A Delphi Survey of Experts’ Opinions Regarding Prevention of Impairment in Professional Psychology Training

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A DELPHI SURVEY OF EXPERTS' OPINIONS REGARDING PREVENTION
OF IMPAIRMENT IN PROFESSIONAL
PSYCHOLOGY TRAINING

by

Kin-Ming Chan

A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Dr. James M. Croteau, Advisor

Western Michigan University
Kalamazoo, Michigan
December 2006
This study sought to identify the most important measures that may be implemented in professional psychology training to prevent the future impairment of professionals. An adjunctive research question of this study addressed how these important measures can be successfully implemented. A 2-round Delphi method was conducted. Twenty-eight experts in impairment prevention participated in the first round study, and 20 of them continued to participate in the second round. In the first round, the experts rated the importance of an original list of 38 preventive measures, suggested additional important preventive measures, and provided considerations for successful implementation of their most important preventive measures. In the second round, the experts rated the importance of an augmented list of 83 preventive measures developed through the first round, and provided further considerations for successful implementation of their important preventive measures.

Sixty-seven items from were rated as above important, and 24 of them were found to be the most important preventive measures according to consensus by the experts. These 24 items were classified under seven training areas: handling trainees with problems, cultivating personal qualities of trainees, providing impairment
prevention education, cultivating program culture, utilizing supervision and feedback, training faculty, and facilitating trainees' development of support networks. The experts also provided a varying amount of information on the successful implementation of these measures.

The two major implications for the results concern the practice of professional psychology training: clarifying the relative importance of various preventive measures, and suggesting partial avenues for successful implementation of the most important preventive measures. Among the limitations are insufficient information for the understanding of how the preventive measures contribute to impairment prevention and the redundancy in conceptualizing the most important preventive measures. Future research needs to address how the most important preventive measures can be successfully implemented and how these preventive measures contribute to impairment prevention. It may also be useful to gain perspectives on impairment prevention from graduate students, faculty who are providing graduate training, and professionals who themselves have experienced impairment. Research which evaluates actual prevention efforts is needed.
ACKNOWLEDGMENTS

It is with deep gratitude and appreciation that I write this acknowledgments section because it signals the end of my dissertation as well as the journey of my doctoral program. I would like to express my heart-felt thanks to those who have contributed, in their own special ways, to the accomplishment of this dissertation project. I want to first thank my whole dissertation committee for their support and guidance throughout the process of my dissertation. Especially, as Chair of the committee, Dr. James Croteau provided for me continuous guidance to reach for a high standard of scholarly work. As committee members of my dissertation, Dr. Patrick Munley and Thomas Holmes also gave me their invaluable advice to help improve my dissertation study and manuscript. I tremendously appreciate the assistance from all of them as it was very crucial to the accomplishment of this work. Hardly will I ever forget the memorable Sunday defense, which really attests to the extent of their generosity in supporting me.

Second, I want to thank my colleagues and my friends both in the United States and Hong Kong, who were supportive of me in their different thoughtful and generous ways during the process of my dissertation. I am very appreciative of Dr. Karen Horneffer-Ginter who encouraged me throughout the process, and helped me edit draft after draft of my manuscript. I thank Dr. Melissa Bullard for her generous help with the data check, and her uplifting conversations during the dissertation process. I also thank my intern peers at UC Berkeley, Dr. Yolanda Gamboa and Dr. Jay Valdez, who gave me tremendous support to make progress for my dissertation while on internship. Also, I appreciate my colleagues Dr. Laura Guillen, Dr Gloria...
Acknowledgments—continued

Saito, Dr. Susana Lowe, Dr. Chris McLean, and Dr. Peggy Yang who helped me to do the pilot test for the first questionnaire. I am also very grateful for other friends whose love, friendship, and support sustained me through the process; especially Vicki Carter (and her mother Mary Jackson), Daisy Chan (and her family: Desmond Chan, Jonathan Chan, and Joshua Chan), Suk-Chong Cheung (and her family: Colin Trevor and Oliver Trevor), Miki Koyama, Lai-Kwan Kwok, Miu-Sheung Law, Hoi-Yin Luk, Greta Rey (and her sister Dori Rey), Fung-Yee Tsang, and Gay Walker.

Third, I want to thank my family and my lover for their special love, which helped sustain me during the dissertation process. I am particularly indebted to my mother Sui-King Choi and my father Jick-Kwai Chan, whose unending love and support deeply nurtured me at a distance from Hong Kong during the whole process of my doctoral study. I am very thankful of my brother Kin-Sang Chan, sister-in-law Suk-Fun Chung, nephew Lok-Hang Chan, and niece Wai-Hang Chan for the warmth and love that they have given to me. I also have much gratitude toward my aunt So-Fong Tsui whose generosity touched me deeply during my doctoral study. Also, I want to thank my darling Alvaro Silva, whose love has meant so much to me and who has contributed much to my hope and joy in finishing my dissertation as well as facing a new chapter of my life.

Finally, I want to express my whole-hearted appreciation of the Universe which flow their love to and through me abundantly all through my dissertation process, my doctoral study, my days on earth, and my whole Life.

Kin-Ming Chan
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CHAPTER I

INTRODUCTION

Overview

This chapter is an introduction of the dissertation research on the prevention of impairment in professional psychology training. The research sought to identify the most important measures that could be implemented in professional psychology training to prevent future impairment of professionals. An adjunctive research question of this study addressed how these important measures could be successfully implemented. First, in this chapter, the importance of impairment prevention in professional psychology training is pinpointed. The second section is the rationale for the study. This section contains the definition of impairment, and a brief review of research findings relating to impairment in the profession, factors contributing to impairment, prevention efforts in the field of psychology, and prevention of impairment in professional psychology training. (A full literature review is in Chapter II.) Third, the objectives of this study are provided.

Importance of Impairment Prevention in Professional Psychology Training

The issue of professional impairment started receiving organized attention in the institution of psychology in the United States in the early 1980’s (Kilburg, 1986; Orr, 1997). The importance of this issue is three-fold: impairment can hurt the psychologist, it may cause harm to the clients, and it can damage the reputation of the profession (O’Connor, 2001; Sherman, 1996). Although different levels of prevention against
impairment have been discussed in the literature (Caplan, 1964; Thoreson, 1986),
existing research literature on the issue of professional impairment and its prevention is
sparse (Sherman, 1996). Among this scant literature on impairment, there is even less
attention given to the study of prevention against future impairment in psychology
training. If the most important preventive measures are known and can be successfully
implemented early on in the training of graduate students in professional psychology,
there may be fewer psychologists suffering from impairment and fewer clients adversely
affected by impaired professionals.

Rationale for the Study

Definition of Impairment

The term impairment started to be used in the field of psychology in the early
1980s to capture various situations that involve deficiencies in professional performance
(Forrest, Elman, Gizara, & Vacha-Haase, 1999). However, after the elapse of two
decades, a consensus has still not been reached within the field with regard to the
definition of impairment (Sherman, 1996). Among these proposed definitions, two
elements are, nevertheless, consistently contained in most of the definitions (Coster &
Schwebel, 1997; Guy, 1987; Laliotis & Grayson, 1985; Orr, 1997; Sherman & Thelen,
1998, Wood, Klein, Cross, Lammers, & Elliott, 1985). One element is the focus on the
consequence of impairment, which is a decline in professional functioning; and the
second element is the occurrence of distress as the cause of such decline. Hence, in this
study, the following definition of impairment is used: a decline in professional
functioning to substandard performance due to the occurrence of distress.
Research Findings Pertinent to the Prevalence of Professional Impairment

Studies in the literature can be found concerning the prevalence of distress (Deutsch, 1985; Guy, Poelstra, & Stark, 1989; Prochaska & Norcross, 1983; Thoreson, Miller & Krauskopf, 1989), suicide (Deutsch, 1985; Mausner & Steppacher, 1973; Ukens, 1995) and impairment (Guy et al., 1989; Floyd, Myszka, and Orr, 1998; Pope, Tabachnick, & Keith-Spiegel, 1987; Schwebel, Skorina, & Schoener, 1988; Wood et al., 1985) in the field of professional psychology. Concerning the prevalence of distress, there are variations reported by these studies. However, they provide rough estimates regarding the current and the past rate of distress experienced by psychologists. Current prevalence of distress among psychologists was found to range from 9% to 19% (Thoreson et al., 1989), whereas prevalence of having experienced distress in the past was found to range from 74% (Guy et al., 1989) to above 82% (Deutsch, 1985; Prochaska, & Norcross, 1983). In addition, suicide studies on psychologists are limited. Ukens (1995) cited a study by the epidemiologists at the National Institute of Occupation Safety and Health, and commented that the occupation with the highest risk of committing suicide was psychologist, at 3.47 times more likely than the general public. This data suggests that a comparatively higher level of distress is experienced among psychologists.

Concerning the prevalence of impairment in the profession, big variations are reported among the published studies with suggestions that the current prevalence of impairment ranges from 5% (Guy et al., 1989) to 28% (Wood et al., 1985). However, 15% is a more common figure of current impairment estimated by the professionals (Floyd et al., 1998; Wood et al., 1985). The past incidence of impairment among psychologists (i.e.
psychologists who have experienced impairment) seems to vary from 30% (Schwebel et al., 1988) to 60% (Pope et al., 1987).

Hence, existing findings pertinent to impairment seem to indicate that distress has been experienced by a large majority (at least 74%) of psychologists. Moreover, psychologists seem to experience relatively higher levels of distress relative to other professions, and have higher suicide risk. In addition, the rate of impairment in the profession seems to indicate that impairment is not a rare phenomenon in the profession. Sherman and Thelen (1998) pointed out in their study that distress and the decline in professional functioning are highly correlated in a positive direction. Hence, because of the common occurrence of distress, any psychologists may, at some point in life, run the risk of having their professional functioning be compromised by distress; hence, having impairment (Orr, 1997). As a result, it warrants organized responsibilities as well as actions to prevent impairment in the profession (Orr, 1997). In particular, early important preventive measures need to be provided in the training for graduate students, equipping them to prevent future impairment.

**Factors Contributing to Impairment in the Profession**

Concerning the factors contributing to impairment in the profession, three clusters of factors are described in the literature: personal characteristics, characteristics of the profession, and personal life events (Guy, 1987; Sherman, 1996). In terms of personal characteristics, there is a lack of strong evidence in the literature suggesting that there exist certain types of therapists who are prone to impairment (Sherman, 1996). However, two variables about personal characteristics were speculated in the literature, which interact with work and life stressors in contributing to distress: problematic motivations
for entering the field (Guy, 1987) and personal developmental issues (Groesbeck & Taylor, 1977). The kinds of problematic motivation that have been raised in the literature include the use of practicing psychotherapy as a means of resolving one's own problem (Goldberg, 1986) or the use of practicing psychotherapy to reduce one's loneliness and isolation (Guy, 1987). Research regarding this cluster of factors is lacking in the literature.

In terms of characteristics of the profession, three studies focus on job-related stressors and hazards in the profession, especially for psychotherapists, and provide empirical data for understanding what occupational factors in the profession are associated with distress and how frequent clinicians experience certain types of work hazards (Farber & Heifetz, 1981, Kramen-Kahn & Hansen, 1998; Sherman & Thelen, 1998). Farber and Heifetz (1981) found three big factors of therapeutic stress: personal depletion, therapeutic relationship, and working conditions. Kramen-Kahn and Hansen (1998) found that the most frequently endorsed occupational hazards were business concerns, economic uncertainty, professional conflicts, time pressures, sense of enormous responsibility and excessive workload. Sherman and Thelen (1998) revealed in their study that the occurrence rates of work distress were highest in the majority of psychologists for the following kinds of work events: working with difficult clients, having too much paperwork, inadequate time for all obligations, restriction imposed by managed care company, and uncertainty regarding best intervention.

In terms of personal life events, psychologists are not immune from the personal problems at various points in the life span as any other people (Coster & Schwebel, 1997). Sherman and Thelen (1998) found that stressful life events among psychologists are as follows in decreasing order of occurrence rate: serious illness/injury of close family.
members, borrow significant amount of money, major marital relationship problems, changes in spouse’s work outside the home, major change in financial status, son/daughter experiencing significant problems, and death of other close family members. Baker (2003) pinpointed that psychologists, as persons, go through a series of potential developmental crises in life due to their developmental stage changes from young adulthood through middle age to old age. These potential developmental crises in life can be sources of distress for the professionals.

Although the three clusters of factors contributing to professional impairment are discussed separately, it is likely that more than one factor within a cluster or among the clusters may operate simultaneously to affect the well-being of a psychologist at different points in life. They may interact in a dynamic way that leads to the potential impairment of the professional (Sherman, 1996). It seems to be an essential step in the early prevention of impairment to help students in professional psychology training programs to be aware of such risk factors and reduce the negative impact of these risks on their future professional functioning.

**Prevention of Impairment in the Profession**

The typology of Caplan (1964) has been used in the field of professional psychology to discuss three different levels of prevention (Sherman, 1996; Thoreson, 1986): primary, secondary and tertiary preventions. The three levels of prevention are discussed in this section. Tertiary prevention refers to the necessary diagnosis and treatment given to a psychologist with impairment so that the psychologist can be helped, preventing the impairment from deteriorating and reoccurring. On this level of prevention, the American Psychological Association formed a semi-independent committee called
the Advisory Committee on the Impaired Psychologist (ACIP) in 1986, now known as Advisory Committee on Colleague Assistance (ACCA). This committee has put forth effort to promote the establishment of colleague assistance programs on the state level. Two studies have findings concerning the availability of such service nationwide (Barnett & Hillard, 2001; Laliotis & Grayson, 1985). The earlier study by Laliotis and Grayson (1985) surveyed all the state psychological associations and found that only eight associations were starting to develop such service. Barnett and Hillard (2001) revealed that the majority, around 70% of all 59 state or provincial psychological associations did not have a colleague assistance program for distressed or impaired psychologists in late 1990s. Moreover, Barnett and Hillard further pinpointed that comparatively few psychologists, only an average of five per year, sought assistance from a state colleague assistance program. Barnett and Hillard speculated that the low utilization of such programs was a reflection of possible barriers to treatment.

Secondary prevention addresses the early detection of distressed psychologists whose professional functioning may not yet be significantly impacted by their distress, so that appropriate support strategies can be adopted to help them. Only a few studies in the literature provide sketchy data with respect to efforts of colleagues helping distressed psychologists, especially in relation to their alcohol abuse or substance abuse problem (Good, Thoreson & Shaughnessy, 1995; Skorina, Bissell & DeSoto, 1990; Thoreson, Budd & Krauskopf, 1986; Wood et al., 1985). These studies suggest that psychologists in the profession seem to be aware of their colleagues in distress, but are in general hesitant in helping their peers to address their problems. Hence, efforts on an agency level, both in
terms of helping behaviors and offering supportive service for distressed colleagues, seem to be needed.

Primary prevention refers to efforts in education and training to increase awareness and enhance well-functioning, thereby preventing the occurrence of impairment. The literature on primary prevention for professional psychologists consists of two sources: empirical studies and theoretical discussion. Concerning empirical research, three published studies focused on the self-care methods adopted by clinicians to maintain their well-functioning, and the results can inform psychologists about primary prevention work on a personal level (Coster & Schwebel, 1997; Mahoney, 1997; Sherman & Thelen, 1998). Theoretical discussion on primary prevention also mainly focuses on an individual level of self-care, although there are some discussions about prevention work on the agency level and on the level of the profession in general. An individual level of primary prevention work consists of personal self-care and professional self-care (Baker, 2000; Brem, 2000; Skovlt, 2001). Regarding personal self-care, Baker (2000) suggested the need for the professional to take care of himself or herself psychologically, physically and spiritually across the life-span. Concerning professional self-care, various authors (Baker, 2000; Guy & Norcross, 1988; Norcross, 2000; Sherman, 1996; Skovolt, 2001) suggest that the professionals need to pay attention to areas such as hazards of the profession, professional boundaries, supportive work environment and relationships, diversity of work nature, workload management, and professional growth. On an agency level, Sherman and Thelen (1998) suggested the need for fostering an open discussion and attitude to discuss the issue of impairment, and providing mandated training in the agency to staff on the prevention of professional impairment.
impairment. On the level of the profession, Sherman and Thelen (1998) suggested the needs for more workshops at national or state psychological conferences, more funding and logistic support for prevention programs to be recognized by the policy makers and leaders, and broader professional effort to encourage research on the primary prevention of impairment.

Prevention of Impairment in Professional Psychology Training

Prevention of impairment in professional psychology training is an early form of prevention against impairment that can take place in the profession. Primary prevention in particular is relevant for graduate students. In spite of its importance, research and theoretical discussion in the literature on the prevention of impairment in graduate training is scant. Only one study (Schwebel & Coster, 1998) was found in a published journal on the primary prevention of impairment in graduate training. Schwebel and Coster (1998) did a national survey on the views of training heads of APA certified programs in professional psychology regarding well-functioning, and on what they had done or would like to do to enhance it among their students. When asked to respond to planned efforts in the programs to prevent impairment, 16 programs indicated no planned effort. For the rest of them (91), the researchers reported that the indicated efforts were mostly one shot experiences and not integral to the entire graduate program. Schwebel and Coster concluded that “to summarize planned efforts, it is fair to say that in most instances, little is offered to all students with the express purpose of preventing mental health problems” (p. 288). In the same study, training directors were asked to propose measures to prepare students to function as unimpaired psychologists. The more
frequently proposed measures were required therapy, ongoing support group, ongoing direct supervision, course content, ethics training, and more attention by faculty.

Theoretical discussions on the prevention of impairment in graduate training mostly focus on students' own initiatives to seek out self-care strategies (Brems, 2001; Corey, 2001; Echterling et al., 2002; Gladding, 2000; Kottler, 2004; Moursund & Kenny, 2002; Srebalus & Brown, 2001), similar to the discussion on self-care for professionals in the previous section. However, there are also suggestions proposed by different authors to be implemented in graduate training programs as part of the required professional training (Baker, 2000; Corey, Corey & Callanan, 2003; Schwebel & Coster, 1998). These suggestions range from specific content to be addressed (e.g., hazards and rewards of the profession); to experiential opportunities in the programs for the students to explore, experience and develop self care; to a course on impairment and prevention; to well-planned modules on personal and professional self-care; to structural changes of programs aiming at promoting well-functioning.

Objectives of Study

Although measures in professional psychology training to prevent impairment were proposed from the perspective of training directors in one study (Schwebel & Coster, 1998) and suggested by some authors in the literature (e.g., Baker, 2000; Corey, Corey & Callanan), there was no research illuminating what preventive measures were more important than others. Moreover, there was no research informing how these measures could be successfully implemented in training programs. This study aimed at addressing such gaps in the research literature. Hence, this study had three objectives: (a) to compile a list of important measures in professional psychology training to prevent
future impairment in professionals, (b) to determine the relative importance of these preventive measures, and (c) to explore the ways of successful implementation of the most important preventive measures.
CHAPTER II

LITERATURE REVIEW

Overview

This chapter is a literature review pertaining to the main question of this study: what effective measures can be implemented in professional psychology training to prevent future impairment of professionals. An introduction will first be given regarding the importance of prevention of impairment in professional psychology, especially in graduate training. Second, the definitional issues concerning impairment in the profession are addressed. Third, research findings pertinent to the prevalence of professional impairment are presented. Fourth, factors contributing to impairment in the profession are discussed. Fifth, the literature concerning prevention effort against impairment in the field of professional psychology will be summarized. Sixth, the literature regarding prevention of impairment in professional psychology training will be discussed. Finally, a conclusion will be given, relating the literature review to the objective of the present study.

Introduction

The issue of professional impairment started to received organized attention in the institution of psychology in the United States in the early 1980’s (Kilburg, 1986; Orr, 1997). The importance of this issue is three-fold: it can hurt the psychologist, it may cause harm to the client, and it can damage the reputation of the profession (O’Connor,
2001; Sherman, 1996). With regard to the psychologist, impairment not only threatens the personal well-being of the psychologist, but it can also result in possible legal liabilities to the psychologist when substandard service has been delivered or negligence has taken place (Kilburg, 1986). Concerning the client, the psychologist with impaired professional performance is more susceptible to misjudgments in service delivery. Hence, not only will the psychologist run the risks of not being able to help the client to improve, this psychologist might also do harm to the client when inappropriate interventions are given to the client (Nathan, 1986). Regarding the profession, the malpractice of psychologists with impairment can harm the accountability of our profession to the public and subsequently lead to decreased trustworthiness of the whole profession to the public (Thoreson & Skorina, 1986).

Because of the importance of the issue of impairment, Thoreson (1986) first borrowed from the typology of Caplan (1964) concerning prevention of impairment and applied it to professional psychology. Thoreson suggested three levels of prevention are necessary against impairment: primary, secondary and tertiary preventions. Primary intervention refers to the prevention work of providing education and training necessary to increase awareness and enhance well-functioning of practitioners, thereby preventing the occurrence of professional impairment. Secondary prevention refers to the early detection of psychologists who are so distressed but have not yet deteriorated to the state of impaired performance, and refers to the development of support strategies to help distressed psychologists overcome their problems to prevent impairment. Tertiary prevention, also termed as remediation or treatment, refers to the necessary diagnosis and treatment given to a psychologist with impairment so that the psychologist can be helped,
while addressing the needs to protect the clients from negative impacts of that psychologist. It is a prevention effort in the sense of preventing the psychologists from getting worse or from having reoccurrence of impairment.

Prevention is indeed better than remediation in our profession in that legal and professional liabilities stemming from professional impairment can be costly, in terms of the damages caused to the clients, the impaired psychologists and the profession (Reaves, 1986). However, among the sparse research literature on the issue of professional impairment (Sherman, 1996), even less attention has been paid to the study of prevention against impairment in professional psychology training. When effective measures, if known, can be employed early on in the training of student psychologists to prevent future professional impairment, there may be fewer psychologists suffering from professional impairment and less legal liabilities in the profession would be seen. Instead, psychologists could become better functioning professionals and the profession could be more effective in rendering services of better qualities to society. Unfortunately, according to Schoener (1999), primary prevention in student training has not been adequately addressed in the research literature and the institution of psychology. After pinpointing the importance of the issue of impairment and its early prevention in the profession in professional psychology training above, the concept of impairment is discussed in the following section.

**Definitional Issues Concerning Impairment**

The term impairment started to be used in the field of psychology in the early 1980s to capture various situations that involve deficiencies in professional performance (Forrest, Elman, Gizara, & Vacha-Haase; 1999). Thoreson, Nathan, Skorina, and Kilburg
1983 noted that a broad range of psychological problems related to impairment (including sexual intimacies with clients, substance abuse, mental illness, and physical and emotional limitations) were identified in a forum at the 1981 American Psychological Association (APA) convention. Forrest et al. (1999) commented that the event had marked the beginning efforts within the field of psychology to shape the definition of impairment. However, after the elapse of two decades, a consensus has not been reached within the field with regard to the definition of impairment (Sherman, 1996). Although the terminology has been used in our field, there are only a few explicit definitions of the concept having been proposed by various authors to refer to the impairment of psychologists. These definitions are reviewed in the following.

Two earlier definitions depicted impairment as consisting of two elements: (a) the consequence of impairment to professional functioning and (b) the cause of impairment as distress. Moreover, the emphasis of the nature of impairment was placed on the consequence of impairment in professional functioning. Wood, Klein, Cross, Lammers, and Elliott (1985) used the definition of an APA steering committee report on distressed psychologists in their survey of psychologists' opinions on impaired practitioners: “impaired practitioners are broadly defined as psychologists whose work is impaired or adversely affected by physical, emotional, legal, or job-related problems” (p. 843). Hence, adversely affected work was the consequence of impairment in professional functioning; whereas physical, emotional, legal, or job-related problems were the types of distress that caused the decline in professional functioning. Laliotis and Grayson (1985) in their study concerning the availability of services to impaired psychologists from state psychological association defined impairment as “interference in professional functioning due to
chemical dependency, mental illness, or personal conflict” (p. 85). Interference in professional functioning was the consequence of impairment; whereas, chemical dependency, mental illness, and personal conflict were included as the major types of distress that caused the decline in professional functioning. In both definitions, the emphasis of the nature of impairment was placed on the decline in professional functioning, qualified by the necessary cause of different types of distress.

In two other definitions particularly pertaining to clinicians, the same two elements were included and the emphasis of the nature of impairment was again placed on the consequence in professional functioning. However, the types of distress as the cause of impairment were not specifically spelled out, although the occurrence of distress was recognized. Guy (1987) in his book discussing about the life of psychotherapist defined impairment as “diminution or deterioration of therapeutic skill and ability due to factors which have sufficiently impacted the personality or the therapist to result in potential clinical incompetence” (p. 199). The consequence of impairment in professional functioning as the diminution or deterioration of therapeutic skills, or clinical incompetence was pinpointed. Sherman and Thelen (1998) in a study about distress and professional impairment among psychologists in clinical practice defined impairment as “the interference in ability to practice therapy, which may be sparked by a variety of factors and results in decline in therapeutic effectiveness” (p. 79). Hence, interference in ability to practice therapy or decline in therapeutic effectiveness was the consequence of impairment, and it was the main focus the definition. Also, both definitions broadly referred to the distress as factors affecting the clinicians’ professional functioning.
In two recent definitions, although the emphasis of the nature of impairment was also placed on the consequence in professional functioning, more stringent criterion was qualified in either the extent of distress or the extent of the consequence in professional functioning. Coster and Schwebel (1997) in their study of well-functioning in professional psychologists defined impairment as "a decline in quality of an individual's professional functioning that results in consistently substandard performance" (p. 5). Although the cause of impairment was omitted in this definition, the consequence of impairment was qualified that the decline in professional functioning needed to reach the extent of consistent substandard professional performance in order to be considered impaired. In contrast, Orr (1997) in a discussion article put a conservative criterion on the extent of distress. She maintained that the distress needed to reach the extent of a diagnosable illness in order to be considered impairment. Her viewpoint of impairment was as follows:

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.... In its broadest definition, impairment is illness, diagnosable as an Axis I, II, III disorder; conversely, if there is no diagnosis using the Diagnostic and Statistical Manual of Mental Disorder... there is no impairment. (p. 293)

In addition, the consequence of impairment as incapability of maintaining acceptable practice standards was part of the definition.

Despite the differences in defining impairment, there seems to be two consistent elements central to the concept of impairment among these different definitions: (a) the decline in professional functioning, and (b) the occurrence of distress, which might be
related to personal life or work, as the essential cause. Moreover, the emphasis of the nature of impairment is placed on the decline in professional functioning. All the above definitions contained the former part and only Coster and Schwebel (1997) omitted the latter part in the definition of impairment. I consider it to be important to state the occurrence of distress as an essential condition in defining professional impairment because it rules out those mal-practicing psychologists who are just being irresponsible, incompetent or unethical, but who are not suffering from any distress. With regard to the consequence of impairment, I agree with all the above authors concerning the emphasis of the decline in professional functioning in the definition of impairment because of it being the centrality of concern in the profession. Moreover, a psychologist who experiences distress in life does not necessarily exhibit decline in professional performance (Sherman, 1996). Hence, in my opinion, a definition of impairment should contain both elements with the emphasis on the decline in professional functioning.

Besides a decline in professional functioning and the occurrence of distress being important elements in the definition of impairment, there remain the issues of qualifying the extent of professional dysfunction and the extent of distress in the definition. Concerning the former, a decline in professional functioning to substandard performance, in my opinion, is already a sufficient indicator of dysfunction, no matter a temporary or consistent pattern, because it is already affecting the quality of service to the public. Regarding the latter, the distress doesn’t necessarily need to set at a pathological level as diagnosed by DSM criteria as proposed by Orr (1997). As long as it affects the professional functioning to reach substandard performance, it is already a sufficient
criterion. Hence, I suggest that the definition of impairment as "a decline in professional functioning to substandard performance due to the occurrence of distress."

In connection with my definition of impairment, I consider that distress as a normal part of life condition that can impact a person, including any psychologist, to various extents, dependent upon the type(s) of the distress on the person. Instead of pathologizing a minority of psychologists who may suffer from dysfunction, personally or professional, due to severe form of distress, I consider it to be more helpful for the profession to recognize that any psychologists may, at some point in life, run the risks of having impairment (Orr, 1997). In fact, in their study of distress and professional impairment among psychologists in clinical practice, Sherman and Thelen (1998) found out that distress and interference in professional functioning were significantly and highly correlated in a positive direction. Hence, professional dysfunction would likely occur when major distress arises from life conditions. Unfortunately, as a veteran in his work on professional impairment in APA, Schoener (1999) criticized that there had been limited interest in organized psychology to take responsibility for impairment in the profession. I hope that with a developmental perspective of impairment, it may contribute to help the field of psychology to own our responsibility for impairment: to be compassionate to help out colleagues with impairment and to seek out effective measures of preventing impairment. As a result, I consider it to be important for professional psychology training programs to convey such a developmental stance of impairment to students in early prevention work against impairment in the profession.
Research Findings Pertinent to the Prevalence of Impairment

Since impairment is a decline in professional functioning to substandard performance due to the occurrence of distress, understanding the extent of distress experienced by psychologists in general can be helpful in understanding the phenomenon of impairment. In addition, being the outcome of a severe level of distress (Jamison, 1999), the rate of suicide in the profession warrants attention. Hence, in the following, findings in the literature concerning the prevalence of distress and the prevalence of suicide in the profession are first presented. Then, findings regarding the prevalence of impairment, in terms of decline in professional functioning to substandard performance due to distress, will be given. Finally, a conclusion, with my critique on these prevalence studies, will be presented that connects to the need for prevention of impairment in early professional psychology training.

Prevalence of Distress

Four studies were found in journal publication related to the prevalence of distress among psychologists. They are presented in the following in chronological order of their publication year. Prochaska and Norcross (1983) did a study investigating the processes of change that therapists used to help clients handle psychic distress and the processes therapists used to handle their own psychic distress. The researchers described that the symptoms which associated with psychic distress were “anxiety, depression, cognitive impairment, somatic complaints, lowered self-esteem, and feelings of confusion and helplessness about one’s problem” (p. 643). In this national survey, members of Division 29 (Psychotherapy) of the APA were randomly selected. The study reported that around
82% of the participants had self-reported experiencing psychic distress at least once in the past.

In another study, Deutsch (1985) explored the trend of personal problems and treatments among therapists. The researcher surveyed professional psychotherapists in Iowa. In part of the study, the subjects were asked to self-report their experience of different types of distress. The results indicated that participants had self-reported various types of distress as follows: 82% percent of the subjects indicated having experienced relationship difficulties, 57% indicated depression occurrence at some time in their lives, and 11% indicated having experienced substance abuse. Hence, it is likely that more than 82% of the subjects might have experience one or more types of distress.

In the study by Thoreson, Miller and Krauskopf (1989), the general health status, the prevalence of distress, the relationships between health and distress, and treatment-seeking behavior among psychologists were explored. Members of a Midwestern psychological association were surveyed. The results of this study revealed that approximately 10% of the subjects had self-reported having frequent levels (often or very often in a Likert scale) of distress in the past year in each of the following categories: depression, marriage/relationship problem, recurrent physical illness, problems with alcohol use, and feelings of loneliness. With regard to the current incidence of distress, 19% indicated one type of distress, and 9% reported having two to four types of distress. The researchers concluded that these two prevalence rates were the maximum and minimum estimates of the current rate of distress respectively.

Guy, Poelstra and Stark (1989) did a national survey of psychologists practicing psychotherapy from APA Divisions 12 (Clinical), 29 (Psychotherapy), and 42
(Independent Practitioners. This study reported that 74% of the subjects had experienced one or more of the following distress in the past three years: job stress, illness in family, martial problem, death in family, financial problems, mid-life crises, physical illness, legal problems, mental illness, drug abuse and others.

In summary, figures concerning the prevalence of distress vary among these studies. Nevertheless, they suggest rough estimates regarding the current and the past rate of distress experienced by psychologists. Current prevalence of distress among psychologists seems to range from 9% to 19% (Thoreson et al., 1989), whereas prevalence of having experienced distress in the past ranges from 74% (Guy et al., 1989) to above 82% (Deutsch, 1985; Prochaska & Norcross, 1983).

Prevalence of Suicide

Only three sources were found in journal publications concerning the prevalence of suicide among psychologists. Mausner and Steppacher (1973) explored the rate of suicide among psychologists. In this study, the researchers attempted to locate death certificates for deceased psychologist members of APA who died in the decade 1960-1969. The results indicated that female psychologists were 2.8 times higher than their age group in the population in committing suicide, whereas male psychologists were 0.7 times the expected number. Deutsch (1985), in a previously mentioned study in which professional psychotherapists were surveyed, revealed that 2% of the subjects had self-reported to have previously attempted suicide. Ukens (1995), in a discussion article on the high risk of suicide among pharmacists, cited a study by the epidemiologists at the National Institute of Occupation Safety and Health (NIOSH). In this study, death certificates which had been filed in 26 states between 1979 and 1988 were studied in the
analysis and a comparison among different professions was conducted. Ukens commented that the occupation with the highest risk of committing suicide was psychologist, which are 3.47 times more likely than the general public.

Although the phenomenon of suicide among psychologists seems to be one of the less studied areas, the higher rate of suicide in the profession compared with other professions, especially according to the recent study by NIOSH, seems to reflect the comparatively higher level of distress experienced among psychologists.

Prevalence of Impairment

Five sources were found in the literature which provided data pertinent to the prevalence of impairment among psychologists. These statistics are presented in the following in chronological order of their publication year. Wood et al. (1985) did a study concerning licensed psychologists' opinions about prevalence of impairment and proposals for intervention. In this study, the researchers used the definition of Nathan, Thoreson, & Kilburg (1983) to defined impairment as professional work being "adversely affected by physical, emotional, legal, or job-related problems." (p. 843) Training directors as well as their colleagues of APA approved clinical programs and practitioners selected from the list of National Register of Health Service Providers were surveyed. The result revealed that participants had estimated a mean of about 28% and a median of 15% when asked to give a "total percentage of colleagues whose work is impaired" (p.847) by any distress. The researchers commented that the median estimates seemed to be more consistent with self-reported incidence of impairment in other professions.

In another study, Pope, Tabachnick and Keith-Spiegel (1987) did a study on the beliefs and behaviors of psychologists as therapists. Members of APA Division 29
(Psychotherapy) were surveyed. Among the respondents, only 40% indicated that they never worked when too distressed to be effective, whereas 60% acknowledged having worked when too distressed to be effective and 85% believed that such practice unethical.

Schwebel, Skorina and Schoener (1988), in the APA manual for the colleague assistance program for state psychological associations, provided data concerning a New Jersey Psychological Association survey. They reported that respectively 15% and 10% of the respondents had personal knowledge of psychologists impaired by alcohol use and drug use. (Impairment is defined in this study as diminished quality in work-related behavior.) Moreover, more than 30% identified themselves as formerly or currently impaired. The top three impairment categories are family/marital problem (15%), depression (14%) and anxiety (12%). (Note: There can be overlap of the percentages.)

In the national survey of psychologists by Guy et al. (1989) as mentioned in the previous section, 37% of the respondents agreed that their personal distress decreased the quality of patient care and 5% agreed that the distress was serious enough to result in inadequate patient care. Since it was not known whether the 37% of the respondents decreased the level of patient care to substandard performance and there was no further elaboration of the two statistics in the study, I use 5% as the conservative estimate of impairment; that is, the decline of professional functioning to substandard performance.

Floyd, Myszka and Orr (1998) did a survey on licensed psychologists' knowledge and utilization of colleague assistance program in Tennessee. In part of the survey, participants were asked to estimate the prevalence of impairment among colleagues. Definition of impairment was not given by the researchers. The participants estimated that 10% of their colleagues were currently impaired in their capacity to practice because
of a psychological problem, and 9% were impaired because of substance abuse. In addition, respondents estimated that 15% of their colleagues had been impaired in the past because of a psychological problem, and 13% because of substance abuse. (Note: The researchers did not mention if the two categories overlapped or not.)

Hence, there seems to be big variations concerning the rate of impairment among psychologists in these studies. They suggest that the current prevalence of impairment ranges from 5% (Guy et al., 1989) to even around 28% (Wood et al., 1985). However, 15% seems to be a more frequent figure of current impairment estimate by professionals (Floyd et al., 1998; Wood et al., 1985). Concerning the past incidence of impairment among psychologists, data seem to vary from 30% (Schwebel et al., 1988) to 60% (Pope et al., 1987).

Conclusion about Prevalence

There are several general limitations regarding all these prevalence studies that call for caution when interpreting the data. These limitations mainly relate to sampling, instrumentation, response rate, and the date of the studies. Concerning sampling, there were inconsistencies among the studies with regard to the choice of target subjects. Subjects varied from a heterogeneous sample of psychotherapists, including psychologists, to members of APA, to members of some Divisions of APA, and to members of a particular Division of APA. Also, samples varied from a state sample to a national sample. The heterogeneity of these samples poses difficulty in making generalization to the population of all psychologists. Concerning instrumentation, the methods used has been either self-reported questions or estimations by professionals. Moreover, researchers used their different self-constructed questionnaires in data
collection. Hence, variations in the definition of impairment or even variations in the availability of the definitions existed among these studies. On one hand, the self-reported answers or the estimated rates by professionals may not be the most accurate account of actual incidence. On the other hand, variability in the wording of items and in definitions poses challenge for reader to compare across studies. Regarding return rates, it varied from 40% to the highest 54% among these studies. It is still unknown whether there are differences between the respondent and the non-respondent group, and the latter group comprises the majority in most cases. Hence, we do not know if the non-respondent group would or would not affect the outcome of the prevalence rate. Lastly, most of the studies were published in the 1980’s. Hence, research on the prevalence of distress, suicide and impairment in the profession need to be done to give more accurate and updated information to the field.

Despite the above limitations, existing findings pertinent to impairment seems to indicate that distress has been experienced by a large majority (about at least three quarters) of psychologists. Moreover, psychologists seem to experience relatively higher levels of distress relative to other professions and have higher suicidal risk. In addition, the rate of impairment (decline in professional functioning to substandard performance due to the occurrence of distress) among the profession seems to indicate that impairment is not a rare phenomenon in the profession. Both the frequent estimate of about 15% current prevalent rate and a total past incidence rate of more than 30% suggest that the prevalence of impairment is really high enough to warrant an organized response and actions to prevent impairment (Orr, 1997). In particular, prevention work in the profession needs to be done to reduce such high incidence. It is important to find out
Factors Contributing to Impairment

Understanding the factors contributing to impairment can be helpful in targeting prevention work in the profession. Hence, these contributing factors are reviewed in this section. By definition, the decline in professional functioning of impairment is caused by distress. Hence, the factors contributing to impairment are the factors contributing to distress. Sherman (1996), in reviewing these factors, concluded that there were three clusters of factors: personal characteristics, characteristics of the profession, and personal life events (Guy, 1987). These three conglomerate factors are discussed individually in the following.

Personal Characteristics

To date, there seems to be no strong evidence in the literature suggesting that there exists certain types of therapist who are prone to distress or impairment (Sherman, 1996). However, there are two personal variables which have been speculated to interact with work and life stressors and contribute to distress: problematic motivations for entering the field (Guy, 1987) and personal developmental issues (Groesbeck & Taylor, 1977).

With regard to the former, Goldberg (1986) considered that some psychologists might use practicing psychotherapy as a means of resolving one’s own problem. Guy (1987) commented similarly that certain practitioners entered the field with the motivation to cope vicariously with their own problems in life and to reduce their sense of loneliness and isolation. When personal needs are not met and fulfilled in reality
through their practice, additional stressors from work and personal life might precipitate distress.

Concerning personal developmental issues, Elliot and Guy (1993), in their study, compared the rates of childhood trauma and adult functioning between female mental health professionals and females in other professions. They discovered that female therapists reported significantly higher rates of physical and sexual abuse, loss of a parent or sibling, hospitalization of a mentally ill parent, and alcoholism in a parent during childhood than females in other professions. Although these female therapists reported lower rates of current symptoms in daily life than their control counterparts, O'Connor (2001) argued that it might be likely that “these mental health professionals underestimated or underreported current evidence of impairment” (p. 346). O'Connor based this argument upon unpublished data which had revealed that identical problems were judged by psychologists to be more impairing when they were attributed to others as opposed to self. In fact, the impact of development issues on mental health professionals at work was explored by Follete, Polusny and Milbeck (1994). Follete et al. conducted a study to assess current and past trauma experiences, exposure to traumatic client material, and the consequences of both types of experiences of mental health and law enforcement professionals. The results revealed that mental health professionals who had indicated a history of physical or sexual abuse during childhood reported higher levels of trauma-specific symptoms when working with child sexual abuse survivors than did professionals who had not indicated such history. Hence, it is possible that mental health professionals who have unresolved developmental issues, when handling clients who
have similar issues, can have their own issues triggered and can cause distress to themselves.

In conclusion, concerning personal characteristics as a potential a cluster of factors contributing to the impairment of a professional, two factors are explored in the literature: problematic motivation for entering the field and personal developmental issues. However, such factors are mostly theoretically speculated. Empirical research about this cluster of factors is still generally lacking.

*Characteristics of the Profession*

There are some studies found in the literature mainly focused upon job-related stressors and hazards in the profession, especially for psychotherapists, and these studies provide empirical data for understanding what occupational factors in the profession are associated with distress and how frequently clinicians experience certain types of work hazards.

With regard to the former, Farber and Heifetz (1981) carried out a study to investigate the satisfactions and stresses of psychotherapeutic work. Participants were psychotherapists in a northeastern community. In part of the study, the researchers did a factor analysis on psychotherapists' responses relating to therapeutic stress items. It resulted in three big factors of therapeutic stress: personal depletion, therapeutic relationship, and working conditions. Personal depletion included social difficulties after work, emotional depletion, physical exhaustion, difficulty leaving psychodynamics at the office, inevitable need to relinquish patients and time constraints. Therapeutic relationship included responsibility for patients' lives, controlling one's emotions, the monotony of work, difficulty in evaluating progress, difficulty in working with disturbed...
people, doubts regarding efficacy of therapy, and lack of gratitude from patients. Working conditions included organizational conditions, excessive paperwork, excessive workload, and professional conflicts.

Concerning the prevalence of the work hazards, Kramen-Kahn and Hansen (1998) did a study to explore the occupational hazards, rewards and coping strategies of psychotherapists. A national survey was conducted. In this study, the researchers found that the most frequently endorsed items of occupational hazard in decreasing order were as follows: business aspects (29%), economic uncertainty (28%), professional conflicts (25%), time pressure (23%), sense of enormous responsibility (20%), excessive workload (20%), and caseload uncertainties (19%). Sherman and Thelen (1998) conducted a study to investigate distress among psychologists in clinical practice. In part of their study, they explored different factors at work that contributed to distress. The results revealed that the rates, in decreasing order, of the occurrence of these different factors were as follows: work with difficult clients (72%), too much paperwork (68%), inadequate time for all obligations (68%), restrictions imposed by managed care company (67%), uncertainty regarding best intervention (54%), counter-transference issues (45%), insufficient income (42%), frustration surrounding lack of therapeutic success (39%), personal boundary violations (34%), office politics (33%), changed work situation (31%), reactivation of personal issues in clinical work (26%), obligations regarding “duty to warn” (26%), conflicts in relationship with colleagues (21%), secondary traumatization (20%), insufficient opportunities for consultation (15%), other (10%), and malpractice claims (2%).
In conclusion, concerning the characteristics of the profession, three studies have been published illuminating different types of stressors and occupational hazards encountered by psychotherapists in the profession. Such information can help raise the awareness of professionals in the field to find ways of reducing the negative impact of such factors on professional functioning.

**Personal Life Events**

As a usual part of human experience, psychologists are not immune from the personal problems at various points in the life span as any other people (Coster & Schwebel, 1997). To understand the prevalence of these life events in the profession, Sherman and Thelen (1998), mentioned previously, in a part of their study, surveyed clinicians and found the rate of occurrence of life events among subjects in decreasing order as follows: serious illness/injury of close family members (24%), borrow significant amount of money (21%), major marital relationship problems (21%), changes in spouse’s work outside the home (21%), major change in financial status (21%), son/daughter experiencing significant problems (19%), death of other close family member (14%), other (14%), serious illness/injury of close friend (12%), major personal illness/injury (11%), son/daughter leaving home (11%), minor law violation (10%), death of close friend (9%), and divorce (2%).

From a developmental perspective, psychologists, as persons, go through a series of potential developmental crises in life due to their developmental changes from young adulthood through middle age to old age (Baker, 2003). These developmental crises are either resolved successfully for the psychologists to emerge strengthened, or unsuccessfully to emerge weakened as a result of heightened conflicts (Schwebel &
Coster, 1997). To discuss these developmental challenges, Baker used Goldberg’s (1986) three-stage conceptualization: beginner, journeyman, and seasoned professional. For beginning practitioners, there are more stressors associated with being a novice because of fear and anxiety of getting familiarize with a wide range of professional issues (Skovholt, 2001). The journeyman stage is one in which most professionals are in middle adulthood and midlife usually consists of accumulated responsibilities, personally and professionally. Especially in personal life, Baker pinpointed that professionals had to juggle among the needs of young children, aging parents and marital relationships. Moreover, difficult issues such as the death of parents, health concerns and even terminal illnesses are challenging distress to grapple with. Baker further explained that during the stage of seasoned professional, practitioners were experiencing aging and losses (including physical, emotional, personal and social) of all sorts continued to accumulate over time. Baker commented that these losses could pose distress to psychologists at a later life stage.

In conclusion, both the limited empirical data and theoretical discussion in the literature suggested that psychologists experience different kinds of personal problems as other people do going through different life stages. Moreover, these personal problems can cause distress to the professionals. Professionals need to find measures to prevent such distress from compromising their ability to function well professionally.

Conclusion about Factors Contributing to Impairment

The three clusters of factors contributing to impairment in the profession have been discussed above; they are personal characteristics, characteristic of the profession, and personal life events. Although the three clusters of factors contributing to impairment
are discussed separately above, it is likely that more than one factor within a cluster or among the clusters may operate simultaneously to affect the well-being of a psychologist at different points in life. Hence, these factors may interact in a dynamic manner that affects the formation and course of distress, which may subsequently lead to the potential impairment of the professional (Sherman, 1996).

Following from the discussion of the contributing factors to impairment, it seems to be an essential first step in the early prevention of impairment to help students in professional psychology training programs to be aware of such risks factors and reduce the negative impact of these risk factors on their future professional functioning. In this connection, with regard to the risk factor of personal characteristics, it seems to be important to help students address their developmental issues and their motivations for entering into the profession. Concerning the risk factor of the characteristics of the profession, it seems to be important to help students understand the hazards of the profession. Regarding the risk factor of personal life events, it seems to be important to help students understand how different life events in their course of personal development might have an impact on their professional functioning.

Prevention of Impairment in the Profession

In the field of psychology, the beginning of prevention efforts to alleviate the problem of impairment in professionals can be traced back to the 1980’s when the APA formally started to address the issue of impairment (Kilburg, 1986). However, to date, according to Orr (1997), a comprehensive approach to tackle this issue has not been implemented. Although notions concerning remediation and prevention of impairment were raised in the literature, a conceptual model of prevention was first introduced to the
field professional psychology by Thoreson (1986), using the typology of Caplan (1964). This typology was still used in a recent review of the impairment literature by Sherman (1996). Thoreson (1986) suggested that there should be three levels of prevention regarding impairment: primary prevention, secondary prevention and tertiary prevention. Primary prevention refers to effort in education and training to increase awareness and enhance well-functioning, thereby preventing the occurrence of impairment. Secondary prevention refers to the early detection of distressed psychologists and the development of support strategies to help them. Tertiary prevention refers to the necessary diagnosis and treatment given to a psychologist with impairment so that the psychologist can be handled and helped, preventing the impairment from deterioration and reoccurrence. In this section, I use this framework to present a review of the literature regarding prevention of impairment in the profession.

**Tertiary Prevention**

To understand what progress has been made in the profession with regard to tertiary prevention, a brief outline of the milestones might highlight such development. According to Kilburg (1986), a Steering Committee on Distressed Psychologists first met in 1982 to start designing an organization to provide self-help and peer-support services for distressed members. A non-profit organization called Volunteers in Psychology was proposed as a trial program to render services to help psychologists in distress and to collect more data on the extent of the needs in the profession (Kilburg, 1986). However, there was continuing opposition among the APA members to implement this organization because of unsettled issues such as confidentiality in the service system, the criteria for program success and evaluation, and the type of people the system would serve (Kilburg,
1986). It was finally decided that some funding would be provided for several state psychological associations to start small demonstration projects instead (Kilburg, 1986).

In 1985, the committee decided that the primary responsibility of the committee was for program design and implementation, while APA serving as a central consultative role (Kilburg, 1986). Nevertheless, a self-help group with a national network called Psychologists Helping Psychologists which focused on professionals with substance-abuse problems was formed (Kilburg, 1986). According to Orr (1997), the issue of professional impairment was assigned to a semi-independent committee called the Advisory Committee on the Impaired Psychologist (ACIP) in 1986, now known as Advisory Committee on Colleague Assistance (ACCA). This committee reported to the Board of Professional Affairs within the Practice Directorate (Orr). In 1988, this committee developed a manual for use by state associations so that each state could tailor their own assistance program for colleagues (Schwebel et al., 1988). The manual consisted of an introduction to the issue of impairment, administrative and legal issues of an assistance program, functions of program committee for impaired psychologists, and sample references.

Because the APA’s policy of assisting colleagues on a state level, assistance programs were started to be available to impaired psychologists from state psychological associations. Two studies in publication were found concerning the availability of such services nationwide. The first study was conducted by Laliotis and Grayson (1985). They surveyed all the state psychological associations to see if they had an operating program for remediation or help for impaired psychologists. The responses were all negative. Yet, eight associations indicated that they were starting to develop such service. The second
study was done by Barnett and Hillard (2001). Barnett and Hillard surveyed all 59 state and provincial psychological associations (SPPA) to examine the services available for distressed and impaired member psychologists. The result revealed that between 1998 and 1999, the majority, 69%, of all SPPAs (41 out of 59) reported not having a colleague assistance programs for distressed or impaired psychologists. Yet, 10 (24%) out of these 41 SPPAs without such program, had such program in the past. The reasons for program discontinuation were lack of use (70%), risk of liability (10%), lack of volunteers (10%), and unknown. Besides, the majority of these 41 SPPAs, 61%, maintained not planning to establish such a program in the future, and 54% reported that their SPPAs leadership had not considered a need for this type of program. On the other hand, colleague assistance programs were available in 31% of SPPAs (18 out of 59). The most common services offered to the distressed or impaired psychologists were consultation and referral.

Barnett and Hillard (2001) further pointed out that a great amount of variation existed among these programs with regard to the number of psychologists receiving services from any one of them. It ranged from 0 to 25 each year. Only an average of 5 psychologists sought assistance from any one SPPA colleague assistance program. Barriers to treatment were reflected in that comparatively few psychologists readily sought assistance from these programs. I think it is important to understand these barriers to treatment, so that the profession may start to find solutions to overcome such barriers in helping our colleagues. Barnett and Hillard speculated six possible barriers: three barriers stemmed from the distressed or impaired psychologists and the other three arose from the characteristics of such assistance programs. Concerning the former barriers, first, psychologists may feel more comfortable to seek help from experienced private
practitioners (Guy, Poelstra & Stark, 1989; Pope & Tabachnick, 1994) whom they can seek out themselves without the need to reveal the issues to an institution. Second, a psychologist may have a tendency to deny one’s own problem because of one’s role as the helper (Guy, 1987). Third, distressed or impaired colleagues may be worried about the stigma of openly seeking help and may be concerned if their seeking help might diminish their competence or status (Swearingen, 1990). Concerning the barriers associated with the characteristics of the assistance program, first, since almost half of all licensed psychologists are not SPPA members, nonmembers may not seek help from these state services or they may not be aware of such services (Barnett & Hillard, 2001). Second, psychologist might have limited awareness of available services (Barnett & Hillard, 2001). Third, the composition of these program committees may be threatening to the distressed psychologists when all the committee members are psychologists themselves, because distressed colleagues might feel embarrassed or be concerned about feeling judged by their peers (Barnett & Hillard, 2001).

In conclusion, despite the intention of the APA to encourage colleague assistance on a state level and contrary to the data available with regard to the prevalence of distress and impairment in the profession, the needs for organized tertiary prevention are not perceived in most SPPAs, resulting in the limited number of colleague assistance programs available across the country (Barnett & Hillard, 2001). It seems ironic that psychologists are trained to attend to people’s personal distress and problems but our profession does not put priority in attending to the mental health of colleagues (Laliotis and Grayson, 1985). Moreover, the low rates of use of colleague assistance programs pinpoint the importance of future investigation into the barriers to treatment, so that better
modes of service delivery can be tailored to meet the need of distressed or impaired psychologists.

It seems to be beneficial for students to know what resources are available or unavailable in the field, and to understand the barriers to such helping process. Such knowledge can serve at least three purposes. First, it gives resources to students to cope with future impairment. Second, it gives resources to students to help future colleagues with impairment. Third, it helps students to understand service shortfalls in the profession and prepares students for advocacy work in the area of professional impairment. Hence, in the prevention work of impairment in professional psychology training, educating students with resources and shortfalls of tertiary prevention in the field can be a potentially useful measure.

*Secondary Prevention*

Secondary prevention addresses the issue of early detection of distressed psychologists in order that appropriate measures can be done to help colleagues. Except for close relationships in personal circles, colleagues working together, especially in the same agency, may be the ones who can detect if a psychologist is distressed or is having troubles in functioning professionally. However, little information can be found in the literature with respect to efforts in the profession of colleagues helping distressed psychologists. Nevertheless, sketchy data can be found relating to the intervention behaviors from colleagues of distressed psychologists in a few studies, and these studies mainly focused on alcohol abuse or substance abuse problems (Good, Thoreson & Shaughnessy, 1995; Skorina, Bissell & DeSoto, 1990; Thoreson, Budd & Krauskopf,
Skorina et al. (1990) did a study on the routes to recovery in alcoholic psychologists. In part of the study, participants were asked their histories and experiences regarding their colleagues' readiness of offering help to them. It was found that less than half of those recovering psychologists were confronted informally by their colleagues concerning their signs of drinking behavior, and even less (27%) had received warnings by their supervisors. Although it was not explicit whether the observed distress had caused a decline in professional functioning to substandard level, little effective intervention on such distress was offered by colleagues or agencies. Good et al. (1995) did a study on substance use, confrontation of impaired colleagues, and psychological functioning among counseling psychologists. In this national survey, the researchers reported that although 43% of respondents had knowledge of male psychologists and 28% had knowledge of female psychologists having a current drinking problem, only 19% had actually confronted their colleagues on their issues. In the survey of Wood et al. (1985), which has been mentioned previously, 58% of the subjects indicated that they had not offered help to a colleague with signs of impairment, 92% had not reported such a colleague to a regulatory agency, and 40% had been aware of situations in which they believed no action was taken by colleagues to help colleagues with signs of impairment. Concerning the reasons for non-intervention from colleagues, Good et al. (1995) found that the most common reasons were the perceived lack of tangible evidence, the belief that the problem was not detrimental to work performance, the belief that confrontation would not have a good result, and the belief that it was not their business.
In sum, these data suggest that psychologists in the profession seem to be aware of colleagues in distress. However, psychologists are in general hesitant in helping their peers to address their problems. Hence, effort on an agency level both in promoting helping behaviors and in offering supportive service for distressed colleagues seems to be needed. Although secondary prevention has more direct bearing on professional psychologists than students in training, it seems to be important to prepare the latter with ways of helping colleagues in distress in the prevention of impairment. Moreover, it also seems to be important to train students with regard to the need for creating supportive organizational environment to help each other, especially when distress is experienced by a colleague.

Primary Prevention

The APA’s Council of Representatives once made a resolution in 1988 to provide information and assistance to the states, in hopes of preventing the occurrence of impairment in psychologists (Floyd, Myszka & Orr, 1998). However, Orr (1997) commented that efforts to meet these promises had not been realized. Little information can be gathered in the literature with regard to both the availability of organized primary prevention work offered to colleagues in the field, although Sherman and Thelen (1998) mentioned some symposia on professional self-care had been taken place in previous APA conventions. The literature on primary prevention for professional psychologists consists of two main sources. One source comes from a few recent empirical studies related to primary intervention, pinpointing how psychologists may individually use different strategies to buffer their distress. The other source comes from discussion
articles of different authors suggesting what needs to be done in primary prevention of impairment. These two sources are presented separately in the following.

Research

Concerning research on self-care, three published studies highlighting the self-care methods adopted by clinicians to maintain their well-functioning have been published in recent years (Coster & Schwebel, 1997; Mahoney, 1997; Sherman & Thelen, 1998). They are presented in the following in chronological order. Mahoney did a study on the personal problems and self-care pattern of psychotherapists. Concerning self-care pattern, participants self-reported that they had used self-care methods in decreasing percentages as follows: engage in a hobby or reading for pleasure (87%), attend cultural events (85%), take pleasure trips or vacations (84%), engage in physical exercise (78%), participate in peer supervision (64%), practice meditation or prayer (52%), play recreational games (50%), engage in volunteer work (43%), attend church services (34%), be in personal therapy (28%), receive massage or chiropractic services (27%), and keep a personal diary (24%).

Sherman and Thelen (1998) did a study on distress and impairment among psychologists in clinical practice nationwide. In part of the study, the researchers explored prevention behaviors of psychologists. These behaviors in decreasing percentage were as follows: participate in non-work-related activities (90%), take periodic vacations (87%), seek periodic consultation (74%), exercise regularly (73%), schedule breaks in day (72%), utilize stress management techniques (66%), utilize social support network (60%), keep caseload at certain level (59%), utilize time management skills (57%), refuse certain types of clients (56%), utilize professional networks (49%),
limit number of back-to-back sessions (48%), engage in church/spiritual activities (45%), seek periodic supervision (40%), balance caseload by difficulty (27%), utilize personal therapy (26%), and attend support group (12%).

In another study, Coster and Schwebel (1997) explored the factors that contributed to the well-functioning of professional psychologists. They were the first in the profession to introduce the concept of well-functioning in contrast to impairment. They defined well-functioning as “the enduring quality in one’s professional functioning over time and in the face of professional and personal stressors” (p. 5). They first developed the Well-Functioning Questionnaire (WFQ) by a qualitative study of nominated well-functioning licensed psychologists to identify factors that contributed to their well-functioning. In their second study, they used the WFQ to survey members of a state psychological association and obtained rankings of aspects of which psychologists thought to contribute to their well-functioning. The rankings in descending order of importance are as follows: self-awareness/self-monitoring, personal values, preserving balance between personal & professional lives, relationship with spouse/partner/family, personal therapy, vacations, relationship with friends, professional identity, mentor, informal peer support, postdoctoral supervision, supervision during training, physical activities, financial stability, internship experiences, occasional consultation, individual/group supervision, peer supervision, relaxation program, diversity of professional roles, continuing education, steady referral sources, and childhood relationship with family of origin. From these studies, practicing psychologists can be able to get some ideas about what strategies their peers have found helpful in their personal and professional self-care, to enhance their primary prevention of impairment.
Theoretical Discussions

Among the discussions on primary prevention of impairment in the literature, most of the writings emphasize self-care strategies that psychologists can adopt to prevent impairment (e.g., Baker, 2000; Brems, 2001; Brems, 2000; Guy 1987; Guy & Norcross, 1998; Norcross, 2000; Skovholt, 2001). Only few (Sherman, 1996; Sherman & Thelen, 1998) provided a broader scope of discussion other than self-care on an individual level, including possible primary prevention work on the agency level, and on the level of the profession in general. Hence, a review of these three levels (individual, agency & the profession) of primary prevention work is presented in the following.

On an individual level, psychologists are suggested to be aware of the need to tend to both the personal self and the professional self; hence, personal self-care and professional self-care are needed (Baker, 2000; Brem, 2000; Skovolt, 2001). This conceptualization also echoes the previous discussion on the contributing factors of impairment coming from both the personal level (personal characteristics and personal life events) and the professional level (characteristics of the profession). For personal self-care, Baker (2000) offered the most detailed discussion; therefore, her salient ideas are presented. Baker commented that the fundamental components of self-care were self-awareness, self-regulation and balance. She pinpointed the importance of the attitude of the professional to take responsibility and own the right to self-care. Moreover, she suggested that there is a need for the professional to take care of oneself psychologically, physically and spiritually across the lifespan. To take care of oneself psychologically, six areas seem to warrant attention according to Baker: (a) understanding the psychological development of oneself (such as the influence of one's family of origin and significant
identities that contribute to the current psychological self and contribute to the motivation of entering the profession; (b) understanding one’s own needs and finding ways of fulfilling such needs; (c) finding meaning and purpose in life; (d) taking charge of life by optimizing coping mechanisms and limiting stress; (e) engaging in replenishing activities such as relaxation, recreational activities or personal therapy; (f) creating meaningful interpersonal connections as in family, social circle and society. To take care of oneself physically, Baker highlighted the importance of six areas: physical exercises, rest, sexuality, nutrition, the caution of substance abuse, and general medical care. To take care of oneself spiritually, Baker suggested the importance of finding one’s own spirituality and developing spiritual practice. For professional self-care, there seems to be eight important areas altogether mentioned by various authors (Baker, 2000; Guy & Norcross, 1988; Norcross, 2000; Sherman, 1996; Skovolt, 2001) that warrant the attention of the professionals: (a) recognizing the hazards or demands of the profession; (b) recognizing the rewards of the profession; (c) setting professional boundaries; (d) creating supportive relationships with colleagues and supervisors, as well as creating a flourishing environment at work (e) diversifying the nature of work; (f) avoiding perfectionism; (g) managing workload and time; and (h) fostering professional growth and commitment to the profession.

On the agency level, Sherman and Thelen (1998) suggested the following two things that could be done indirectly and directly in primary prevention of impairment. First, an agency can develop explicit procedures to handle and accommodate impairment and openly address them to colleagues. By creating an open attitude of addressing impairment, an agency can advocate and foster a supportive work environment and may
encourage prevention measures of impairment to be implemented within the agency.

Second, mandated training to staff on professional impairment and its prevention can be provided by the agency.

On the level of the profession, Sherman and Thelen (1998) suggested the following three things to promote the primary prevention of impairment. First, workshops on the topic of impairment and its prevention can be encouraged at national or state psychological conferences so that the information can be widely disseminated. Second, funding and logistic support for prevention programs need to be recognized by the profession’s policy makers and leaders. Third, broader professional effort needs to be put forth to encourage research on the primary prevention of impairment.

Conclusion about Primary Prevention

Within the literature on primary prevention of impairment in the field of professional psychology, available empirical studies mainly focus on the personal and professional self-care strategies used by professional psychologists while the scant theoretical discussions encompass a broader scope. Theoretical discussions not only provide a more elaborate conceptualization of personal and professional self-care that focus on what a psychologist can do on a personal level, but they also pinpoint the need for efforts on an agency level and on the level of the profession in promoting primary prevention of impairment in the profession. Hence, professionals in the field can use the information to work on primary prevention on an individual level as well as collaborating with colleagues to promote primary prevention within an agency and the profession.

With regard to profession psychology training, it seems to be important for training programs to equip students with an understanding of the components of personal
self-care and professional self-care, and to facilitate the ongoing development of such
skills during their training and beyond. Moreover, it seems to be beneficial for training
programs to train students with regard to their role in an agency and in the profession in
the primary prevention of impairment.

**Prevention of Impairment in Professional Psychology Training**

Prevention of impairment in professional psychology training is an early form of
prevention against impairment that can take place in the profession. Although tertiary or
secondary interventions are not directly relevant to graduate students because they have
not yet reached their full professional credentials for the definition of impairment to be
applicable to them, primary prevention work against impairment is very relevant for
graduate students. With regard to primary prevention of impairment for graduate
students, two sources of information from the literature are found: research and
theoretical discussion. The two sources of information are discussed in the following.

**Research**

Only one empirical study was found in published journals on primary prevention
of impairment in graduate training. Schwebel and Coster (1998) did a national survey on
the views of program heads of APA certified programs in professional psychology
regarding well-functioning, and on what they had done or would like to do to enhance it
in their programs. Out of 292 doctoral clinical, counseling, and school psychology
programs, 107 (37%) responded. When asked to respond to planned efforts in the
programs to prevent impairment, 16 programs had indicated no planned effort. For the
rest of them, the researchers reported that their indicated efforts were mostly one shot
experiences and not integral to the entire graduate program; such as a course in
professional ethics, an experiential group or encouraging personal therapy. Schwebel and Coster concluded that “to summarize planned efforts, it is fair to say that in most instances, little is offered to all students with the express purpose of preventing mental health problems” (p. 288). In the same study, the researchers asked training directors to proposed measures that could be introduced in the program to prepare students to function as unimpaired psychologists. The top ten suggestions, proposed in descending frequencies, were as follows: required therapy (20), ongoing support group (13), ongoing direct supervision (11), course content (10), ethics training (10), more attention by faculty (9), promote balanced lifestyle and self-care (8), encourage self-awareness and exploration of personal value (8), workshops on impairment (8), and develop support among students (7).

_Theoretical Discussions_

Two levels of primary prevention are mentioned in the literature: on an individual level and on the level of training programs. The majority of the discussions in fact focus on the former, which are mostly found in some introductory textbooks on counseling/psychotherapy/helping (e.g., Brems, 2001; Corey, 2001; Echterling et al, 2002; Gladding, 2000; Kottler, 2004; Moursund & Kenny, 2002; Srebalus & Brown, 2001). These textbooks inform students about the stress and demands of being a counselor or psychotherapist, and the need for self-care to prevent burnout. Such information in fact overlaps with what has been previously discussed in details in this chapter concerning the work characteristics of the profession that contribute to impairment, and on the self-care strategies for the professionals. [Note: I would like to mention a phenomenon that I noticed during my literature review of introductory textbooks of counseling/clinical
psychology in the past five years since 1999. There are no introductory textbooks of counseling psychology or clinical psychology (Compas & Gotlib, 2002; Gelso & Fretz, 2001; Plante, 1999; Todd & Bohart, 1999; Trull & Phares, 2001; Nietzel, Bernstein, Kramer & Milich, 2003; Wierzbicki, 1999) found discussing the issue of impairment and its prevention. I wonder if it is an indicator reflecting the lack of awareness of professional psychology training on the whole to acknowledge the importance of and need for educating students concerning the issue.

On the level of training programs, discussions on what can be done to prevent future impairment were scarce and mainly piecemeal. Only a few authors discussed what can be done in training to prevent impairment. Focusing mostly on professional self-care; Corey, Corey and Callanan (2003) suggested that graduate training programs should include a course on burnout and prevention strategies, and should prepare students for the rewards and hazards of the profession. Baker (2000), however, maintained that training programs should focus on the issues of both personal and professional aspects of self-care through well-planned and coherent self-care training modules. She also suggested that training should help students to explore balance in their lives and to develop self-care habits. Moreover, she considered it to be beneficial for training programs to provide opportunities for students to experience interpersonal support, recreation and psychotherapy as an integral part of the training experience. Schwebel and Coster (1998) made the most extensive discussion concerning what training programs can do to facilitate well-functioning of trainees. They advocated for structural changes of training programs to integrate well-functioning in the whole curriculum and emphasized that training should provide the opportunities for students to practice self-care. Schwebel and
Coster provided an example of how a program could structurally emphasize well-functioning of students by suggesting the following nine aspects. First, programs should only admit healthy students. Second, training programs should convey their support to help new trainees to complete their training. Third, training programs should involve students as an integral functioning of the programs' governance and value student opinions. Fourth, training programs can revise curriculum to incorporate initiatives to promote well-functioning; such as promoting peer-colleague support, lightening the load of the curriculum to encourage the desired balanced life, helping students to build lifelong learning habits to adapt to changing conditions, and being sensitive to the personal as well as the professional needs of students. Fifth, training programs can develop and revise courses with well-functioning criteria in mind; such as relating the course material to students' personal and professional self-understanding and growth. Sixth, training programs can promote various peer group activities to enhance personal support, trust and interdependence. Seventh, training programs can create an inclusive and cohesive training environment by reducing competitiveness and rivalry. Eighth, training programs should seek the advice and expertise of practitioners in course and curriculum review for information regarding the real world of full-time practice. Ninth, training programs should reorient students, staff and faculty in an ongoing manner regarding the emphasis on well-functioning and their corresponding roles to achieve the purpose.

Conclusion about Prevention of Impairment in Graduate Training

In spite of its importance, the literature, both research and theoretical discussion, on the prevention of impairment in graduate training is scant. Only one published study is
available, which provides the perspectives of training directors concerning what can be
done in graduate training against impairment. Theoretical discussions on the prevention
of impairment in graduate training mostly focus on individual level of self-care.
However, there are suggestions on primary prevention proposed by different authors to
be implemented in graduate training programs. These suggestions range from specific
content (e.g., hazards and rewards of the profession); to experiential opportunities in the
programs for the students to explore, experience and develop self-care; to a course on
impairment and prevention; to well-planned modules on personal and professional self-
care; to structural changes of program aiming at promoting well-functioning.

Conclusion

This chapter reviews the literature pertaining to the research question: what
effective measures can be done in professional psychology training to prevent future
professional impairment. First, I explain the importance of prevention work against
impairment in the field of professional psychology. Because the liability of impairment to
the professionals, the clients and the profession is high, it is essential for the field of
professional psychology to put forth efforts in preventing impairment of professionals. In
particular, prevention work against impairment is desirable to be started early on during
graduate training. Second, I clarify definitional issues regarding the concept of
impairment and define impairment as a decline in professional functioning to substandard
performance due to the occurrence of distress. I support a developmental perspective
toward the issue of impairment in that any professional psychologists may run the risks of
becoming impaired (Orr, 1997) when impacted by distress. Hence, I encourage a
compassionate stance of the profession, and consider it to be important for training
programs to convey such a developmental perspective to students in early prevention work against impairment. Third, I look into the research findings related to the prevalence of impairment. The research findings suggest high enough incident rate of impairment in the field that further substantiates the need for prevention work in the profession and the need for early effective preventive measures against impairment in graduate training. Fourth, I review the factors contributing to impairment. Three clusters of factors are found: personal characteristics, work characteristics and personal life events. It seems to be important for professionals and students to have awareness of these factors that may impact in their professional functioning. Respective to each of the factors, it seems to be beneficial to help students understand their developmental issues and their related motivations entering into the profession; help students understand the hazards of the profession; and help students understand the impact of various life events to their professional functioning. Fifth, I summarize the three levels of prevention efforts that have been put forth in the profession. Although tertiary and secondary prevention are less relevant to students under professional training, I consider it to be important for students to understand what resources are available in the field and to understand the barriers to helping colleagues with impairment. Also, I consider it to be important for training programs to train students with regard to the need for creating supportive organizational environment, and to offer help when distress is experienced by a colleague. Concerning primary prevention, the literature pinpoints that efforts need to be on an individual level, an agency level and on the level of the profession. I consider it to be important for training programs to equip students with an understanding of personal and professional self-care and to facilitate the development of such skills. Moreover, it
seems beneficial for training programs to educate students regarding their role in an agency and in the profession in the primary prevention of impairment.

Finally, I review the literature on the prevention of impairment in professional psychology training. The literature on the topic is indeed scant. The only one relevant published study by Schwebel and Coster (1998) explores training directors’ perspective on what can be done in the program to facilitate well-functioning of students. The few theoretical discussions on the topic suggest additional proposals to the possible prevention work to be adopted by training programs, ranging from specific content, to experiential self-care opportunities, to a course on impairment and prevention, to well-planned module in self-care, to structural changes of the program aiming at facilitating well-functioning of students.

Hence, in addition to the training directors’ suggestions resulting from the study of Schwebel and Coster (1998), an expanded list of suggestions regarding what can be done in professional psychology training to prevent future impairment can be generated, by incorporating additional suggestions obtained from this literature review.

Nevertheless, there was not any research that illuminated the most important preventive measures against impairment in professional psychology training. Hence, I sought the opinions of experts in the phenomenon of impairment in the field of professional psychology to see what most important preventive efforts should be implemented in graduate training to prevent impairment. I intended that the results of this study could provide training programs opinions from experts concerning what the most important preventive measures against impairment should be adopted in training graduate students.
CHAPTER III

METHODS

Overview

This chapter describes the Delphi method that was used to study the main question of this research: what are the most important measures to be implemented in professional psychology training to prevent future professional impairment. In addition, this chapter will also explain the Delphi method that was used to address the adjunctive question in this research: how to successfully implement the most important measures. To describe the Delphi method of this study, the objectives of the study are first discussed. Second, the rationale for using the Delphi method in this study will be provided. Third, an introduction of the Delphi method will be presented. Fourth, panel selection procedures of this study will be given. Fifth, recruitment and the data collection procedures will be described. Sixth, the construction of the Delphi questionnaires will be discussed. Seventh, the data analysis procedures will be presented. Lastly, a conclusion will summarize this chapter.

Objectives of Study

As concluded in the last chapter, measures in professional psychology training to prevent impairment were proposed from the perspective of training directors in a study and suggested by some authors in the literature. However, there was not any research illuminating what preventive measures were more important than the others from the
perspective of experts in the phenomenon of impairment. Moreover, there was not any research informing how these measures could be successfully implemented in training programs. This study was carried out to address such gaps in the research literature. By addressing this gap, the results of this study could provide practical suggestions to professional psychology training programs regarding what important measures were needed in training to prevent against future impairment and the considerations to successfully implement these measures. Hence, in using the perspectives of experts regarding the phenomenon of impairment, this study aimed at achieving three objectives: (a) to compile a list of important measures in professional psychology training to prevent future impairment in professionals, (b) to determine the relative importance of these preventive measures through the consensus of the experts in order to find out the most important preventive measures, and (c) to explore the ways of successful implementation of the most important preventive measures.

Rationale of Using Delphi Method

To achieve the objectives, the Delphi method was used in this study. The rationale for the use of Delphi method in this study was three-fold and is explained in this section. First, my intention of generating usable knowledge for the practice of graduate training matched the philosophical underpinnings of the Delphi method which focuses on the application of knowledge (Stone Fish & Busby, 1996). Although impairment prevention measures in graduate training had been discussed in the literature, the relative importance of specific measures had not been studied, and was, therefore, uncertain. As a result, it was not yet known which preventive measures among all the suggested ones were most important to be adopted in graduate training programs. However, as discussed in the
literature review chapter, the research findings suggested high enough incident rate of impairment in the field that substantiated the need for early prevention work in graduate training. Ziglio (1996) commented that when policy would require knowledge which was not readily available, policy makers must rely on the opinion of experts. The Delphi method offers a way of working on a complex problem under conditions of uncertainty (Pill, 1971) by trying to obtain the distilled insights and informed judgments of experts as systematically as possible (Ziglio, 1996).

Second, my intention of pooling experts’ opinions for consensus coincided with the purpose of the Delphi method, which is to gather the perspectives and consensus of a panel of knowledgeable persons on a subject matter (Stone Fish & Busby, 1996). The philosophical assumption behind gathering consensus from experts in the Delphi method rests upon the premise that it is possible and valuable to reach consensus through a collective human intelligence process (Linstone & Turoff, 1975). More importantly, the accuracy of the pooled informed judgment or the consensus from experts has been demonstrated in the literature (McGaw, Browne, & Rees, 1976; Ono & Wedemeyer, 1994; Riggs, 1983).

Third, my intention to gather experts’ opinions from across the country asked for a method that could provide both structure and efficiency to achieve the task. The Delphi method allows a structured and efficient way of communication among experts without the need for face-to-face interaction (Stone Fish & Busby, 1996). The structure of the method consists of a survey of two or more rounds (Boroson, 1980) in which participants can express their opinions anonymously among the group, gather feedback from the group, and revise their opinions (Stone Fish & Busby, 1996). Regarding efficiency, this
method enables the economy of time and expense in gathering geographically dispersed experts' opinions because the experts do not need to either schedule for a common time or travel to a group meeting place (Clayton, 1997). In addition, this method offers efficiency in the communication process by overcoming some major drawbacks of traditional face-to-face methods of pooling opinions or consensus, including the influence of dominant individuals, irrelevant and biasing communication, and group pressure for conformity (Uhl, 1983).

Introduction to Delphi Method

In this section, I first provide a brief account of the historical development of the Delphi method. Then, I will describe the essence of the Delphi method. Finally, I will explain the form of Delphi method that was used in this study. (Note: Other details of the Delphi method used in this study will be explained in subsequent sections after this introduction section.)

Historical Development of Delphi Method

Historically, the method was invented in the 1950s at the Rand Corporation and first applied using experts' consensual judgments for national defense purpose (Boronson, 1980). It was subsequently applied in the area of forecasting in science and technology (Stone Fish & Busby, 1996). Then, the method started to gain wider recognition for its potential in solving complex problems (Uhl, 1983). As a result, the method has been used in the area of public health, social policy, social work, and nursing and medical training (Ziglio, 1996). It has also been used in the field of education (e.g., Cramer, 1991; Fleming & Monda-Amaya, 2001). Furthermore, the method has been used in the field of counseling (e.g., Klutschkowski & Troth, 1995; Thielson & Leahy, 2001) and marriage
and family therapy (Dawson & Brucker, 2001; Jenkins & Smith, 1994). In fact, this method has been used in professional psychology to predict future trends (Heath, Neimeyer & Pederson, 1988; Neimeyer & Diamond, 2001), clarify concepts (Leclerc, Lefrançois, Dubé, Hébert & Gaulin, 1998), explore ethical issues (Malley, Gallagher & Brown; 1992), and describe training needs (Rogers & Lopez, 2002; Speight, Thomas, Kennel, & Anderson, 1995).

**Essence of Delphi Method**

In their seminal work of introducing the Delphi method, Linstone and Turoff (1975) pinpointed that this method and its applications had been in a stage of evolution, with regard to how it was applied and to what it was applied. Linstone and Turoff (1975) commented that there were many different variations on the Delphi method and that its design was “more of an art than a science” (p. 3). Therefore, instead of posing a restrictive definition of the method, Linstone and Turoff (1975) were only willing to subscribe to the general view of the method that “Delphi may be characterized as a method of structuring a group of communication process so that the process is effective in allowing a group of individuals, as a whole to deal with a complex problem” (p. 3).

In its most general form, Gibson and Miller (1990) described that the Delphi method was characterized by using a panel of experts who participated anonymously with each other in responding to an iterative series of written questionnaires; and that in each round of the responses to the questionnaires, the researcher analyzed the results and reported to the panel experts in the next round. Gibson and Miller (1990) explained that by the researcher refining the subsequent round of questionnaires and by the panel experts re-evaluating the responses of the previous round, the issues in question were able
to get further clarified in the next round. Ziglio (1996) divided such iterative process into two phases: the exploration phase and the evaluation phase. In fact, the two phases can overlap in the actual process of a Delphi. Ziglio (1996) conceptualized that in the exploration phase, usually in the first round and sometimes also continuing in the second round, the options for the issues in question were fully explored. Ziglio (1996) further explained that the evaluation phase, usually in the second and subsequent rounds, involved assessing and gathering the experts' judgments until the objective of the study was achieved. In a conventional Delphi, as in most Delphi studies in the literature, generating group consensus is the major objective; whereas in a policy Delphi, as applied in studying more complex social policy issues, the prime objective is to solicit a comprehensive forum of ideas to explore consequences of options or rationale behind the agreements and disagreements among the interdisciplinary panel “experts” or stakeholders (Gibson & Miller, 1990; Turoff, 1970). Actually, in the evolution of the Delphi method, the method has been used to gather consensus of experts, while also incorporating the exploration of policy concerns to enrich the understanding of the issues in question (Turoff, 1975).

*Form of Delphi Method in this Study*

This study aimed at gathering consensus of experts as well as exploring the implementation concerns of policies. By using Delphi studies in the literature, I explain in the following how the Delphi method was conducted, in the exploration phase and the evaluation phase, in order to gather the consensus of experts and explore policy concerns.
Gathering Consensus

In general, in the exploration phase, the issue(s) in question need to be explored in order that all the options to address the issue(s) are generated and the initial judgments of the experts about the issue(s) in questions are sought. In this exploration phase, options to address the issue(s) can be generated by one of the following ways: (a) using a literature review of the researcher to generate a list of options (e.g., Critcher & Gladstone, 1998), (b) asking experts to generate these options from the first round of Delphi using open-questions (e.g., James, Aitken & Burns, 2002), or (c) beginning with a list of options generated by the researcher and asking the experts to generate further options (e.g., Rogers & Lopez, 2002). Moreover, in this exploration phase, initial judgments of the experts are usually obtained by asking experts to rate all the options using Likert scale(s).

In the evaluation phase, panelists are usually asked to re-evaluate their previous judgments after the initial round, based upon the result of the exploration phase, in the hope that consensus can be obtained. Hence, panelists are asked to indicate their re-rating of all the options generated in the initial round. By comparing the central tendency of the ratings and the variability of the items, the respective priorities of the items and the degree of consensus are obtained.

For example, Rogers and Lopez (2002) aimed at identifying critical cross-cultural school psychology competencies. They first generated a list of cross-cultural school psychology competencies to be used in the first round for expert panelists to rate the importance of each of the items using Likert scale. At the same time, they asked panelists to add new items in the first round to be rated in the next round. In the second round, they asked panelists to re-rate the augmented list of cross-cultural school
psychology competencies. Then the researchers used criteria for selecting items, based upon the level of importance and the degree of consensus. Finally, the final critical school psychology competencies were selected.

Exploring Policy Concerns

To further explore policy concerns in conventional Delphi study, researchers may ask each one of the expert panelists to select a certain number of top priorities among the options related to the issue(s) in question. Depending on the particular policy concerns involved, each of the experts may be asked to rank one's selected options, and/or to give comments on these choices, such as the rationale behind the selections (Walker, Barker, & Pearson, 2000) or suggested actions for these choices (Cramer, 1991).

For example, Walker, Baker and Pearson (2000) investigated the required role of the psychiatric mental health nurse in primary health care. After the first round of the Delphi, the researchers collected a list of items under four subject areas in relation to the role of the psychiatric mental health nurse. In the second round, panelists were asked to select up to three items in each of the four areas and gave rationale behind their selections. Another example is the study of Cramer (1991). In this study, Cramer (1991) wanted to explore the priorities of issues in the education of gifted children. A list of 12 issues was selected from a literature review by the researcher. In addition to rating the importance of the 12 issues in the first round of the Delphi, each of the panelists was asked to select the top three priorities and to suggest action to be taken for all of the most important issues.

Panel Selection Procedures

This section discusses panel selection procedures. It consists of panel selection criteria, panel identification procedures, and panel size.
Panel Selection Criteria

The selection of the panel of experts is a critical element in the Delphi method (Stone Fish & Busby, 1996), because the validity of the result is closely tied to the relevance of the expertise of the panel with respect to the study area in question (Dawson & Brucker, 2001). Hence, expertise is the key requirement in selecting members of a Delphi panel (Clayton, 1997). Also, there must be explicit criteria governing the selection process (Jenkins & Smith, 1994). To select the experts who were knowledgeable in contributing to the research question of this study, I decided that panel members should meet the following two criteria:

1. Panel members should be psychologists with a doctorate degree who had worked in the United States. The reason for this criterion was that this study focused on professional phenomenon of psychologists in this country.

2. Panel members had to possess expertise in one of the four areas: (a) contributing scholarly work to the understanding of the phenomenon of impairment and its prevention in the profession, (b) providing field educational work on the prevention of impairment in the profession through workshops/ seminars at professional conferences, (c) serving in working committee on the advocacy of prevention of impairment in the profession, or (d) working clinically to alleviate impairment in the profession. To be considered as having expertise in one of the four areas, panel members needed to satisfy one of the following four corresponding criteria:

   A. Panel members needed to be first author/ editor of a book, book chapter or psychological journal article concerning the professional phenomenon of
impairment or its prevention in the last 10 years, between 1995 and 2005; or second author/editor of two or more books, book chapters, or psychological journal articles concerning the professional phenomenon of impairment or its prevention in the current year and the last 10 years between 1995 and 2005). This scholar criterion enabled the selection of psychologists who had the specialty of understanding/studying the phenomenon of impairment or its prevention. In addition, this authorship criterion was also consistent with other published Delphi studies in professional psychology with regard to defining expertise of an area (e.g., Lopez & Rogers, 2001; Rogers & Lopez, 2002; Speight, Thomas, Kennel, & Anderson, 1995).

B. Panel members needed to have provided workshop or seminars on the prevention against impairment at the American Psychological Association annual conferences in the last ten years between 1995 and 2005. This criterion enabled the selection of psychologists who had provided credible education to colleagues in the field.

C. Panel members needed to be a member of the Advisory Committee on Colleague Assistance (ACCA) of the American Psychological Association in the last 10 years between 1995 and 2005, or needed to be a member of a state colleague assistance program/committee in the last 10 years between 1995 and 2005. Members of ACCA were chosen because they were peer nominated psychologists with experience in prevention of professional distress and occupational health. They helped carry out the mission of
ACCA including the investigation of the needs of psychologists for professional health and the promotion of development of colleague assistance programs as well as peer assistance network across the country (APA, 2002). The committee members of state colleague assistance programs were chosen because they represented local efforts in advocacy against impairment and in organization to help colleagues having problems.

D. Panel members needed to have direct clinical experience working to help psychologists who were distressed or impaired. They needed at least to have worked with three psychologists to alleviate their potential impairment or actual impairment.

Panel Identification Procedures

Because the experts to be identified in this study came from different sources, they were located by different ways as explained in the following:

1. To locate experts who met the authorship criterion, journal articles, books, book chapters between 1995 and 2005 concerning impairment and prevention were sought through the *psycINFO 1887* and *Worldcat* online databases, by using keywords (*impairment, self-care, well-functioning, psychologist, and training*) and their combinations. Also, ancestry search were used by finding relevant cited sources of publication already obtained (Cooper, 1982; Roger & Lopez, 2002). The contact information of these experts was identified from their publications and the APA online membership directory.
2. To locate experts who had provided workshops/seminars concerning impairment prevention, the handbooks of APA annual conference from 1995 to 2005 were reviewed. The contact information of these experts was obtained from the handbooks and the APA online membership directory.

3. To locate experts who had been members of ACCA, APA from 1995 to 2005; liaison with current staff of ACCA was made in order to get the contact information of these potential panel members.

4. To locate experts who had been members of state colleague assistance programs/committees, research results of Barnett and Hillard (2001) were used, which had found that 17 states in the United States had colleague assistance programs. These state psychological associations were contacted to get contact information of the members of their colleague assistance programs/committees. APA online membership directory was also used to obtain the updated contact information of the experts.

5. To locate clinicians who had worked with psychologists in distress or with impairment, I sought recommendations from experts who satisfied any one of the four criteria. APA online membership directory was also used to obtain the contact information of the recommended experts.

Panel Size

In the theoretical discussion of panel size, Ziglio (1996) stated that the criterion for deciding the size of a Delphi panel should not be a statistical one and the size would be varied dependent on the nature of the study. Concerning the minimum panel size of a Delphi panel, Ziglio (1996) suggested that with a homogeneous group of experts, good
results can be generated even with a small panel size of 10-15 individuals. In fact, among Delphi studies in journal publication, an interdisciplinary panel with 12 experts (Turner & Weiner, 2002) and a panel with 9 experts of the same field (Strauss, Chassin & Lock; 1995) can be found. Ziglio (1996) commented that there would be an improvement of the result of the group judgment with increasing group size, but there would not be significant benefit above a certain threshold. Nevertheless, no further information can be found regarding this upper threshold of panel size.

Among published journal articles in the field of professional psychology and counseling, the number of invited panel members ranged from as low as 20 (Thielsen & Leahy, 2001) to 216 (White, Edwards & Russell, 1997). However, in terms of the general application of the Delphi method, Walker, Barker and Pearson (2000) noted that reports of panel size varied even more from 16 to over 1000. In this study, the recommendation of Turoff (1975) was adopted regarding the panel size for a Delphi study involving policy exploration: a minimum of 10 and a maximum of 50. Hence, a minimum panel size of 20 was aimed at for the first round of this study, to account for the possible attrition of the second round to even 50% (Critcher & Gladstone, 1998). To limit the panel size of not exceeding 50, the potential panelists were contacted in phases in the first round of Delphi as will be explained in the immediate next sub-section.

Recruitment and Data Collection Procedures

Ziglio (1996) considered that the Delphi method could be roughly divided into two phases: the exploration phase and the evaluation phase. In the exploration phase, all the options for the issue(s) in question are explored and generated, and panelists indicate their own initial judgments of the options. In the evaluation phase, experts, based upon
the results of the exploration phase, re-evaluate their judgments. There are variations as to how researchers accomplish the two phases with differing number of rounds of survey in a Delphi study (Stone Fish, 1996). Linstone and Turoff (1975) suggested that three rounds proved sufficient to achieve stable responses and that further rounds tend to be redundant and unacceptable to participants in general. Also, Martino (1972) considered Delphi studies with two rounds to be methodologically acceptable. In fact, among the published Delphi studies in professional psychology, two-round Delphi studies seems to be common, if not the majority. Jenkins and Smith (1994) noted that panel members' fatigue might be an important reason why Delphi studies stopped at round two. Moreover, some researchers, instead of using an open-ended questionnaire in the first Delphi questionnaire, developed their Delphi questionnaire items from their literature review or previous instrument (e.g., Heath, Neimeyer & Pederson, 1988; Norcross, Hedges & Prochaska, 1992; Rogers & Lopez, 1992). As described in the next section, the first Delphi questionnaire in this study was developed from the result of a previous study and my literature review. According to Riggs (1983), this way of starting a Delphi round may reduce the number of rounds in a study, in particular, saving time in the first phase of exploring the subject area.

In this study, I adopted a two-round format, like most of the conventional published Delphi studies in professional psychology, to achieve the two phases of Delphi (Ziglio, 1996). After the study was approved by the Human Subject Investigation Review Board (HSIRB), two rounds of data collection were carried out. During the first phase of the first round, potential panelists who satisfied the authorship criterion, who had presented in the APA annual conferences, or who had worked in APA ACCA committee
were invited to participate in the study. Forty-eight potential participants were identified and invited, and 19 returned the completed questionnaires. In the second phase, recommended clinical experts suggested by the participants from the first phase were invited. Five additional potential participants were invited, and 4 of them returned the completed questionnaires. The two phases already included experts with all four expertise areas. In the original recruitment plan, if the number of return for the two phases exceeded 20, further phases of recruitment would stop. However, 5 participants of the first two phases actually returned the questionnaires later than expected before the launch of the third phase. The third phase was decided to continue because it would not still exceed the intended maximum panel size. In the third phase, 17 additional potential panelists who had been chairpersons of a state psychological association colleague assistance program were invited, and 5 of them returned the completed questionnaire. Hence, a total of 70 invitations were sent out in the first three phases, and 28 experts participated in the study, creating a response rate of 40%. (Note: The fourth, the fifth, and the sixth phases of the original plan were not carried because more than 20 experts already participated in the first three phases. The fourth phase was inviting recommended clinical experts from the second phase and the third phase. In fifth phase was inviting potential panelists who were committee members of a state psychological association colleague assistance program. The sixth phase was inviting recommended clinical experts from the fifth phase.)

Upon receiving the first round of questionnaires, the data were analyzed to understand how the entire panel initially viewed the issue under study. In the second round of data collection, a second research package was mailed to each of the 28 panel
members who had participated in the first round. This research package consisted of a cover letter (Appendix G), the second Delphi questionnaire (*DQII*) (Appendix H) which contained the results of the first round survey, and a stamped return envelope. After three weeks, a reminder letter (Appendix I) together with the research package was sent to each of those panels who had not yet returned the package. After three weeks of the first reminder letter, a second reminder letter (Appendix K) was sent to those panel members who had not yet returned the package. Twenty-one participants returned the research package. However, one return was considered invalid because the panel member did not complete most of the questionnaire. Hence a total of 20 were counted as valid returns, resulting in a response rate of 71%.

**Delphi Questionnaires**

As discussed above, there were two rounds of Delphi survey in this study. Hence, in each of the rounds of survey, a different questionnaire was used. The content of each of the two questionnaires was discussed below. Also, identified potential participants were coded on a master list of names and contact information. Hence, each of the potential or actual panelists had a code, and questionnaires were coded correspondingly to enable follow up contacts of the potential or actual panelists.

*Delphi Questionnaire (I)/ DQI (Appendix C)*

The first round questionnaire was pilot-tested with five doctoral psychologists who had agreed to complete the questionnaire and give feedback concerning the time of completing the questionnaire and the construction of the questionnaire. The average estimated duration of time to complete the questionnaire by an expert participant was about 30 minutes. Overall, the pilot participants commented that the survey was well-
designed and the format was easy to follow. Hence, the original 4-part format of the survey was unaltered. However, changes of wording or grammatical changes were suggested by the pilot participants. These changes are elucidated in the following description of the final version of the questionnaire.

The final version of the first Delphi Questionnaire (DQI) contained four parts: demographic information, preventive measures in graduate training against future impairment of professionals, considerations for successful implementation of the most preventive measures, and recommended clinicians. The four parts of the questionnaires are explained below.

*Part I*

The first part consisted of nine questions. They were demographic information of a panelist and the demographic information concerning the background expertise of the panelist in the studied area of interest (in this case, impairment and its prevention in professional psychology). In fact, the inclusion of similar demographic information of both areas was consistent with the conventional practice of published Delphi studies in professional psychology (Lopez & Rogers, 2001; Rogers & Lopez, 2002; Speight, Thomas, Kennel, & Anderson, 1995). Moreover, the background expertise information also served as an expertise validity check of the experts who were included in this study. Demographic information included gender and ethnicity. The demographic information related to their expertise included highest degree, specialty in psychology, years of experience as a psychologist, current professional position, years of interest in the area of impairment and its prevention in the profession, and the kinds of professional activities having engaged in concerning the phenomenon of impairment and its prevention.
In this part, wording changes for item #2 and #8 were made according to the suggestions of the pilot participants. For item #2(e), “Latino(a)” was changed to “Chicano(a)/ Latino(a)” to encompass people of Mexican descent. For item #8, grammatical error was corrected from “What kind(s) of professional activities have your engaged...” to “What kind(s) of professional activities have you engaged...,” and “the phenomenon of impairment/ its prevention” was reworded to “the phenomenon of impairment and its prevention.”

*Part II*

The second part solicited opinions from an expert panel regarding the research question. Panel participants were provided with a list of 38 items of suggested preventive measures in graduate training against future impairment of professionals. They were requested to review the items and to rate how important these measures were on a 5-point Likert scale (0 = unimportant, 1 = less important, 2 = important, 3 = very important, 4 = essential). Then, they were asked to list, if any, up to five other important preventive measures that had not been included among the 38 items. Item selection and scale selection are explained in the following.

Concerning item selection, 29 items were selected based on the results of the study of Schwebel and Coster (1998), as described already in the chapter two. A summarized list of 30 preventive measures in graduate training against impairment was proposed by training directors of psychology graduate programs in the study. Some of the wordings were altered to keep the structure of the items parallel by starting with a verb in every item. Also, one of the original items was split into two to maintain a single idea per item. Moreover, two items were deleted because both items suggested nothing to be done.
In addition to the resulting 29 items derived from the study, nine items were added to the list based upon the conclusion of my literature review. Therefore, there were 38 items in total in the list. The original wordings of item #30, 32 and 38 in the list were further edited to the final version as suggested by the pilot participants. For item #30, it was changed from “Restructure program to aim at well-functioning of students” to “Restructure program to focus on well-being of students.” For item #32, “Help students to be awareness that any professional may run the risk of becoming impaired” was modified to “Help students to be aware of the risks of impairment in the profession.” For item #38, “Develop awareness of students in creating supportive organizational environment and in offering help to distressed colleagues” was reworded to “Help students to be aware of their own ability to create a supportive organizational environment and to provide assistance to distressed colleagues.”

Concerning the choice of scale, the Likert scale was chosen because it was the type of scale most commonly used among the published Delphi studies, having varying number of points in the scale which may range from 5 points (Malley, Gallegher & Brown, 1992; Toward & Ostwald, 2002) to 7 points (Adams, Piercy, Jurich & Lewis, 1992; Norcross, Hedges & Prochaska, 2002), and to even 11 points (Health, Neimeyer & Pederson, 1988), depending on the nature of the question being asked. In terms of rating the importance of the items, a five-point Likert scale is commonly used in the literature (e.g., Rogers & Lopez, 2002; Thielsen & Leahy, 2001; White, Edwards & Russell, 1997). In this study, I adopted the five-point Likert scale as used by James, Aitken, and Burns (2002).
Part III

In this part, panelists were asked to rank their top five priorities of preventive measures. For each of these priorities, panelists were requested to list what was (were) needed/included in order to make it successful in implementation, or how to make it successful in implementation.

Part IV

This part requested panelists who satisfied at least one of the criteria (the authorship criterion, the advocacy criterion or the clinical criterion) to nominate psychologists who had clinical expertise working with psychologists with issues concerning impairment.

Delphi Questionnaire (II)/ DQII (Appendix H)

The second Delphi questionnaire was constructed after data of the first round were analyzed. The DQII consisted of two parts.

Part I

This part contained two sections. Section A contained a summary of the first round results. The summary included an augmented list of preventive measures (the original 38 items and the additional suggested measures by the panelists). The mean and standard deviation (as explained in the next section) of each of the 38 items on the original list of the first round were included. The 38 items were rank-ordered in such a way that an item with a higher mean was placed higher up on the list, because the item higher up was considered to be more important than the lower item by the panel as a whole. In section B, a summary of considerations relating to the successful implementation of selected preventive measures by the panelists was be included in this
part. In section C, panelists were asked to select up to three important preventive measures in section B, and to give additional feedback regarding the consideration to make these important preventive measures successful in implementation in graduate training.

Part II

This part contained two sections. In section A, panelists were asked to rate the importance of the augmented list of preventive measures, using the same 5-point Likert scale in DQI. In section B, panelists were asked to choose their top 10 choices and to rank order them; so that additional rank-ordering could be obtained, to prepare for possible same resulting ratings for top choices.

Data Analysis

Two main goals of data analysis in this Delphi study were to draw comparisons among all the items of suggested preventive measures to determine which were considered to be more important than the others by the experts, and the extent to which consensus was reached on each item. Moreover, an additional goal was to understand how the most important measures could be successfully implemented in training programs. In order to achieve the first two goals, a measure of central tendency and a measure of variability for each item were needed respectively. So far, within the larger field of counseling, the former are more commonly used in the field of Family Therapy (Jenkins & Smith, 1994), and the latter were commonly used in the field of Professional Psychology (e.g., Lopez & Rogers, 2001; Neimeyer & Diamond, 2001; Norcross, Hedges & Prochaska, 2002). However, only researchers in Family Therapy have provided a rationale for their choice. Stone Fish (1996) argued that the distributions of the items in a
Delphi study would be skewed toward the high or the low ends of a scale when fostering consensus; and hence, the median and the interquartile range would be better indexes of representing central tendency and variability, because they are less affected by extreme scores. Owing to this theoretical reason, I originally planned to use these two statistics in reporting the central tendency and the variability of the items. But, during the first round data analysis, the two statistics were found to be less useful than the mean and standard deviation in summarizing the results of the items and discriminating among the items. In Appendix L, the median and the interquartile range were juxtaposed alongside the mean and standard deviation of the first round rating of the items. A lot of the items ended up having identical medians and/or interquartile ranges. The reason for this pseudo-uniformity among the items was because the variability of the items was not adequately represented after "discarding" 50% of the data from the items when using the interquartile range. Also, the median was less influenced by scores on the two ends.

Statistically, the median and the interquartile range have the advantage of eliminating the effect of extreme scores, especially outliers which may represent errors in measurement, data recording or data entry (Howell, 1997). However, with Delphi studies, in which experts are expected to give their thoughtful opinions, it is not uncommon for experts to hold disagreements, if not strong disagreements, on the issues being studied. It is exactly the strength of Delphi study to facilitate the expression of differing views for further exploration (Linstone & Turoff, 1975). Hence, extreme scores in a Delphi study should not be automatically treated as errors or as not useful, when they may represent legitimate values deserving equal attention in the expert panel. In this regard, when reporting the opinions of the experts, it is important to give equal weight to each one of the experts and
to capture the actual variability. Hence, the mean is a better representing index which gives equal weights to the differing opinions, and the standard deviation offers a better index reflecting the actual variability of the opinions. Also, they provided better differentiation among the items in this Delphi study. One additional statistical benefit of using the mean is its being a generally more stable estimate of the population central tendency than is the median (Howell, 1997). Therefore, the mean and the standard deviation were finally adopted in summarizing the results of the items in this Delphi study.

In order to achieve the additional goal of understanding the considerations for the successful implementation of the most important measures, content analysis was carried out and explained in the following relevant parts. Since there were two rounds of data analysis as a result of two rounds of survey in this study, the data analysis of each of the two rounds of survey were discussed below.

Round One

After the completed DQIs were returned in the first round of Delphi survey, the data of the two parts of the questionnaire were analyzed. For Part I, the frequency statistics were computed for each of the items with categorical variables: gender, ethnicity, highest degree, specialty in psychology, current professional positions, and the kinds of professional activities against impairment/its prevention. Concerning the remaining two items with a continuous variable of year (years of post-doctorate professional experiences and years of interest in the area of impairment/its prevention in the profession), the central tendency (mean) and the range of the data were computed.
For Part II, the mean and the standard deviation were computed for all the original items. Concerning the additional list of suggestions by the experts, content analysis (e.g., Kaufman, Holden & Walker, 1989; Thielsen & Leahy, 2001) was conducted. First, all the suggestions were compiled into one beginning list of suggestions. When a suggestion contained only one preventive measure, the wordings of the suggestion were condensed using the original key words as much as possible. When a suggestion contained more than one preventive measure, it was split into separately preventive measures. When more than one suggestion described in essence the same preventive measure, only one remained in order to eliminate repeated suggestions. Using these criteria, a final list of additional preventive measures was then created. As commented by Jenkins & Smith (1994), a reliability checker can ensure the accurate representation of the original data. Hence, a reliability check of the final list of additional preventive measures was carried out by using an independent rater. The independent rater matched the beginning list of suggestions with the final edited list. Inter-rater reliability (number of agreements between the researcher and the independent rater divided by the number of agreements plus the number of disagreements) was calculated (Adams, Piercy, Jurich, & Lewis, 1992; Miles & Huberman, 1994). Krippendorff (2004) recommended the general criterion for reliability level in content analysis to be .80, and this criterion was adopted in this study. Hence, if the resulting inter-rater reliability was lower than .80, the researcher would discuss with the independent rater for the discrepancies so that the beginning list would be re-edited until the inter-rater reliability reached at least .80.

For Part III, frequency was tallied for the items which were selected as top priorities. In addition, content analysis for each of the chosen priority items was carried
out in a way similar to data analysis of Part II. When an item was chosen by more than one panelist, the lists of comments under the same item were complied into one list of comments. When a comment carried only one idea, the wordings were condensed but the original key words were used to preserve the original meaning of the idea. However, when a comment carried more than one idea, the comment was split into separate comments of single idea. On the other hand, when more than one comment carried the same idea, only one comment was kept. When the comments of all the chosen priority items were edited, a final list of comments for each of these items was resulted. A reliability check of the final lists of comments under the priority items was carried out by using an independent rater. The criterion for inter-rater reliability was again set at .80 as in Part II. This independent rater was asked to match, for each of the priority items, the original comments with the edited summarized comments in the final list. Inter-rater reliability was calculated. If needed, re-editing of the original comments would be made until the criterion was met.

**Round Two**

After the completed DQII questionnaires were returned in the second round of the Delphi survey, the data were analyzed. For Part I, section A and B did not need to be analyzed because they were summaries of the first round results. Section C contained qualitative data concerning the additional comments from the panelists. The qualitative data were analyzed using content analysis similar to Part III of round one survey. The independent rater was again used for reliability check. If the reliability criterion of .80 was not reached, the researcher would discuss the discrepancies with the independent rater and the refining of items would be done again until the reliability criterion was met.
For Part II section A, the mean and the standard deviation were calculated for each of the items. Then, the items were rank-ordered from the highest mean to the lowest one. As a result, a final list of preventive measures was obtained in such a way that the items higher on the list with higher mean represented preventive measures considered to be most important by the experts, and the items lower on the list with lower mean represented measures least considered to be important by the experts. The standard deviation of the items provided information the amount of consensus of the expert panel; the smaller the standard deviation, the greater consensus it had for an item. For section B, the top 10 priority priorities for each of the panelists were originally designed to calculate another rank-ordered list. The purpose for this analysis was to ensure that if a lot of the top most important items in section A had the same resulting central tendency, this analysis offered additional ranking information concerning the rankings of the top most important items. Weighted scores were used to calculate for each of the chosen priority items (Cramer, 1991). Any 1st priority was given a value of 10, 2nd priority a value of 9, 3rd 8, and so forth; and 10th priority was given a value of 1. Depending on how many panelists selected a particular item and their priority rating of the item, the sum of the weighted scores for an item could be calculated. As a result, the larger the sum of the weighted scores, the higher priority was an item. A rank-ordered list could then be obtained. However, I found a problem with this rank-ordering method in this Delphi study during the data analysis process. This problem is explained in the following. In Appendix M, the weighed scores of the beginning items of the second round were displayed. Because of not asking the experts to rank-order the whole list of items, there was missing information in most of the data cells. This situation was similar to asking the
experts to rank-order the whole list, and then truncating the information after their top 10 choices. It was not known how the rank-ordering of the rest of the items, hence the weighed scores of the empty cells, might change the total weighed scores and the final rank-ordering of the items. Therefore, it was not an accurate way of generating the rank-order of the list of items by just using the top 10 choices. Because of this potential inaccuracy in rank-ordering, this method was not finally employed. As explained earlier, the use of the mean and standard deviation were already established as practically good indexes differentiating among the items. Additional ranking information was unnecessary, at least in this Delphi study.

Conclusion

In summary, the main objective of this study was to seek consensus among experts in the field of professional psychology for the most important preventive measures in graduate training against future impairment. In addition, an adjunctive objective of this study was to understand how the most important preventive measures can be successfully implemented. To achieve the two objectives, the Delphi method was used because (a) it is a tool using experts to solve complex practical issues when existing knowledge is unavailable, (b) it is a tool for gathering opinions and consensus from experts regarding an area of interest, and (c) it allows both a structured and an efficient way of group communication with geographically dispersed members. Participants of this study were experts in the field of professional psychology regarding the phenomenon of impairment and its prevention. The criteria of expertise were explicitly spelled out which were based on their scholarly contribution, their provisions of workshops and seminars in professional conferences, their advocacy work in the field against impairment, or their
clinical expertise to work with psychologists' impairment issues. They were respectively located by using the contact information/their institutional affiliations of their publications, by using the APA annual conference handbooks, through APA/state psychological association, and by their colleagues' recommendations. Two rounds of surveys were used in this study to achieve the two phases of the Delphi process. By using DQI, the first round of survey allowed the experts to explore the subject, and enabled preliminary group opinions to be formed after the first round of data analysis. By using DQII, the second round of survey allowed the experts to see the differences of opinion among the panelists to reevaluate their viewpoints, and enabled final group opinions to be concluded after the second round of data analysis. A list of rank-ordered of preventive measures was obtained in a way that the ones higher on the list with higher means represented measures that were considered to be more important; whereas the ones lower on the list with lower means represented measures that were considered to be less important. Furthermore, considerations for the successful implementation of the most important measures were generated from the experts. Training programs in professional psychology can then make use of the results of this study by incorporating those important measures in their training and using the ideas for successful implementation for early primary prevention work against impairment in the profession.
CHAPTER IV

RESULTS

Overview

This chapter presents the results of the two rounds of the Delphi study, which (a) sought to identify the important measures that may be implemented in professional psychology graduate training to prevent future impairment of professionals, and (b) explored how the most important preventive measures can be successfully implemented. The chapter consists of three sections. The first section summarizes the findings of the first round of the Delphi study, which includes recruitment information, the demographic information of the expert participants, the preventive measures in graduate training against future impairment of professionals, and the considerations for successful implementation of the most important measures. The second section summarizes the findings of the second round of the Delphi study, which comprises the participants’ response information, the re-evaluation of the importance of the preventive measures, the “consensual most important measures,” and the considerations for successful implementation of the preventive measures. The last section is a conclusion of the findings of the whole Delphi study.
Findings of First Round Delphi Study

Recruitment Information

As described in more detail in the Methods chapter, potential participants were psychologists in the United States who possessed any one of the following four kinds of expertise: (a) contributing scholarly to understanding of the phenomenon of impairment and its prevention through publication, (b) providing field educational work on the prevention of impairment through workshops/seminars at professional conferences, (c) serving to work against impairment in the field as member of the American Psychological Association (APA) Advisory Committee on Colleague Assistance (ACCA), or a psychological association colleague assistance committee (CAC) at the state level, or (d) having direct clinical experience helping psychologists who have potential or actual issue of impairment. In the first round Delphi study, three phases of recruitment were carried out to obtain more than 20 participants who had at least one kind of the above expertise. During the first phase, potential panelists who had expertise in scholarly contribution, who had expertise in field educational work, and who had served in ACCA were invited. Forty-eight of these potential participants were identified and invited. Nineteen returned the completed questionnaires. During the second phase, recommended clinical experts from the first phase were invited. Five additional potential participants were identified and invited. Four of them returned the completed questionnaires. During the third phase, potential panelists who had been chairpersons of a CAC were invited. Seventeen additional potential participants were identified and invited. Five of these experts returned the completed questionnaires. Hence, a total of 70 invitations were sent out, and 28 experts participated in the Delphi study, creating a response rate of 40%.
Demographic Information

This sub-section presents the demographic information as obtained from Part I of the first Delphi questionnaire (Appendix C); which included gender, ethnicity, highest degree, specialty in psychology, years of post-doctorate experience, work experience, years of interest in the area of impairment and its prevention, and professional activities in the area of impairment and its prevention. In responding to the question of gender (What is your gender?), out of the 28 participants, 13 (46%) self-identified as females and 15 (54%) as males. In terms of ethnicity (What is your ethnicity?), 25 (89%) self-identified as Caucasian, 1 Chicano(a) (4%), and 2 (7%) others (1 European American, and 1 Caucasian/ Native American). Concerning the question of highest degree (What is your highest degree?), all participants indicated having a doctorate degree in psychology. Regarding specialty in psychology (What is your specialty in psychology?), 22 (78%) specialized in clinical psychology, 5 (18%) counseling psychology, and 1 clinical/counseling psychology. With regard to the number of year of post-doctorate professional experience (How many years of post-doctorate professional experience do you have?), the range varied from 9 to 56 with a mean of 25.30.

In terms of work experience, the 28 experts had the following demographic information concerning current primary professional position, secondary professional position, and training experience in a graduate program. In response to the question of current primary profession position (What is your current primary professional position?), 18 (64%) experts identified themselves as clinicians, 4 (14%) as administrators, 3 (11%) as retired, 2 (7%) as full-time faculty, and 1 (4%) as both clinician and faculty. Concerning current secondary job position (What is your current secondary professional position?)...
position?), 14 (50%) did not indicate having any secondary position; whereas, 4 (14%) indicated part-time faculty, 4 (14%) as administrators, 3 (11%) as clinicians, and 3 (11%) as consultants. Regarding current involvement with training in a graduate program (Are you directly involving in training committee of graduate program?), 24 (86%) indicated not being involved while 4 (14%) responded being involved.

In terms of the number of years of interest in the area of impairment and its prevention (How many years have you had interest in the area of impairment/its prevention in the profession?), the 28 experts indicated a range from 2 to 25 years with a mean of 16.40. With regard to participants’ professional activities in the area of impairment and its prevention (What kind(s) of professional activities have you engaged in concerning the phenomenon of impairment and its prevention in the profession from 1995 to 2005?), Table 1 provides the details of such professional activities. The following highlights the professional activities in publication, presentation, service in work committee, and clinical work. Concerning publications on impairment and its prevention, 18 (64%) indicated having published in the area. All 18 participants indicated having first authorship, and 10 also indicated having second authorship. Regarding conference presentations, 21 (75%) indicated having presented nationally or regionally. Seventeen of them had presented nationally, and 14 participants had presented regionally. Concerning service in committee against impairment, 20 (71%) indicated having had such experience. Seven of them had worked in ACCA, 17 in a CAC, and 4 in both. Lastly, regarding clinical work, 21 (75%) had such experience helping psychologists. Among these four kinds of professional activities (publication, presentation, service in work
Table 1
Experts' Professional Activities Related to Impairment Prevention

<table>
<thead>
<tr>
<th>Types of Professional Activity</th>
<th>No</th>
<th>Yes</th>
<th>Other Information</th>
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</table>
| 1. Publication on impairment/its prevention | 10 (36%) | 18 (64%) | First authorship: 18 experts  
Second authorship: 10 experts  
Cumulative publications info (first & second authorship): Range: 1-13 publications  
Mean: 4.67, $SD = 3.04$  
(3 not indicated # of publication) |
| 2. Presentation on impairment/its prevention | 7 (25%) | 21 (75%) | Presented Nationally: 17 experts  
Range: 1-50 presentations  
Mean: 7.29, $SD = 12.67$  
(3 not indicated # of presentation)  
Presented Regionally: 14 experts  
Range: 1-50 presentations  
Mean: 7.89, $SD = 15.85$  
(5 not indicated # of presentation) |
| 3. Service in Committee Against Impairment | 8 (29%) | 20 (71%) | Range: 1-18 years  
Mean: 7.05, $SD = 5.29$  
Service in ACCA: 7 experts  
Service in CAC: 17 experts  
Service in Both: 4 experts |
| 4. Clinical work against impairment of psychologists | 7 (25%) | 21 (75%) | Range: 2-75 psychologists  
Mean: 14.60, $SD = 18.27$  
(6 not indicated # of psychologists having been helped) |
| 5. Research on impairment/its prevention | 16 (57%) | 12 (43%) | Range: 1-3 projects  
Mean: 1.80, $SD = 0.79$  
(2 not indicated # of research projects) |
| 6. Teaching on impairment/its prevention | 18 (64%) | 10 (36%) | Range: 1-100 courses  
Mean: 16.20, $SD = 29.95$ |

4 (14%) had 1 kind of such professional activity, 5 (18%) had 2 kinds, 10 (36%) had 3 kinds, and 9 (32%) had all 4 kinds.
Preventive Measures in Graduate Training Against Future Impairment

This sub-section presents the findings of Part II of the first Delphi questionnaire (Appendix C). It contains two sub-sub-sections: the relative importance of the preventive measures, and the additional suggested preventive measures. The first sub-sub-section following summarizes the central tendency and variability of the experts’ ratings of the original list of 38 preventive measures. The second sub-sub-section following summarizes the participants’ suggested additional important preventive measures.

Relative Importance of Preventive Measures

Participants rated the importance of an original list of 38 preventive measures on a scale from 0 (unimportant) to 4 (essential). The mean rating (M) and the standard deviation (SD) of all the items were summarized in Table 2. The mean ratings of the items varied from 3.70 to 0.82. This signified that the importance of the items on the list, from the viewpoints of the experts, varied from almost essential to lower than less important. The first 18 items (47%) had means above 3.00 (very important). The next 14 items (37%) had means less then 3.00 but above 2.00 (important). After that, 5 items (13%) had means less than 2.00 but above 1.00 (less important). The last 1 item (3%) had a mean less than 1.00.

The standard deviations of the items varied from 0.54 to 1.31, which implied that the participants held varying degree of consensus on the items. In general, participants had higher consensus, less than 1.00 SD, to the items at the top of the list. The first 13 items had SD less than 1.00. However, the participants had lower consensus, more than 1.00 SD, on the items at the bottom of the list. Eleven of the last 14 items of the list had SD more than 1.00.
Table 2
First Round Ratings of Preventive Measures in Descending Importance

<table>
<thead>
<tr>
<th>Item</th>
<th>Preventive Measure in Graduate Training Against Future Impairment</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reinforce acceptability of asking for help</td>
<td>3.70 0.54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Include the issue of impairment in ethics training</td>
<td>3.59 0.57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Identify and handle trainees early who have problems</td>
<td>3.54 0.58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Include impairment and its prevention in course content</td>
<td>3.50 0.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Encourage self-awareness of students</td>
<td>3.46 0.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Promote openness to feedback</td>
<td>3.43 0.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Help students to be aware of the risks of impairment in the profession</td>
<td>3.43 0.74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Promote personal and professional growth</td>
<td>3.37 0.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Help students understand the impact of personal life events to their professional functioning</td>
<td>3.32 0.72</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Promote students’ balanced lifestyle and self-care</td>
<td>3.29 0.98</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Help students to learn about resources for assistance in the profession regarding impairment</td>
<td>3.25 0.75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Help students to be aware of their own ability to create supportive organizational environment and to provide assistance to distressed colleagues</td>
<td>3.21 0.69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Prepare students for the rewards and hazards of the profession</td>
<td>3.18 0.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Emphasize ongoing direct supervision and feedback</td>
<td>3.14 1.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Facilitate students to develop self-care skills/ habits</td>
<td>3.11 1.07</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Develop peer relationships in profession</td>
<td>3.07 0.66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Provide information to students about professional life after graduation</td>
<td>3.07 0.77</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Use faculty to model well-functioning</td>
<td>3.04 1.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Develop a sense of community among students</td>
<td>2.96 0.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Promote personal identity</td>
<td>2.86 0.89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Provide informal discussion of impairment in training program</td>
<td>2.82 0.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Provide workshops to students on impairment</td>
<td>2.75 0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Create ongoing support group for students</td>
<td>2.75 0.84</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Provide well-planned modules on personal and professional self-care</td>
<td>2.75 0.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Select trainees more carefully</td>
<td>2.64 1.13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Teach students debriefing for traumatic case</td>
<td>2.64 1.31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Give more attention to students by faculty</td>
<td>2.57 0.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Provide stress management workshops to students</td>
<td>2.43 1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Restructure training program to focus on the well-being of students</td>
<td>2.18 1.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Provide relationship enhancement skill training</td>
<td>2.15 1.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Require students to take a course on impairment and its prevention</td>
<td>2.14 1.24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. Require students to receive therapy</td>
<td>2.11 1.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. Promote peer supervision among students</td>
<td>1.96 0.88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34. Help students to integrate research, course and practice</td>
<td>1.96 1.19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Provide retreats for students</td>
<td>1.48 1.01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Increase financial aid and assistance to students</td>
<td>1.46 1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Depoliticize admission process</td>
<td>1.44 1.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Reduce demands in the curriculum</td>
<td>0.82 0.67</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To conclude, there were variations concerning the ratings of the importance of the preventive measures. A large majority of the list (32 items, 84%) was considered at least *important*. Among them, 18 items were considered at least *very important*. Also, the experts in general had a higher degree of consensus to the items rated at least *very important*.

**Additional Suggested Preventive Measures**

Participants were asked to list other important preventive measures in graduate training against future impairment, in addition to the original 38 items. They gave 49 entries of additional suggested preventive measures. Using the original wordings as much as possible, I condensed and edited these additional entries to eliminate duplications, and to separate multiple ideas of an entry into single separate ideas (as described in detail in the Methods chapter). After editing, there remained 45 final additional items of preventive measures, as shown in Table 3. In order to ascertain that the edited final items satisfied an a priori reliability criterion of .80 (Krippendorff, 2004), an independent rater (who was a psychologist) was used to match the original list of 49 entries with the final list of 45 items. Inter-rater reliability (number agreements between the researcher and the independent rater divided by the number of agreement plus the number of disagreement), was .89. Because of meeting the reliability criterion of .80, the final list of 45 items was adopted.

**Considerations for Successful Implementation of the Most Important Measures**

This sub-section presents the findings of Part III of the first Delphi questionnaire (Appendix C). The participants were asked to choose their top five priorities of preventive measures, and to make comments under each of their selected items regarding
Table 3
Additional Suggested Preventive Measures

<table>
<thead>
<tr>
<th>Item</th>
<th>Additional Suggested Preventive Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.</td>
<td>Select trainees committed to continuing growth</td>
</tr>
<tr>
<td>40.</td>
<td>De-emphasize GREs and GPAs in selecting students</td>
</tr>
<tr>
<td>41.</td>
<td>Provide info about stages in professional growth along with life development stages</td>
</tr>
<tr>
<td>42.</td>
<td>Promote the exploration of students' personal values in relation to their professional work throughout training</td>
</tr>
<tr>
<td>43.</td>
<td>Foster safety in professional forums for discussion of challenges, limitations and failures at work</td>
</tr>
<tr>
<td>44.</td>
<td>Educate students regarding specific occupational hazards, etiology and vulnerability</td>
</tr>
<tr>
<td>45.</td>
<td>Encourage students to continue to work on their personal issues in therapy and involve in self-growth activities after graduation</td>
</tr>
<tr>
<td>46.</td>
<td>Encourage students to continue to receive supervision from an experienced professional after graduation</td>
</tr>
<tr>
<td>47.</td>
<td>Develop ongoing relationship with professionals in the field to provide modeling</td>
</tr>
<tr>
<td>48.</td>
<td>Provide training on the diagnosis and treatment of chemical dependency in professionals</td>
</tr>
<tr>
<td>49.</td>
<td>Help students assess their own personal risk for impairment</td>
</tr>
<tr>
<td>50.</td>
<td>Help students understand that asking for help is rare among professionals and that the most likely help obtained is through the intervention of colleagues</td>
</tr>
<tr>
<td>51.</td>
<td>Address understanding of impairment by faculty, administrators, supervisors, and university attorneys</td>
</tr>
<tr>
<td>52.</td>
<td>Develop clear model for early intervention and remediation that involve proper assessment, remediation contracts and attainment of desired outcome</td>
</tr>
<tr>
<td>53.</td>
<td>Focus on competency of professional behaviors that can be assessed and are relevant to professional functioning</td>
</tr>
<tr>
<td>54.</td>
<td>Refine definition of impairment by including not attaining or displaying professional competence</td>
</tr>
<tr>
<td>55.</td>
<td>Clarify program policies about the role of personal therapy in remediation plans</td>
</tr>
<tr>
<td>56.</td>
<td>Establish clearer professional standards for minimal levels of competence to advance in program and graduate from program</td>
</tr>
<tr>
<td>57.</td>
<td>Make psychological healthiness, in direct connection to professional functioning, as a critical component of annual evaluation process</td>
</tr>
<tr>
<td>58.</td>
<td>Clarify at time of admission program policies concerning remediation</td>
</tr>
<tr>
<td>59.</td>
<td>Provide students a safe environment to discuss issues that they are concerned about</td>
</tr>
<tr>
<td>60.</td>
<td>Help students learn to engage in critical thinking about themselves and others</td>
</tr>
<tr>
<td>61.</td>
<td>Give students skills and support to intervene with distressed peers</td>
</tr>
<tr>
<td>62.</td>
<td>Develop student assistance committee for the program emphasizing prevention and rehabilitation</td>
</tr>
<tr>
<td>63.</td>
<td>Encourage dissertation research in the area of distress-impairment continuum</td>
</tr>
<tr>
<td>64.</td>
<td>Train faculty in area of stress-distress-impairment research and intervention with students</td>
</tr>
<tr>
<td>65.</td>
<td>Link appropriate student assistance program with the Dean of student office and academic standing committee</td>
</tr>
<tr>
<td>66.</td>
<td>Screen students for substance abuse (potential) and provide resources for those who may require assistance in the future</td>
</tr>
<tr>
<td>67.</td>
<td>Consider use of psychological tests for admission to address suitability for field</td>
</tr>
<tr>
<td>68.</td>
<td>Require honesty in letters of recommendation to identify concerns when they exist</td>
</tr>
<tr>
<td>69.</td>
<td>Develop better measures of student functioning and train faculty to use them candidly</td>
</tr>
<tr>
<td>70.</td>
<td>Teach faculty how to identify and confront impairment</td>
</tr>
<tr>
<td>71.</td>
<td>Update ethics code to require honesty and candor in evaluation of trainees</td>
</tr>
<tr>
<td>72.</td>
<td>Provide students information of the incidence of impairment in all health professions</td>
</tr>
<tr>
<td>73.</td>
<td>Have recovering role models participate in seminars and share their stories of recovery</td>
</tr>
</tbody>
</table>
Table 3 –Continued

<table>
<thead>
<tr>
<th>Item</th>
<th>Additional Suggested Preventive Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>74.</td>
<td>Help students know that psychologists are as vulnerable to mental illness and substance abuse as anyone else</td>
</tr>
<tr>
<td>75.</td>
<td>Notice early signs of chemical dependency or impulse control disorders of students</td>
</tr>
<tr>
<td>76.</td>
<td>Encourage early treatment of chemical dependency or impulse control disorders of students</td>
</tr>
<tr>
<td>77.</td>
<td>Debunk shame of mental disorders in graduate students or psychologists</td>
</tr>
<tr>
<td>78.</td>
<td>Encourage early treatment of mood disorders of students</td>
</tr>
<tr>
<td>79.</td>
<td>Encourage students to join psychological associations or peer support groups after graduation to reduce isolation</td>
</tr>
<tr>
<td>80.</td>
<td>Encourage mentor relationships outside of graduate program</td>
</tr>
<tr>
<td>81.</td>
<td>Help students to be familiar with literature on universal risks as much or more than impairment</td>
</tr>
<tr>
<td>82.</td>
<td>Use of countertransference as part of prevention training on relationship models of boundary maintenance</td>
</tr>
<tr>
<td>83.</td>
<td>Emphasize prevention of occupational hazards and self care specific to risks of work such as vicarious traumatization</td>
</tr>
</tbody>
</table>

considerations for successful implementation. The participants listed a total of 195 comments among a total of 39 items chosen as top five priorities. Among these 39 items, 29 items were from the original list, and 10 items from the additional list. Using the original wordings as much as possible, I edited these 195 comments to eliminate duplications, and to separate multiple ideas of an entry into single separate ideas (as described fuller in the Methods chapter). The original 195 comments were edited into a total of 205 considerations for successful implementation among the 39 items. In order to ascertain that the edited final considerations satisfied an a priori reliability criterion of .80 (Krippendorff, 2004), an independent rater (who was a psychologist) was used to match the original list of 195 comments with the final list of 205 considerations among the 39 items. An inter-rater reliability of .97 was obtained. Because of meeting the reliability criterion of .80, the final list of 205 considerations among the 39 items was adopted and
presented to the participants in the second round Delphi study. All these considerations with the corresponding preventive measures are listed in Part I (B) of Delphi Questionnaire II (Appendix H).

**Findings of Second Round Delphi Study**

**Participants’ Response Information**

In the second round study, a research package was sent to each of the 28 experts who had participated in the first round of the survey. Twenty-one participants returned the research package. However, one return was considered invalid because of not completing most of the questionnaire. Hence, a total of 20 were counted as valid returns, resulting in a response rate of 71%.

**Re-evaluation of Importance of Preventive Measures**

This sub-section presents the findings of Part II (A) of the second Delphi questionnaire (Appendix H). The participants were asked, after reviewing the first round results, to re-evaluate the importance of the list of preventive measures, which included 38 original items and 45 additional items. The same rating scale as in the first questionnaire, from 0 (unimportant) to 4 (essential), was used. The mean rating ($M$) and the standard deviation ($SD$) of all the items were summarized in Table 4. The mean ratings of the items varied from 3.83 to 0.89. This signified that the importance of the items on the list, from the viewpoints of the experts, varied from almost essential at the top of the list to lower than less important at the bottom of the list. The first 26 items (31%) had means above 3.00 (very important). The next 41 items (49%) had means less than 3.00 but above or equal to 2.00 (important). After that, 14 items (17%) had means
Table 4
Second Round Ratings of Preventive Measures in Descending Importance

<table>
<thead>
<tr>
<th>Item</th>
<th>Preventive Measure in Graduate Training Against Future Impairment</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Identify and handle trainees early who have problems</td>
<td>3.83</td>
<td>0.38</td>
</tr>
<tr>
<td>2.</td>
<td>Reinforce acceptability of asking for help</td>
<td>3.78</td>
<td>0.55</td>
</tr>
<tr>
<td>3.</td>
<td>Include the issue of impairment in ethics training</td>
<td>3.67</td>
<td>0.59</td>
</tr>
<tr>
<td>4.</td>
<td>Promote openness to feedback</td>
<td>3.67</td>
<td>0.59</td>
</tr>
<tr>
<td>5.</td>
<td>Help students to be aware of the risks of impairment in the profession</td>
<td>3.61</td>
<td>0.70</td>
</tr>
<tr>
<td>6.</td>
<td>Encourage self-awareness of students</td>
<td>3.56</td>
<td>0.51</td>
</tr>
<tr>
<td>7.</td>
<td>Promote personal and professional growth</td>
<td>3.44</td>
<td>0.62</td>
</tr>
<tr>
<td>8.</td>
<td>Help students understand the impact of personal life events to their profession</td>
<td>3.39</td>
<td>0.78</td>
</tr>
<tr>
<td>9.</td>
<td>Promote students' balanced lifestyle and self-care</td>
<td>3.39</td>
<td>0.78</td>
</tr>
<tr>
<td>10.</td>
<td>Help students to learn about resources for assistance in the profession regarding impairment</td>
<td>3.33</td>
<td>0.77</td>
</tr>
<tr>
<td>11.</td>
<td>Include impairment and its prevention in course content</td>
<td>3.17</td>
<td>0.71</td>
</tr>
<tr>
<td>12.</td>
<td>Prepare students for rewards and hazards of the profession</td>
<td>3.17</td>
<td>0.79</td>
</tr>
<tr>
<td>13.</td>
<td>Facilitate students to develop self-care skills/ habits</td>
<td>3.17</td>
<td>0.79</td>
</tr>
<tr>
<td>14.</td>
<td>Emphasize ongoing direct supervision and feedback</td>
<td>3.11</td>
<td>0.76</td>
</tr>
<tr>
<td>15.</td>
<td>Teach faculty how to identify and confront impairment</td>
<td>3.11</td>
<td>0.76</td>
</tr>
<tr>
<td>16.</td>
<td>Help students know that psychologists are as vulnerable to mental illness and substance abuse as anyone else</td>
<td>3.11</td>
<td>0.76</td>
</tr>
<tr>
<td>17.</td>
<td>Develop peer relationships in profession</td>
<td>3.11</td>
<td>0.83</td>
</tr>
<tr>
<td>18.</td>
<td>Encourage early treatment of chemical dependency or impulse control disorders of students</td>
<td>3.11</td>
<td>0.83</td>
</tr>
<tr>
<td>19.</td>
<td>Encourage students to join psychological associations or peer support groups after graduation to reduce isolation</td>
<td>3.00</td>
<td>0.77</td>
</tr>
<tr>
<td>20.</td>
<td>Encourage students to continue to receive supervision from an experienced professional after graduation</td>
<td>3.00</td>
<td>0.84</td>
</tr>
<tr>
<td>21.</td>
<td>Develop clear model for early intervention and remediation that involve proper assessment, remediation contracts and attainment of desired outcome</td>
<td>3.00</td>
<td>0.91</td>
</tr>
<tr>
<td>22.</td>
<td>Help students learn to engage in critical thinking about themselves and others</td>
<td>3.00</td>
<td>0.97</td>
</tr>
<tr>
<td>23.</td>
<td>Debunk shame of mental disorders in graduate students or psychologists</td>
<td>3.00</td>
<td>1.08</td>
</tr>
<tr>
<td>24.</td>
<td>Use faculty to model well-functioning</td>
<td>3.00</td>
<td>1.08</td>
</tr>
<tr>
<td>25.</td>
<td>Facilitate discussion of impairment in training program</td>
<td>2.94</td>
<td>0.64</td>
</tr>
<tr>
<td>26.</td>
<td>Provide information to students about professional life after graduation</td>
<td>2.89</td>
<td>0.83</td>
</tr>
<tr>
<td>27.</td>
<td>Help students assess their own personal risk for impairment</td>
<td>2.89</td>
<td>0.96</td>
</tr>
<tr>
<td>28.</td>
<td>Develop a sense of community among students</td>
<td>2.83</td>
<td>0.71</td>
</tr>
<tr>
<td>29.</td>
<td>Provide workshops to students on impairment</td>
<td>2.83</td>
<td>0.71</td>
</tr>
<tr>
<td>30.</td>
<td>Provide well-planned modules on personal and professional self-care</td>
<td>2.83</td>
<td>0.86</td>
</tr>
<tr>
<td>31.</td>
<td>Educate students regarding specific occupational hazards, etiology and vulnerability</td>
<td>2.83</td>
<td>0.99</td>
</tr>
<tr>
<td>32.</td>
<td>Help students to be aware of their own ability to create supportive organizational environment and to provide assistance to distressed colleagues</td>
<td>2.78</td>
<td>0.81</td>
</tr>
<tr>
<td>33.</td>
<td>Create ongoing support group for students</td>
<td>2.78</td>
<td>0.88</td>
</tr>
<tr>
<td>34.</td>
<td>Encourage students to continue to work on their personal issues in therapy and involve in self-growth activities after graduation</td>
<td>2.78</td>
<td>0.88</td>
</tr>
<tr>
<td>35.</td>
<td>Encourage mentor relationships outside of graduate program</td>
<td>2.72</td>
<td>1.13</td>
</tr>
<tr>
<td>36.</td>
<td>Develop ongoing relationship with professionals in the field to provide modeling</td>
<td>2.67</td>
<td>0.77</td>
</tr>
</tbody>
</table>
Table 4 –Continued

<table>
<thead>
<tr>
<th>Item</th>
<th>Preventive Measure in Graduate Training Against Future Impairment</th>
<th>Score</th>
<th>Standard Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>39.</td>
<td>Foster safety in professional forums for discussion of challenges, limitations and failures at work</td>
<td>2.67</td>
<td>1.03</td>
</tr>
<tr>
<td>40.</td>
<td>Select trainees more carefully</td>
<td>2.61</td>
<td>1.04</td>
</tr>
<tr>
<td>41.</td>
<td>Make psychological healthiness, in direct connection to professional functioning, as a critical component of annual evaluation process</td>
<td>2.56</td>
<td>1.15</td>
</tr>
<tr>
<td>42.</td>
<td>Clarify at time of admission program policies concerning remediation</td>
<td>2.56</td>
<td>1.20</td>
</tr>
<tr>
<td>43.</td>
<td>Promote personal identity</td>
<td>2.50</td>
<td>0.79</td>
</tr>
<tr>
<td>44.</td>
<td>Notice early signs of chemical dependency or impulse control disorders of students</td>
<td>2.50</td>
<td>0.92</td>
</tr>
<tr>
<td>45.</td>
<td>Give students skills and support to intervene with distressed peers</td>
<td>2.50</td>
<td>0.99</td>
</tr>
<tr>
<td>46.</td>
<td>Address understanding of impairment by faculty, administrators, supervisors, and university attorneys</td>
<td>2.44</td>
<td>1.10</td>
</tr>
<tr>
<td>47.</td>
<td>Provide training on the diagnosis and treatment of chemical dependency in professionals</td>
<td>2.39</td>
<td>1.04</td>
</tr>
<tr>
<td>48.</td>
<td>Develop better measures of student functioning and train faculty to use them candidly</td>
<td>2.39</td>
<td>1.20</td>
</tr>
<tr>
<td>49.</td>
<td>Provide stress management workshops to students</td>
<td>2.33</td>
<td>1.14</td>
</tr>
<tr>
<td>50.</td>
<td>Have recovering role models participate in seminars and share their stories of recovery</td>
<td>2.33</td>
<td>1.14</td>
</tr>
<tr>
<td>51.</td>
<td>Establish clearer professional standards for minimal levels of competence to advance in program and graduate from program</td>
<td>2.33</td>
<td>1.28</td>
</tr>
<tr>
<td>52.</td>
<td>Emphasize prevention of occupational hazards and self care specific to risks of work such as vicarious traumatization</td>
<td>2.29</td>
<td>1.05</td>
</tr>
<tr>
<td>53.</td>
<td>Require students to take a course on impairment and its prevention</td>
<td>2.28</td>
<td>0.83</td>
</tr>
<tr>
<td>54.</td>
<td>Develop student assistance committee for the program emphasizing prevention and rehabilitation</td>
<td>2.28</td>
<td>1.07</td>
</tr>
<tr>
<td>55.</td>
<td>Teach students debriefing for traumatic case</td>
<td>2.28</td>
<td>1.13</td>
</tr>
<tr>
<td>56.</td>
<td>Update ethics code to require honesty and candor in evaluation of trainees</td>
<td>2.28</td>
<td>1.23</td>
</tr>
<tr>
<td>57.</td>
<td>Promote the exploration of students’ personal values in relation to their professional work throughout training</td>
<td>2.22</td>
<td>0.94</td>
</tr>
<tr>
<td>58.</td>
<td>Provide students information of the incidence of impairment in all health professions</td>
<td>2.22</td>
<td>1.31</td>
</tr>
<tr>
<td>59.</td>
<td>Give more attention to students by faculty</td>
<td>2.17</td>
<td>0.99</td>
</tr>
<tr>
<td>60.</td>
<td>Provide info about stages in professional growth along with life development stages</td>
<td>2.17</td>
<td>0.99</td>
</tr>
<tr>
<td>61.</td>
<td>Train faculty in area of stress-distress-impairment research and intervention with students</td>
<td>2.17</td>
<td>1.34</td>
</tr>
<tr>
<td>62.</td>
<td>Clarify program policies about the role of personal therapy in remediation plans</td>
<td>2.11</td>
<td>1.13</td>
</tr>
<tr>
<td>63.</td>
<td>Promote peer supervision among students</td>
<td>2.11</td>
<td>1.18</td>
</tr>
<tr>
<td>64.</td>
<td>Help students understand that asking for help is rare among professionals and that the most likely help obtained is through the intervention of colleagues</td>
<td>2.11</td>
<td>1.23</td>
</tr>
<tr>
<td>65.</td>
<td>Focus on competency of professional behaviors that can be assessed and are relevant to professional functioning</td>
<td>2.11</td>
<td>1.23</td>
</tr>
<tr>
<td>66.</td>
<td>Screen students for substance abuse (potential) and provide resources for those who may require assistance in the future</td>
<td>2.06</td>
<td>1.30</td>
</tr>
<tr>
<td>67.</td>
<td>Restructure training program to focus on the well-being of students</td>
<td>2.00</td>
<td>0.91</td>
</tr>
<tr>
<td>68.</td>
<td>Select trainees committed to continuing growth</td>
<td>1.94</td>
<td>1.16</td>
</tr>
<tr>
<td>69.</td>
<td>Require honesty in letters of recommendation to identify concerns when they exist</td>
<td>1.83</td>
<td>1.54</td>
</tr>
<tr>
<td>70.</td>
<td>Use of countertransference as part of prevention training on relationship models of boundary maintenance</td>
<td>1.81</td>
<td>1.17</td>
</tr>
<tr>
<td>71.</td>
<td>Help students to integrate research, course and practice</td>
<td>1.78</td>
<td>1.00</td>
</tr>
</tbody>
</table>
Table 4 –Continued

<table>
<thead>
<tr>
<th>Item</th>
<th>Preventive Measure in Graduate Training Against Future Impairment</th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>72.</td>
<td>Provide relationship enhancement skill training</td>
<td>1.72</td>
<td>0.89</td>
</tr>
<tr>
<td>73.</td>
<td>Help students to be familiar with literature on universal risks as much or more than impairment</td>
<td>1.65</td>
<td>0.79</td>
</tr>
<tr>
<td>74.</td>
<td>Increase financial aid and assistance to students</td>
<td>1.61</td>
<td>0.92</td>
</tr>
<tr>
<td>75.</td>
<td>Refine definition of impairment by including not attaining or displaying professional competence</td>
<td>1.61</td>
<td>1.38</td>
</tr>
<tr>
<td>76.</td>
<td>Screen students for substance abuse (potential) and provide resources for those who may require assistance in the future</td>
<td>1.44</td>
<td>1.29</td>
</tr>
<tr>
<td>77.</td>
<td>Encourage dissertation research in the area of distress-impairment continuum</td>
<td>1.39</td>
<td>1.20</td>
</tr>
<tr>
<td>78.</td>
<td>Link appropriate student assistance program with the Dean of student office and academic standing committee</td>
<td>1.39</td>
<td>1.20</td>
</tr>
<tr>
<td>79.</td>
<td>Provide retreats for students</td>
<td>1.28</td>
<td>0.89</td>
</tr>
<tr>
<td>80.</td>
<td>De-emphasize GREs and GPAs in selecting students</td>
<td>1.22</td>
<td>0.73</td>
</tr>
<tr>
<td>81.</td>
<td>Reduce demands in the curriculum</td>
<td>1.11</td>
<td>1.13</td>
</tr>
<tr>
<td>82.</td>
<td>Consider use of psychological tests for admission to address suitability for field</td>
<td>0.94</td>
<td>1.06</td>
</tr>
<tr>
<td>83.</td>
<td>Depoliticize admission process</td>
<td>0.89</td>
<td>0.90</td>
</tr>
</tbody>
</table>

less than 2.00 but above 1.00 (less important). The last 2 items had means less than 1.00 (3%).

The standard deviations of the items varied from 0.38 to 1.38, which implied that participants held a slightly greater varying degree of consensus on the items than in the first round. Yet, similar to the first round results, items at the top of the list in general have greater consensus from the experts than those lower on the list. All of the first 24 items had standard deviations less than 1.00. Hence, the experts had better agreement on the most important preventive measures.

To conclude, there were variations regarding the ratings of the importance of the preventive measures. A large majority of the items (67 items, 80%) was considered at least important. Among them, 26 items were considered at least very important. Also, the experts in general had higher consensus on the items rated at least very important.
"Consensual Most Important Measures"

To select the final most important measures with consensus, the criterion of Fleming and Monda-Amaya (2001) was used: a mean score of at least 3.00 with standard deviation no more than 1.0. As a result, the first 24 items were the "consensual most important preventive measures" from the viewpoint of the experts. These measures included 15 items out of the 16 top items in the first round and 9 items from the additional list.

In order to conceptualize the 24 items to help understand impairment prevention in graduate training in a more parsimonious way, additional content analysis procedures were used to classify the items by themes in three steps: (a) creating tentative themes to classify the items, (b) refining the themes, and finally (c) establishing theme integrity (Johnson & LaMontagne, 1993). First, after becoming familiar with the items, I tentatively created different themes to classify the items. Three criteria were used for the creation of the themes: (a) the themes were related to graduate training, (b) the themes were different areas of graduate training but not necessarily independent of each other, and (c) the number of themes was limited to less than half of the number of items to maximize parsimony. Second, I allocated each item to the tentative set of themes. I then refined the themes by modifying the old ones, and by creating new themes to assign the items that did not suit previous themes, until all the items could be classified and each item was classified in only one theme. Third, and finally, to establish theme integrity, I used an independent rater to match the items with the themes, again using an a priori reliability criterion of .80. If the inter-rater reliability between the independent rater and I were less than .80, the categories were refined until the criterion of .80 was met.
After employing the above procedures, seven themes for the 24 items were finally developed, with a resulting inter-rater reliability of .88. These themes together with their corresponding preventive measures are summarized in Table 5: (a) handling trainees with problems, (b) cultivating personal qualities of trainee, (c) providing impairment prevention education, (d) cultivating program culture, (e) utilizing supervision and feedback, (f) training faculty, and (g) facilitating trainees' development of support network.

Considerations for Successful Implementation of Preventive Measures

This sub-section contains three sub-sub-sections: additional considerations from the second round, compiled considerations from the two rounds, and considerations for successful implementation of the consensual most important measures.

Additional Considerations from the Second Round

This sub-sub-section presents the findings of Part I (c) of the second Delphi questionnaire (Appendix H). Participants were asked to select up to three important preventive measures in Part I (B) which they could list further supplementary considerations for successful implementation of the preventive measures. Participants listed a total of 90 additional comments, among a total of 20 preventive measures which had been chosen as the most important ones and had been commented in the first round. Using the original wordings as much as possible, I edited these 90 comments to eliminate duplications, and to separate multiple ideas into single separate ideas (as described fuller in the Methods chapter). Hence, these original 90 comments were finally edited into a total of 101 considerations for successful implementation (including five duplications from the first round) among the 20 items. Because an inter-rater reliability of .97 was
Table 5

Classification of Consensual Most Important Measures

<table>
<thead>
<tr>
<th>Theme</th>
<th>Consensual Most Important Preventive Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Handling Trainees with Problems</td>
<td>1. Identify and handle trainees early who have problems</td>
</tr>
<tr>
<td></td>
<td>19. Encourage early treatment of chemical dependency or impulse control disorders of students</td>
</tr>
<tr>
<td></td>
<td>20. Encourage early treatment of mood disorders of students</td>
</tr>
<tr>
<td></td>
<td>23. Develop clear model for early intervention and remediation that involve proper assessment, remediation contracts and attainment of desired outcome</td>
</tr>
<tr>
<td>B. Cultivating Personal Qualities of Trainee</td>
<td>2. Reinforce acceptability of asking for help</td>
</tr>
<tr>
<td></td>
<td>4. Promote openness to feedback</td>
</tr>
<tr>
<td></td>
<td>6. Encourage self-awareness of students</td>
</tr>
<tr>
<td></td>
<td>8. Promote personal and professional growth</td>
</tr>
<tr>
<td></td>
<td>10. Promote students' balanced lifestyle and self-care</td>
</tr>
<tr>
<td></td>
<td>24. Help students learn to engage in critical thinking about themselves and others</td>
</tr>
<tr>
<td>C. Providing Impairment Prevention Education</td>
<td>3. Include the issue of impairment in ethics training</td>
</tr>
<tr>
<td></td>
<td>5. Help students to be aware of the risks of impairment in the profession</td>
</tr>
<tr>
<td></td>
<td>9. Help students understand the impact of personal life events to their professional functioning</td>
</tr>
<tr>
<td></td>
<td>11. Help students to learn about resources for assistance in the profession regarding impairment</td>
</tr>
<tr>
<td></td>
<td>12. Include impairment and its prevention in course content</td>
</tr>
<tr>
<td></td>
<td>13. Prepare students for rewards and hazards of the profession</td>
</tr>
<tr>
<td></td>
<td>14. Facilitate students to develop self-care skills/ habits</td>
</tr>
<tr>
<td></td>
<td>17. Help students know that psychologists are as vulnerable to mental illness and substance abuse as anyone else</td>
</tr>
<tr>
<td>D. Cultivating Program Culture</td>
<td>7. Provide students a safe environment to discuss issues that they concern about</td>
</tr>
<tr>
<td>E. Emphasizing Supervision &amp; Feedback</td>
<td>15. Emphasize ongoing direct supervision and feedback</td>
</tr>
<tr>
<td>F. Training Faculty</td>
<td>16. Teach faculty how to identify and confront impairment</td>
</tr>
<tr>
<td>G. Encouraging Support Network</td>
<td>18. Develop peer relationships in profession</td>
</tr>
<tr>
<td></td>
<td>21. Encourage students to join psychological associations or peer support groups after graduation to reduce isolation</td>
</tr>
</tbody>
</table>
achieved, these 101 considerations were adopted. A compilation of all these considerations with the corresponding preventive measures is available in Appendix K. The results of the considerations for the successful implementation of most important preventive measures will be further explained in the next sub-sub-section in which all the considerations were compiled together.

Compiled Considerations from Two Rounds

From the two rounds of the study, there were 301 compiled considerations for successful implementation, among 41 items. Of all these considerations, 218 (72%) took place in 20 items out of the top 26 items which had means greater or equal to 3.00 (very important). Out of these very important measures, 199 (66% of the total considerations) were attributed to the 24 “consensual most important measures.” Seventy-nine (26%) belonged to 19 items out of 41 preventive measures with means lower than 3.00 but higher than or equal to 2.00 (important). Only 4 (1%) belonged to 2 items out of the 14 items with means lower than 2.00 but higher than or equal to 1.00 (less important). No comment was given to the last two items with means lower than 1.00 but higher than 0 (unimportant). Hence, about two thirds, which is a large majority of the comments, were attributed to the 24 “consensual most important preventive measures,” indicating that the experts in this study did mostly focus on giving suggestions to the most important measures with consensus.

Considerations for Successful Implementation of “Consensual Most Important Measures”

The number of considerations was unevenly distributed across the 24 "consensual most important measures;" with a range from 0 to 26 considerations and a mean of 8.29
for each item. Also, the number of experts who had commented on an item ranged from 0 to 14. Participants provided considerations for successful implementation for 18 out of these 24 items. The number of considerations, in general, decreased from the top items to the bottom ones of the list.

In the following, the method for summarizing the considerations for each of the "consensual most important preventive measures" is provided. For each of these 18 measures to which considerations for implementation were given, I first describe the data, and then provide a summary of the considerations that are relevant to successful implementation. [Considerations that do not directly inform about how to implement the particular measure are considered irrelevant. Take the first "consensual most important measure" as an example: "identify and handle trainees early who have problems." There was a consideration attributed to this measure as follows: "Training programs teach in ethics and other courses, both trainee and practitioner issues of stress-distress-impairment continuum." It is not considered as relevant because teaching such courses is not directly related to how to successfully identify and handle trainees early who have problems.]

Three aspects of the data are described: the number of experts who commented on the item, the amount of information given, and the amount of irrelevant information. The number of experts is described as follows: "very many" is used to qualify 10 or more experts, "many" is used for 7-9 experts, "some" for 4-6 experts, and "a few" for 1-3 experts. To describe the amount of information given by the experts, "very large amount" is used to qualify 20 or above considerations, "large amount" is used for 11-19 considerations, "some" for 6-10 considerations, and "a little" for 1-5 considerations. To describe the amount of irrelevant of the information, the term "no irrelevant information"
is used to qualify an item with all considerations relevant to informing how to successfully implement the item. The term “a little irrelevant information” is used to qualify an item with 1 to 2 considerations not relevant to informing how to successfully implement the item, whereas the term “some irrelevant information” is used with 3 to 4 such considerations. In order to summarize the considerations for an item, I made use of the following principles: (a) including only those considerations which, in my opinion, provided relevant information on how to successfully implement the item, (b) giving equal weight to any idea which informed how to successfully implement the item, (c) using the wordings of the experts as much as possible, (d) interpreting and organizing the pieces of information in a coherent way regarding how to successfully implement the item, (e) using “[ ]” to bracket my commentary in the summary. The following is a summary of the considerations for successful implementation concerning the 18 "consensual most important measures" for which considerations were given.

Identify and handle trainees early who have problems. This item was commented on by very many of the experts, who provided a very large amount of information along with a little irrelevant information. According to the information provided, there are five actions that training programs can take to successfully identify and handle trainees early who have problems. First, training programs need to create an environment that encourages openness to help-seeking and actions to promote wellness, so that students will be more honest to identify having problems and actively seek help on their own. Fellow students and faculty will be more ready to intervene and offer assistance to students with problems in such an environment. In order to create such a training environment, a positive, non-punitive, direct and proactive stance of prevention and early
intervention are needed in the training program. Second, training programs need to
develop a model for intervening with trainees' problems in advance, by seeking the
collaboration, understanding, and agreement among administrators, faculty, and students.
Such a model for intervention needs to include good remediation plans for specific
trainee problems and due process. In addition, the information concerning such a model
of intervention needs to be articulated in the program brochures, web-pages and
handbooks for students. Third, training programs need to facilitate faculty's taking
responsibility for identifying, confronting and offering assistance to students with
problems. To achieve this, training programs need to make it a requirement for faculty to
monitor students' progress and performance by providing them frequent, direct and
honest feedback and evaluations, and by conveying to them clear minimum standards of
professional functioning. Training program can provide training to faculty so that they
know how to do honest feedback and evaluations, especially with students who have
problems. With close monitoring, students with problems can be identified early and can
get helped sooner. Fourth, training programs need to provide resources to assist students
with problems. For example, training programs can utilize outside resources to help
struggling students, and provide free counseling services for them. [There was no further
information given regarding what outside resources they were referring to.] Finally,
training programs need to be willing to dismiss students who do not reach the minimum
standard of professional functioning after remediation, by counseling such trainees out of
the program. In this context, training programs need to address barriers for such dismissal,
including the financial incentive to retain the tuition-paying trainee.
Reinforce acceptability of asking for help. This item was commented on by very many of the experts. There was also a very large mount of information provided by these experts with a little irrelevant information. According to the information provided, there are six actions that training programs can take to successfully reinforce acceptability of asking for help in the program. First, training programs need to foster a program culture in which self-care, balance and help-seeking are valued, instead of subtly or overtly judging the behavior of asking for help as incompetence. Second, training programs need to let students know why it is acceptable to ask for help. The reasons why it is acceptable to ask for help are as follows: (a) no one is expected to be invulnerable, and anyone will need assistance at some point in time; (b) anxiety and burnout are part of what most graduate students go through; (c) asking for help is a professional and ethical responsibility; (d) the likelihood of impairment will be reduced if we ask for help early; and (e) impairment may negatively affect career advancement. Third, training programs need to raise the students’ awareness regarding the greater propensity for men, both in the general population and in the profession, to deny having problems, and to resist seeking help early before crises happen. Fourth, training programs can convey the message of acceptability toward asking for help using direct and indirect ways. Direct ways include: (a) every year, training programs convey to all students their full commitment to assist them, (b) supervisors/advisors emphasize this message one on one with each student, and (c) training programs actually praise students when they ask for help. Indirect ways include: (a) faculty provide role modeling to students to talk about their own therapy or help-seeking experience, and (b) training programs make psychotherapy a requirement for students, or at least encourage it in the program. Fifth, training programs need to help
students to recognize and accept their own personal and professional limitations. To achieve this, training programs need to encourage students to discuss their personal weaknesses and professional challenges. Also, training programs can help students reframe such limitations in a positive fashion, as a source of pride when they continue to work on improving themselves. Finally, training programs need to pinpoint resources for students to get help. Examples of such resources include forming peer support groups, using on-going supervision, joining professional communities, and resources for help from APA and local associations.

*Include issue of impairment in ethics training.* This item was commented on by many of the experts, who provided a very large amount of information along with a little irrelevant information. According to the information provided, there are three actions that training programs can take to successfully include the issue of impairment in ethics training. First, training programs can design materials about impairment prevention to be used in appropriate classes, such as professional ethics, laws related to the profession, assessment, and professional issues. Useful materials or resources for teaching impairment may include: (a) case studies, (b) statistics of licensing board complaints, (c) articles in the edited book of Bersoff (2003) on ethical conflicts in psychology, (d) the ACCA monograph on advancing colleagues assistance in professional psychology, and (e) speakers from the licensing board or CAC. Second, training programs need to help students understand the various issues related to impairment, including the sources contributing to impairment, the connection between impairment and unethical practice, assessing impairment, and their responsibilities for themselves as well as their peers regarding impairment. To ascertain that students have a good understanding of the issue
of impairment, training programs may require them to write essays on the issue either as class assignments or in exams. Third, training programs need to help students personalize the issue of impairment. To achieve this, training programs need to emphasize the importance of openness, and discuss how they will personally react to their own impairment and how they expect others to respond to their impairment.

*Promote openness to feedback.* This item was commented on by some experts, who provided some information with no irrelevant information. According to the information provided, there are four actions that training programs can take to successfully promote openness to feedback. First, training programs need to provide a safe context for feedback to take place. [There was no further information about how to provide such a safe context.] Second, training programs need to give students honest and constructive feedback. In order to achieve this, training programs may need to help faculty learn how to give such feedback for promoting learning but not evoking fear in students. Moreover, training programs may have annual assessments of a student's progress by a committee, not just by the advisor. Third, training programs need to encourage students to offer feedback about all aspects of the program on a regular basis. Fourth, faculty need to model openness to feedback.

*Help students to be aware of the risks of impairment in profession.* This item was commented on by a few of the experts, who provided a little information as well as a little irrelevant information. According to the information provided, there are two actions that training programs can take to help students to be aware of the risks of impairment in the profession. First, training programs need to help students know the demands of the profession, such as providing therapy for difficult clients. [No further information was
given by the experts concerning the other demands of the profession. Second, training programs need to help students examine their readiness for such demands of the profession. For those students who are not ready for the demands of the profession, training programs need to counsel them into more suitable career choices.

Encourage self-awareness of students. This item was commented on by many of the experts, who provide a large amount of information with some irrelevant information. According to the information provided, there are two actions that training programs can do to successfully encourage the self-awareness of students. First, training programs can raise the general self-awareness of students through different avenues; such as (a) encouraging them to examine and analyze their reactions to people in case studies, role play and practice, (b) encouraging them to critically evaluate what aspects of course content carry more personal significance, (c) encouraging them to identify their personal value systems and how they fit with professional ethics code, (d) encouraging journaling and discussion of personal experiences in peer supervision, (e) encouraging students' own therapy, and (f) providing them workshops and seminars on self-awareness. Second, training programs can facilitate self-awareness specific to impairment, by teaching them danger signs for impairment, self-assessment, and self-monitoring.

Promote personal and professional growth. This item was commented on by some of the experts, who provided some information and a little irrelevant information. According to the information provided, there are three actions that training programs can do to successfully promote personal and professional growth. First, training programs need to emphasize to the students that such growth is individualized. Second, training programs can promote the personal growth of students by the following means: (a)
facilitating the exploration of their own personal history by applying theories of human
development; (b) facilitating the exploration of their own deep rooted biases, such as
sexism, racism and ageism; and (c) providing them information regarding different
cultural and recreational opportunities, and (d) encouraging them to explore new life
experiences. Third, training programs can promote the professional growth of students by
providing new professional opportunities for students, such as creating opportunities for
students to meet professionals who can be potential mentors. [There was no further
information concerning what other new professional opportunities are.]

Help students understand the impact of personal events on professional
functioning. This item was commented on by some of the experts, who provided a large
amount of information in spite of some irrelevant information. According to the
information provided, there are three actions that training programs can take to
successfully help students understand the impact of personal events on professional
functioning. First, training programs need to help students understand that it is a natural
part of being a psychologist to have one’s professional functioning impacted by personal
events. Therefore, this is not a sign of weakness. Second, training programs can facilitate
students’ understanding of this by using the following methods: (a) describing case
studies, (b) teaching about counter-transference, (c) focusing on the parallel process in
supervision, and (e) encouraging self-assessment regarding the relationship between their
personal events and their practice. Third, training programs need to teach students
problem solving skills so that they can apply the skills to minimize the negative effects of
their personal events on professional functioning.
Promote students' balanced lifestyle and self-care. This item was commented on by many of the experts, who provided a large amount of information with a little irrelevant information. According to the information provided, there are five actions that training programs can do to successfully promote students' balanced lifestyle and self-care. First, training programs need to provide a caring training environment to facilitate students' learning about self-care. To create such an environment, training programs need to establish a friendly atmosphere in the program, and show that students' well-being is as important as their work. For example, training programs can encourage students to take vacations and days off for self-care when necessary. Second, training programs need to encourage students to develop life interests outside of their professional work. This includes developing interests other than psychology, and building friendships outside of work. Third, training programs can offer students courses on self-care, or incorporate self-care material into classes. This might include positive psychology, the inclusion of the topic of leisure in a career development course, and optimal health practices such as physical exercises, mindfulness, and nutrition. Fourth, training programs can help students actually take actions for self-care by facilitating their self-evaluation, encouraging their self-care plan, and following up by faculty. Fifth, faculty need to model a balanced lifestyle and positive self-care to students.

Help students learn about resources for assistance in the profession regarding impairment. This item was commented on by some of the experts, who provided some information along with some irrelevant information. According to the information provided, there are two actions that training programs can take to successfully help students learn about resources for assistance in the profession regarding impairment. First,
training programs can help students learn about such resources in a de-stigmatized way. [No further elaboration was given by the experts.] Second, training programs can provide information about the resources of the APA ACCA. Third, training programs can provide information about the resources of the CAC of local psychological association. Such information can also be communicated to the students by inviting speakers from the CAC.

*Include impairment and its prevention in course content.* This item was commented on by many of the experts, who provided a large amount of information along with a little irrelevant information. According to the information provided, there are three actions that training programs can take to successfully include impairment and its prevention in course content. First, training programs need to address impairment and its prevention honestly and openly in training. In particular, training programs should inform students early on regarding the expectations of the program. Second, training programs need to integrate the prevention of impairment in the curriculum. [No further information was given regarding how to integrate prevention of impairment in the curriculum.] Third, training programs need to include the following content areas in teaching impairment prevention: the rewards of professional work, the risks of impairment in the profession, the consequences of impairment, the ways of seeking help, and well-being. Fourth, training programs can use different educational tools to teach impairment and its prevention, such as didactic teaching, experiential teaching, discussions with students, and sharing of personal experiences.

*Prepare students for the rewards and hazards of the profession.* This item was commented on by some of the experts, who provided some information as well as a little irrelevant information. According to the information provided, there are three actions that
training programs can take to successfully prepare students for the rewards and hazards of the profession. First, training programs need to be honest with the students regarding the rewards and hazards of the profession. Second, training programs need to give students a comprehensive overview of the profession in order to help students understand the profession fully, covering all the elements of professional practice. Examples of these elements include the financial implications, political implications, and implications to their own family. To help students have a fuller understanding of professional practices, training programs can create communication between students and established professionals. Third, training programs need to help students understand the different hazards of the profession. Examples of these hazards include getting assaulted, stalked, or harassed by clients, or handling demanding clients, such as those with serious personality disorder or suicidal intent. Fourth, training programs need to help students learn how to handle the hazards of the profession. [There was no further information concerning how to help students learn to handle the hazards. There was also no information about preparing students for the rewards of the profession.]

Facilitate students to develop self-care skills/ habits. This item was commented on by a few of the experts, who provided some information with no irrelevant information. According to the information provided, there are three actions that training programs can take to successfully facilitate the students’ development of self-care skills/ habits. First, training programs should create an environment in which students feel safe to voice their needs and to take care of themselves. In order to create such an environment, faculty and supervisors need to care about the well-being of the students, such as asking about and responding to their elevated stress, and giving overt permission
for students to take care of themselves even if it means missing classes. Second, training programs need to integrate the development of self-care skills into the program, starting from the beginning. [There was no further information concerning how to integrate the development of self-care skills into the program.] Third, training programs can teach students about different self-care strategies, such as stress management skills, problem-solving skills for themselves, and forming support systems by actually providing opportunities for students to work and play together.

*Emphasize ongoing direct supervision and feedback.* This item was commented on by a few of the experts, who provided some information along with a little irrelevant information. According to the information provided, there are three actions that training programs can take to successfully emphasize ongoing direct supervision and feedback. First, training programs need to let students know the importance of ongoing supervision and feedback in the prevention of impairment. Second, training programs need to assure students that personal issues being brought up in supervision are not graded and are separated from academic evaluation. Third, training programs need to teach students skills to be open and curious to feedback in order to render direct supervision and feedback beneficial to them.

*Teach faculty how to identify and confront impairment.* This item was commented on by a few of the experts, who provided some information as well as a little irrelevant information. According to the information provided, there are three actions that training programs can take to successfully teach faculty how to identify and confront impairment. First, training programs can develop and provide training modules to teach faculty how to identify and confront impairment. Training programs can incorporate real
cases, role-play and other active learning strategies to facilitate the learning of faculty. Second, training programs can require faculty to take a course on supervision issues, including identifying and confronting impairment, and taking responsibility for gate-keeping in the profession. Third, training programs can require newer faculty to be supervised by senior faculty, so that they can discuss and learn how to identify and confront impairment from senior faculty.

*Develop peer relationships in the profession.* This item was commented on by some of the experts, who provided some information and some irrelevant information. According to the information provided, there are two actions that training programs can do to successfully help students develop peer relationships in the profession. First, training programs need to create an atmosphere that encourages the exposure of vulnerabilities, such as faults and weakness, to facilitate deeper contacts among students. To achieve this, training programs need to help students see the strength required to be vulnerable with each other, and to see the importance of providing honest and direct support for each other. Second, training programs can help students build peer relationships in the program in the following ways: (a) developing assignments where collaboration is required, (b) creating learning experiences where peers look to each other as sources of wisdom and information, (c) developing study groups, (d) creating supervision groups, (e) encouraging therapy groups among students, (f) promoting blogging in training, (g) creating lunch symposiums where peers present to each other, and (h) inviting graduates back as guests and consultants to establish connections with students.
Encourage early treatment of chemical dependency or impulse control disorders of students. This item was commented by on a few of the experts, who provided a little information with no irrelevant information. According to the information provided, there is one action that training programs can do to successfully encourage the early treatment of chemical dependency or impulse control disorders in students. Training programs need to provide training to faculty concerning how to intervene with students having such problems (such as group intervention meeting), and how to best get students into treatment from an ethical and legal standpoint.

Encourage students to receive supervision from an experienced professional after graduation. This item was commented on by a few of the experts, who provided some information in spite of a little irrelevant information. According to the information provided, there are two aspects that training programs can do to successfully encourage students to receive supervision from an experienced professional after graduation. First, training programs need to let students know why it is important and beneficial to receive supervision after graduation, such as (a) monitoring the therapist to practice within legal and ethical boundaries, and (b) providing support and validation. Second, faculty can provide modeling to students by having supervision themselves.

Conclusion

Two rounds of a Delphi study were carried out with the purposes of (a) identifying the important preventive measures that can be included in graduate training in order to prevent future impairment of professionals, and (b) exploring the considerations for successful implementation of the “consensual most important measures.” There were 28 experts participating in the first round and 20 experts continuing into the second round.
All of the experts were experienced psychologists with at least 9 years of post-doctorate professional experience. They also engaged in at least one kind of professional activities concerning the phenomenon of impairment and its prevention. Within the four kinds of professional activities being focused in this study (publication, presentation, service on a working committee, and clinical work related to impairment of psychologists), the large majority of them (86%) had more than one kind of expertise. Hence, they were well-qualified to inform training programs on the issue of impairment prevention.

These experts generated 45 additional preventive measures in graduate training against future impairment in addition to the original 38 items, resulting in a list of total 83 preventive measures. After re-evaluating the importance of all the items, a list of 67 items were generated at least important or above, which met the first purpose of the study by identifying the important preventive measures against impairment in graduate training. Among these 67 items, the 24 top items were the “consensual most important measures.” These “consensual most important measures” pinpointed what measures training programs need to do in seven areas: (a) handling trainees with problems, (b) cultivating personal qualities of trainee, (c) providing impairment prevention education, (d) cultivating program culture, (e) emphasizing supervision and feedback, (f) training faculty, and (g) facilitating a support network for trainees. (Please refer to Table 5 for the list of "consensual most important measures" classified under the seven areas.) Moreover, in providing considerations for successful implementation of the most important measures, the experts mainly focused on these top 24 items. These 199 considerations for the 24 items were compiled in Appendix L and summarized earlier. These considerations were unevenly distributed across the items; and hence, a varying amount of information
was obtained regarding how best to successfully implement the items. As a result of the incomplete information obtained from the study concerning how to successfully implement these "consensual most important measures," the second purpose of this study was only partially achieved.
CHAPTER V

DISCUSSION

Overview

This chapter discusses the findings of the Delphi study. First, a synopsis of the study and its results are presented. Second, the implications of the results for professional psychology training are discussed. Third, the limitations of the study are discussed. Fourth, the directions for future research regarding impairment prevention in professional psychology training are discussed. Finally, an ending note of the researcher concludes the chapter.

Synopsis of Study and Results

The study sought to identify the most important measures that could be implemented in professional psychology training to prevent future impairment of professionals. An adjunctive research question of the study addressed how these important measures could be successfully implemented. The Delphi method was used to answer the above research questions. The Delphi method focuses on the generation of knowledge for application in practice (Stone Fish & Busby, 1996). It is characterized by using a panel of experts who participate anonymously with each other in responding to an iterative series of written questionnaires, with the aim of generating consensus on the issues in question (Gibson & Miller, 1990; Ziglio, 1996). A total of 28 experts in the phenomenon of impairment participated in this 2-round Delphi study. All the experts
were experienced psychologists with at least nine years of post-doctorate professional experience. They engaged in at least one of the four kinds of professional activities concerning the phenomenon of impairment and its prevention: publication, presentation, service in a working committee, and clinical work related to impairment of psychologists. The large majority of them had even more than one kind of such professional activities. Hence, they were well-qualified to inform training programs on the issues of impairment prevention.

In the first round survey, the experts rated the importance of a list of 38 preventive measures which had been generated by training heads of professional psychology training programs (Schwebel & Coster, 1998) with additional items generated through a literature review of the researcher. The experts also suggested additional important preventive measures, and commented on the considerations for successful implementation of their chosen most important measures. In the second round survey, the experts were provided the results of the first round. They rated the importance of an augmented list of 83 preventive measures, which contained the original 38 measures and 45 additional measures suggested by the experts. The experts also gave further comments regarding the considerations for successful implementation of their chosen important measures. By using the mean rating and standard deviation of the preventive measures, the list of 83 preventive measures were prioritized according to their relative importance as well as the degree of consensus. (Please refer to Table 4 of Chapter IV.) While a large majority of the items (67 items) was considered at least important, 24 of them were "consensual most important measures." The top six measures were considered as almost essential. Therefore, the main research question was answered.
For the sake of parsimony in conceptualization, I classified them under seven areas: (a) handling trainees with problems, (b) cultivating personal qualities of trainees, (c) providing impairment prevention education, (d) cultivating program culture, (e) emphasizing supervision and feedback, (f) training faculty, and (g) facilitating a support network for trainees. (Please refer to Table 5 of Chapter IV for the list of "consensual most important measures" classified under the seven areas.) In regard to the adjunctive research question, after compiling the experts' comments on the considerations for successful implementation of their chosen important measures, it was found that a large majority (about two thirds) of these considerations were attributed to the "consensual most important measures." However, the considerations were unevenly distributed across these "consensual most important measures," with a range from 0 to 26. Hence, a varying amount of information was obtained regarding how best to successful implement these measures, and a partial answer to the adjunctive research question was therefore achieved. The considerations under each of the "consensual most important measures" were summarized in Chapter IV.

Implications for Professional Psychology Training

The generation of usable knowledge for practice, which coincides with the philosophical underpinning of the Delphi method, was one main goal of this study. Hence, the major implications of results of this study are practice-oriented, and in this case concern the practice of professional psychology training. There are two implications of the results of this study for professional psychology training. First, the results clarify the relative importance of various impairment prevention measures in graduate training, so that training programs may know what preventive measures are the most important to
implement in training. Second, the results suggest partial avenues for the successful
implementation of these preventive measures, so that training programs may begin to use
these avenues to successfully implement the preventive measures. The two implications
are elaborated separately in the following sub-sections.

**Clarify the Relative Importance of Various Preventive Measures**

As pointed out in the Literature Review chapter, the literature on impairment
prevention in graduate training has been rather scant and piecemeal. In particular, with
regard to the question of what impairment preventive measures are important in graduate
training, so far the suggestions in the literature have mostly been based upon the opinions
of individual or a few professionals. The authors who have addressed such a question
have mostly offered a very limited scope of suggestions; such as including a course on
prevention and preparing students for rewards and hazards of the profession (Corey,
Corey, & Callanan, 2003), or developing well-planned self-care training modules (Bakers,
2000). Moreover, these authors suggested different measures as important impairment
prevention effort in graduate training. The only peer-reviewed published empirical study
on impairment prevention in graduate training addressed the above question (Schwebel &
Coster, 1998), as it gathered the suggestions from program heads of American
Psychological Association accredited programs in professional psychology to prepare
students to function as unimpaired psychologists (synonymous with well-functioning
according to the definition of the two researchers). The resulting list of suggested
measures from that study broadened the scope of impairment prevention in graduate
training, by aggregating the opinions of individual professionals. Program heads, like
other authors in the literature, also suggested different measures as impairment
prevention effort in graduate training. Hence, the relative importance of the preventive measures in the literature was still unknown before this Delphi study.

The results of Delphi study provide an even more extensive array of important preventive measures that can be implemented in professional psychology training. There are altogether 67 preventive measures generated from this study, which were considered to be at least important. This finding opens up the possible scope of impairment prevention in graduate training. More importantly, instead of just turning to the opinions of individuals to come up with what impairment preventive efforts are the most important in professional psychology training, the results of this Delphi study improve upon such individual judgment by pooling the group consensus of experts in the phenomenon of impairment prevention. According to the philosophical underpinning of the Delphi method, this group consensus can provide more accurate judgment as to what the most important preventive efforts are. Twenty-four preventive measures were considered to be the most important with consensus by the experts of this Delphi study.

In addition, these 24 “consensual more important measures” were rank-ordered with respect to their relative importance. The top six measures had mean ratings higher than 3.5 from the experts, which were therefore almost considered as essential. (Note: 3.5 is midway between important and essential of the rating scale.) Hence, I recommend that training programs can begin impairment prevention efforts in graduate training by implementing these top six measures. They are listed as follows in descending order of importance: (a) identify and handle trainees early who have problems, (b) reinforce acceptability of asking for help, (c) include the issue of impairment in ethics training, (d)
promote openness to feedback, (e) help students to be aware of the risks of impairment in the profession, and (f) encourage self-awareness of students.

**Suggest Partial Avenues for Successful Implementation of Preventive Measures**

Clarifying the relative importance of various preventive measures will end up being a futile academic research exercise if the measures are not actually put into practice in professional psychology training to prevent impairment. This study was the first attempt in the literature to explore how the most important preventive measures could be successfully implemented in professional psychology training. Although only a partial answer to this adjunctive research question was obtained from this Delphi study, the experts in the study did provide a varying amount of information that training programs can refer to and use to plan actions to successfully implement 18 out of the 24 “consensual most important measures.” For example, there are three actions suggested by the experts for the successful implementation of measure #3 (include the issue of impairment in ethics training). Action one concerns the design of materials about impairment prevention to be used in appropriate classes. Training programs can consider using the resources as suggested by the experts for teaching; such as case studies, statistics of licensing board complaints, articles in the edited book of Bersoff (2003) on ethical conflicts in psychology, and a monograph of Advisory Committee on Colleague Assistance. Action two concerns helping students understand the various issues related to impairment, including the sources contributing to impairment, the connection between impairment and unethical practice, assessing impairment, and their responsibilities for themselves as well as their peers. In my opinion, training programs can consider at least introducing some of these issues in a professional ethics class, in a professional
development class, or even in a class about personal and professional self-care. Also, training program can make use of experts’ suggestions to ask students to write essays on these issues as class assignment or in exams, to ascertain that students have a good understanding of them. Action three concerns the need to help students personalize the issue of impairment. In my opinion, training programs can make use of a practicum or a supervision class to facilitate the discussion as suggested by the experts regarding how students will personally react to their own impairment and how they expect others to respond to their impairment.

However, as indicated from the results of the study by Schwebel and Coster (1998), there are potential obstacles present in training programs that may prevent changes to take place in training programs with regard to impairment prevention. In the study, program heads rated, on a scale ranging from 1 (very little) to 5 (very great), the five potential obstacles they would face if they were to introduce their proposed changes. The top obstacles were “no time or space in the curriculum” (mean = 3.47) and “budgetary constraints” (mean = 3.16). An optimistic interpretation of such results is that these biggest obstacles to changes were still considered to be moderate in degree; and hence, were not considered to be too great to overcome by most program heads. Ideally, it would be desirable to implement the 24 “consensual most important measures” all at once for impairment prevention in training. But, the introduction of a multitude of additional measures in a training program may require a lot of additional effort, in terms of time and resources, such as meeting time for their implementations and mobilizing faculty to plan as well as carry out the details of their implementations. In order to address the obstacles of time and resources, I consider it to be helpful to approach
impairment prevention in graduate training not as an all-or-none effort. Instead, in my opinion, impairment prevention work in graduate training can be a gradual incremental process in implementation. Hence, preventive measures can be initially implemented gradually within the existing content of courses as a continuing work in progress process, given time and budgetary constraints, and then continually expand such preventive effort when resources are created in the future.

Take the top six preventive measures as examples. With reference to experts' suggested actions for their successful implementation, it seems to me that five measures can be incorporated into the existing content of courses more readily, while one measure may need more time and resources to implement. Measure #2 (reinforce acceptability of asking for help), measure #3 (include the issue of impairment in ethics training), measures #4 (promote openness to feedback), measure #5 (help students to be aware of the risks of impairment in the profession), and measures #6 (encourage awareness of students) seem to be able to be incorporated into the existing content of courses more readily as most of the actions for their successful implementation can be easily added in existing content of courses. Measure #3 is used earlier to illustrate how it can be more readily incorporated into the content of courses. However, by no means do the actions need to be taken all at once. They can be planned and implemented even one at a time. On the other hand, measure #1 (identify and handle trainee early who have problems) seems to require more time and resources for its successful implementation; such as developing of a model for intervening with trainee's problems, creating of internal and external resources to help students with problems, structuring of more frequent regular
feedback and evaluations, and developing a due process for dismissing students (Forrest, Elman, Gizara, & Vacha-Haase, 1999).

Maybe, impairment prevention in graduate training is similar to the integration of multiculturalism into the curriculum in that the concept should be blended into different classes. In the case of impairment prevention, the concept of well-being and well-functioning should be blended into different classes as well, so that faculty can make use of the actions suggested by the experts in this study to creatively integrate the other impairment prevention measures into their classes. For example, in a psychopathology class, faculty can introduce the notion that psychologists are as vulnerable to mental illness and substance abuse as anyone else (measure #17) by showing the statistics of mental illness concerning professionals, so that students can be alert to their own well-being and to prevent impairment as a result of mental health issues. They can also help students learn about resources for assistance in the profession regarding impairment (measure #11) such as providing information about the colleague assistance committee in the psychological association at a state level, so that students know how to get help early when they have problems in the future. As another example, in a supervision class, faculty can help students understand the impact of personal events on their professional functioning (measures #9) so that they can understand how their future supervisees’ professional functioning can be compromised. Also, faculty can teach students how to identify and confront impairment (measure #16), so that they know how to provide intervention to their future supervisees who exhibit the issue of impairment.

In addition to putting forth impairment prevention efforts under the existing curriculum structure, training programs may need to mobilize resources, either by
shifting priorities or getting more human resources, to institute a more comprehensive prevention effort in the long run. I believe that the priorities of a training program are a function of the training program and the endorsement of the accreditation body. In terms of the training programs, I consider it to be essential that there is a common mission among faculty and staff to train well-functioning psychologists who not only can help others, but can also take care of themselves. Hence, training committees, as a whole, need to discuss in an ongoing way how such a mission can be realized in the short-term and long-term development of a training program. In particular, training committees can discuss about how the most important preventive measures against impairment can be gradually implemented in the training program, and how to mobilize resources to implement them.

In terms of the accreditation body, impairment prevention should be named as one of the priorities in training programs to be accredited. However, impairment prevention is not such a priority in the current accreditation guidelines of professional psychology training (APA, 2000), because there is little mention of the issue of impairment prevention in the guidelines. Only one standard in Domain E (student-faculty relations) is related to impairment prevention in the guidelines; which mentions that training programs should provide students with written policies concerning a training program’s expectations for them and due process, and provide regular feedback to students. It would be conducive to impairment prevention and hence well-functioning in graduate training if the American Psychological Association takes the lead to advocate for the importance of impairment prevention by prescribing it as one of the priorities of accreditation. In my opinion, an additional standard should be added to the Domain B3 of current
accreditation guidelines of doctoral graduate programs. Domain B concerns program philosophy, objectives, and curriculum plan. Standard 3 describes that the program has and implements a clear and curriculum plan that provides the means whereby all students can acquire and demonstrate substantial understanding of and competence in different areas. In the current standard, five areas are specified: (a) the breadth of scientific psychology, its history, its research methods, and its applications; (b) the scientific, methodological, and theoretical foundations of practice in the substantive area(s) of professional psychology to which the program has its training emphasis; (c) psychological assessment as well as intervention strategies; (d) issues of cultural and individual diversity; and (e) attitude essential for life-long learning, scholarly inquiry, and professional problem-solving in an evolving body of scientific and professional knowledge. I suggest that a sixth area be added regarding impairment prevention as follows: “(f) The understanding of the risk of impairment as a professional. To achieve this end, students should be exposed to knowledge about the phenomenon of impairment and ways of preventing impairment.”

Limitations of Study

There are four limitations of this Delphi study. First, only a partial answer was obtained for the adjunctive research question. Although this study attempted to address the adjunctive research question of how the most important preventive measures can be successfully implemented; the experts only gave much comment on one third of the 24 “consensual most important measures,” and provided just some or little comment for the rest the measures. Hence, the answer to the question was incomplete, which therefore lacked depth of coverage of all the measures. One possible reason for the resulting partial
answer might be because of participants' fatigue. Jenkins and Smith (1994) noted that participants' fatigue might be an important reason why Delphi studies stopped at round two. In this study, the second round survey required the experts to spend more time to review the first round results and to complete a longer survey. That could reduce the motivation for the experts to give more comments in the second round. A possible improvement of the study to compensate for this fatigue effect could have been recruiting more experts in the first round, so that the likelihood of getting more comments for both rounds would have been higher. Another possible reason for the resulting partial answer might be because of the structured question in which experts were asked to list their comments. Hence, it could have discouraged experts from elaborating their points.

Second, the findings of this study reveal what preventive measures are the most important ones in graduate training, but there is insufficient information for the understanding of why the most important measures are so important, or how they contribute to the prevention of future impairment. For example, the resulting list of "consensual most important measures" contains some measures which seem to be less directly related to impairment per se on the face value; such as promoting openness to feedback (measure #4), and helping students learn to engage in critical thinking about themselves and others (measure #24). It is not explicitly clear in what ways promoting openness to feedback help prevent impairment, or the reasons for the importance of critical thinking in impairment prevention. Although it was not the objective of this study to address such questions, it occurs to me, as the results emerged, that further understanding of impairment prevention efforts may be facilitated when the reasons for
their importance or the ways they contribute to impairment prevention can be more explicitly spelled out.

Third, there seems to be redundancy in conceptualizing the most important preventive efforts in the resulting list of “consensual most important measures.” Because of my intention to reduce my bias over the conceptualization of preventive measures, I tried to preserve the original suggested ideas of the experts as much as possible in the study, especially in the first round survey when experts suggested additional important preventive measures. Through the process of analyzing data and the emergence of results, it occurs to me that there is redundancy in conceptualizing the most important preventive efforts, as the actions for the successful implementation of a measure may include the implementation of another measure. For example, an action for the successful implementation of measure #1 (identify and handle trainees early who have problems) is to develop a clear model for early intervention and remediation (measure #23). As another example, an action for the successful implementation of measure #12 (include impairment and its prevention in course content) is to help students to be aware of the risks of impairment in the profession (measure #5). Hence, the action for the successful implementation of a measure can be a measure itself, or the action for the successful implementation of a measure may overlap with a similar action for the successful implementation of another. Therefore, the extent of this redundancy may become clearer when a more complete answer to the adjunctive research question can be obtained.

Fourth, the answers to the research questions in this study lack a diversity of perspectives, as his study only provided the single perspective of the experts, whose expertise was defined in terms of the following kinds of professional activity: publication,
presentation, service in a working committee, and clinical work related to impairment of psychologists. Turoff (1975) noted that perhaps experts can be seen as only advocates and referees from a particular point of view. Hence, the results of this study can be viewed as a negotiated reality through the lens of a particular kind of experts. Therefore, it will be beneficial to also find out other perspectives on the research questions. For example, psychologists who have gone through and recovered from the experience of impairment may also bring another valuable perspective concerning prevention of impairment in graduate training. In addition, faculty who directly involve in the graduate training may bring a different perspective, as they know the actual potentials and limitations in their particular training programs concerning impairment prevention efforts. Also, students for whom impairment prevention training is provided can give a valuable perspective concerning how they are actually impacted by such training.

Directions for Future Research

As a result of the above four limitations of the results of this Delphi study, I suggest that future research be done to address these limitations respectively as follows. First, further studies can be carried out to provide a fuller in-depth answer to the question of how the most important measures can be successfully implemented. For example, the 24 top most important measures can be divided into 4 groups, each with 6 measures; and a survey can be sent to experts with a random choice of a group of measures. Experts can be asked to elaborate their opinions regarding considerations for the successful implementation of each of the 6 measures. In this case, all the measures will be extensively commented. Along the same idea, 12 or more experts can be recruited for an interview regarding how the most important measures can be successfully implemented.
The 24 measures can be divided into groups of less number of measures; for example, three groups with 8 measures for each group. Each expert will be assigned to comment on one group of measures and to elaborate with follow up questions from the interviewer. In this case, each measure will be commented extensively by at least 4 experts. Hence, the study will both improve the depth of coverage of all the measures. Second, further studies can be carried out to address the question of how the most important measures contribute the prevention of impairment. For example, this question can be added to the interviews of experts as illustrated above, so that experts can then give their opinions in response to the question. Third, as pointed out in the previous section, the extent and kind of the redundancy in the conceptualization of the most important preventive measures will be unfolded more fully after an in-depth answer to the question of how the most important measures can be successfully implemented. When such an answer is achieved through the suggested studies, future researchers may then be able to reduce redundancy in conceptualization; such as by eliminating measures that are largely overlapped by the other measures. Fourth, further studies on impairment prevention in graduate training can be conducted to solicit other perspectives. For example, the perspective of psychologists who have gone through and recovered from the experience of impairment can be sought. Through their own recovery experience, they can share, in addition to their recovery experience, their insight regarding what could have been implemented in their previous training to prevent them from impairment or speed up the recovery, and how such suggested measures could have prevented them from impairment. In this case, a phenomenological approach might be best to study the experience of recovered psychologists with the aim of informing professional psychology training about
impairment prevention measures. Alternatively, the perspective of faculty can be solicited. For example, a similar Delphi study can be carried out to explore the same research questions using faculty in training committees. Or, another Delphi study can be conducted, from the vantage point of faculty, to explore the feasibility and obstacles of implementing the most important preventive measures as generated from this study.

In addition to conducting research that addresses the four limitations of this Delphi study, another important line of inquiry concerns the evaluation of the actual implementation of impairment prevention in training programs; such as to what extent impairment prevention is a priority of training programs, how much has been done in training programs regarding impairment prevention, what preventive measures training programs have implemented, and how successful the measures are in impairment prevention. In order to answer the first three questions, survey could be sent to training directors, faculty, or students to acquire this information from different perspectives. For example, the important and the most important preventive measures of this study could be used as a list of preventive measures for participants to rate on a Likert scale as to the degree to which they would agree that a program has implemented the measures. In this case, this survey will inform the field about how much impairment prevention has been carried out in training, and what preventive effort has been implemented. In order to explore the question regarding how successful the measures are in impairment prevention, evaluation studies may be carried out by training programs. For example, training programs can send evaluation survey to graduates after one or two years of their graduation. Graduates can be asked to evaluate on a rating scale how successful each preventive measure was implemented in the program, to what extent they agree that
training programs have equipped them to prevent them from impairment, and what suggestions they would give to improve on the impairment prevention effort in the training program.

An Ending Note of the Researcher

Turoff (1975) commented that a Delphi involving policy exploration is a tool for the analysis of the policy in question and not a mechanism for making a decision. Hence, it can only supply a basis for informed decisions, but cannot substitute the decision process of the policy makers. In the case of this Delphi study, although it has achieved some clarification as to what impairment preventive efforts are the most important, and provided partial avenues for their successful implementation, the results can only provide recommendations from the voice of the experts as well as the researcher. Such information cannot replace the actual decision making process of training programs in regard to what and how to implement impairment prevention efforts. It is reasonable to think that training programs may have their individual values, characteristics, and differences that render the implementation of certain preventive measures easier or more preferable than others. Since decisions are value-laden, the results of this study can only provide an array of pooled informed judgments from the experts, for training programs to refer to, and make their own decisions as to what they want to select to implement in their own context. Finally, I hope that the results of this study not only can increase awareness about impairment prevention efforts in graduate training to the field of professional psychology, especially to training programs, but it can also stimulate more actions to actually put forth such efforts.
REFERENCES


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Appendix A

First Invitation Letter
Re: INVITATION TO BE OUR EXPERT PANELIST

Dear Dr. (Last Name of Panel Expert):

We are conducting a Delphi study, which has been approved by the Human Subject Institutional Review Board (HSIRB) at Western Michigan University, concerning important preventive measures in graduate professional psychology training against future impairment of professionals. We would very much like to invite you to be one of the expert participants of this study who have expertise in the area of impairment and its prevention in professional psychology. Expertise is based upon at least one of the four criteria: (1) contributing scholarly to the understanding of impairment/its prevention (being a 1st author at least once or a 2nd author at least twice on the topic of professional impairment or its prevention), (2) providing education on the prevention against impairment through workshop/ seminar at a previous annual conference of the American Psychological Association, (3) serving in APA Advisory Committee on Colleague Assistance or state psychological association colleague assistance committee, or (4) being recommended by other experts as having direct clinical intervention expertise (helping at least three psychologists with issues of professional impairment). By giving your expert opinions, your participation in this study will therefore be very invaluable in shedding light upon early prevention measures in graduate training against future impairment.

The Delphi method is a research tool that solicits opinions from experts of a field and facilitates structured communication among the experts, in the hope of obtaining consensus from the experts regarding the area of interest in the study. The process of this Delphi study consists of two rounds of survey:

(1) In this first round, you are requested to sign one of the HSIRB consent forms and to complete a Delphi Questionnaire (I). Then, you are requested to return the signed consent form (keep the second for your files) and the questionnaire to us in the included stamped envelope. After we receive all the panel experts’ questionnaires, data analysis will be done by us.

(2) Then, a second round of survey will be carried out. A Delphi Questionnaire (II), including the results of the first round, will be mailed to you. You will be asked to reevaluate your opinions after you have reviewed the summarized results of the first round, and to return the completed questionnaire to us with an included stamped envelope.

We hope that you will consider our invitation to be one of the expert panelists in this research. If after reading the consent document, you decide to participate; then please sign one of the consent documents and complete the attached Delphi Questionnaire (I). Then, please return the signed consent form and the questionnaire to us by using the attached stamped envelope in two weeks time. Thank you for considering our invitation and spending your precious time to give us your expert opinions!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.
Sincerely,

Kin-Ming Chan, MSW
Doctoral Student in Counseling Psychology
Department of Counselor Education and Counseling Psychology
Western Michigan University

James M. Croteau, PhD
Professor

Department of Counseling Psychology
Western Michigan University
Appendix B

HSIRB Informed Consent Form
You have been invited to participate in a research project entitled “A Delphi Survey of Experts’ Opinions Regarding Prevention of Impairment in Professional Psychology Training.” This research is intended to study important preventive measures and their successful implementation in graduate training against future impairment of professionals. This Delphi study is part of the dissertation of Kin-Ming Chan under the supervision of Dr. James M. Croteau.

In this Delphi study, you will participate as one of the expert panelists to give your opinions in structured paper-and-pencil communication with other expert panelists. You will be asked to fill out two rounds of survey. In the first round survey, you will be asked to complete a questionnaire, which asks for your demographic information, your ratings and suggestions about preventive measures against impairment, your opinions regarding the successful implementation of such measures, and your recommendations of clinical experts in the area of impairment in professional psychology. It will take about 30 minutes to complete this first round questionnaire. You will then be asked to mail back the questionnaire to the researcher. In the second round survey, you will be asked to review the results of the first round and complete another questionnaire. This survey asks for your additional comments on the successful implementation of the preventive measures, and your re-evaluation of your previous ratings of preventive measures against impairment. It will take about 30 minutes to complete this second round questionnaire. You will then be asked to mail back the questionnaire to the researcher.

Potential participants are coded on a master list of names and the two rounds of questionnaires are coded corresponding to the names of the participants. You will receive questionnaires having the same code to enable the researcher carrying out follow-up mailings and reminders. All information collected from you is confidential. That means that the researcher knows your identity in connection with your responded data, but will not release any identifying information when sharing the data with others. Demographic data as well as information on impairment prevention will be reported and presented in aggregate only. Also, the coded master list will be destroyed by the researcher when data collection and analysis are finished. Thus, the data will then no longer be traceable to any individuals.

Expected risks of participation include only possible discomfort in recalling past experiences of working with issues of impairment for the profession. However, since you have much experience
working in this area, the anticipated discomfort should be minimal. Also, participation in this research entails inconveniencing yourself to spend effort and time (around 1 hour in total) reading the material and completing the questionnaires.

By your participation in this study, you will have the opportunity to get to know the first round aggregate opinions of all participating experts including you during the second round survey. Also, you can contribute your expertise to the understanding of early prevention against impairment in the field of professional psychology. Also, the results of this study may inform graduate training programs concerning what important preventive measures against impairment can be implemented and how they can be implemented successfully.

You may refuse to participate or quit at any time during the study without prejudice or penalty. You may choose to not answer any question and simply leave it blank. If you have any questions or concerns about this study, you may contact the researcher, Kin-Ming Chan, at (415) 469-7998 or kinming.chan@wmich.edu; or the dissertation supervisor Dr. James M. Croteau, at (269)-387-5111 or james.croteau@wmich.edu. You may also contact the chair of the Human Subjects Institutional Review Board at (269)-387-8293 or the vice president for research at (269)-397-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

Your signature below indicates that you have read the purpose and requirements of the study and that you agree to participate.

__________________________   __________________
Signature                   Date

Please keep one copy of the consent form and return the signed consent form with the questionnaire! Thank you very much!
Appendix C

Delphi Questionnaire I
Delphi Questionnaire (I)

Part I: Demographic Information

Instruction: Please indicate your answers to the following questions by either circling the appropriate choice or filling your answers in the space.

1. What is your gender? (a) Female (b) Male (c) Transgender (d) Other: __________

2. What is your ethnicity? (a) African/ African American (b) Asian/ Asian American & Pacific Islander (c) Biracial/ Biracial American (d) Caucasian/ Caucasian American (e) Chicano(a)/Latino(a) or Chicano(a)/Latino(a) American (f) Middle Eastern/ Middle Eastern American (g) Native American/ American Indian (h) Others: ______________

3. What is your highest degree? (a) Doctorate (b) Master’s (c) Others: ______________

4. What is your specialty in psychology? (a) Clinical (b) Counseling (c) School (d) Others: ______________

5. How many years of post-doctorate professional experience do you have? ______________

6. What is your current primary professional position? (a) Administrator (b) Clinician (c) Full-time Faculty (d) Others: ______________

What is your current secondary professional position (if applicable)? (a) Administrator (b) Clinician (c) Part-time Faculty (d) Others: ______________

Are you directly involving in training committee of graduate programs? (a) Yes (b) No
In this study, impairment is defined as a decline in professional functioning to substandard performance due to the occurrence of distress.

7. How many years have you had interest in the area of impairment/its prevention in the profession?

8. What kind(s) of professional activities have you engaged in concerning the phenomenon of impairment and its prevention in the profession from 1995 to 2005? (Note: You may indicate more than one choice.)
   (a) Direct clinical work: # of psychologists whom you have helped
   (b) Publication on impairment/its prevention: # as 1st author, # as 2nd author
   (c) Presentation on impairment/its prevention: # in national conference, # in regional conference
   (d) Research on impairment/its prevention: # of research projects
   (e) Teaching on impairment/its prevention: # of courses
   (f) Working committee on impairment/its prevention:
      # of years of appointment Which committee(s)
   (g) Others:

Part II: Preventive Measures in Graduate Training Against Future Impairment of Professionals

Instruction: The following is a list of suggested preventive measures in graduate training against future impairment of professionals. [The first 29 items are derived from the results of a study by Schwebel and Coster (1998), and the remaining 9 items are derived from a literature review by the researchers.] Please review all the items first, and then indicate your opinion concerning how important each one of them is by circling one of the five choices:
0 = unimportant, 1 = less important, 2 = important, 3 = very important, 4 = essential.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Content</th>
<th>Unimportant</th>
<th>Less Important</th>
<th>Important</th>
<th>Very Important</th>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Select trainees more carefully</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2.</td>
<td>Identify and handle trainees early who have problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Depoliticize admission process</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Increase financial aid and assistance to students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5.</td>
<td>Reduce demands in the curriculum</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6.</td>
<td>Require students to receive therapy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7.</td>
<td>Create ongoing support group for students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Promote students' balanced lifestyle and self-care</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9.</td>
<td>Encourage self-awareness of students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10.</td>
<td>Develop a sense of community among students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11.</td>
<td>Develop peer relationships in profession</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12.</td>
<td>Promote personal identity</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13.</td>
<td>Promote personal and professional growth</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14.</td>
<td>Promote openness to feedback</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15.</td>
<td>Reinforce acceptability of asking for help</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16.</td>
<td>Provide relationship enhancement skill training</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>Use faculty to model well-functioning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>Emphasize ongoing direct supervision and feedback</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>Include impairment and its prevention in course content</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>Include the issue of impairment in ethics training</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>Give more attention to students by faculty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>Provide workshops to students on impairment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>Help students to integrate research, course and practice</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>Provide informal discussion of impairment in training program</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>Provide stress management workshops to students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>26.</td>
<td>Provide information to students about professional life after graduation</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>27.</td>
<td>Teach students debriefing for traumatic case</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>28.</td>
<td>Provide retreats for students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>29.</td>
<td>Promote peer supervision among students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>30.</td>
<td>Restructure training program to focus on the well-being of students</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>31.</td>
<td>Provide well-planned modules on personal and professional self-care</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>32.</td>
<td>Help students to be aware of the risks of impairment in the profession</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>33.</td>
<td>Help students understand the impact of personal life events to their professional functioning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>34.</td>
<td>Prepare students for the rewards and hazards of the profession</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>35.</td>
<td>Require students to take a course on impairment and its prevention</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>36.</td>
<td>Facilitate students to develop self-care skills/ habits</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>37.</td>
<td>Help students to learn about resources for assistance in the profession regarding impairment</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>38.</td>
<td>Help students to be aware of their own ability to create supportive organizational environment and to provide assistance to distressed colleagues</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

In additional to the above suggestions, please list, if any, other important preventive measures in graduate training against future impairment in the following space:

39.

40.

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Part III  Suggestions for Successful Implementation of the Most Important Measures

Instructions: From the list in Part II (including your suggested items), please choose the top 5 priorities and write their item numbers in the following. Then, for each of these 5 measures, please make comments, by listing, on what is(are) needed/included in order to make it successful in implementation, or how to make it successful in implementation.

1st choice: item # ______

Comments:
1. 

2. 

3. 

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2nd choice: item # ______

Comments:
1.

2.

3.

3rd choice: item # ______

Comments:
1.

2.

3.

4th choice: item # ______

Comments:
1.

2.

3.
Part IV Nomination of Clinical Experts

Instructions: We also want to invite psychologists who have the clinical expertise of helping other psychologists (at least three) with issues on impairment, to participate in this Delphi study. Therefore, we would like to request your nomination for these psychologists. If you know of such psychologists, please recommend to us with their names and contact information in the following:

Name                                  Contact information (Address/phone #/email address)

1.

2.

3.

--End--

Thank you very much for completing this questionnaire!

Please use the pre-stamped envelope provided in the packet and mail the completed questionnaire back to the researchers! Please remember to include the signed copy of the consent form!
Appendix D

Second Invitation Letter
Re: SECOND INVITATION TO BE OUR EXPERT PANELIST

Dear Dr. (Last Name of Panel Expert):

We sent an invitation to you approximately 3 weeks ago. Since we haven’t received your feedback, we would like to send you a second invitation to ask you to consider participating in our study. If you have already sent us your feedback and it is still on its way back to us, you may ignore this second invitation and package.

We are conducting a Delphi study, which has been approved by the Human Subject Institutional Review Board (HSIRB) at Western Michigan University, concerning important preventive measures in graduate professional psychology training against future impairment. We would very much like to invite you to be one of the expert participants of this study who have expertise in the area of impairment and its prevention in professional psychology. Expertise is based upon at least one of the four criteria: (1) contributing scholarly to the understanding of impairment/its prevention (being a 1st author at least once or a 2nd author at least twice on the topic of professional impairment or its prevention), (2) providing education on the prevention against impairment through workshop/seminar at a previous annual conference of the American Psychological Association, (3) serving in APA Advisory Committee on Colleague Assistance or state psychological association colleague assistance committee, or (4) being recommended by other experts as having direct clinical intervention expertise (helping at least three psychologists with issues of professional impairment). By giving your expert opinions, your participation in this study will therefore be very invaluable in shedding light upon early prevention measures in graduate training against future impairment.

The Delphi method is a research tool that solicits opinions from experts of a field and facilitates structured communication among the experts, in the hope of obtaining consensus from the experts regarding the area of interest in the study. The process of this Delphi study consists of two rounds of survey:

1. In this first round, you are requested to sign one of the HSIRB consent forms and to complete a Delphi Questionnaire (I). Then, you are requested to return the signed consent form (keep the second for your files) and the questionnaire to us in the included stamped envelope. After we receive all the panel experts’ questionnaires, data analysis will be done by us.

2. Then, a second round of survey will be carried out. A Delphi Questionnaire (II), including the results of the first round, will be mailed to you. You will be asked to reevaluate your opinions after you have reviewed the summarized results of the first round, and to return the completed questionnaire to us with an included stamped envelope.

We hope that you will consider our invitation to be one of the expert panelists in this research. If after reading the consent document, you decide to participate; then please sign the consent document and complete the attached Delphi Questionnaire (I). Then, please return the signed consent form and the questionnaire to us by using the attached stamped envelope as soon as you are convenient. Thank you for considering our invitation and spending your precious time to give us your expert opinions!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.

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Sincerely,

Kin-Ming Chan, MSW  James M. Croteau, PhD
Doctoral Student in Counseling Psychology  Professor

Department of Counselor Education and Counseling Psychology
Western Michigan University
Re: LAST INVITATION TO BE OUR EXPERT PANELIST

Dear Dr. (Last Name of Panel Expert):

We sent two invitations to you earlier. Since we haven’t received your feedback, we would like to send you a last invitation to ask you to consider participating in our study. If you have already sent us your feedback and it is still on its way back to us, you may ignore this invitation and package.

We are conducting a Delphi study, which has been approved by the Human Subject Institutional Review Board (HSIRB) at Western Michigan University, concerning important preventive measures in graduate professional psychology training against future impairment. We would very much like to invite you to be one of the expert participants of this study who have expertise in the area of impairment and its prevention in professional psychology. Expertise is based upon at least one of the four criteria: (1) contributing scholarly to the understanding of impairment/its prevention (being a 1st author at least once or a 2nd author at least twice on the topic of professional impairment or its prevention), (2) providing education on the prevention against impairment through workshop/seminar at a previous annual conference of the American Psychological Association, (3) serving in APA Advisory Committee on Colleague Assistance or state psychological association colleague assistance committee, or (4) being recommended by other experts as having direct clinical intervention expertise (helping at least three psychologists with issues of professional impairment). By giving your expert opinions, your participation in this study will therefore be very invaluable in shedding light upon early prevention measures in graduate training against future impairment.

The Delphi method is a research tool that solicits opinions from experts of a field and facilitates structured communication among the experts, in the hope of obtaining consensus from the experts regarding the area of interest in the study. The process of this Delphi study consists of two rounds of survey:

(1) In this first round, you are requested to sign one of the HSIRB consent forms and to complete a Delphi Questionnaire (I). Then, you are requested to return the signed consent form (keep the second for your files) and the questionnaire to us in the included stamped envelope. After we receive all the panel experts’ questionnaires, data analysis will be done by us.

(2) Then, a second round of survey will be carried out. A Delphi Questionnaire (II), including the results of the first round, will be mailed to you. You will be asked to reevaluate your opinions after you have reviewed the summarized results of the first round, and to return the completed questionnaire to us with an included stamped envelope.

We hope that you will consider our invitation to be one of the expert panelists in this research. If after reading the consent document, you decide to participate; then please sign the consent document and complete the attached Delphi Questionnaire (I). Then, please return the signed consent form and the questionnaire to us by using the attached stamped envelope as soon as you are convenient. Thank you for considering our invitation and spending your precious time to give us your expert opinions!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.
Sincerely,

Kin-Ming Chan, MSW  
Doctoral Student in Counseling Psychology

James M. Croteau, PhD  
Professor

Department of Counselor Education and Counseling Psychology  
Western Michigan University
Appendix F

Acknowledgement Note
Dear Dr. (Last Name of the Panel Expert):

Thank you very much for participating in our study entitled "A Delphi Survey of Experts' Opinions Regarding Prevention of Impairment in Professional Psychology Training." We very much appreciate the time and effort that you have put forth in completing the first round questionnaire for us. We will contact you again for the second round data collection after we have completed the first round data collection and data analysis.

Best wishes!

Sincerely,

Kin-Ming Chan, MSW                        James M. Croteau, PhD
Doctoral Student in Counseling Psychology       Professor

Department of Counselor Education and Counseling Psychology
Western Michigan University
Appendix G

Cover Letter of Second Round Survey
Dear Dr. (Last Name of Panel Expert):

Thank you very much for your participation as one of our expert panelists in our Delphi study! We received your valuable opinions as well as those of other expert panelists. We have already had the analyzed results of the first round survey in this second, as well as the last, round of our survey.

Just to serve as a reminder to you, this is a Delphi study concerning important preventive measures in graduate professional psychology training against future impairment in professionals. We have invited experts, like you, who have expertise in the area of impairment and/or its prevention in professional psychology. Expertise is based upon at least one of the four criteria: (1) contributing scholarly to the understanding of impairment/its prevention (being a 1st author at least once or a 2nd author at least twice on the topic of professional impairment or its prevention), (2) providing education on the prevention against impairment through workshop/seminar at a previous annual conference of the American Psychological Association, (3) serving in APA Advisory Committee on Colleague Assistance or state psychological association colleague assistance committee, or (4) having direct clinical intervention experience (helping at least three psychologists with issues of professional impairment). The Delphi method is a research tool that solicits opinions from experts in a field and that facilitates structured communication among the experts, in order to seek consensus among these experts. There are two rounds of surveys in this Delphi study and you have already completed the first round survey.

We appreciate your time reading this letter. Please complete the attached Delphi Questionnaire (II), and send it back to us using the stamped envelope in this package in two weeks time. This will complete your participation in the study.

Again, thank you very much for contributing your expert opinions in this study! We greatly appreciate your time and effort being spent in the process!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.

Sincerely,

Kin-Ming Chan, MSW
Doctoral Student in Counseling Psychology
Western Michigan University.

James M. Croteau, PhD
Professor
Department of Counselor Education and Counseling Psychology
Western Michigan University.
Appendix H

Delphi Questionnaire II
In this study, *impairment* is defined as a decline in professional functioning to substandard performance due to the occurrence of distress.

### Part I: Results of First Round Delphi Survey and Further Comments

*Instructions: Please review section A and B in this part, and then give your comments in section C.*

(A) The following is a list of suggested preventive measures in graduate training against future impairment of professionals. Item 1-38 are the ones that all expert panelists rated in the first round survey and re-arranged according to their resulting relative importance in descending order. Item 39-83 are the ones that expert panelists, including you, added to the list. The mean (M) and standard deviation (SD) of each item are reported accompanying the original 38 items. The mean informs you of the average rating of the whole panel for the item on a scale from 0 to 4 (0 = *unimportant*, 1 = *less important*, 2 = *important*, 3 = *very important*, 4 = *essential*). The standard deviation informs you of how much the whole panel agrees upon rating of an item. The bigger the standard deviation is, the less agreement the panelists have toward the item; on the other hand, the smaller the standard deviation is, the more agreement the panelists have toward the item.

<table>
<thead>
<tr>
<th>Item #</th>
<th>Preventive Measure in Graduate Training Against Future Impairment of Professionals</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Reinforce acceptability of asking for help</td>
<td>3.70</td>
<td>0.54</td>
</tr>
<tr>
<td>2.</td>
<td>Include the issue of impairment in ethics training</td>
<td>3.59</td>
<td>0.57</td>
</tr>
<tr>
<td>3.</td>
<td>Identify and handle trainees early who have problems</td>
<td>3.54</td>
<td>0.58</td>
</tr>
<tr>
<td>4.</td>
<td>Include impairment and its prevention in course content</td>
<td>3.50</td>
<td>0.69</td>
</tr>
<tr>
<td>5.</td>
<td>Encourage self-awareness of students</td>
<td>3.46</td>
<td>0.79</td>
</tr>
<tr>
<td>6.</td>
<td>Promote openness to feedback</td>
<td>3.43</td>
<td>0.69</td>
</tr>
<tr>
<td>7.</td>
<td>Help students to be aware of the risks of impairment in the profession</td>
<td>3.43</td>
<td>0.74</td>
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<tr>
<td>8.</td>
<td>Promote personal and professional growth</td>
<td>3.37</td>
<td>0.69</td>
</tr>
<tr>
<td>9.</td>
<td>Help students understand the impact of personal life events to their professional functioning</td>
<td>3.32</td>
<td>0.72</td>
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<td>10.</td>
<td>Promote students’ balanced lifestyle and self-care</td>
<td>3.29</td>
<td>0.98</td>
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<tr>
<td>11.</td>
<td>Help students to learn about resources for assistance in the profession regarding impairment</td>
<td>3.25</td>
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<tr>
<td>12.</td>
<td>Help students to be aware of their own ability to create supportive organizational environment and to provide assistance to distressed colleagues</td>
<td>3.21</td>
<td>0.69</td>
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<tr>
<td>13.</td>
<td>Prepare students for the rewards and hazards of the profession</td>
<td>3.18</td>
<td>0.77</td>
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<tr>
<td>14.</td>
<td>Emphasize ongoing direct supervision and feedback</td>
<td>3.14</td>
<td>1.04</td>
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<tr>
<td>15.</td>
<td>Facilitate students to develop self-care skills/habits</td>
<td>3.11</td>
<td>1.07</td>
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<tr>
<td>16.</td>
<td>Develop peer relationships in profession</td>
<td>3.07</td>
<td>0.66</td>
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<td>17.</td>
<td>Provide information to students about professional life after graduation</td>
<td>3.07</td>
<td>0.77</td>
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<td>18.</td>
<td>Use faculty to model well-functioning</td>
<td>3.04</td>
<td>1.04</td>
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<tr>
<td>19.</td>
<td>Develop a sense of community among students</td>
<td>2.96</td>
<td>0.88</td>
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<tr>
<td>20.</td>
<td>Promote personal identity</td>
<td>2.86</td>
<td>0.89</td>
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<tr>
<td>21.</td>
<td>Provide informal discussion of impairment in training program</td>
<td>2.82</td>
<td>0.67</td>
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<tr>
<td>22.</td>
<td>Provide workshops to students on impairment</td>
<td>2.75</td>
<td>0.84</td>
</tr>
<tr>
<td>23.</td>
<td>Create ongoing support group for students</td>
<td>2.75</td>
<td>0.84</td>
</tr>
<tr>
<td>24.</td>
<td>Provide well-planned modules on personal and professional self-care</td>
<td>2.75</td>
<td>0.97</td>
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<tr>
<td>25.</td>
<td>Select trainees more carefully</td>
<td>2.64</td>
<td>1.13</td>
</tr>
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<td>26.</td>
<td>Teach students debriefing for traumatic case</td>
<td>2.64</td>
<td>1.31</td>
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<td>27.</td>
<td>Give more attention to students by faculty</td>
<td>2.57</td>
<td>0.79</td>
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<td>28.</td>
<td>Provide stress management workshops to students</td>
<td>2.43</td>
<td>1.00</td>
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<td>29.</td>
<td>Restructure training program to focus on the well-being of students</td>
<td>2.18</td>
<td>1.09</td>
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<tr>
<td>30.</td>
<td>Provide relationship enhancement skill training</td>
<td>2.15</td>
<td>1.03</td>
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<tr>
<td>31.</td>
<td>Require students to take a course on impairment and its prevention</td>
<td>2.14</td>
<td>1.24</td>
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<tr>
<td>32.</td>
<td>Require students to receive therapy</td>
<td>2.11</td>
<td>1.19</td>
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<tr>
<td>33.</td>
<td>Promote peer supervision among students</td>
<td>1.96</td>
<td>0.88</td>
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<tr>
<td>34.</td>
<td>Help students to integrate research, course and practice</td>
<td>1.96</td>
<td>1.19</td>
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<td>35.</td>
<td>Provide retreats for students</td>
<td>1.48</td>
<td>1.01</td>
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<tr>
<td>36.</td>
<td>Increase financial aid and assistance to students</td>
<td>1.46</td>
<td>1.00</td>
</tr>
<tr>
<td>37.</td>
<td>Depoliticize admission process</td>
<td>1.44</td>
<td>1.04</td>
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<tr>
<td>38.</td>
<td>Reduce demands in the curriculum</td>
<td>0.82</td>
<td>0.67</td>
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<tr>
<td>39.</td>
<td>Select trainees committed to continuing growth</td>
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<td>40.</td>
<td>De-emphasize GREs and GPAs in selecting students</td>
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<td>41.</td>
<td>Provide info about stages in professional growth along with life development stages</td>
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<td>42.</td>
<td>Promote the exploration of students’ personal values in relation to their professional work throughout training</td>
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<td>43.</td>
<td>Foster safety in professional forums for discussion of challenges, limitations and failures at work</td>
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<td>44.</td>
<td>Educate students regarding specific occupational hazards, etiology and vulnerability</td>
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<td>45.</td>
<td>Encourage students to continue to work on their personal issues in therapy and involve in self-growth activities after graduation</td>
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<td>46.</td>
<td>Encourage students to continue to receive supervision from an experienced professional after graduation</td>
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<td>47.</td>
<td>Develop ongoing relationship with professionals in the field to provide modeling</td>
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<td>48.</td>
<td>Provide training on the diagnosis and treatment of chemical dependency in professionals</td>
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<td>49.</td>
<td>Help students assess their own personal risk for impairment</td>
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<td>50.</td>
<td>Help students understand that asking for help is rare among professionals and that the most likely help obtained is through the intervention of colleagues</td>
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<td>51.</td>
<td>Address understanding of impairment by faculty, administrators, supervisors, and university attorneys</td>
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<td>52.</td>
<td>Develop clear model for early intervention and remediation that involve proper assessment, remediation contracts and attainment of desired outcome</td>
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<td>53.</td>
<td>Focus on competency of professional behaviors that can be assessed and are relevant to professional functioning</td>
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<td>54.</td>
<td>Refine definition of impairment by including not attaining or displaying professional competence</td>
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<td>55.</td>
<td>Clarify program policies about the role of personal therapy in remediation plans</td>
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<td>56.</td>
<td>Establish clearer professional standards for minimal levels of competence to advance in program and graduate from program</td>
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<td>57.</td>
<td>Make psychological healthiness, in direct connection to professional functioning, as a critical component of annual evaluation process</td>
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<td>58.</td>
<td>Clarify at time of admission program policies concerning remediation</td>
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<td>59.</td>
<td>Provide students a safe environment to discuss issues that they are concerned about</td>
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<td>60.</td>
<td>Help students learn to engage in critical thinking about themselves and others</td>
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<td>61.</td>
<td>Give students skills and support to intervene with distressed peers</td>
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<td>62.</td>
<td>Develop student assistance committee for the program emphasizing prevention &amp; rehabilitation</td>
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<td>63.</td>
<td>Encourage dissertation research in the area of distress-impairment continuum</td>
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<td>64.</td>
<td>Train faculty in area of stress-distress-impairment research and intervention with students</td>
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<td>65.</td>
<td>Link appropriate student assistance program with the Dean of student office and academic standing committee</td>
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<td>66.</td>
<td>Screen students for substance abuse (potential) and provide resources for those who may require assistance in the future</td>
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<td>67.</td>
<td>Consider use of psychological tests for admission to address suitability for field</td>
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<td>68.</td>
<td>Require honesty in letters of recommendation to identify concerns when they exist</td>
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<td>69.</td>
<td>Develop better measures of student functioning and train faculty to use them candidly</td>
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<td>70.</td>
<td>Teach faculty how to identify and confront impairment</td>
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<td>71.</td>
<td>Update ethics code to require honesty and candor in evaluation of trainees</td>
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<td>72.</td>
<td>Provide students information of the incidence of impairment in all health professions</td>
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<td>73.</td>
<td>Have recovering role models participate in seminars and share their stories of recovery</td>
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<tr>
<td>74.</td>
<td>Help students know that psychologists are as vulnerable to mental illness and substance abuse as anyone else</td>
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<td>75.</td>
<td>Notice early signs of chemical dependency or impulse control disorders of students</td>
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<tr>
<td>76.</td>
<td>Encourage early treatment for chemical dependency or impulse control disorders of students</td>
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<tr>
<td>77.</td>
<td>Debunk shame of mental disorders in graduate students or psychologists</td>
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<tr>
<td>78.</td>
<td>Encourage early treatment for mood disorders of students</td>
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<tr>
<td>79.</td>
<td>Encourage students to join psychological associations or peer support groups after graduation to reduce isolation</td>
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<td>80.</td>
<td>Encourage mentor relationships outside of graduate program</td>
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<td>81.</td>
<td>Help students to be familiar with literature on universal risks as much or more than impairment</td>
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<tr>
<td>82.</td>
<td>Use of countertransference as part of prevention training on relational models of boundary maintenance</td>
<td></td>
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<tr>
<td>83.</td>
<td>Emphasize prevention of occupational hazards and self care specific to risks of work such as vicarious traumatization</td>
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</tbody>
</table>
(B) The following is a summary from the first round survey regarding top choices of important preventive measures which were selected by all the panelists and the considerations for successful implementation of these measures.

<table>
<thead>
<tr>
<th>Preventive Measure</th>
<th>Considerations for Successful Implementation</th>
</tr>
</thead>
</table>
| 1. Reinforce acceptability of asking for help | - Training programs create a climate that includes self-care, balance, help-seeking, and open discussion of these issues.  
- Training programs make it clear on a department level that seeking help is not only acceptable, but a normal, encouraged behavior for everyone.  
- Training programs help students be aware that no one is expected to be invulnerable and everyone will need assistance at some point in time.  
- Training programs encourage students to talk about challenges.  
- Training programs create culture in which asking for help is valued rather than subtly or overtly defined as incompetence.  
- Training programs have direct supervisor/adviser emphasize this one on one with each student.  
- Every year, training programs convey to all students their full commitment to assist students who need help without punishment.  
- Training programs help students be aware that if we have this courage and habit of asking for help, we will be less likely to become impaired.  
- Training programs encourage students to form peer support groups and establish ongoing supervision after graduation.  
- Training programs encourage students to join professional communities and participate actively after graduation.  
- Training programs explain this as a professional/ethical challenge and responsibility.  
- Men in the profession, both professional and trainee, seem to have a much harder time asking for help, like the general population. Men wait until the crisis point before asking for help. |
| 2. Include the issue of impairment in ethics training | - Training programs use case examples of how distress/impairment leads to poor judgment or unacceptable conduct.  
- Training programs include modules in curriculum such as ethics and the law.  
- Training programs design materials to be used in appropriate training curriculum, such as courses of ethics, assessment, and professional issues.  
- Training programs identify sources for impairment to students.  
- Students need to know personal responsibility for one’s own impairment.  
- Training programs teach students how to intervene with peers who may be impaired.  
- Training programs emphasize the necessity of openness throughout training as a matter of professional development  
- Training programs draw greater attention to assessment and responsibility issues regarding impairment.  
- Training programs tie mindfulness of impairment to ethical practice  
- Training programs articulate connection between impairment and unethical practice. |
| 3. Identify and handle trainees early who have problems | - All the preventive education of impairment is undermined if faculty are unable/unwilling to identify and assist vulnerable students; hence, faculty need to confront the students & offer assistance.  
- Fellow students may be the first to notice a problem; therefore it must be desirable for them to bring this to the attention of faculty/supervisors.  
- Training programs have outside resources available to help struggling students.  
- Faculty must meet regularly with students, monitor their ongoing functioning, speak to students when minor concerns arise, and offer non-punitive assistance.  
- Training programs normalize help-seeking.  
- Training programs create an environment that encourages openness to help-seeking. |
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and actions to promote wellness.
- Training programs introduce in handbook all early program guidance, such as due
  process and good ethics.
- Training programs develop plan in advance and review with students, administrators,
  and others to make sure all parties are aware of and accepting the plan before there is
  a problem.
- Training programs teach in ethics and other courses, both trainee and practitioner
  issues of stress-distress-impairment continuum.
- Faculty provide early intervention and regular monitoring by making minimum
  standards of competence clear to students early in training
- Training programs create good remediation plan that addresses specific concerns
  identified as problematic, and require continuing remediation until problems are
  adequately addressed.
- Faculty need to be more willing to dismiss students who do not reach minimum
  standard of professional competence after remediation
- Training programs require candor in trainee evaluations; and teach faculty how to do
  it, when to do it, and the need/benefits for doing it for the field.
- Training programs provide frequent, direct and honest formative and summative
  feedback of trainees.
- Training programs counsel students out of programs when trainee functioning is not
  acceptable.
- Research shows that any kind of intervention or feedback helps promote self-
  recognition of problems and recovery
- Interns have been found with personal problems or characteristics that impede their
  clinical training, and that their faculty ignored and left to internship sites to deal with.
  Hence, closer and more assertive faculty supervision/evaluation are needed.

<table>
<thead>
<tr>
<th>4. Include impairment and its prevention in course content</th>
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</table>
| - As with ethics, understanding the potential for impairment, identifying risk factors, and most importantly, prevention of impairment should be woven throughout the training process, including course content.
- It can be a powerful educational tool for faculty or supervisor to share the impact of specific patients or personal life events on their ability to be effective.
- Training programs can use didactic education.
- Training programs can use experiential workshops.
- Training programs make the topic a noticeable part of curriculum.
- Training programs introduce students to consequences of impairment on clients and profession early in graduate program prior to any problems being identified.
- Training programs discuss with students about how they will handle this among themselves and what faculty expect of them if they observe peers who are functioning poorly, unethically or illegally. Faculty make clear of the expectations to students early and ongoing.
- Training programs embed well-being and growth across the curriculum.
- Training programs include information on the emotional rewards of professional work.
- It is essential for training programs to help students to know their risks and how to seek help.
- Item 2, 4, 22 & 21 share the same objective |

<table>
<thead>
<tr>
<th>5. Encourage self-awareness of students</th>
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</table>
| - In didactic courses, training programs encourage students to critically evaluate course content with a focus on what aspects make sense for them, and how that differs from one person to the next.
- In experiential work, such as practicum and internship settings, supervisors support the self-awareness of students, especially in context of providing treatment to others.
- Students’ own therapy can enhance self-awareness, but making it mandatory for all may be too much of a burden. Financial considerations, available skilled therapists, and individual level of self-awareness may all be factors in deciding who would best benefit.
- Training programs facilitate open discussion of different issues. |
1. **Training programs** require journaling and discussion of personal experiences in peer supervision or supervisory format.
2. **Training programs** encourage personal therapy for students.
3. **Training programs** require students to identify their own personal value systems and how they fit with ethical codes.
4. **Training programs** use supervision and other forums to encourage self-awareness.
5. **Training programs** utilize systematic strategies for the training and use of self-assessments.
6. **Training programs teach self-monitoring.**
7. **Training programs** teach students to look for danger signs.

6. **Promote openness to feedback**
   - Training programs provide a safe context for the provision of feedback.
   - Training programs encourage students to offer feedback about all aspects of the program.

7. **Help students to be aware of the risks of impairment in the profession**
   - Many students are very idealistic about helping clients and are ill prepared for demands of providing good therapy to difficult clients.
   - Training programs help students examine their readiness for difficulties of profession.
   - Training programs counsel students who are threatened by the demand of profession into less demanding professions.
   - Training programs encourage students to examine how competence problems would negatively impact performance in the domain of relevance; such as providing examples in supervision and courses.

8. **Promote personal and professional growth**
   - Students starting graduate school are often uprooted from support systems. Training programs create ways to encourage students to meet others, in addition to fellow students, to form new social support.
   - Training programs provide information of cultural and recreational opportunities, and make available access to such activities.
   - Training programs encourage students to explore and experience new things.
   - Training programs provide opportunities for students to explore different professional opportunities.
   - Training programs create opportunities for students to meet with professionals who could be mentors/supervisors.
   - Training programs emphasize individualized personal growth.
   - Training programs have a course on self-care.

9. **Help students understand the impact of personal life events to their professional functioning**
   - Training programs need to use more case study analysis in impairment training.
   - Supervisors focus on the parallel process in supervision.
   - Training programs teach problem solving regarding ways to minimize the negative effects of personal challenges on work functioning.
   - Training programs encourage self-assessment.
   - Training programs emphasize relationship between personal experiences/emotions and practice.
   - Training programs teach about counter transference.
   - Item 1 & 9 are related.
   - Students and young psychologists often don't adequately understand the impact of personal events on their professional functioning or how to deal with them. Consequently, some psychologists avoid or behave rigidly concerning some problems, or continue to treat patients with these problems. This is sometimes a form of denial or an attempt to work through one's own issues.

10. **Promote students' balanced lifestyle and self-care**
    - Training programs teach courses in self-care.
    - Faculty model balance lifestyle and good self-care.
    - Training programs help students plan their self-care and have their plan followed up by supervisors.
    - Training programs promote self-evaluation and follow-up.
    - Training programs teach optimal health practices; such as physical exercise, mindfulness, and nutrition.
- Training programs encourage students to develop interests other than psychology.
- Training programs reframe the issue of impairment to one of self-care and self-growth to reduce stigma.
- Training programs establish a friendly and open atmosphere in the program.
- Training programs teach positive psychology.
- Students are often very driven and highly focused. They fail to maintain normal activities, neglect relationships and reduce the diversity of activities and rewards. Hence, this may result in negative consequences of lost relationships and impaired health.

### 11. Help students to learn about resources for assistance in the profession regarding impairment

- Students should know what resource is available in and out of their profession in a de-stigmatized way.

### 12. Help students to be aware of their own ability to create supportive organizational environment and to provide assistance to distressed colleagues

- Training programs educate students about peer assistance committees in psychology and other professions.
- Training programs educate students concerning the need for volunteer assistance for peer assistance committees to function.
- Training programs provide case discussions about how psychologists identify problems in developing impairment conditions and the most effective and ethical ways of finding help.
- Graduate schools rarely encourage students to participate in state organizations which can be invaluable assets.
- Training programs often do not know that state professional impairment programs exist.
- Training programs should tell students how to refer an impaired professional to a colleague assistance program and when to consider self-referral.

### 13. Prepare students for the rewards and hazards of the profession

- Training programs identify to the students all the elements of professional practice, such as financial and political.
- Training programs help students understand the impact of being a psychologist on their own family.
- Training programs provide for students readings on professional stressors.
- Training programs create contacts between students and established professionals.

### 14. Emphasize ongoing direct supervision and feedback

- Supervision following a degree is the best burnout preventive.
- Supervisor must focus on parallel processes.
- The most crippled psychologists exhibit grandiosity that prevent them from being influenced by others.
- Formative and summative feedback is critical to identifying potential problems that may be affecting professional functioning.
- Students' responses to feedback are critical indicators of their ability to develop adequate professional skills. Openness and willingness to be curious about feedback are critical skills that need to be taught early and monitored in an ongoing way.
- Supervision and feedback can be open for personal issues only if it is separated from academic evaluation; i.e., it can't be graded or students won't/ can't/ shouldn't be fully open.

### 15. Facilitate students to develop self-care skills/habits

- Training programs provide opportunities for students to work and play together to form support systems.
- Training programs promote safety in expression of worries, differences, and self-disclosure.
- Faculty and supervisors should ask about and respond to the elevated stress levels of students. They should help the students to solve problems. They should give permission overtly for students to take care of themselves even if it means missing

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| 16. Develop peer relationships in profession | It is essential to prevention of impairment to have collegial relationships that provide honest and direct support. Study groups, supervision groups, and therapy groups would be helpful. |
| 17. Provide information to students about professional life after graduation | Realistic job previews are a solid burnout preventative. Glamorizing the profession guarantees burnout. Providing practical info on professional life after graduation would reduce burnout and impairment. It would also help keep people in the profession longer. Students are often clueless about the actual demands of the profession, especially in terms of paper work. Such knowledge helps normalize the process of a day in the life of a therapist. Training programs can convey the importance of not becoming isolated and the danger of grandiolizing ourselves. Training program can help students understand the responsibility and power of a PhD with a license, and how it can seduce us into thinking we know. It is important to avoid political correctness and to value open and honest communication among colleagues. |
| 18. Use faculty to model well-functioning | Training well-functioning students begin with the role-modeling of well-functioning by faculty. Faculty model appropriate self-care through limit setting, striking a balance, saying "no" when needed, exercises/ sleep, and other aspects of self-care. Faculty openly discuss with students self-care strategies, challenges, and efforts. Training programs increase such importance. The systems of training programs should not work against well-functioning. It is only possible to cultivate a climate of balanced lifestyle, ethics and integrity when faculty live it as well as expect it of students. Training program should address faculty impairment issues if present. Faculty teach, role-play, and model how to address issues. Faculty model emotional openness, assertiveness and honesty. Faculty need to monitor open discussion of problems that they have had professionally, not just successes and how they deal with challenges, both personal and professional. Training programs should first orient faculty to model and provide training to them so that faculty can do a better job in modeling. Well functioning includes some self-disclosure of conflicts and professional traumas. Faculty make explicit their expectations of students and how to “work smart” as well as “work hard.” Faculty show compassion and kindness whenever possible. Training programs raise awareness among faculty that they exemplify well-functioning psychologists in class, supervision & informal relationship and that their modeling is making an important contribution to the development of the students. Training program bear this role in mind when hiring faculty. |
| 19. Develop a sense of community among students | A strong social support is one of the key buffers in reducing distress. Training programs include more collaborative and cooperative learning assignments in classes. Training programs promote students’ involvement in professional associations. Training programs structure courses and curriculum to foster cooperation and trust rather than competition among students. |
| 22. Provide | Training programs teach in ethics and other courses, both trainee and practitioner |
| 24. Provide well-planned modules on personal and professional self-care | It is essential that good self-care starts early in training.  
- Therapist can often tell others what to do but can't follow their own recommendations.  
- It is important to have some clear guidelines to help students assess their own level of well-being. |
| 25. Select trainees more carefully | - Trainees come to programs with much of their personal problems & susceptibility to stress already set.  
- Students can receive good training on impairment yet still become impaired.  
- Students can be led to ideas about lifestyle habits, but they can still refuse to follow them.  
- Training programs seek greater self-disclosure of students  
- Training programs seek more comprehensive collateral information of students  
- Training programs teach how to counsel inappropriate candidates from entering field  
- Training programs address financial incentives so they don’t keep inappropriate students  
- Students are often selected based primarily on their academic achievements & research potential rather than their overall adjustment, ability to relate, demonstrated balance in life, range of interests and life experiences. |
| 26. Teach students debriefing for traumatic case | - Training programs educate students concerning vicarious traumatization and compassion fatigue.  
- Training programs increase students' understanding of trauma and post trauma sequels.  
- Training programs can normalize trauma experience and link to personal history when appropriate. |
| 27. Give more attention to students by faculty | - Training programs should model good nurturing and caring environment.  
- Training programs should focus on students' well-being so that students can learn these skills and pass them on. |
| 28. Provide stress management workshops to students | - Graduate students often have poor stress management skills. Education in this area would help them live a more balanced life.  
- It is important to role model well-being to our clients. Clients will not want help from an unhealthy, stressed out therapist.  
- Quality of life would be better for therapist, their families, and everyone they work with. |
| 29. Restructure training program to focus on the well-being of students | - Training programs put students' well-being first.  
- Training programs review components of curriculum to ascertain if they contribute to the development of well-functioning psychologists |
| 32. Require students to receive therapy | - This is an important role-modeling technique to help students be aware of the pros and cons of doing therapy personally, in order to make them more compassionate with clients.  
- There are always things to process in therapy as a result of being in graduate school facing many difficulties.  
- We need to support our profession by using the services and believing in the benefits of therapy.  
- Training programs assure confidentiality in the guidelines for such a requirement.  
- Our own therapy teaches us more than a million courses. We all need it to be good therapists and know ourselves better. |
| 34. Help | - Training programs generate research possibilities in this under researched area. |
| students to integrate research, course and practice | -A good way to strengthen the profession is to implement solid programs in our training programs.  
-Training programs coordinate efforts with APAGS. |
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>38. Reduce demands in curriculum</td>
<td>-Students can’t be expected to practice good self-care upon graduation after years of not having a “life” and “dehumanized” by training programs.</td>
</tr>
</tbody>
</table>
| 43. Foster safety in professional forums for discussion of challenges, limitations and failures at work | -Professionals and faculty provide modeling to students.  
-Training programs increase open forum discussions. |
| 46. Encourage students to continue to receive supervision from an experienced profession after graduation | -Ongoing case consultation especially in private practice is critical to therapist and therapist’s clients.  
-It helps keep the therapist practicing within the legal and ethical boundary.  
-It helps regardless of work setting.  
-It provides much needed support and validation in an otherwise isolated private practice. |
| 51. Address understanding of impairment by faculty, administrators, supervisors, and university attorneys | -Larger systems are crucial. University attorneys, deans and department chairs must be knowledgeable about the issues, due process, etc. If not, the fear and threat of a student’s litigation will intimidate and things will become adversarial and get worse.  
-Knowledge of legal precedents may be very helpful in promoting good planning and actions. |
| 62. Develop a student assistance committee for the program emphasizing prevention & rehabilitation | -Training programs develop a colleague assistance program for those in training.  
-Research indicates that colleague assistance program is needed in training programs.  
-Careful examination of legal/ethical component is needed along with a collaborative effort between trainees and training program.  
-A joint task force may be needed to study the models and recommend to the administration. |
| 70. Teach faculty how to identify and confront impairment | -Training programs require candor in trainee evaluation.  
-Faculty need to know how to do candid trainee evaluation, when to do it, and the need/ benefits for doing it for the field.  
-Newer faculty need to be monitor and supervised by senior faculty because they may be more naïve about their responsibilities and may not realize that they are likely to confront impairment issues.  
-Training programs develop protocols for addressing trainee problems early.  
-Training programs encourage faculty discussion of strengths and concerns of students. |
<p>| 71. Update ethics code to | -Currently, professionals who write letters for students for jobs and internships view their role as advocates for students more than gatekeepers for the profession. |</p>
<table>
<thead>
<tr>
<th>Requirement</th>
<th>Details</th>
</tr>
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<tr>
<td>Require honesty in evaluation of trainees</td>
<td>Psychology faculty and supervisors are fearful of reprisal if they address impairment issues. They need support and mechanisms that can help them when dealing with impaired trainees.</td>
</tr>
<tr>
<td>Notice early signs of chemical dependency or impulse control disorders of students</td>
<td>Training programs conduct training on how psychologists as well as other professionals manifest symptoms of impairment. -Training programs include in seminar on denial and the progressive nature of the disorder -Training programs include in seminar concerning genetics and other factors such that shame is not indicated.</td>
</tr>
<tr>
<td>Encourage early treatment for chemical dependency or impulse control disorders of students</td>
<td>Training program educate faculty about how to best get students into treatment from the ethical and legal standpoints. -Training program educate faculty in techniques of doing so, such as instances where group intervention meeting with the students may help, etc.</td>
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<tr>
<td>Debunk shame of mental disorders in graduate students or psychologists</td>
<td>Training program educate faculty and students about past and present high levels of shame about mental and addictive disorders. -Training program educate faculty and students about scientific reasoning of causes, such as genetic factors, neuroscience causes, psychosocial causes beyond patients’ real control. -Training programs educate faculty and students instances where this concept of shame can actually be used by the patients as a means of not seeking treatment.</td>
</tr>
<tr>
<td>Encourage mentor relationship outside of graduate program</td>
<td>There is no structure for mentoring or professional scrutiny after graduation. -Psychologists all need mentoring or professional scrutiny. -Training programs require graduate students to begin searching for mentors while still in graduate school.</td>
</tr>
</tbody>
</table>
(C) Feedback

Instructions: Please select up to three important preventive measures in the last section (B) which you can list further supplementary comments regarding the considerations to make these important preventive measures successful in implementation in graduate training.

Preventive measure: _________________________________________________________
Comments:
1.  

2.  

3.  

Preventive measure: _________________________________________________________
Comments:
1.  

2.  

3.  

Preventive measure: _________________________________________________________
Comments:
1.  

2.  

3.
## Part II Re-evaluation of the Importance of Preventive Measures

(A) Re-evaluate the Importance of Preventive Measures Against Future Impairment

**Instructions:**
*After reviewing the results of the first round Delphi survey in Part I, please reevaluate your opinions concerning how important each of the following 83 suggestions are preventive measures in graduate training against future impairment of professionals, by circling one of the five choices:

0 = unimportant, 1 = less important, 2 = moderately important, 3 = very important, 4 = essential*

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<th>Item number</th>
<th>Preventive Measure</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>M</th>
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<td>Reinforce acceptability of asking for help</td>
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<td>Identify and handle trainees early who have problems</td>
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<td>Help students to be aware of the risks of impairment in the profession</td>
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<td>Facilitate students to develop self-care skills/ habits</td>
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<td>Provide information to students about professional life after graduation</td>
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<td>Use faculty to model well-functioning</td>
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<td>Provide informal discussion of impairment in training program</td>
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<td>Create ongoing support group for students</td>
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<td>Give more attention to students by faculty</td>
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<td>Provide stress management workshops to students</td>
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<td>Restructure training program to focus on the well-being of students</td>
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<td>Provide relationship enhancement skill training</td>
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<td>Require students to take a course on impairment and its prevention</td>
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<td>Require students to receive therapy</td>
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<td>Promote peer supervision among students</td>
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<td>Help students to integrate research, course and practice</td>
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<td>Provide retreats for students</td>
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<td>Increase financial aid and assistance to students</td>
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<td>Depoliticize admission process</td>
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<td>Reduce demands in the curriculum</td>
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<td>Select trainees committed to continuing growth</td>
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<td>De-emphasize GREs and GPAs in selecting students</td>
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<td>Provide info about stages in professional growth along with life development stages</td>
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<td>Promote the exploration of students' personal values in relation to their professional work throughout training</td>
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<td>Foster safety in professional forums for discussion of challenges, limitations and failures at work</td>
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<td>44.</td>
<td>Educate students regarding specific occupational hazards, etiology and vulnerability</td>
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<td>Encourage students to continue to work on their personal issues in therapy and involve in self-growth activities after graduation</td>
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<td>46.</td>
<td>Encourage students to continue to receive supervision from an experienced professional after graduation</td>
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<td>47.</td>
<td>Develop ongoing relationship with professionals in the field to provide modeling</td>
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<td>48.</td>
<td>Provide training on the diagnosis and treatment of chemical dependency in professionals</td>
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<td>49.</td>
<td>Help students assess their own personal risk for impairment</td>
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<td>50.</td>
<td>Help students understand that asking for help is rare among professionals and that the most likely help obtained is through the intervention of colleagues</td>
<td>0</td>
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<td>51.</td>
<td>Address understanding of impairment by faculty, administrators, supervisors, and university attorneys</td>
<td>0</td>
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<td>52.</td>
<td>Develop clear model for early intervention and remediation that involve proper assessment, remediation contracts and attainment of desired outcome</td>
<td>0</td>
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<td>53.</td>
<td>Focus on competency of professional behaviors that can be assessed and are relevant to professional functioning</td>
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<td>54.</td>
<td>Refine definition of impairment by including not attaining or displaying professional competence</td>
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<td>55.</td>
<td>Clarify program policies about the role of personal therapy in remediation plans</td>
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<td>56.</td>
<td>Establish clearer professional standards for minimal levels of competence to advance in program and graduate from program</td>
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<td>57.</td>
<td>Make psychological healthiness, in direct connection to professional functioning, as a critical component of annual evaluation process</td>
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<td>58.</td>
<td>Clarify at time of admission program policies concerning</td>
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<td>remediation</td>
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<td>59</td>
<td>Provide students a safe environment to discuss issues that they are concerned about</td>
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<td>60</td>
<td>Help students learn to engage in critical thinking about themselves and others</td>
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<td>61</td>
<td>Give students skills and support to intervene with distressed peers</td>
<td>o 1 2 3 4</td>
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<td>62</td>
<td>Develop student assistance committee for the program emphasizing prevention &amp; rehabilitation</td>
<td>o 1 2 3 4</td>
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<td>63</td>
<td>Encourage dissertation research in the area of distress-impairment continuum</td>
<td>o 1 2 3 4</td>
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<tr>
<td>64</td>
<td>Train faculty in area of stress-distress-impairment research and intervention with students</td>
<td>o 1 2 3 4</td>
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<td>65</td>
<td>Link appropriate student assistance program with the Dean of student office and academic standing committee</td>
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<td>66</td>
<td>Screen students for substance abuse (potential) and provide resources for those who may require assistance in the future</td>
<td>o 1 2 3 4</td>
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<td>67</td>
<td>Consider use of psychological tests for admission to address suitability for field</td>
<td>o 1 2 3 4</td>
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<td>68</td>
<td>Require honesty in letters of recommendation to identify concerns when they exist</td>
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<td>69</td>
<td>Develop better measures of student functioning and train faculty to use them candidly</td>
<td>o 1 2 3 4</td>
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<td>70</td>
<td>Teach faculty how to identify and confront impairment</td>
<td>o 1 2 3 4</td>
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<td>71</td>
<td>Update ethics code to require honesty and candor in evaluation of trainees</td>
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<td>72</td>
<td>Provide students information of the incidence of impairment in all health professions</td>
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<td>73</td>
<td>Have recovering role models participate in seminars and share their stories of recovery</td>
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<td>74</td>
<td>Help students know that psychologists are as vulnerable to mental illness and substance abuse as anyone else</td>
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<tr>
<td>75</td>
<td>Notice early signs of chemical dependency or impulse control disorders of students</td>
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<td>76</td>
<td>Encourage early treatment for chemical dependency or impulse control disorders of students</td>
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<td>77</td>
<td>Debunk shame of mental disorders in graduate students or psychologists</td>
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<td>78</td>
<td>Encourage early treatment for mood disorders of students</td>
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<td>79</td>
<td>Encourage students to join psychological associations or peer support groups after graduation to reduce isolation</td>
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<td>80</td>
<td>Encourage mentor relationships outside of graduate program</td>
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<td>81</td>
<td>Help students to be familiar with literature on universal risks as much or more than impairment</td>
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<td>82</td>
<td>Use of countertransference as part of prevention training on relational models of boundary maintenance</td>
<td>o 1 2 3 4</td>
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<td>83</td>
<td>Emphasize prevention of occupational hazards and self care specific to risks of work such as vicarious traumatization</td>
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</table>

(To be continued on the next page)
(B) Rank-Ordering Your Top 10 Choices

Instructions:
Please select from the above list 10 of your top choices and rank order them in the following:

1st priority: item # ________ 6th priority: item # ________
2nd priority: item # ________ 7th priority: item # ________
3rd priority: item # ________ 8th priority: item # ________
4th priority: item # ________ 9th priority: item # ________
5th priority: item # ________ 10th priority: item # ________

---End---

Thank you very much for completing this questionnaire!
Please use the pre-stamped envelope and mail the completed questionnaire back to the researchers!
Appendix I

Reminder Letter of Second Round Survey
Re: SECOND ROUND DELPHI SURVEY ON PREVENTION OF IMPAIRMENT: REMINDER

Dear Dr. (Last Name of Panel Expert):

We sent a second round package of information to you approximately 3 weeks ago. Since we haven't yet received your feedback, we would like to send this invitation to ask for your continued participation in our study. However, if you have already sent us your feedback and it is still on the way, you may ignore this letter and package. Again, thank you very much for your participation as one of our expert panel members in our first round of this Delphi study! We have already received your valuable opinions as well as those of the other expert panelists in our first round survey. We have included the analyzed results of the first round survey in this second, as well as the last, round of our survey of your opinions.

Just to serve as a reminder to you, this is a Delphi study concerning important preventive measures in graduate professional psychology training against future impairment in professionals. We have invited experts, like you, who have expertise in the area of impairment and its prevention in professional psychology. Expertise is based upon at least one of the four criteria: (1) contributing scholarly to the understanding of impairment/its prevention (being a 1st author at least once or a 2nd author at least twice on the topic of professional impairment or its prevention), (2) providing education on the prevention against impairment through workshop/seminar at a previous annual conference of the American Psychological Association, (3) serving in APA Advisory Committee on Colleague Assistance or state psychological association colleague assistance committee, or (4) having direct clinical intervention experience (helping at least three psychologists with issues of professional impairment). The Delphi method is a research tool that solicits opinions from experts in a field and that facilitates structured communication among the experts, in order to seek consensus among these experts. There are two rounds of surveys in this Delphi study and you have already completed the first round survey.

We appreciate your time reading this letter. Please complete the attached Delphi Questionnaire (II), and send it back to us using the stamped envelope in this package as soon as you are convenient. This will complete your participation in the study.

Again, thank you very much for contributing your expert opinions in this study! We greatly appreciate your time and effort being spent in the process!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.

Sincerely,

Kin-Ming Chan, MSW  James M. Croteau, PhD
Doctoral Student in Counseling Psychology  Professor
Department of Counselor Education and Counseling Psychology
Western Michigan University.
Appendix J

Last Reminder Letter of Second Round Survey
Re: SECOND ROUND DELPHI SURVEY 2ND REMINDER

Dear Dr. (Last Name of Panel Expert),

Thank you for your participation in our study entitled “A Delphi Survey of Experts' Opinions Regarding Prevention of Impairment in Professional Psychology Training!” We sent a second round research package of our Delphi study to you twice (approximately 6 weeks ago and 3 weeks ago). Since we still haven’t received your feedback, we would like to send you this short last reminder to invite you to help us complete the last round of Delphi survey.

Thank you very much for your attention! We very much appreciate your participation!

If you have any queries, please feel free to contact Kin-Ming Chan by email at kinming.chan@wmich.edu or by phone at (415) 469-7998.

Sincerely,

Kin-Ming Chan, M.S.W.  James M. Croteau, Ph.D.
Doctoral Student in Counseling Psychology  Professor
Department of Counselor Education and Counseling Psychology
Western Michigan University
Appendix K

Second Round Additional Considerations for Successful Implementation of Preventive Measures
## Second Round Additional Considerations for Successful Implementation of Preventive Measures

<table>
<thead>
<tr>
<th>Preventive Measure</th>
<th>Additional Considerations for Successful Implementation of Preventive Measures</th>
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</table>
| 1. Identify and handle trainees early who have problems | - Training programs focus on prevention or early intervention, which helps normalize the intervention.  
- Positively, non-punitively will promote more students be more honest about distress, actively seek help and take more positive action.  
- Training programs model positive, proactive, helping behaviors to encourage students do the same after graduation.  
- Training programs conduct monthly review of students for their 1st year of school.  
- Training programs provide free counseling services for students who have problems.  
- Training programs be very direct with students about their problems and how they can be corrected as soon as problems are noticed.  
- Training programs articulate their and definitions of impairment in all brochures, webpages and handbooks for student to read prior to entering the program.  
- Training programs are reluctant to terminate students who are inappropriate for the field because they have a financial incentive to retain all tuition-paying students, especially in large professional school programs. These programs need to recognize such conflict of interest and barriers to addressing impairment.  
- Too often, interns have been found with significant problems because faculty overly invested in their research potential and ignored students’ personal problems that affect their performance in clinical settings. Faculty need to be more invested in evaluating students’ training in clinical setting. |
| 2. Reinforce acceptability of asking for help | - Training programs make psychotherapy a requirement for students, or at least encouraged rather than something to hide.  
- Faculty provide role modeling to students by talking about the important of their own therapy or help-seeking experience.  
- Training programs normalize that anxiety and burnout are part of what most graduate students go through.  
- Training programs praise students when they ask for help.  
- Training programs help students aware of resources for help such as free colleague assistance services from APA and local associations for any problems.  
- Training programs must encourage this from the beginning of training.  
- Mutual vulnerability openly shared increases trust.  
- Training programs help students understand that clients will grandiolize them and mislead them to believe in their own invincibility.  
- Training programs help students recognize their personal weaknesses and see it as a source of pride to work on themselves.  
- Training programs reward humility.  
- Training programs help students define areas of expertise and refer to others when they feel overwhelmed.  
- Training programs emphasize the need for early help in coping with problem because personal problems may limit promotion or retention in setting with high competitiveness or much isolation.  
- Men tend to see personal problems as a weakness and cover up any problem which compound the problem. Training programs need to address this very directly to students. |
| 3. Include the issue of impairment in ethics training | - Training programs have students talk in advance how they will respond if they are later identified by faculty or peers as impaired.  
- Training programs have students indicate in advance how they would like to be approached by peer if peer is concerned about their professional functioning.  
- Case studies are great for helping students understand the relationship between ethical |
practice and impairment but personalizing the issue is also important.  
- Training programs provide statistics about the licensing board complaints and outcomes.  
- Training programs have licensing board member and colleague assistance committee member as guest lectures in ethics class to talk about distress/impairment continuum.  
- Training programs conduct written or oral exams on awareness of impairment issues as related to ethics.  
- Training programs use the ACCA monograph “Advancing Colleague Assistance in Professional Psychology” as supplemental reading in ethics class.  
- Training programs have students in ethics class write brief essays on issues of self-care.  
- Training programs include articles in Bersoff’s book for ethics training, such as “Ethics education: An agenda for the 90s,” “Ethics and professional practice: The role of virtues and principles,” and “Ethical dilemmas encountered by members of APA.”  
- Training programs teach ethics from a narrative ethics point-of-view.

| 4. Promote openness to feedback | - Faculty model openness to feedback.  
- Training programs have annual assessment of student progress by committee, not just advisor.  
- Training programs give honest and constructive feedback to students throughout the program.  
- Training programs ask for feedback from students on a regular basis.  
- Students often fear feedback, especially negative one, as threatening their future. Training programs need to help faculty learn how to give negative feedback to students in a way that promotes learning exchange but not fear. |

| 6. Encourage self-awareness of students | - Training programs help students examine and analyze their reactions to people in case studies, role play and practice.  
- Training programs require students to have therapy which is not link to the school.  
- Training programs provide workshops, seminars and programs on self-awareness.  
- Training programs encourage faculty to teach interactively in addition to lecturing.  
- Training programs train faculty regarding danger signs indicating at risk for impairment. |

| 8. Promote personal and professional growth | - Such growth can derive from broadening of consciousness and recognizing deeply rooted biases (e.g. sexism, racism, ageism etc). It needs ongoing interactions, discussions and reading to explore causes and our personal biased past history.  
- Personal growth can be facilitated through exploration of one’s own personal history by applying theories of human development to one’s self. |

| 9. Help students understand the impact of personal events on their professional functioning | - Training programs help students see this as part of being a psychologist, but not a sign of weakness.  
- This helps make ongoing self-care an essential and conscious effort by all.  
- This is relevant to graduate school. We can’t wait until after graduation to begin addressing these issues. |

| 10. Promote students’ balanced lifestyle and self-care | - Faculty needs to show more concern for students’ well-being than how many hours they work.  
- Training programs encourage students to build friendship outside of the profession.  
- Training programs encourage students to take vocations and days off for self-care.  
- Training programs include leisure in career development course |
<table>
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<tr>
<th>11. Help students to learn about resources for assistance in the profession regarding impairment</th>
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</table>
| - APA APAGS compiles resources and have them available on the internet.  
- During graduate school, students are developmentally incapable of envisioning personal troubles for themselves. It is important for them to learn and remember resources and routes to get assistance.  
- Training programs arrange meetings with representatives from state psychological association or CAP to learn about available resources.  
- If CAP is not available in your state, training programs work with state association to develop one and promote interaction among students, faculty and the association.  
- Training programs help students learn resources of ACCA for professionals and students, and support the use of the available resources. |

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<th>12. Include impairment and its prevention in course content</th>
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| - This will help increase self-awareness and normalize help-seeking behaviors.  
- Impairment and its prevention need to be addressed honestly and openly in training for the purpose of prevention. |

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<tr>
<th>13. Prepare students for the rewards and hazards of the profession</th>
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| - Training programs need to be honest about this.  
- The profession requires 1 year of monthly case consultation, after psychologists are licensed, with another psychologist in good standing who has at least 5 years of experience.  
- Training programs should teach students how to respond to low frequency but high impact events such as assaults, stalking or sexual harassment by patients.  
- Training programs should teach students how to handle demanding patients such as those with serious personality disorder or suicidal intent. |

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<th>16. Teach faculty how to identify and confront impairment</th>
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| - Training programs require faculty and supervisors to take a course about supervision, including their responsibilities in gatekeeping and techniques for confronting impairment.  
- Training programs develop training modules in which students and faculty participate, and use role play and other active learning strategies to reduce avoidance because of discomfort or lack of skills.  
- Training programs model appropriate use of confidentiality to demonstrate skills in intervention when real cases surface. |

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<th>18. Develop peer relationships in profession</th>
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| - Training programs promote blogging in training.  
- Training programs invite graduates back as guests and consultants.  
- More regional conferences are to be held.  
- Training programs develop assignments where collaboration is required.  
- Training programs reward those who seek out help from peers.  
- Training programs create learning experiences where peers look to each other as sources of wisdom and information.  
- Training programs create lunch symposiums where peers present to each other.  
- Training programs create an atmosphere that encourages exposure of fault and weakness.  
- Training programs help students see the ego-strength required to ask a peer for help instead of competing.  
- The profession gives APA continuing education credits for peer groups that meet regularly. |

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<tr>
<th>22. Encourage students to receive supervision from an experienced professional</th>
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| - Faculty should currently be in therapy or supervision.  
- Students have outside people on dissertation committees.  
- Training programs encourage students join local psychotherapy associations. |
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<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>30.</td>
<td>Develop a sense of community among students</td>
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<td>31.</td>
<td>Provide workshop to students on impairment</td>
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<td>45.</td>
<td>Give students skills and support to intervene with distressed peers</td>
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<td>46.</td>
<td>Address understanding of impairment by faculty, administrators, supervisors, and university attorneys</td>
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<td>50.</td>
<td>Have recovering role models participate in seminars and share their stories of recovery</td>
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<td>54.</td>
<td>Develop student assistance committee emphasizing prevention and rehabilitation</td>
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</table>

- The sense of community should apply to everyone, not just other students.
- Training programs encourage students to treat undergraduates, faculty, support staff and others with courtesy and respect.
- Training programs more explicitly convey expectations to students that students are to facilitate the growth and well-being of others.
- Throughout my long career in psychology, it is my peers who have helped the most and they are friends who care about me and give honest feedback and consultation. I will always need them.

- The problem with teaching about professional risks and impairment is its contradiction to the necessary personal denial and grandiosity needed to enable students to learn about all the disorders. Therefore, it is better and enough to learn that psychologist are subject to same ailments as others and what resources are available.

- Training programs develop training modules in which students and faculty participate, and use role play and other active learning strategies to reduce avoidance because of discomfort or lack of skills.
- Training programs model appropriate use of confidentiality to demonstrate skills in intervention when real cases surface.

- Training programs develop plan and review with appropriate administrators and university attorneys, so faculty are not caught between a student and the unknowns in the system.
- Training programs clarify the responsibilities among faculty, external supervisors and internships so that it is clear who has what responsibility in identification and intervention.
- Training programs clarify policy on how program will communicate with internship to address impairment determined there as to meeting program standards.

- The ethos of a recovering person has greater credibility to everyone.
- Recovering stories provide much wisdom, not only academics.
- Most peer assistance committees for impaired psychologist have impaired psychologist on their committee.

- Training programs use the ACCA monograph and the APAGS material to develop a student assistance program which involves both students and faculty.
- Training programs have articles about student assistance in student newsletter.
- Students join state associations.
- Students do research, present posters on student assistance, and inform faculty regarding their needs.
- Training programs consider linking student assistance committee to the academic standards committee; and assess school procedure for complaints, due process, and discipline of students.
Appendix L

Mean & Standard Deviation versus Median & Interquartile Range of First Round Items
## Mean & Standard Deviation versus Median & Inter-quartile Range of First Round Items

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<tr>
<th>Item #</th>
<th>$M$</th>
<th>$SD$</th>
<th>Median</th>
<th>Inter-quartile Range</th>
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<td>1.</td>
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<td>0.54</td>
<td>4.00</td>
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(Note: Subject #18 did not provide top priorities information)
Appendix N

Approval Letter from the Human Subjects Institutional Review Board
Date: September 29, 2005

To: James Croteau, Principal Investigator
    Kin Ming Chan, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 05-09-14

This letter will serve as confirmation that your research project entitled “A Delphi Survey of Experts’ Opinions Regarding Prevention of Impairment in Professional Psychology Training” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: September 29, 2006