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Counselors-in-Training Problematic Behaviors: A Pilot Study

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The Hippocratic Oath, "above all, do no harm," has been adopted by the counseling profession as a basic tenant to ethical therapeutic practice (American Counseling Association [ACA], 2005; National Board of Certified Counselors, 2005) and academic instruction (Council for the Accreditation of Counseling Related Education Programs, 2009). To prevent harm, counselors are encouraged to employ both gatekeeping and self-monitoring practices. Self-monitoring, as noted in C.2.g of the *American Counseling Association Code of Ethics* (2005) states:

> Counselors are alert to the 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. They seek assistance for problems that reach the level of professional impairment, and, if necessary, they limit, suspend, or terminate their professional responsibilities until such time it is determined that they may safely resume their work. (p. 9)

The counseling profession has increasingly attended to this concept of preparing professional counselors and counselors-in-training to self-monitor and address problematic behavior (Kress & Protivnak, 2009; Lawson & Venart, 2005; Roach & Young, 2007; Rosenburg, Getzelman, Arcinue, & Oren, 2005; Wilkerson, 2006; Yager & Tovar-Blank, 2007). However, self-regulation might be a lofty request for a clinician who is experiencing impairment. Thus, it continues to be imperative that the profession focus on problematic behavior among counseling professionals and counselors-in-training until realistic and effective methods are identified.

There is a lack of consensus on defining and treating behaviors in clinicians that are potentially harmful or deficient. Previously, these behaviors were often referred to in terms of impairment. Impairment has been identified as "a significant negative impact on a counselor's professional functioning which compromises client care or poses the potential for harm to the client. Impairment may be due to substance abuse, mental illness, personal crisis or physical illness," (Lawson & Venart, 2005, p. 3) Within the profession, the concept of impairment has received criticism due to the term's close association with disability, which would then potentially require accommodations (McAdams & Foster, 2007). Other terms to describe harmful or deficient behaviors in counseling students are problematic student (Kress & Protivnak, 2009) and deficient trainees (Gaubatz & Vera, 2002). Deficiencies have been referred to by Gaubatz and Vera (2002) as "marginal" (p. 297). Comparatively, problematic behaviors, according to Kress and Protivnak (2009), occur when a practitioner is functioning at a below acceptable standard influenced by either deficient clinical skills or psychological limitations potentially causing damage to clients, students, supervisees, colleagues, or society-at-large. Although there is not a consensually agreed upon term or definition, Kress and Protivnaks' conceptualization of problematic behavior provides a structure for examining the presence of these behaviors. For the purpose of this research this definition of problematic behavior is incorporated.

One of the challenges in addressing problematic behavior is that while counselors are trained to explore and treat the emotional pain of their clients, they are often not educated on how to attend to their own mental health needs (Kilburg, Kaslow, & VandenBos, 1988; Lambie, 2006). Researchers found that helping professionals experience burnout, psychopathology, and impairment at a higher rate than the general population (Maslach, Schaufeli, & Letier, 2001). In 1996, Kottler and Hazler projected that approximately 6,000 mental health counselors within the United States experienced impairment either mentally or emotionally. Paralleling this finding, ACA (2004) found that among the ACA members surveyed, 64% reported personal experiences with an impaired colleague. These findings demonstrate the need for continued training and awareness of problematic behavior within the profession.

Problematic Behaviors and Counselors-in-Training

Counselor Education faculty hold a significant professional responsibility related to monitoring, assessing, and intervening in incidences of problematic behaviors among students (Gaubatz & Vera, 2002; Gizara & Forrest, 2004). This 'gatekeeping' task is reinforced throughout professional and education guidelines and standards (ACA, 2005; CACREP, 2009). One of the challenges that counselor educators face in meeting this responsibility is identifying what behaviors constitute problematic behavior. In an effort

to identify specific problematic student critical indicators, Li, Trusty, Lampe, and Lin (2007) polled 35 CACREP accredited faculty and discussed 86 different cases of problematic peers. Through the administration of the Behavioral Indicators of Student Impairment Survey, faculty and supervisors reported problematic behaviors including lying, addiction, refusal to participate in counseling, inappropriate boundaries, acting seductively toward clients, inability to demonstrate multicultural sensitivity, psychological impairment, engagement in sexual relationships with clients, harassing peers, and interpersonal deficiencies (Li et al., 2007). Corresponding to these findings, Gaubatz and Vera (2002) reported that approximately up to 10.4% of enrolled master's students may be ill-suited for the profession. These constructs have broadened the profession's understanding of the nature and type of problematic behavior and highlight a need to understand the pervasiveness of this problem. Previous to that study's findings, Forrest, Elman, Gizara, and Vacha-Haase (1999) found that an estimated 5% of counseling graduate students are remediated or dismissed each year. These studies clearly identify that counseling programs have addressed or will address issues related to problematic behavior.

Currently most counselor education programs are meeting this ethical responsibility through gatekeeping and remediation policies. It is recommended that these policies; 1) assist students in obtaining appropriate remedial services, 2) document the process to remediate or dismiss the student, and 3) provide the counselor-in-training ample time for due process or remediation to occur (ACA, 2005, p. 16). While the professional and ethical responsibility to engage in these activities is clear, the process of implementing such policies is often challenging. Faculty are often placed in the dual position of educating counselors-in-training on how to be a counselor and evaluating their personal fitness or disposition to be a counselor. However, defining and identifying problematic behaviors when working with institutional policies and student dynamics can be complicated. One cause for the lack of confronting problematic behaviors may be the difficulties associated with remediating and dismissing students due to litigation processes causing faculty to "heed with caution" (Cole & Lewis, 1993; Lamb et al., 1987; McAdams, Foster, & Ward, 2007). "Counselor educators who are concerned about the fitness of a particular trainee are faced with navigating a formidable maze of student, institutional, and client rights" (Gaubatz & Vera, 2002, p. 295). Thus, it is not surprising that some students with problematic behaviors may not be identified or their problems addressed. These students are termed "gate slippers," as the gatekeeping process was not implemented in an effort to remediate the student (Gaubatz & Vera, 2002).

With the problems inherent in identifying or addressing problematic behavior by program faculty it is not surprising that students sometimes are the first to recognize such behavior among their peers. Although a problematic student may attempt "impression management" within the classroom environment, these behaviors are not typically maintained when interacting with peers (Myers, Mobely, & Booth, 2003; Rosenberg et al., 2005). Rosenberg et al. (2005) found in their study of counseling psychology students that a majority reported having a negative experience with a problematic peer during course enrollment. Of 129 students, only 5% reported experiencing no impact as a result of interacting with an impaired peer. Of the 95% of reported difficulties with a problematic peer, disturbances included (a) disruption of class time, (b) difficulties applying the cohort model during supervision, and (c) challenges related to individual

student learning (Oliver et al., 2005). Research suggests that non-problematic students are impacted by a problematic student in the following areas: experienced negative feelings emotionally, encountered difficulties within the classroom environment, decreased confidence in the mental-health profession, and decreased confidence in faculty (Oliver et al., 2004). Graduate students typically will not confront the problematic peer (Rosenberg et al., 2005) instead there is an attempt to avoid interacting with this peer. This can lead to decreased motivation and interaction within the classroom. This disengagement impacts the academic and emotional functioning of all students within the classroom (Rosenberg et al., 2005). Thus, having a student with significant problematic behavior(s) can cause harm on multiple levels, including within classroom and learning environments.

Self-Care

The issue of problematic behavior is a critical element of the recent increase in attention paid to self-care. Preparing professional counselors and counselors-in-training to engage in self-care to prevent or decrease the development of problematic behavior has been emphasized as a critical element of counselor training and ethical behavior (Lawson & Vernart, 2005; Roach & Young, 2007; Yager & Tovar-Blank, 2007). Self-care has been defined as, "a holistic approach toward preserving and maintaining our own wellness across domains" (ACA, 2004, para 1). According to the ACA Task Force (2004), self-care activities should be maintained by counselors to achieve wellness; however, the specific type of self-care behavior a person engages in may not be as important as the individual's report of self-care practices (ACA, 2004). This suggests that self-care may be a critical element of addressing or reducing ethical and professional problems related to problematic behavior (Kaslow, Mitrick, & Baker, 2002; Kress & Protivnak, 2009; Lawson & Vernart, 2005; Roach & Young, 2007; Wilkerson, 2006; Yager & Tovar-Blank, 2007).

ACA and CACREP both endorse self-care and encourage counselor education programs to educate students on wellness and self-care (ACA, 2005; CACREP, 2009; Roach & Young, 2007). Training counseling students to monitor their own problematic behavior and use self-care may help provide a foundation for their behavior as professional counselors. It may also improve their ability to effectively engage in their training. For example, once students begin to experience stress, they may exhibit a range of symptoms including anxiety, fatigue, and decreased motivation (Hill, 2004; Theriault & Gazzola, 2005). This may compromise an individual's motivation and potentially lead to problematic behaviors. This suggests that a critical part of counselor training is education on problematic behavior and self-care. As Olsheski and Leech (1996) stated "The continued healthiness of the profession depends on individual awareness of personal wellness" (p. 135). Currently, there are no consensually standardized professional training models for counseling programs on self-care and wellness. Bradley and Post (1991) suggested that the absence of standardization may be an accidental professional endorsement to promote problematic behaviors. This research suggests that identifying problematic behaviors among counselors-in-training is a critical part of their training and development. This specifically relates to their ability to identify their own problematic behavior and engage in self-care practices. However, this is limited information in the profession on the use of self-care practices and self-care training

among counselors-in-training. The purpose of this study was to examine these issues among counselors-in-training. Specifically, the study focused on:

1. What self-care behaviors do counselors-in-training use?
2. What is the nature of problematic behaviors that counselors-in-training identify personally?
3. What training have counselors-in-training received on self-care?
4. What is the relationship between self-care methods use and self-identification of problematic behaviors?

Method

Participants

Participants for this study were recruited from master's-level community and/or school counseling programs. Subjects were 99 counselors-in-training from 12 counseling programs within the United States (N= 44 from CACREP programs; N=55 from Non-CACREP programs). Of those polled, 52 subjects identified as community counselors, 33 identified as school counselors, and 13 did not provide a specific discipline. Participants graduate course completion included N=25 of 0-12 credits; N=31 13-24 credits; N=22 24-40 credits; N=21 41+ credits. Of the subjects polled, gender sampled was N=86 females; N=13 males.

Procedure

The data collected for this research study was facilitated through one researcher-designed survey. Community and/or School Counseling Faculty (N=104) were randomly selected and contacted (one from each regionally designated institution) via email requesting their assistance in disseminating the research. A total of 12 faculty members from regionally, randomly selected institutions agreed to disseminate surveys to students in their programs.

Of the 12 faculty subjects, five faculty representatives were from CACREP programs and seven faculty represented Non-CACREP programs. A total of 292 surveys were sent through standard mail with an accompanying mailing envelope and information sheet. Evaluation packets consisted of the IRB letter of approval to conduct research and the Awareness of Problematic Behaviors Survey. Participants were provided a self-addressed stamped envelope with the survey materials.

Measures

The Awareness of Problematic Behavior Survey was developed for the purposes of this study based on previous research exploring problematic behaviors (Li et al., 2007; Rosenberg et al., 2005). The survey included 13 questions including; 1) four closed-ended questions on demographics, such as gender, degree program, credit hours completed, and specialty; 2) one item on self-care: What type of self-care behaviors do you engage in, with options that include exercise, meditate, spending time with friends, et cetera; 3) one item on problematic behaviors: Have you experienced any of the following problematic behaviors? With options that include engagement in unprofessional behavior, emotional problems, difficulties maintaining appropriate and professional boundaries, et cetera; 4) two items on training experiences on self-care or problematic behaviors: Have

you had training in your counselor education program on self-care. If you answered yes what was the nature of the training? With options that include integrated into course, supervision, advisement, or other; 5) one item that questioned remediation experiences: If you answered yes, did you receive any remediation within your program ("no" or "yes" with explanation)? This survey was reviewed by a panel of experts (6), faculty and advanced students in counselor education to address content. The cronbach alpha (estimate of internal consistency) was .684 for the present study for subscales self-care, self-care training, and problematic behavior training.

Results

One hundred percent of the participants polled reported that they engaged in self-care behavior. Table 1 outlines the behaviors that were endorsed by the participants.

Table 1
Self-Care Behaviors Endorsed by Participants (N=99).

Self-Care Behavior	TOTAL
Reported Self-Care Behaviors	99 (100%)
Exercise	68 (69%)
Meditation	25 (25%)
Spending time with friends	90 (91%)
Seeking consultation	25 (25%)
Talking with supervisor	35 (35%)
Spending time with hobbies	69 (70%)
Talking with peers	78 (79%)
Relaxation exercises	22 (22%)
Listening to music	78 (79%)
Personal counseling	17 (17%)

Of the 99 participants, 57 (58%) reported experiencing problematic behaviors on the survey's checklist. Table 2 further explores the frequency of reported problematic behaviors.

Of the 99 subjects, a total of 50 (50%) reported receiving self-care training. A total of 45% of the sample (N=45) reported that they received this content through their courses (integration of content) and 12% (N=12) through supervision. On the issue of training on problematic behavior, the majority of the participants reported receiving training (N=44). A total of 40% (N=40) received training integrated into courses, and 12% (N=12) in supervision.

While investigating the relationship between self-care practices, self-care training and problematic behavior training with the number of reported problematic behaviors, a bivariate correlation was conducted between the three independent variables; self-care practices, self-care training, and problematic behavior training. Results of the bivariate analysis indicated that out of four correlations, three correlations were not statistically significant. There does appear to be one statistically significant relationship with self-care training and problematic behavior training suggesting that subjects who received the one training may likely receive the other ($r(98) = .58$, $p < .01$); likewise, if the subject did not

receive one of the aforementioned trainings, it was also likely that they would not receive the other training.

Table 2
Reported Problematic Behaviors (N=99)

Problematic Behavior	TOTAL
Reported Problematic Behaviors	57 (57.6%)
Unprofessional behavior	5 (5.1%)
Emotional problems/concerns	38 (38%)
Academic limitations/deficiencies	12 (12%)
Eating disordered behavior	16 (16%)
Counseling skill limitations	8 (8%)
Substance abuse	3 (3%)
Inappropriate boundaries	2 (2%)
Personality problems/concerns	10 (10%)
Avoidant/withdrawn	29 (29%)
Anger or aggression	15 (15%)
Problem interactions with peers	9 (10%)
Inappropriate dual relationships	1 (1%)
Response to supervisors	3 (3%)
Inappropriate sexual behavior	2 (2%)

A multiple regression analysis was conducted to evaluate how well self-care practices, self-care training, and problematic behavior training predicted problematic behavior. The results, shown in Table 3 indicate that the model was not significant.

Table 3 includes the correlation indices to demonstrate the strength of the individual predictors. The bivariate correlations represented negative and positive correlations. One indice was statistically significant ($p < .05$). The predictor variable self-care training was significant as it correlated with problematic behavior. This may suggest that fewer problematic behaviors were reported if the participant reported receiving self-care training. The other predictor variables were not statistically significantly. There seemed to be a positive correlation between self-care and problematic behavior. This implies that the more self-care practices identified the more problematic behaviors were equally reported.

Table 3
Correlation Coefficients of Self-Care, Self-Care Training and Problematic Behavior Training

Predictors	Correlation Predictor/Criterion	Correlation
Self-Care	-.048	-.046
Self-Care Training	-.104	-.082
Problematic Behavior Training	-.066	-.004

Discussion

All subjects reported that they practiced self-care. The most frequently reported activities were spending time with friends, discussing concerns with peers, and spending time with hobbies. In addition to those identified on the survey, some of the following activities were identified as self-care activities journaling, spending time with family, praying, yoga, dancing, watching television, surfing the internet, and dinner and/or movie with a spouse. Interestingly, the most commonly reported methods of self-care that students identified are not the most commonly reported activities included in remediation plans. According to Ziomek-Diagle and Christensen (2010), popular remediation plan activities consist of increased supervision and personal development initiatives including referral for counseling and leave of absence. It was surprising that some of the least common responses regarding self-care practices were personal counseling, meditation, and seeking consultation. One of the least common activities, participating in personal counseling, seems consistent with the available research suggesting that counselors do not frequently access personal counseling despite its known benefits (Linley & Joseph, 2007).

A significant part of the results was the self-identification of problematic behavior. It was surprising that upwards of 58% of the participants indicated that they had experienced problematic behaviors. Across the sample, the most commonly reported concerns were emotional concerns, reported by 38% of the participants. Additionally, 29% of the sample reported problematic behaviors defined as avoidant or withdrawn. This is concerning because this behavior may lead students to withdraw from their peers, and their program faculty and be less likely to seek assistance. The least commonly reported problematic behaviors were inappropriate dual relationships, inappropriate boundaries, and inappropriate sexual behavior.

A follow-up question to the problematic behavior checklist was an inquiry if the participants' had ever experienced remediation, and if so, what was the nature of the remediation. Of the 99 subjects, nine respondents reported receiving remediation. In these nine cases, one subject received "supervision" and another subject reported, "I met with key faculty members to disclose items outside of school that was affecting my academic performance. I tried to, with the help of faculty, develop a strategic plan for overcoming pressing obstacles." Additional examples of remediation included: "able to share issues with faculty member," "discuss problems with professor", "discussions," "encouraged to make personal art and see campus counselor," and "within class."

While there was not a statistically significant relationship between self-care practices, self-care training, and problematic behavior training. Upon closer examination, through a multiple regression analysis of the predictor variables, the predictor variable of self-care training was negatively correlated with problematic behaviors and suggests that the respondents who received problematic behavior training reported experiencing less problematic behaviors. The other predictor variables did not yield significant results. As training and self-care have traditionally been recommended to combat the pervasiveness of problematic behaviors, the study's absence of supporting data is intriguing.

Limitations

The survey's design was created in consideration of the identified problematic behaviors in previous research (Li et al., 2007; Rosenberg et al., 2005). The Awareness of

Problematic Behavior Survey was developed primarily for this study and has not previously been used to collect data, thus there is insufficient information available regarding the survey's validity. The constructs identified as problematic and self-care are by no means exhaustive and reflect factors commonly associated in popular society. Future research should also focus on a larger sample of counseling graduate students. This study included 99 counselors-in-training, 13 males and 86 females. In consideration of the large number of counseling graduate programs within the United States, a larger sample size to explore trends may also be beneficial.

Recommendation for Future Research Studies

As indicated in this study's results, the variables explored in this study are by no means exhaustive and may not adequately represent the constructs required to identify problematic behaviors. A future study of this nature should consider including additional objective methods to measure problematic behaviors and self-monitoring skills of students to reduce subjective bias. Pairing counselor-educator and/or supervisor reports with graduate student responses is one example.

Discussion

This is one of the first studies that examined students' reports on self-identified problematic behaviors. For this particular study, data indicated that there is a relationship between self-care training received and problematic behavior training. Furthermore, 100% of respondents reported practicing self-care and 58% consequently reported problematic behaviors. This implies that counselors-in-training possess self-awareness and suggests the possibility of personal responsibility when regulating problematic behaviors. Specifically, the participants utilized social outlets and personal activities versus seeking more structured assistance with counseling or consultation. Measuring the severity of self-care concerns may help to elucidate how challenging maintaining self-care is for students leading to addressing specific training needs. The themes associated with this study are comparable to similar implications as noted by the ACA Task Force in 2003 when they studied impaired counselors.

In their study, the ACA Task Force found that counselors may be more vulnerable to impairment than the average American population (Lawson & Venart, 2005). According to the Task Force, clinicians could be conceptualized across a spectrum from "well-balanced" to "problematic" (ACA, 2004). These constructs are fluid in nature and can be experienced by counselors throughout their career; thus, a discussion that considers prevention, support and advocacy may be advantageous. "It would be useful for counselors to know what places them at risk for progressing along the spectrum and to better equip them with activities and strategies that promote health," (Lawson & Venart, 2005, p. 3). According to Maslach (2003) prolonged stress can lead to burnout, thereby potentially leading to decreased quality of care and services rendered to clients. Symptoms may be expressed physically (e.g., decreased motivation, exhaustion), emotionally (e.g., lethargic, easily discouraged), and/or cognitively (e.g., skeptical, paranoid) which ultimately may lead to poor work attendance or change in profession (Lambie, 2006).

Research that evaluates training experiences and counselor knowledge is necessary in an effort to promote self-monitoring skills. This enhanced understanding may provide practitioners with a more advanced comprehension the *ACA Code of Ethics* (2005) thereby assisting in the decreased need for peer gatekeeping as well as increased personal responsibility. Considering this format, training should include educating counselors-in-training in becoming acquainted with professional mistakes, personal concerns related to ethical slip-ups (e.g., regret, remorse), and assessing possible rehabilitative measures.

A method to support supervisees is through self-monitoring techniques and appropriate professional relationships. Within the literature, supportive relationships are noted as an intervention that reduces impairment and stress (Lamb et al., 1987). Thus, a supervisor could introduce self-reflection skills to further develop the practitioner's own abilities including personal strengths and limitations relevant to professional counseling (Bernard & Goodyear, 2004). As most counselors perceive themselves as highly competent, the awareness of a personal ethical infraction can be quite difficult (Welfel, 2005). Introducing methods that can assist clinicians without minimizing the action would be beneficial. Welfel (2005) identified a four-stage model that may be relevant when a professional encounters an ethical infraction. This model includes: 1) recognition of error, 2) experience of regret, 3) evaluation of possibilities of restitution, 4) rehabilitation to prevent recurrence. In the final stage, the counselor is asked to reexamine their ethical misstep and consider available resources in an effort to prevent the infraction's occurrence in the future. Preventative measures may include becoming aware of one's own responses to stress and continuing education opportunities. Theriault and Gazzola (2005) suggested that a life-long model for clinicians throughout their careers to increase practitioner coping skills as well as assist in feelings of incompetence would improve therapist self-care initiatives. Approaches like these found within the counseling literature help to increase professional awareness of problematic behaviors and encourages responsible behavior.

One objective as identified by the Task Force is advocacy at the state and national levels to assist professionals in defining problematic behaviors, clarifying the *ACA Code of Ethics* (2005) and increasing professional confidence in managing the presence of problematic behaviors. Lawson and Venart (2005) noted that one common misconception in the professional field of counseling is that counselors are highly self-actualized and must therefore be mentally healthy in order to provide competent care. The reality is that counselors are vulnerable to difficulties. One method to decrease the persistence of problematic behaviors is by lessening the stigma associated with a counselor who is experiencing difficulties. A climate that promotes counselor accountability, personal care, and support when reporting a personal ethical violation is one such consideration (Welfel, 2005).

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