusal to accept feedback.	7.00 (7)	1.00
Boundary violations.	7.00 (7)	0.75
The behavior consistently and negatively impacts relationships.	7.00 (7)	1.00
Lying.	7.00 (7)	1.00
Cannot create/maintain therapeutic relationship with any client.	7.00 (7)	1.00
Ethical violations.	7.00 (7)	1.00
Denial of responsibility.	7.00 (7)	1.00
Unwilling to work on the problem causing the deficiencies.	7.00 (7)	1.00
Behavior or trait stems from an ingrained characterological trait or difficult to treat mental illness.	7.00 (7)	1.00
Intolerant of diverse viewpoints and or people.	6.50 (7)	1.00
Failure to attend class or counseling sessions.	7.00 (7)	1.00
Problem behavior or trait is present and apparent in the majority of academic and clinical work.	6.50 (7)	1.00
Depression, anxiety, bipolar disorder.	5.50 (7)	1.00
Cognitive rigidity, emotional dysregulation, and or use of defense mechanisms concurrent with poor insight.	1.00 (4)	1.00
The problematic behavior or trait is present and consistent with or without stress.	1.00 (4)	1.00
Moderate Category of Counselor Impairment Continuum		
Turning in late work	5.00 (7)	1.00
Misdiagnosing.	2.00 (4)	1.00
Difficulties with skill development (e.g., reflecting, active listening, etc.).	2.00 (4)	1.00
Applying wrong treatment.	2.00 (4)	1.00
Does not follow directions.	2.00 (4)	1.00
Lacks awareness and insight.	2.00 (4)	0.00
Failure to complete internship tasks or coursework.	2.00 (4)	1.00
Does not accept responsibility.	2.00 (4)	1.00
Behavior or trait that negatively impacts social functioning.	2.00 (4)	1.00
Deficiencies are present in at least half of the student's academic and or clinical work.	2.00 (4)	1.00
Substance abuse issues.	2.00 (4)	1.00
Problem behavior or trait is consistent and present with or without stress.	2.00 (4)	1.00
Clinical work suffers as a result of deficiencies.	2.00 (4)	1.00
The problematic behavior or trait impacts the student's relationships with peers and faculty.	2.00 (4)	1.00
Questionable ethical behavior	2.00 (4)	1.00
Mild Category of Counselor Impairment Continuum		
Deficiency stems from lack of awareness and or knowledge.	3.00 (4)	1.00
Just meets minimal professional standards.	3.00 (4)	1.00
Accepts being mediocre.	3.00 (4)	1.00
Behaviors that mildly impacts social functioning.	3.00 (4)	1.00
Behavior and or trait are transient and may only be present with stress.	3.00 (4)	1.00
Is not curious	3.00 (4)	1.00
Being snippy and irritable with peers and or faculty.	3.00 (4)	1.00
Showing up late.	3.00 (4)	0.00
Late academic work and or late case notes.	3.00 (4)	1.00
The problem is present in some academic and or clinical work.	3.00 (4)	1.00

x.xx (7) indicates the mdn is based on a 7-point Likert scale
x.xx (4) indicates the mdn is based on a 4-point Likert scale 1 = severe, 2 = moderate, 3 = mild, 4 = not impairment

Alternative Terms for Impairment

Some of the current literature suggests the term impairment should no longer be used to describe students with deficiencies that limit their ability to counsel (Forrest et al., 1999). However, the term impairment continues to be used in much of the literature and within counselor education programs. In the current study, panelists were asked to provide alternative terms for impairment they believed better captured the phenomenon. The responses were subjected to content analysis and the results indicated the panel was divided in their belief about the appropriateness of the term impairment. For example, four panel members indicated their belief that the term impairment was appropriate to use. Five panelists suggested terms similar to "problems in professional competence" or "incompetence." Two panelists proposed terms similar to "problem student behavior including skills and dispositions." One panelist suggested the term "a counselor who is unsafe to practice."

In the third round, panel members were presented with alternative terms suggested by the panel in the previous round and were asked to rate their level of agreement regarding the appropriateness of each term. The results indicated the panel failed to reach consensus regarding the level of appropriateness of any term. However, median scores indicated the term "problems in professional competence" or "incompetence" was rated highest (*Mdn* = 6.00) in terms of its appropriateness whereas the term "problem student behavior including skills and dispositions" was rated lowest (*Mdn* = 5.00) in terms of its appropriateness in describing the phenomenon. The other two terms (i.e., "impairment," *Mdn* = 5.00 and "a counselor who is unsafe to practice," *Mdn* = 5.00) were rated similarly.

Panel members who believe the term impairment should not be utilized also provided a description of the issues associated with using such a term. The responses were subjected to content analysis and the results suggested the term impairment should no longer be used because it: (a) overlaps with the term as it is used in the American's with Disability Act (1990), (b) creates legal risk for counselor educators, (c) intermingles etiology with observable behaviors leading to confusion, and (d) suggests a medical model approach or deficiency of personality even when the problems might have more to do with dispositions and skills of the student.

Discussion

The purpose of this study was to create a systemic process to reach consensus regarding the definitional boundaries and essential descriptors of counselor impairment. The Delphi method allowed for a communication process among a panel of experts, which allowed for the development of: (a) consensus on a semi-definition, (b) lists of problematic behaviors for each counselor competency area, (c) a continuum with problematic behavior along various anchor points, and (d) proposed alternative terms to utilize in place of impairment despite a lack of consensus. These results are discussed further below in relation to the current literature on student impairment.

Complexity of Impairment

The impairment literature described the importance to increase a counselor educator's ability to identify and remediate trainees displaying deficiencies (Bemak et al., 1999; Boxley et al., 1986; Elman et al., 1999; Forrest et al., 1999). The literature also reflected disagreement within the field regarding what constitutes impairment, which, in turn, decreased the ability to adequately address such deficiencies. Impairment is a

complex issue due to the multifaceted nature of evaluating counselor competency and the existence of vague evaluative procedures (Duba et al., 2010).

Methodological Inadequacies in Reducing a Complex Issue

Although the Delphi method is often used because of its ability to empirically derive consensus among a panel of experts, I realized this method might have been insufficient for investigating the complexity of counselor impairment. Although some aspects of this method were beneficial, the topic might have been better suited for a real-time, face-to-face interaction. I found difficulty in reducing a dynamic and multifaceted issue into succinct questions. I believe in order to thoroughly capture the complexity of counselor impairment to reach consensus among panelists, I would have needed to include considerably more questions than were included within the study. However, the sheer number of questions required to address every nuance of impairment would have added to panelist fatigue and potential dropout. Therefore, I struggled to find a balance between being thorough to capture the phenomenon and reducing attrition.

In some areas, panelists failed to reach consensus, which may have been due to the lack of in-depth discussion. The Delphi method allows for a group communication process leading to group consensus (Dalkey, 1969); however, I believe the communication between the experts in my study had limited impact on the results. Considering the communication process available for the panelists, it might have been difficult for them to describe the nuances of impairment. Perhaps future studies similar to this one might implement a modified Delphi study (Hasson & Keeney, 2011) with one round being a focus group of experts.

Differences Among Panelists

A tale of two professional perspectives. I received multiple personal communications from potential panelists, which either indicated their excitement and belief in the importance of my study or expressed their concern regarding my use of the term impairment within my study. These comments seemed to illuminate a difference between counselor educators and counseling psychologists in terms of the current level of understanding and development of the term impairment. Those potential panelists who indicated concern of me using impairment each had a psychology background; however, panelists with a counseling background lacked similar feedback. This difference sparked my curiosity to see if a similar difference between counselor educators and psychologists existed within the impairment literature.

Upon examining the literature, it became clear the psychology profession had engaged in discussions of professional impairment earlier and overall had more attention to the topic. In addition, the psychology literature was more direct regarding no longer using the term impairment. Multiple psychology articles were published starting in 2007 that urged other professionals to discontinue the term impairment and provided issues with the terminology (Elman & Forrest, 2007; Falender, Collins, & Shafranske, 2005; Kaslow et al., 2007; Schwartz-Mette, 2011). Yet, a similar review of the counseling literature indicated there were less articles published and started at a later date. Yet the overall trends indicated the counseling literature followed the psychology field and began using impairment less. However, despite the reduction in authors using the term impairment, some current literature continued to use the term (APA, 2014; Duba et al., 2010; Williams, Pomerantz, Segrist, & Pettibone, 2010).

Results mirroring psychology and counseling differences. Although some areas reached consensus, two areas that displayed a difference between panelists were questions related to the terminology used to describe student deficiencies and questions relating to the likelihood of remediating such issues. The panel was unable to reach consensus regarding the most appropriate term. Further, some individuals believed impairment was the most appropriate term to describe such a phenomenon. Psychologists suggested an alternative term at a higher rate than did counselor educators (i.e., 80% of psychologists and 71% of counselor educators). The real difference came when considering the commentary from an optional comment box. An examination of these comments indicated while both psychologists and counselors were similar in their belief that an alternative term should be used, psychologists were more adamant in voicing their opinions and the issues with utilizing impairment (i.e., 50% of psychologists commented and 17% of counselors commented).

Differences among psychologists and counselors were also evident within the questions referring to beliefs about the likelihood of certain impaired behaviors being remediable. More specifically, on average, counselors identified 8.8 behaviors and psychologists on average identified 13.7 behaviors out of 63 to be non-remediable. This difference might suggest those with a counseling background are less likely to identify a behavior as non-remediable, which reflects the counseling profession's focus on human growth and development.

Difficulty Identifying Impairment

Both the literature and the results from the current study indicated difficulty and dis-ease when attempting to define and identify impairment in counselors-in-training

(Bradey & Post, 1991). One explanation is the personal and often times critical nature of trainees' non-academic behaviors. Those ascribing to a typical developmental approach might hesitate to identify any behavior as true impairment as such a definitive stance would interfere with a belief that students can grow, improve, and change. In addition to this reluctance, impairment is difficult to identify and remediate because of the lack of a professionally agreed upon process and protocol.

Adding to the ambiguity of student evaluations and the identification of counselor impairment is concretely identifying personal factors aiding in deficiencies is much less straightforward than academic struggles (Markert & Monke, 1990). It is my belief that typical didactic coursework often leads to passivity within students, which requires less interaction and revealing oneself leading to decreased opportunities for adequate evaluation of non-academic deficiencies. I believe the ability to assess personal and interpersonal behaviors is only increased within the clinical portion of training. In this environment, there (a) is more interaction among peers and with clients, (b) exists higher levels of stress and anxiety related to being observed and evaluated and (c) is increased time spent in direct supervision. The findings from the current study perhaps call into question the very way we train. Because of high didactic requirements (often to meet accreditation standards), there is, in turn, less interaction and opportunities for deficient behaviors to be identified and addressed.

The Definition That Captures the Essence of Impairment

An initial aim of the current research study was for panel members to reach consensus on a set of alternative terms for impairment. However, this was not a realistic outcome. The literature demonstrated an ongoing struggle to reach such consensus and

reasons why consensus was so difficult. Agreeing on a single term or set of terms might not be feasible; a more realistic goal might be to develop a universally agreed upon process and protocol for evaluating and addressing impairment behaviors. This might include (a) a set of behaviors that are unlikely to be changed as a result of intervention; (b) a spectrum of problematic behaviors that assists in the identification of the severity and intensity of such behaviors; and (c) potential client harm if these problematic behaviors are not remediated in an appropriate fashion.

Limitations

Several limitations of this study should be noted. First, the Delphi methodology requires intentional use of experts (Hasson et al., 2000), which eliminates the possibility of probability sampling. For the current study, non-probability sampling was utilized to ensure an appropriate panel consisting of experts on the topic of impairment was recruited. An additional limitation was the study's small sample size (i.e., $N = 12$). Although this sample size was consistent with recommendations for conducting a Delphi study (i.e., 10-18; Okoli & Pawlowski, 2004; Sklumoski, Hartman, & Krahn, 2007), a small sample size should still be considered a limitation.

An additional limitation was the subjectivity involved in the development of the surveys as well as the analysis of the results (i.e., content analysis and determining consensus). The Delphi literature suggested open-ended questions in the first round to reduce the amount of researcher bias included in survey development (Okoli & Pawlowski, 2004). An open-ended round allowed panel members to essentially develop the content for future surveys rather than the researcher identifying the information believed necessary to include in subsequent rounds. The current study utilized an open-

ended first round; however, through the process of content analysis, I analyzed the data by means of content analysis, which is subject to personal bias in reducing the text to themes. Lastly, the Delphi method literature indicated a limitation of the methodology is lack of direction in terms of determining consensus (Graham, Regehr, & Wright, 2003, Hasson et al., 2000; Keeney et al., 2001). Each researcher determines how consensus will be determined prior to data collection. In the current study, consensus was determined by an interquartile range (IQR) of less than or equal to one. Depending on how consensus was determined might have provided varying results and should be considered as a limitation.

Implications for Counselor Education and Supervision

The findings from this study suggested multiple implications for the field of counselor education. The results offered lists of problematic behaviors associated with each counselor competency area suggested by Foaud et al. (2009) as well as behaviors and characteristics associated with anchor points along a continuum of counselor impairment. Counselor educators and clinical supervisors could utilize the findings from this study in many ways.

Considerations for Admission Process

Existence of an empirically derived set of behaviors along a continuum of impairment might assist counselor educators to screen for some common deficient behaviors at the admissions stage. The results from this study underscored the importance of personal interviews prior to admittance. This process might be valuable in since it could provide an opportunity to observe candidates' professional interactions and non-academic behaviors. While an in-person interview would only provide a brief

snapshot of an individual's way of being, it would provide additional information to the required admissions requirements.

Counselor educators might also utilize this opportunity to introduce the concept of counselor impairment and the various behaviors and characteristics often considered to be impaired, thus limiting one's ability to effectively and ethically work with clients. These conversations during the admissions stage could be an opportunity for applicants to understand how their behaviors might be considered impaired, the consequences, and processes faculty must take to remediate such behaviors from counseling programs and ultimately the counseling profession. These conversations might increase students' ability and awareness to self-select into counseling programs based on their perceived ability and history of managing problematic behaviors that would hinder their ability to be a professional counselor.

Training Master's and Counselor Education and Supervision Doctoral Students

An implication from this study might highlight the need for more training regarding counselor impairment within training programs. Although many Counselor Education and Supervision doctoral programs educate their students about remediation and gatekeeping, the depth of these discussions and understanding is potentially questionable considering a lack of understanding and agreement on impaired behavior. This education must include more than readings and discussions regarding gatekeeping; it must also include an in-depth understanding of the procedures and protocols to implement when problematic student behaviors arise. A failure to provide such an in-depth training might perpetuate the hesitancy and lack of understanding in addressing

student concerns, which ultimately might lead to graduating impaired counselors who might increase client harm.

A similar understanding might be useful for master's level trainees. A common topic is counselor wellness where counselor educators discuss wellness with students and require students to complete a wellness plan. This conversation could be supplemented with a presentation of hallmarks of impairment, which would increase the students' level of awareness regarding problematic behaviors in order to attend to these issues within themselves or assist a struggling colleague. Not to mention, many master's level counselors will serve in a supervisory role at some point in their career so an understanding of indicators of impairment and potential remedial measures might prove to be essential.

Assistance for Counselor Educators

A potential implication from this study is some problematic behaviors containing high potential for client harm are often less substantial (i.e., interpersonal deficiencies). Such non-academic behaviors might be less likely to be identified or be identified with any certainty, potentially leading to decreased willingness to address them (Bradey & Post, 1991). The results from this study might provide supporting documents that could assist faculty members in identifying impairment and the decisions they make regarding remediation procedures.

Reconsideration of Pedagogy

The results suggested a need to implement a variety of forms of assessment for student evaluations. Although grades are an effective and essential aspect of training, especially to uphold the CACREP (2009) student learning outcome requirements, it is

important for the field to consider a potential imbalance regarding the focus on objective grades versus subjective evaluations. The findings suggested student evaluation needs to be more about multiple measures capable of assessing non-academic behaviors and less about grades for courses. Thus, the current pedagogy might reconsider a process of frequent and consistent observation of specific counselor behaviors over time with immediate and recursive feedback. In this way, patterns of deficiencies would be more likely to emerge, leading to a more concrete and confident decision to remediate or remove the student from the training program.

More Than a Term

Many articles discussed problems with the term impairment and multiple reasons to no longer utilize the terminology to describe problems with professional competence (Falender et al., 2005; Forrest et al., 1999; Schwartz-Mette, 2011; Wilkerson, 2006). However, the term impairment continues to be used within much of the literature (ACA, 2014; Smith & Moss, 2009; Williams et al., 2010). The results mirrored this ongoing debate and beliefs regarding the term; however, the findings indicated the issue of counselor impairment is more about reaching consensus on a term. The findings might encourage further discussions, which might eventually result in a protocol for assessment and identification of problematic behaviors and a remediation process.

Conclusion

This study attempted to reach expert agreement regarding the definitional boundaries and characteristics of counselor impairment. The implications of this study have the potential to increase education and much needed awareness among the counseling community, both in the training and the professional realms. This awareness

is needed because the current understanding of counselor impairment is limited and often conflicting. With a poor understanding of what behaviors constitute impairment, counselor educators and supervisors cannot effectively and efficiently identify and remediate such behaviors. When these problematic behaviors are unable to be concretely identified and thus remediated, they increase the amount of impaired professionals who enter the counseling field. This creates profound implications for the counseling profession and the potential for client harm increases. For counselor educators to withhold their ethical duty to protect the welfare of clients, the profession must begin with a clarified understanding of the problematic behaviors that constitute counselor impairment. The results from this study might provide a starting point and much needed guidance to begin to more efficiently and effectively identify and remediate problematic behaviors, ultimately decreasing the potential risk to client welfare.

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