Clinical Supervisors' Knowledge of Supervisees with Problems of Professional Competency

Abstract

In this exploratory study, the authors surveyed clinical supervisors (n = 138) regarding their knowledge of their supervisees' problems of professional competency (PPC). Findings suggest the majority have supervised a counselor (i.e. supervisee) with PPC working towards licensure. Further, participants who have supervised a counselor with PPC have been negatively impacted by their interactions (e.g., increased workload, increased stress, decreased client care). Practical applications to the field of clinical supervision include the following: 1) increased training for supervisors; 2) formalized contracts with supervisees at the onset of the supervision agreement; 3) formal evaluations of supervisees; and 4) increased support from employers.

Keywords: clinical supervisor*, supervisee*, *competency, impaired*

Clinical Supervisors' Knowledge of Supervisees with Problems of Professional Competency

Counseling literature has historically focused on defining and measuring professional competency in training programs to assist counselor education programs in enhancing training and curriculum delivery (Swank, Lambie, & Witta, 2012). Recently, counseling literature has become more focused on *problems of professional competency* (PPC) and how knowledge around such can help to improve gatekeeping practices in training programs and reduce the problem of students entering the professional world when they are ill-equipped (i.e. *gateslipping)* (Brown, 2013; Dugger & Francis, 2014; Goodrich & Shin, 2013; Herlihy, Hermann, & Greden, 2014; Homrich, DeLorenzi, Bloom, & Godbee, 2014; Hutchens, Block, & Young, 2013; Parker et al., 2014; Rust, Raskin, & Hill, 2013; Ziomek-Daigle & Christensen, 2010). Problems with professional competency have been defined as maladaptive behaviors that fall outside of normal development deficits (Rust et al., 2013) in areas such as academic performance (Falender, Collins, & Shafranske, 2009), ethical decision-making (Herlihy & Dufrene, 2011; Ziomek-Daigle & Christensen, 2010), and interpersonal difficulties (Duba, Paez, & Kindsvatter, 2010). Swank et al. (2012) suggested that it is essential for counselor educators to be astutely aware of PPC not only so they can adjust their practices as educators, but also so they can more effectively execute their roles as gatekeepers.

Training Level and Problems of Professional Competency

Previous literature has mostly focused on PPC at the graduate school training level (Brear & Dorrian, 2010; Brown-Rice & Furr, 2013; Gaubatz & Vera, 2002; Gaubatz & Vera, 2006; Kress & Protivnak, 2009; Ziomek -Daigle & Christensen, 2010). Problems with professional competency have frequently been observed by both peers and faculty (Brear & Dorrian, 2010;

Brown-Rice & Furr, 2013; Gaubatz & Vera, 2002; Gaubatz & Vera, 2006; Kress & Protivnak, 2009; Ziomek -Daigle & Christensen, 2010). As suggested by Swank et. al (2012), faculty often believe that they are not sufficiently trained to intervene with students who demonstrate PPC. It appears that students may agree that faculty are not adequately trained. Brown-Rice and Furr (2013) found that counseling students were frequently frustrated by observing their peers they believed to have PPC graduating and going on to practice as licensed professional counselors. Given those findings, it seems likely that PPC occur both at the graduate program training level and post-graduate program training level.

Graduate Program Training Level

There are disturbing statistics related to graduate counseling students with PPC. Gaubatz and Vera (2002) stated that as many as 10% of counseling students in graduate programs may be ill-suited for the profession. Gaubatz and Vera (2006) noted 98% of the master's level students surveyed were aware of deficient counselors-in-training in their respective program and identified 21% of their peers as potentially having PPC. Brown-Rice and Furr (2013) found that 74% of their 389 participants reported observing a peer with PPC in their graduate training program.

At the graduate training level, it may be assumed that students have expectations that faculty intervene with peers they believe to have PPC. According to Rosenberg, Getzelman, Arcinue, and Oren (2005), 55% of 129 clinical psychology students reported that PPC among peers were often inadequately addressed by university faculty. Additionally, 58% noted being aggravated with faculty for accepting students with PPC in the program and not screening them out. Similarly, Brown-Rice and Furr (2013) found that 65% of their counseling student participants were frustrated by faculty not intervening with peers they believed to have PPC.

Further, 70% of their participants reported concern over faculty approving graduation of their peers with PPC. Forrest, Elman, and Shen-Miller (2008) suggested that perceived lack of action by faculty caused students to mistrust and doubt faculty members' decision making (Foster & McAdams, 2009; Gaubatz & Vera, 2006; Rust et al., 2013). This research suggests that, at the graduate training level, counseling students are negatively impacted in multiple ways by peers they believe to have PPC.

Previous research suggests that counseling students believe both their relationship with faculty and their learning environment are negatively impacted by their peers with PPC (Foster & McAdams, 2009; Gaubatz & Vera, 2006; Rust et al., 2013). Brown-Rice and Furr (2013) found that 68% of their counseling student participants reported they had been directly impacted by their peers with PPC. The top three PPC in their peers that had the greatest impact on them included:1) inability to regulate his or her emotions; 2) academic deficiencies; and 3) acting in unprofessional ways. Given that 65% of their counseling student participants reported that faculty did not intervene with students who demonstrate PPC, it may be highly likely that these and other disruptive behaviors are carried out in to the field post-graduation and go on to impact professional colleagues.

Post-Graduate Program Training Level

Researchers have provided counselor educators with specific protocols and information to assist educators in establishing gatekeeping procedures when working with supervisees with PPC (Forrest, Elman, Gizara, & Vacha-Hasse, 1999; Gaubatz & Vera, 2002; Homrich et al., 2014; Kerl & Eichler, 2007; Kress & Protivnak, 2009; Lumadue & Duffey, 1999; Miller & Koerin, 2001; Russell, DuPree, Beggs, Peterson, & Anderson, 2007; Swank & Smith-Adcock, 2014). Brown-Rice and Furr (2013) casted a wider net for gatekeeping by also examining and

suggesting protocols for peers on how to intervene when they observe a fellow counseling student with PPC. However, there has been a lack of attention in understanding gatekeeping and remediation at the post-graduate program training level. This has left clinical supervisors and practicing counselors with minimal resources to seek when working with counselors who display PPC. Given that counselors have to receive clinical supervision as a part of their training while working toward licensure, those supervised hours might serve as an optimal time for PPC to be addressed through a more formalized professional relationship. As suggested by Brown-Rice and Furr (2013), clinical supervisors in the field have an obligation to address PPC of counselors. The American Counseling Association (ACA) *Code of Ethics* (American Counseling Association, 2014) makes it clear that supervisors are to address impairment (F.5.b.) gatekeeping (F.6.b.), and endorsement matters (F.6.d.). The ACA *Code of Ethics* (2014) states, "Supervisors do not endorse supervisees whom they believe to be impaired in any way that would interfere with the performance of the duties associated with the endorsement" (p. 13).

Given the gap in previous literature, it seems important to start with examining clinical supervisors' knowledge of PPC. The purpose of this pilot study was to investigate how and to what degree clinical supervisors experience supervisees with PPC. Specifically, to answer the following research questions: a) What are clinical supervisors experiences with supervising supervisees with problems of professional competency? b) What types of supervisees' problems of professional competency do clinical supervisors perceive to have the greatest impact on them? c) What do clinical supervisors believe is the most significant impact as a result of supervising a supervisee with problems of professional competency? and d) What is clinical supervisors' knowledge of protocol for addressing a supervisee with problems of professional competency?

To help address these questions, the authors used the following definitions. For this study, *supervisee* is any mental health provider that the clinical supervisor has contracted with to provide supervision toward state licensure, *administration* refers to management at participants' place of employment, and p*roblems of professional competency* refers to attitudes and/or behaviors that could interfere with the professional competence of a supervisee, including (a) a lack of ability or opposition to acquire and integrate professional standards into one's professional counseling behavior; (b) a lack of ability to attain professional skills and reach an acceptable level of competency; (c) a lack of ability to manage one's stress, psychological dysfunction, or emotional responses that may impact professional performance; or (d) engagement in unethical behavior (Falender et al., 2009).

Methods

Participants and Procedures

The focus of this study was to collect preliminary, descriptive data of professional counselors supervising another clinician towards licensure. Therefore, one specific Midwestern state was selected due to their licensing board having a supervision status license. Upon obtaining institutional review board approval, the state licensing board of the Midwestern state was contacted and a list of the names of those holding a current clinical supervisor license (N = 788) was purchased. Packets with the informed consent and survey were mailed via first-class mail and 10 were returned undeliverable; leaving a total sample size of 778 clinical supervisors. A total of 190 participants completed and returned the survey and respondents with missing or invalid data (n = 52) were eliminated via listwise deletion (Sterner, 2011), leaving a final sample of 138 participants (17.7% response rate). According to Heppner, Kivlighan, and Wampold (as cited in Erwin & Toomey, 2005, p. 306) sample size and power are not relevant for studies when

statistical testing is not intended. For the current study, no statistical testing was intended so sample size and power were not considered.

Of the 138 participants (100 women, 38 men), 126 identified their race/ethnicity as being Caucasian, four identified as African American, two identified as Hispanic/Latino, four identified as Multiracial, and two identified as Native American. The following age groups were represented in the participant group: 20 to 29 years (n = 2), 30 to 39 years (n = 34), 40 to 49 years (n = 30), 50 to 59 years (n = 34), and 60 years or older (n = 38). The majority of the respondents identified as heterosexual (n = 126) with 12 identifying as bisexual, Gay or Lesbian. Regarding the participants' employment setting, 62 indicated private practice, 36 indicated non-profit agency, 16 indicated for-profit agency, 12 indicated government agency, six indicated a college counseling center, and eight an elementary/secondary school.

Various programs and degree types were represented by participants in this study: A master's degree in counseling from a CACREP-accredited master's (n = 72), a master's degree in counseling from a non-CACREP program (n = 26), a doctor of philosophy (PhD) in counseling from a CACREP-accredited program (n = 8), a PhD from an APA-accredited program (n = 8), an education specialist degree in counseling (n = 6), a master in social work from a program accredited by the Council of Social Work (n = 4), a PhD in marriage and family (n = 2), and a master's degree in pastoral counseling (n = 2). Eighteen respondents had been a practicing clinician for two to five years, 20 for six to 10 years, 38 for 11 to 15 years, 20 for 16 to 20 years, and 42 for over 20 years. The participants in this study had supervised for various ranges of years: less than two years (n = 34), for two to five years (n = 44), for six to 10 years (n = 30), for 11 to 15 years (n = 10), for 16 to 20 years (n = 12), for over 20 years (n = 8).

Instrumentation

A self-report survey was designed based upon the 38 items of the Problems of Professional Competency Survey – Master Student Version (PPCS-MS) developed by Brown-Rice and Furr (2013). The PPCS-MS was created to assess master students' enrolled in CACREP-accredited programs knowledge of peers with problems of professional competency (PPC). The items for the PPCS-MS were derived from the literature regarding PPC in psychology, counseling, and social work. To establish content validity and reliability, the PPCS-MS underwent an expert review process and two pilot studies to provide clarity and conciseness of the survey questions. Further, a principal components analysis created components representative of what the review of the literature provides on these issues (Brown-Rice & Furr, 2013). The PPCS-MS was adopted for use in this study by changing the terms master's student to supervisee to create the Problems of Professional Competency Survey – Supervisor Version (PPCS-S). Further, four questions from the PPCS-MS that were specific to master's students were deleted and two questions were added specific to clinical supervisors (i.e., I am frustrated with administration for not providing support to me to address a supervisee with problems of professional competency; I am concerned that I have allowed supervisees with problems of professional competency to continue to obtain licensure/certification).

The PPCS-S was divided into two parts: Part I - Demographic Information (8 questions), Part II – Knowledge of Supervisees' Problems of Professional Competency (28 items), which included four nominal questions: a) Have they supervised a clinician with problems of professional competency (*yes, no, don't know*); b) How many total supervisees with problems of professional competency they supervised (*0, 1, 2, 3, 4, 5 or more*); c) Have they been impacted by supervisee(s) with problems of professional competency (*yes, no*); and d) In what way do they

feel you were the most affected (*Interfered with ability to focus and work efficiently; Disrupted work environment; Increased workload; Affected the level of competent care clients were receiving; Affected relationship with other supervisors*). An additional 24 questions based on a 5-point Likert scale (*1= strongly disagree to 5= strongly agree*) regarding respondents' perceptions of the impact of supervisees' problems of professional competency. Higher scores indicate the behavior of the supervisee had a stronger impact on the participant. The Cronbach Alpha for these 24 items was .92. There was also one open-ended question so participants could provide additional information related to the topic.

Results

Experience with Supervisees' Problems of Professional Competency

Of the 138 participants, the majority (*n* = 100) reported they had supervised a supervisee with problems of professional competency (PPC), leaving 38 participants who had not supervised a counselor (i.e. supervisee) with PPC. For those respondents who believed they had a supervisee with PPC (*n* = 100), 46 had observed one supervisee, 20 had observed two supervisees, 12 had observed three supervisees, eight had observed four supervisees, and 14 had observed five or more. Eighty of those 100 participants reported they were impacted by supervising a counselor with PPC while 20 participants stated they were not impacted. Of those 80 participants who were impacted, 38 reported the most significant affect was the level of competent care clients were receiving. Thirty-six participants reported the most significant impact was that it increased their workload. Further, four reported they were impacted due to participants' work environment being disrupted and two indicated the supervisee with PPC interfered with their ability to focus and work.

Perceptions of the Type and Impact of Supervisees' Problems of Professional Competency

All participants (n = 138) reported their degree of agreement (i.e., strongly agree or agree) or disagreement (i.e., disagree or strongly disagree) regarding their observation of a specific type of PPC. Frequencies and percentages are reported in Table 1.

Table 1

Participants' Responses Regarding Degree of Impact of Specific Type of Supervisees' PPC

Type of PPC	Impacted by Supervisees' PPC									
	Strongly Disagree		Disagree		Neither Disagree nor Agree		Agree		Strongly Agree	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Inadequate clinical skills	18	13.0	38	27.5	16	11.6	54	39.1	12	8.7
Unprofessional behavior	26	18.8	42	30.4	18	13.0	40	29.0	12	8.7
Inability to regulate emotions	20	14.5	54	39.1	14	10.1	42	30.4	8	5.8
Psychological unsuitability	30	21.7	54	39.1	16	11.6	32	23.2	6	4.3
Unethical behavior	30	21.7	48	34.8	24	17.4	24	17.4	12	8.7
Signs/Symptoms of personality disorder	32	23.2	48	34.8	26	18.8	26	18.8	6	4.3
Signs/Symptoms of Substance use	38	27.5	62	44.9	18	13.0	14	10.1	6	4.3

The most common types of PPC observed by participants were supervisees' inadequate clinical skills (n = 66), unprofessional behavior (e.g., dishonesty, excessive tardiness, absences) (n = 52), and inability to regulate emotions (n = 50). Other types of PPC observed by participants

were supervisees' psychological concerns (n = 38), unethical behaviors (n = 36), and signs and symptoms of a personality disorder (n = 32) or substance use issue (n = 20).

Perceived Impact of Supervising Supervisee with Problems of Professional Competency

Each of the participants (n = 138) reported their degree of agreement (i.e., strongly agree or agree) or disagreement (i.e., disagree or strongly disagree) regarding their belief of the specific type of impact on them by a supervisee with PPC. Frequencies and percentages are reported in Table 2.

Table 2

Participants' Belief as to the Most Significant Impact on Them

	Impacted by Supervisees' PPC									
Type of Impact	Strongly Disagree		Disagree		Neither Disagree nor Agree		Agree		Strongly Agree	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Supervisor concerned about the counseling profession	10	7.2	22	15.9	6	4.3	66	47.8	34	24.6
Increased supervisor's workload	22	15.9	42	30.4	4	2.9	46	33.3	24	17.4
Supervisor felt stressed	20	14.5	40	29.0	10	7.2	50	36.2	18	13.0
Disrupted overall work environment	24	17.4	36	26.1	6	4.3	56	40.6	16	11.6
Frustrated administration not supporting supervisor	20	14.5	40	29.0	38	27.5	30	21.7	10	7.2
Supervisor felt resentment toward supervisee	28	20.3	54	39.1	26	18.8	26	18.8	4	2.9

Supervisor felt it interfered with ability to concentrate & complete own work	26	18.8	74	53.6	14	10.1	20	14.5	4	2.9
Interfered with ability to be an effective supervisor	38	27.5	62	44.9	14	10.1	20	14.5	4	2.9
Concerned supervisor has allowed supervisee with PPC to get license	40	29.0	76	55.1	0	0.0	12	8.7	10	7.2

One hundred participants indicated concern about the counseling profession when a supervisee with PPC is allowed to obtain licensure. Seventy-two participants perceived that a problematic supervisee had disrupted the work environment at the school/agency. Forty participants believed administration had not provided support to address supervisees with PPC. Twenty-two expressed concern that they have allowed supervisees with PPC to continue to licensure and are frustrated with fellow supervisors for not addressing a supervisee with PPC. When looking at the direct impact on a supervisor, 71 believed supervising a supervisee with PPC increased their workload, 68 felt stressed, and 30 felt resentment toward the supervisee with PPC. Further, 24 felt it interfered with their ability to concentrate and complete their own work and 24 indicated it interfered with their ability to be an effective supervisor.

Knowledge of Agencies/Schools' Protocol for Addressing a Supervisee

When the participants' (n = 138) responses for strongly agree and agree were combined, 136 believed it was their responsibly to be aware of a supervisee with PPC, 114 provided they knew the intervention to take regarding a supervisee who demonstrated PPC, and 104 were aware that their agency/school's policy or procedure for addressing a supervisee with PPC. Furthermore, 78 reported they had received training regarding how to intervene with a supervisee

who demonstrates PPC, 70 of the participants would like more information regarding how to respond to a supervisee with PPC, and 72 would like more information regarding how to identify a supervisee with PPC.

Discussion

The results of this study give the counseling field a first look at how problems of professional competency (PPC) are experienced at the post-graduate program training level (i.e. during clinically supervised hours toward licensure). This preliminary study sought to explore clinical supervisors' knowledge of supervisees' PPC. From the training environment literature, 74 % of counseling students reported observing peers with PPC in their training program (Brown-Rice & Furr, 2013). Interestingly, there were similar results in this study with 72% of clinical supervisors reporting they supervised a counselor with PPC. These findings suggest that gatekeeping practices implemented in counselor educator programs may not be keeping students with PPC from *gateslipping* (Gaubatz & Vera, 2002; Gaubatz & Vera, 2006). In particular, graduate students concern that peers with PPC are allowed to graduate and practice in the field (Brown-Rice & Furr, 2013; Foster & McAdams, 2009; Gaubatz & Vera, 2006; Rust et al., 2013) may be justified.

The results of this study are concerning when considering types of PPC observed by clinical supervisors. Participants reported approximately one-quarter to one-half of their supervisees displayed inadequate skills, unethical behaviors, and unprofessional behaviors (e.g. dishonesty, excessive tardiness, absences), and difficulty regulating emotions. There were a lot of similarities in the types of PPC described in this study and in previous research that focused on counselors-in-training (Brear & Dorrian, 2010; Brown-Rice & Furr, 2013; Duba et al., 2010; Gaubatz & Vera, 2002; Gaubatz & Vera, 2006). Those similarities suggest the same types of

PPC that occur in training settings are continuing into clinical practice. These findings further support the idea that post-graduate program supervision may provide the perfect platform for intervention to occur with counselors who demonstrate PPC.

The current study also demonstrates that supervisors are negatively impacted by the experience of supervising a supervisee with PPC. Of particular interest, 80% of participants who supervised a supervisee with competency problems described being negatively impacted by their interactions with the supervisee they believed to have PPC. About half of the clinical supervisors in this study noted the problematic supervisee had disrupted their work environment (52.2%), believed the supervisee increased their workload (50.7%), and increased the amount of stress they felt (49.2%). Furthermore, 17.4% believed the supervisee with PPC interfered with their ability to complete work, concentrate at work, and be an effective counselor. These findings highlight the destructive domino effect that can take place. Counselors with PPC negatively impact their own clients, their supervisor, *and* their supervisor's clients.

The majority of supervisors (72%) in this study expressed concern about a supervisee with PPC being allowed to continue to practice. Of the 80 clinical supervisors who reported being impacted by a supervisee with PPC, 47.5% believed the greatest impact on them was that client care was affected. Only 15.9% of the participants in this study reported that they believed they had allowed a supervisee to *gateslip*. These results suggest that clinical supervisors in the field may have a strong conviction to intercept counselors with PPC so gateslipping does not continue to happen.

Supervisors reported mixed responses related to addressing or managing supervisees with PPC. For example, the large majority viewed it as their responsibility to be aware of supervisees with PPC (98.4%), knew of steps to take (82.6%), and understood work policies to consider

when addressing PPC (75.3%). On the other hand, some believed administration provided limited support (28.9%) and roughly half wanted more guidance to identify (52.2%) and respond to (50.2%) supervisees with PPC. It appears that although clinical supervisors know what their gatekeeping responsibilities are, half want more guidance regarding supervising these problematic supervisees. These findings are similar to previous research that suggested both graduate counseling students (Brown-Rice & Furr, 2013) and counselor educators (Swank et al., 2012) also want more information on how to identify and intervene with students they believed to have PPC.

Practical Application for Clinical Supervisors

Based on the findings of this study, it is apparent that counseling students with PPC are, in fact, becoming practicing counselors and supervisees with PPC. At the graduate level, faculty are often trained and can collaborate with each other regarding what problematic behaviors fall within a need for intervention (Brear & Dorrian, 2010). Swank et al. (2012) indicated that it is critical for counselor educators to understand what behaviors represent PPC in order to effectively gatekeep. Brear and Dorrian (2010) suggested a need to provide constant training to counselor educators about gatekeeping given how important it is to the field of counseling. Although many of the clinical supervisors in this study were able to identify that they had supervised counselors with PPC, it may be important to provide more and continued training so there is a clearer understanding of PPC and interventions strategies. Trainings could focus on identifying maladaptive behaviors that can occur after graduation such as developmental deficits (Rust et al., 2013), ethical decision-making issues (Falender, Collins, & Shafranske, 2009), and interpersonal difficulties (Duba et al., 2010).

Another practical application for clinical supervisors might be creating formalized contracts and plans of operation when agreeing to supervise a counselor (Falender & Shafranske, 2014). Scholarship has suggested the importance of having policies and program practices in place at the program level to help with intervention and remediation of PPC in students (Furr, 2013; Homrich et al., 2014). The existing literature can help clinical supervisors apply similar procedures that have been developed at the program level. For example, program handbooks are provided to students when they start their graduate program, which outlines expectations while in the program, evaluation procedures, remedial plans, dismissal proceedings, etc. Additionally, formal evaluation occurs regularly and is considered critical in the gatekeeping process at the program level (Brear & Dorian, 2010). Clinical supervisors at the post-graduate level may benefit from formal practices such as developing a contract and doing formal evaluations of their supervisees. These practices might assist clinical supervisors in mitigating PPC by having clear expectations in place and a formalized plan to hopefully intercept PPC early so remediation can take place (Falender & Shafranske, 2014).

Additionally, it is important to consider the support clinical supervisors receive in their work setting. Based on the ethical and professional responsibilities of a clinical supervisor, the role is critical to the growth and development of the counseling profession and client care (American Counseling Association, 2014). At the university level, counselor educators are given workload credits, release time, and are limited to how many supervisees they can supervisee as guided by the Council for Accreditation of Counseling and Related Education Programs (CACREP) standards (Council for Accreditation of Counseling and Related Education Programs, 2016). In the clinical world, Rice et al. (2007) suggested clinical supervision take place during the regular operating hours of agencies to further emphasize that clinical supervision is essential

to the operation of agencies. It seems important for employers to be more involved in supporting clinical supervisors by assisting in activities such as creating the formalized supervision documentation (e.g. clinical supervision contracts, evaluation forms), seeking legal counsel when necessary, and facilitating continuing education that specifically focuses on supervision. Further, perhaps the information in the current study could provide a good resource for clinical supervisors who want to advocate for themselves in their work setting.

Limitations

There are some limitations in this descriptive study that should be considered when applying these findings and considering directions for future research. The most notable limitations in this study were the small sample size and the participants being from one Midwest state. Given this study was designed as pilot study and exploratory in nature, the results may not provide a holistic view of the impact of supervising a clinician with PPC.

Another limitation is the survey being a self-report measure. There is a risk respondents provided answers they considered to be socially desirable. Although participants were informed in advance that their answers would be kept anonymous, they may still have responded in a manner that would not be representative of their true feelings or knowledge (e.g., whether they allowed a supervisee with PPC to obtain licensure).

Future Research

Future direction on this research topic could aim at increasing sample size, including other ways of gathering data, and exploring program preparation for mitigating these situations. Studies including a larger sample more representative of all clinical supervisors would be beneficial as only one Midwest state was sampled. Further, qualitative, quantitative, and mixed methods research studies focusing on the experiences of these supervisors would enhance our

knowledge and understanding and combat the "diminished voice of supervisors as participants" in empirical literature (Crockett, Byrd, Erford, & Hays, 2010, p. 17).

Future research could also look to augment the use of self-report in the process of gathering data on this topic. For example, a collaborative assessment of a supervisees' behavior and supervisors' gatekeeping practices would be beneficial. This could be done by gathering data from clients, supervisees, and supervisors from the same agency or school knowledge regarding PPC within the agency. Future research focusing on how supervisees' PPC were or were not remediated in clinical supervision would also be beneficial.

Another idea for future research could explore what practices prepared clinical supervisors to effectively mitigate when PPC were recognized in their supervisees. This could give insight in to what additional support and training would benefit clinical supervisors. Over half of the participants in this study described a need for additional guidance so it would be important to explore what is currently in place.

Conclusion

There has been considerable counseling profession literature related to students in training programs with PPC and how to address these students. However, understanding the issue of PPC of counselors in the field has largely been overlooked in the literature. The results of this exploratory study provide needed insight regarding clinical supervisors work with supervisees that demonstrate PPC. In particular, the clinical supervisor participants believe that the competency issues of supervisees caused them increased stress, increased workload, negatively impacted their work environment and impacted client care is important to note. While many useful strategies have been provided for counseling training programs (Brear & Dorrian, 2010; Kress & Protivnak, 2009; Rust et al., 2013) and related professions (Johnson et al., 2008;

Russell et al., 2007), more research needs to examine post-graduation program training levels (i.e. during clinically supervised hours) as a means to help the counseling field better adapt to situations when students *gateslip*. Strategies need to be developed to support supervisors in identifying and intervening with PPC demonstrated by supervises as post-graduate program training may intercept and mitigate potential damage of *gateslippin*g that occurs at the graduate program training level. These measures may significantly impact a clinical supervisors' ability to effectively execute his or her ethical obligation to not endorse supervisees believed to be impaired in ways the hinder their professional competence (ACA, 2014).

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