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Relationships with Trainee Professional Commitment and Self-
Efficacy for Addressing Competency Issues**

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TRAINERS WITH PROBLEMS OF PROFESSIONAL COMPETENCE:
RELATIONSHIPS WITH TRAINEE PROFESSIONAL COMMITMENT AND SELF-
EFFICACY FOR ADDRESSING COMPETENCY ISSUES

By

Erica Lynn Magsam

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Abstract

This study examined the relationship between perceptions of trainers' problems with professional competence (PPC), and the resolution of those competency issues, with trainee professional commitment to mental health professions and self-efficacy for addressing PPC they encounter in others. Data were obtained from 233 trainees enrolled in mental health graduate training programs throughout the United States. The findings indicated trainees who reported higher levels of impact by trainers exhibiting competency issues (including psychological distress) and discomfort addressing trainer PPC endorsed lower professional commitment. Additionally, frustration and disruption due to trainer PPC, discomfort addressing PPC, and need for more information about how to address PPC were associated with decreased trainee self-efficacy for addressing PPC. Trainees who reported knowing the policies and procedures to follow when encountering PPC reported higher self-efficacy for addressing their concerns about trainers and peers. Trainee satisfaction with how trainer PPC was addressed was not related to professional commitment or self-efficacy, but post-hoc analyses indicated that trainees who felt their concerns related to trainer PPC were addressed had higher self-efficacy for talking to a trainer about another trainer's PPC in comparison to trainees whose concerns were either not addressed or they were unaware whether the trainer PPC had been addressed. Implications for training are presented.

Keywords: trainer/trainee, competency, problems of professional competence, self-efficacy, development, professional commitment

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Introduction

The development and assessment of competencies have become important in all health professions (Kaslow et al., 2004) and psychology is no exception. In 2002, the Association of Psychology Postdoctoral and Internship Centers, in conjunction with representatives from other psychology training councils and the American Psychological Association (APA) sponsored the Competencies Conference to identify core competencies, formulate training models for the development of the competencies, and develop strategies for the assessment of competence. The development of the competency cube model (Rodolfa et al., 2005) identified 12 competency areas. These included six foundational competencies and six functional competencies. The third dimension of the cube was the development of competencies over time. The developmental approach to competencies is based in the understanding that competence begins in graduate training programs where trainees have contact with multiple trainers and continues during professional careers (Fouad et al., 2009). Hatcher et al. (2013) described the revised competency benchmarks development that simplified the competencies into the current six clusters (i.e., professionalism, relational, science, application, education, and systems) with 16 specific competencies. Professionalism is seen as the overarching competency cluster.

The primary focus of the competency movement has been on trainees' struggles in development, assessment, and remediation of competencies (Poston & Bland, 2020; Vacha-Haase et al., 2019). Numerous studies have noted that training programs frequently experience trainees with problems of professional competence (TPPC) and discussed the challenges inherent in addressing those problems (Demyan et al., 2018;

Furr & Brown-Rice, 2018; Shen-Miller et al., 2015; Vacha-Haase et al., 2019). A smaller number of studies examined the effect on trainees of having a peer with problems of professional competence (Elman & Forrest, 2007; Shen-Miller et al., 2011; Veilleux et al., 2012) and reported that more than 40% of students indicated having a peer with issues related to competency. Of equal importance, but receiving less attention, is how trainer competency concerns also affect trainees. The term “trainers” refers to those who serve as faculty, supervisors, advisors, or mentors to students progressing through their academic and clinical training.

The absence of focus on trainer competence is not due to a lack of awareness regarding its potential negative effects. The 2002 Competencies Conference included discussions identifying competence for psychologists and individuals who serve in training roles and noted the need for comprehensive post-doctoral level training to ensure ethical behavior for acting trainers and other psychological professionals (de las Fuentes et al., 2005). The existing research on trainer competence tends to focus on encountering unethical behavior (an aspect of competency) with clinical supervisors or competency issues with faculty (Furr & Brown-Rice, 2016), but has not addressed how interacting with trainers with problems of professional competence (PPC) affects trainees’ perspectives of their professions or their self-efficacy for addressing competency issues in the future. This study examined the relationships between the perceived impact of trainers’ problems with professional competence, and the resolution of those competency issues with trainee commitment to their profession and self-efficacy for addressing problems of professional competence they encounter in others. For the purposes of this study, it is important to recognize that trainees may not all objectively assess problems of

professional competence in the same manner therefore the study focuses on the trainees perception of behaviors identified as problems of professional competence.

Competencies in Professional Psychology

Nadine Kaslow and colleagues (2009) provided a definition of competence in professional psychology by stating “competencies are defined as elements reflecting specific knowledge, skills, and attitudes that are observable, measurable, and quantifiable, to ensure the outcome of professional competence of the trainee” (Kaslow et al., 2009, p. S34). Other disciplines such as law and medicine recognized the importance of competence prior to the field of psychology (Johnson et al., 2008) and the competency movement in psychology really began in 2002 with the Competencies Conference: Future Directions in Education and Credentialing. This conference focused on promoting competency-based learning for professional psychologists in training programs (Kaslow et al., 2004). After the 2002 competency conference, the cube model of core competency areas in psychology was created (Rodolfa et al., 2005) and identified the 12 core competencies that are divided into either foundational or functional competencies necessary for psychologists throughout their training and career.

The foundational competencies are the basic functions psychologists should be expected to adequately perform. There are six foundational competency domains that include reflective practice/self-assessment, scientific knowledge and methods, relationships, ethical and legal standards/policy issues, individual and cultural diversity, and interdisciplinary symptoms (Fouad et al., 2009; Rodolfa et al., 2005). Functional refers to the competencies needed to perform the specific duties of a psychologist. The six functional competency domains include assessment/diagnosis/conceptualization,

intervention, consultation, research/evaluation, supervision/teaching, and management/administration. Feedback on evaluations based on the organization of the initial Competency Benchmarks documents suggested that the listing of so many separate competencies and subcomponents was challenging and impractical in many clinical settings. A workgroup was formed to integrate and condense the Competency Benchmarks into a more easily understandable framework for tracking trainee development and guiding program and curriculum development (Hatcher et al. 2013). They were reorganized into six competency clusters with 16 specific competencies.

In addition to specifying competencies, the model includes the developmental stages at which the essential components of the competencies are expected to be mastered. Rodolfa et al. (2005) reported that the competency domains are relevant at every stage of professional development. The stages were recognized as doctoral education, doctoral internship/residency, post-doctoral supervision, residency/fellowship, and continuing competency.

In order to provide guidance for trainers who were implementing the competencies, competence benchmarks were developed that established criteria for competent trainee performance (Fouad et al., 2009). The benchmarks were also based on developmental levels of readiness for initial practicum placement, readiness for internship, and entry into the profession. A fourth level of post-licensure development was considered, but not implemented (Hatcher et al., 2013).

Trainees with Problems of Professional Competence

Since the Competency Benchmarks largely focus on the training period, the majority of the literature on individuals with problems of professional competence

focuses on trainees. These studies report that significant numbers of programs encounter trainees with problems of professional competence; between 4% and 95% of training programs reporting having or recently having students in training that were identified as having significant competency issues (Huprich & Rudd, 2004; Shen-Miller et al., 2015; Rust et al., 2013; Nicholson et al., 2017; Shen-Miller et al., 2011). The study reporting only 4% of programs with trainees with competence issues appears to be an outlier as generally between 66% and 95% of programs report students with PPC. Huprich and Rudd (2004) reported that 10% of internship sites also described having trainees who displayed competency problems.

A smaller subset of literature focuses on peers of trainees with problems of professional competence and indicates that having peers with competency problems is associated with negative trainee experiences (e.g., Furr & Brown-Rice, 2018; Forrest et al., 2008). Up to 95% of students interact with and observe consistent concerns regarding peers with competency deficits during training (Shen-Miller et al., 2015). Those concerns include problems in the areas of professionalism, mental health, interpersonal concerns, or lack of clinical and academic skills (Shen-Miller et al., 2015). Many previous studies have recognized there is an overall negative impact of peers with problems of professional competency on trainees who experience it (Gaubatz & Vera, 2006; Shen-Miller et al., 2011; Roberts, 2004). Further, previous research indicated that faculty often underestimate or minimize the impact of trainees with PPC on their peers' emotions, leading to feelings of anger, conflict, or betrayal (Mearns & Allen, 1991). Rosenberg et al. (2005) found that students with peers who had problems with professional competency reported feeling angry or frustrated at faculty for lack of identifying

problematic behaviors of students of concern and lack of response when those behaviors were identified. Approximately 40% of students who recognize having a peer with professional competence concerns chose not to take action in addressing those concerns (Shen-Miller et al., 2011).

Forrest et al. (2008) discussed the impact of various systems on appropriately addressing trainees identified with problems of professional competence. They described a multilevel ecological model where trainers in and outside of the academic setting work together to influence the trainees and address competency issues in multiple settings. This highlights the importance of trainers (as well as others in the professional competence community) in helping trainees attain expected levels of professional competence.

Trainers with Problems of Professional Competence

Although trainers are expected to help their students achieve professional competence, a much smaller body of literature has examined the effects of trainer competence problems on the trainees with whom they work. Trainers include academic faculty, supervisors, advisors, and mentors. Studies on clinical supervisors demonstrating unethical behaviors or competency deficits (Reiser & Milne, 2017; Wall, 2009) indicate that many students experience supervisors who engage in unethical or ethically questionable behavior, resulting in students feeling unsure about their own professional identity. Huprich and Rudd (2004) described the existence of competency concerns or issues throughout all levels of professional careers and development.

Two studies examined the impact of academic faculty with problems of professional competence (Deemer et al., 2011; Furr & Brown-Rice, 2016). These studies found the behavior of faculty directly influenced professional psychology students'

competence beliefs and students were uncomfortable addressing problems with professional competence of faculty members. Studies reported that students needed more information on how to address these issues and recommended that educators serve as advocates so students felt supported when trying to address concerns regarding trainers with problems of professional competence. Addressing these concerns may be difficult for students. Brown-Rice and Furr (2015) described the duty of peers of problematic faculty to hold one another accountable for correcting or addressing concerns so they do not affect the program environment.

Trainers who are demonstrating problems with professional competence pose a serious threat to trainees' development. As students progress through training programs, they learn basic skills and processes from multiple individuals including faculty, supervisors, advisors, consultants, peers, and others with whom they interact. Johnson (2007) reported that students with good mentorship throughout their training experience numerous positive benefits, such as satisfaction in their graduate program, increased levels of skill development and competence, increased professional confidence and career identity, higher levels of productivity and prominence in their field, and greater satisfaction in their careers. Johnson did not address the consequences for students in mental health training programs who experienced negative interactions with a mentor or trainer. However, when the trainers have expertise in the area that the students have interest in and have authority in their organizations, they have significant power (Hayes & Allison, 1998) that must be used appropriately.

Raven (2008), summarizing the earlier work of French and Raven (1959) described the six different types of power and how they relate to social influence. Reward

power and coercive power emphasize the potential reward that is gained from an individual's approval or the negative consequences that might occur if the target subordinate person does not comply with the authority's request. Legitimate power, expert power, and referent power are based in the target's acceptance of the supervisor's right to require the behavior, the supervisor's expertise about the chosen behavior, or identification with the supervisor as a model. Finally, informational power, which was not included in the original French and Raven work, is based on explanations to the subordinate regarding actions that should be taken. Because of the power differential, it is challenging for trainees to confront or intervene when trainers are experiencing problems of professional competency.

Originally, rewards were seen as impersonal tangible items (i.e., bonuses, promotions), but personal approval or the threat of rejection from someone who is valued can be powerful sources of reward and coercive power. It is clear that trainers potentially have access to multiple bases of power in the educational lives of trainees. While reward and coercive power are the most obvious forms, the power based on trainers' knowledge, expertise, and a desire to model their behavior has implications for how trainer problems with professional competence could negatively affect trainees' educational experiences and view of the profession. Expert and referent power, in particular, set the stage for the importance of role modeling by trainers.

Social Cognitive Theory, Modeling, and Self-efficacy

As theorized in Social Learning Theory (SLT, Bandura, 1977), people learn from one another through observation, imitation, and modeling of behaviors, attitudes, and the overall outcomes of modeled behaviors (Bandura, 1977). Social Cognitive Theory (SCT)

expanded SLT to include personal factors (i.e., moral thought, affective self-reactions, moral conduct, and environmental factors) that interact to impact or determine outcomes (Domino et al., 2015). Similarly, SCT posits that viewing another performing a given behavior or task influences perceptions of one's personal ability to successfully perform the behavior (i.e., self-efficacy), the anticipated outcome of the behavior (i.e., outcome expectation), and possible strategies for effective performance (Bandura, 1986). Self-efficacy was directly related to value and experience within a professional setting (Bandura, 1986). Learning experiences within an academic setting are considered a source of self-efficacy for students in training.

Conversely, self-efficacy could be impacted by negative learning experiences suggesting that observing trainers with competency deficits, especially if those deficits were not addressed, might reduce trainee self-efficacy and outcome expectations for addressing PPC in others. Thus, trainees who observe trainers with problems of professional competence may experience lower self-efficacy for addressing competency issues when they arise in peers or other trainers, especially if they perceived that other trainers did not address concerns with the competence issues. Additionally, observing trainers who potentially hold expert, legitimate, and referent power in the field, exhibit problems with professional competence may influence trainees' commitment to their chosen professions.

Professional Commitment

Professional commitment can be viewed as a type of organizational commitment and is sometimes referred to as occupational or career commitment (Tikare, 2017). While organizational commitment has been defined as, "the strength of an individual's

identification with and involvement in a particular organization” (Porter et al., 1974, p. 604), professional commitment adds a focus on the amount that individual members endorse the values their profession holds and the amount they identify with the profession as a whole (Cohen, 2003).

Bogler and Somech (2004) reported that empowerment, professional growth, status, and self-efficacy were significant positive predictors of organizational and professional commitment for teachers in school while burnout was negatively related to professional commitment in nurses (Spence Laschinger et al., 2012). Professional commitment can develop and change based on the environment individuals are in as well as the training they received prior to entering into their profession. Professional commitment has been related to awareness of appropriate work behaviors in accounting students. Specifically, Rafik (2006) reported that accounting students who reported higher levels of professional commitment and could identify the need for financial reporting were more able to detect inappropriate behavior and had less engagement in questionable actions in their careers than others. Students with lower professional commitment had a lower understanding of the need for financial reporting and were not able to identify questionable actions as unethical and problematic. Rafik suggested the importance of instructors and employers during training experiences assisting students in developing higher professional commitment that would lead them to recognize ethical concerns in their field when they practiced in the future. Although no studies exist on professional commitment of graduate students in mental health training programs, it is expected that modeling by supervisors, educators, and other trainers affects professional

commitment such that trainees who observe trainers with problems of professional competence may experience lower commitment to their professions.

Research Questions and Hypotheses

This study addressed gaps in the current literature by exploring how trainees' professional commitment and self-efficacy for addressing future competency issues among trainers or peers is related to their experiences with trainers who trainee's perceived demonstrated problems with professional competence. As there is limited information regarding trainee experiences with trainers with PPC, the study also provided descriptive information regarding the types of trainers with PPC that trainees encountered and trainee reactions to how concerns with trainers experiencing PPC are addressed.

Question 1. Is there a relationship between current mental health trainees' experience of their trainers' problems with professional competence and the trainees' commitment to mental health professions?

Hypothesis 1: Current mental health trainees who have been more strongly impacted by trainer problems with professional competence will express lower professional commitment to their chosen professions.

Question 2. Are there relationships between trainees' experience of trainers with problems of professional competence and trainee self-efficacy for addressing competency concerns in peers or other trainers?

Hypothesis 2: Trainees who have been more strongly impacted by trainer problems with professional competence will experience lower self-efficacy for addressing competence issues when they arise in peers or other trainers.

Question 3. Is there a relationship between trainee's professional commitment to mental health professions and satisfaction with how trainer competence problems were addressed?

Hypothesis 3: Trainees' satisfaction with how the trainers' conduct was addressed will be positively related to trainee professional commitment to the field.

Question 4. Are there relationships between trainee's self-efficacy for addressing competence issues in peers or other trainers and satisfaction with how trainer competence problems were addressed?

Hypothesis 4: Trainees' satisfaction with how the trainers' conduct was addressed will be positively related to trainee self-efficacy for addressing peers and trainers with problems of professional competence.

Method

Participants

Participants were current masters or doctoral level students in marriage and family, counselor education, counseling, clinical, or school psychology programs located in the United States. A total of 280 respondents began the online survey. Out of the 280 responses, 38 participants were removed due to failure to complete the measures, nine were removed due to missing three or more of the five conscientious responder questions, and two participants were removed for not meeting the criteria of current enrollment in graduate level mental health training programs. This left a total of 233 participants in the study.

Respondents' ages ranged from 21-66 ($M = 29.4$ years, $SD = 7.2$). The majority of participants ($n = 193$) identified as women, while 33 identified as men, and 3 participants reported identifying as gender queer/gender non-conforming. An additional four provided written responses describing their gender identity. Of the 233 participants, 13.9% ($n = 32$) reported their race as Black/African American, 72.7% ($n = 168$) identified as White/Caucasian, 7.4% ($n = 17$) identified as biracial or multiracial, and 4.3% ($n = 10$) identified as Asian/Asian American. Seventy-seven participants identified as a first generation college student and one participant did not respond to the first generation demographic question. A total of 231 participants reported their sexual orientation with two participants stating they chose not to respond. Participant identification and responses included 155 heterosexual participants, 9 gay participants, 4 lesbian, 39 bisexual, and 21 who reported none of the previous options. The majority of students were enrolled in doctoral programs ($n = 162$) with 60 participants in terminal master's

counseling or counselor education programs (i.e., Clinical Mental Health, School, Rehabilitation, Marriage/Family) and 11 in “Other” programs including mental health counseling, counseling psychology masters, and neuropsychology programs. Table 1 displays more detailed information on program type.

Table 1

Listing of Participant Training Program

Program Type	<i>N</i>	%
Masters in Counseling/Counselor Education	60	25.8
Doctoral – Counseling Psychology	90	38.6
Doctoral – Clinical Psychology	28	12
Doctoral – School Psychology	13	5.6
Doctoral – Combined Psychology	8	3.4
Doctoral – Counselor Education	23	9.9
Other	11	4.7

Participants were asked to describe the trainer(s) they were basing their responses on. Sixty-three participants reported thinking about one specific trainer related to the questions while 121 participants indicated they were thinking about two to three trainers they believed had problems of professional competence, 31 participants reported they had four to five trainers with PPC, and 17 students described having more than five trainers who had problems of professional competence that influenced the trainees’ overall training experience. Information about trainer roles is shown in Table 2.

Table 2*Trainer Roles*

Trainer Role Related to Trainee	<i>N</i>
Faculty in current graduate program	179
Academic instructor/professor who is not core faculty in current program	75
Graduate Assistantship supervisor who is not faculty in current program	24
Clinical supervisor at practicum/internship placement during current program	105
Practitioner at my practicum/internship placement in current program, but not direct supervisor	36
Faculty in a previous graduate program	34
Academic instructor/professor who was not core faculty in previous program	12
Graduate Assistantship supervisor who was not faculty in previous program	4
Clinical supervisor at a practicum/internship placement in previous program	29
Practitioner at a practicum/internship placement at previous program, but not direct supervisor	19
Other (please describe)	12
Total Referenced Trainers	529

Note: The total is greater than 233 as participants were allowed to identify multiple trainers.

Measures***Demographic Measure***

Demographic information included age, gender, race/ethnicity, sexual orientation, socioeconomic status, education history, program type (area in the mental health field),

current year in their program, first generation status, and full time or part-time registration status.

Professional Commitment Scale

The Professional Commitment Scale (Dwyer et al., 2000) is a 15-item scale assessing commitment to one's profession. This scale was adapted from Porter et al.'s (1974) article researching organizational commitment, job satisfaction, and turnover of psychiatric clinicians. Dwyer et al. (2000) indicated an alpha consistency of 0.90.

Participants responded to items on a seven-point scale ranging from strongly disagree to strongly agree (Porter et al., 1974). In terms of validity, aspects of the study correlated with idealism about one's profession and intentions to leave the profession.

Problems of Professional Competency Survey-Doctoral (PPCS-D)

The 29-item PPCS-D scale was adapted from the Furr and Brown-Rice (2016) scale designed to assess doctoral students' knowledge of faculty who had problems of professional competence. The updated scale was created to assess doctoral students' perceptions of trainers (more broadly defined than faculty) with problems of professional competence as well as the how the behaviors of trainers with PPC impacts students (Furr & Brown-Rice, 2016). This scale also addresses students' overall knowledge about how they respond to the behaviors of trainers with PPC. Responses utilize a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher scores indicate greater impact and effect on students.

Furr and Brown-Rice (2016) reported an internal consistency coefficient of .94 on the 29 items on the scale. Furr and Brown-Rice conducted a factor analysis that indicated three major components of the measure: the type and impact of the faculty with PPC,

identifying and responding to faculty with PPC, and discomfort in discussing faculty PPC that accounted for 60% of the total variance, and an additional two weaker components. Since the scale was adapted for the current study, a factor analysis was conducted and is described in the Results section.

Self-Efficacy and Satisfaction with Program Response

An additional three questions were developed to assess trainees' self-efficacy for raising the issue of a peer's or trainer's problems with professional competency to that peer or another trainer. Bandura (2006) noted that measures of perceived self-efficacy must, "be tailored to the particular domain of functioning that is the object of interest" (p. 308) and that they should have face validity. Each question began with the stem, "How confident are you that you can . . ." followed by the behaviors of "talk to one of your trainers regarding your concern about a peer's professional competency," "talk to one of your trainers regarding your concern about another one of your trainer's professional competency," or "approach a peer to discuss your concerns about that peer's competency behaviors." Responses were on an 11-point response scale ranging from 0 (not at all confident) to 10 (very certain I can do this).

Additional questions addressed the trainees' satisfaction with the program's response in addressing a trainer's problems with professional competency. These questions are, "Were the trainer's problems of professional competence addressed by your training program (e.g., other trainers, Department Chair, University administrators)?" "If yes, how satisfied were you with the program's (e.g., other trainers, Department Chair, University administrators) response to the trainer with problems of professional competency? This last question is answered on a 5-point Likert scale ranging

from 1 (very dissatisfied) to 5 (very satisfied). Participants also provided information on their level of disappointment if concerns were not addressed.

Conscientious Responders Scale (CRS)

The five-item CRS was utilized as an attention check to identify conscientious responders and random responders in research studies (Marjanovic et al., 2014). The scale required participants to read each of the questions and answer the items exactly as the directions instruct them to do. Higher scorers (three and above) were labeled “conscientious responders” and low scorers (two and below) were labeled “random responders.” (Marjanovic et al., 2014).

Procedures

Following approval from the Institutional Review Board (IRB) at the University of Memphis, the primary investigator sent information to training directors of accredited counseling and clinical psychology doctoral programs, accrediting body organizations (American Psychological Association; specifically the American Psychological Association of Graduate Students (APAGS), and online platforms to share the description of the study and online survey link. Researchers encouraged participants to share the study information with individuals who matched the participation requirements (snowball sampling). Participants accessed the survey via the provided link. After providing online consent to participate in the study, participants were directed to the online survey.

Results

Preliminary Analysis

Data were screened to determine missingness, normality, and the presence of univariate outliers. As noted earlier, incomplete data sets were deleted. Normality of the

distribution was assessed by creating z-scores by dividing the skew and kurtosis values by their standard errors. An absolute z-value greater than 3.29 would indicate the distribution was non-normal. No values exceeded this limit. Data were checked for the presence of univariate outliers by standardizing the scale scores for the study variables and checking to see whether any values exceeded the range of the absolute value of 3.29; there were no univariate outliers.

Factor Analysis

An exploratory factor analysis was conducted to determine the similarity of the factors assessing trainer professional competence concerns from the adapted scale to the original Furr and Brown-Rice (2016) scales. Principle factor extraction was used to determine the number of factors to retain for the final solution and oblique rotation for factor interpretation was chosen as factors were expected to correlate. The scree test indicated either a six-factor or seven-factor solution and the eigen value for all six factors was greater than 1. The six-factor solution also yielded interpretable factors and was chosen as the final solution. Two criteria were used to determine whether an item was retained on a factor: (a) a minimum loading of .40 on one factor and (b) no cross-loadings > .30 on other factors. The primary difference between the current factor analysis and the analysis by Furr and Brown-Rice is that the current analysis divided the effect of trainer PPC into two factors, one of general impact based on broadly defined unprofessional behaviors and the second into impact caused by working with a trainer who appeared to be experiencing psychological distress. Those two factors appeared to be combined in Furr and Brown-Rice. Table 3 displays the factor loadings of each item on its designated

factor. Items for each factor were averaged to create subscale scores used in the subsequent analyses.

Table 3

Factors Loadings of Exploratory Factor Analysis of Trainer Problems of Professional Competency

Item	F1	F2	F3	F4	F5	F6
F1. General PPC						
16. PPC lead to trainee resentment	0.96					
14. PPC lead to trainee stress	0.90					
15. PPC lead to difficulty concentrating/completing work	0.86					
1. Impact by trainer PPC	0.80					
2. Trainer inadequate clinical skills	0.72					
13. Increased workload due to PPC	0.69					
3. Trainer inadequate supervision skills	0.67					
9. Trainer cultural incompetence	0.64					
8. Trainer unprofessional behavior	0.48					
F2. Psychological PPC						
5. Trainer psychological concern		0.83				
6. Trainer personality disorder		0.74				
11. Trainer confidentiality violation		0.69				
7. Trainer substance abuse		0.65				
10. Trainer inappropriate boundaries		0.64				
F3. Discomfort Addressing TPPC						
24. Discomfort addressing trainer PPC due to power dynamics			0.86			
25. Fear of recrimination addressing trainer PPC			0.72			
23. Comfort discussing trainer PPC with another trainer*			0.60			
F4. Frustration/Disruption						
18. Profession quality concern due to trainer PPC				0.67		
19. Student discussions about trainer PPC				0.61		
17. Trainee frustration due to lack of addressed PPC				0.54		
20. Trainers hypocritical if unprofessional				0.40		
F5. Lacks Information						
29. Needs information regarding responding to trainer PPC					0.84	
30. Needs information identifying trainer PPC					0.83	
F6. Trainee Awareness						

26. Discussion of program procedures regarding PPC	0.76
27. Knowledge of action items when experienced PPC	0.57

Note: * item reverse coded

Preliminary Analyses

To determine if there were group differences due to racial group, first generation status, and program type (doctoral versus masters) on the six subscales of the professional competency measure, three MANOVAs were calculated. Due to the small number of participants of color, they were combined into one group with White students in the other group. There was no significant effect for racial group, $F(6, 223) = .94, p = .467, \eta^2 = .03$. A second MANOVA was conducted using first generation status as the independent variable. There were no significant differences on the competence concern subscales based on first generation status, $F(6, 223) = 1.163, p = .327, \eta^2 = .03$. There were differences based on doctoral versus master's level status, $F(6, 224) = 5.56, p < .000, \eta^2 = .13$ with doctoral students endorsing more impact from interactions with trainers exhibiting general professional competency issues, $F(1, 229) = 25.28, p < .000, \eta^2 = .10$, more impact from competency issues potentially related to trainer's mental health issues, $F(1, 229) = 10.68, p < .001, \eta^2 = .05$, greater frustration and perceived program disruption around trainer PPC, $F(1, 229) = 10.67, p < .001, \eta^2 = .05$, and more discomfort addressing trainer competency issues, $F(1, 299) = 4.06, p < .05, \eta^2 = .02$. This finding that doctoral students endorsed higher levels of impact is not surprising given the greater amount and intensity of contact between doctoral level trainees and their trainers.

Main analyses

In order to address the primary research questions regarding relationships between experiencing trainers with PPC and professional commitment or self-efficacy for addressing PPC, correlations among study variables were calculated. Means, standard deviations, and correlations among study variables are presented in Table 4.

Table 4

Means, Standard Deviations and Intercorrelations Among Study Variables

Variables	1	2	3	4	5	6	7	8	9	10
1. General PPC	.92									
2. Psychological PPC	.63**	.84								
3. Frustration/Disruption	.65**	.42**	.78							
4. Discomfort addressing TPPC	.43**	.31**	.48**	.82						
5. Lacks Information	.24**	.13	.32**	.24**	.67					
6. Trainee Awareness	-0.1	.00	-.12	-.26**	-.23**	.86				
7. Professional Commitment	-.15*	-.15*	-.07	-.13*	.04	.04	.78			
8. Self-Efficacy Regarding Peer	-.17**	-.09	-.15*	-.35**	-.14*	.28**	.12	—		
9. Self-Efficacy Regarding Trainer	-.14*	-.10	-.18**	-.49**	-.25**	.43**	.08	.63**	—	
10. Self-Efficacy Direct Peer	-.14*	-.09	-.12	-.34**	-.07	.24**	.10	.49**	.43**	—
<i>M</i>	3.16	2.14	3.78	3.66	3.77	3.01	5.69	5.87	5.01	5.61
<i>SD</i>	1.08	0.94	.98	1.08	0.89	1.03	0.67	2.77	2.91	2.93

Note: Internal consistency coefficients for scales are on the diagonal.

* $p < .05$. ** $p < .01$.

Hypothesis one proposed that trainees who had been more strongly impacted by trainer problems with professional competence would have lower professional commitment to the mental health field. As can be seen in Table 4, scores on the professional commitment measure have small, but significant negative correlations with

three aspects of trainer professional competency concerns. Students who reported higher levels of impact by trainers exhibiting general competency issues as well as competency issues that could be associated with psychological distress endorsed lower professional commitment. Similarly, students who endorsed more discomfort regarding addressing trainer PPC had lower scores on the measure of professional commitment. Hypothesis 1 was partially supported.

Hypothesis two stated that trainees who had been more strongly impacted by trainer problems with professional competence would experience lower self-efficacy for addressing competence issues when they arise in peers or other trainers. The results for this hypothesis are divided between self-efficacy with trainers and self-efficacy with peers. As can be seen on Table 3, there are numerous significant correlations between the concerns around trainer-related PPC and self-efficacy for addressing PPC. In general, greater perceptions of being impacted by trainers with PPC, more frustration and disruption related to trainers with PPC, discomfort addressing PPC, and wanting more information about how to address PPC were related to decreased self-efficacy for addressing PPC. Trainees who reported knowing the policies and procedures to follow when encountering trainers with PPC reported higher self-efficacy for addressing their concerns about trainers and peers.

Participants answered questions regarding their knowledge about whether concerns about trainers with PPC had been addressed at the training site and their level of satisfaction with how it had been addressed. Of the 192 participants who responded to this question, 44 said it had been addressed, 75 said it had not been addressed and 73 did not know if it had been addressed. Data from the 44 individuals who reported the concern

had been addressed were used in answering the third and fourth hypotheses. The participants' mean level of satisfaction with how the situation had been addressed was between a neutral (neither satisfied or dissatisfied) and somewhat satisfied response ($M = 3.51$, $SD = 1.08$, range = 1 – 5). Hypothesis three stated there would be a positive relationship between trainees' satisfaction with the response to trainers with PPC and trainee professional commitment to the field. This correlation was $r = .008$, $p > .05$. This hypothesis was not supported.

Finally, hypothesis four stated there would be positive relationships between trainees' satisfaction with how the trainers' conduct was addressed and trainee self-efficacy for addressing peers and trainers with problems of professional competence. The correlations between satisfaction with how concerns were addressed and self-efficacy indicated no significant associations for self-efficacy for addressing trainer concerns with a different trainer ($r = .06$), self-efficacy for addressing peer concerns with a trainer ($r = -.17$), or self-efficacy for addressing peer concerns with that peer ($r = .02$). Hypothesis 4 was not supported.

Since data from only a small subsample of participants (those who reported the concern had been addressed) could be used for Hypotheses 3 and 4, a post-hoc MANOVA was conducted using information on whether the concern had been addressed (yes, no, do not know) as the three levels of the independent variable and professional commitment and the three measures of self-efficacy as the dependent variables. The overall multivariate effect was significant, $F(2, 189) = 4.16$, $p < .001$, $\eta^2_p = .08$ with significant different differences on self-efficacy for talking with trainers about another trainer's PPC, $F(2, 189) = 11.64$, $p < .001$, $\eta^2_p = .11$, and self-efficacy for approaching

a peer to discuss that person's competency concerns, $F(2, 189) = 5.54, p < .01, \eta^2 = .06$. Post-hoc Scheffé tests indicated that participants who indicated their concerns related to trainer PPC were addressed had significantly higher self-efficacy for talking to a trainer about another trainer's PPC in comparison to participants who indicated their concerns weren't addressed or did not know if their concerns had been addressed. Additionally, the results indicated that participants who reported their concerns were not addressed had significantly lower self-efficacy for discussing competency concerns with a peer in comparison to the concerns being addressed or not knowing if they had been addressed.

Finally, participants were asked about their disappointment that the concerns were either not addressed or that they did not know whether or not they had been addressed. Of the 75 who stated that the concern was not addressed, their mean score was 1.97 with 1 being very disappointed and 5 anchored by a response of not feeling any disappointment or distress. Of the 73 who said they did not know whether or not the concern had been addressed, their disappointment score was much closer to the middle neutral option ($M = 2.96, SD = 1.22$) on the same 1 – 5 scale of very disappointed to not experiencing any disappointment or distress.

Discussion

There is very limited research regarding trainee experiences with mental health trainers exhibiting problems of professional competency. This study provided needed information regarding not only the number of trainees that experience trainers with perceived problems of professional competence and who those trainers are but also the

ways in which trainer PPC impacts them and relates to their professional commitment to their chosen field and self-efficacy for addressing PPC when they encounter it.

Results of this study provide insight on the disruptive effects of trainer PPC. In the test of the first hypothesis, there were small but meaningful findings that students who encountered trainer PPC endorsed lower levels of professional commitment. Previous literature has suggested that trainees who encounter trainers (or fellow trainees) with PPC that is not addressed question the quality of their faculty, peers, and the larger field (Bogler & Somech, 2004; Chang et al., 2017; Rafik, 2006; Spence Laschinger, et al. 2012). Witnessing supervisors engaging in ethically questionable behavior resulted in students questioning their own professional identity (Reiser & Milne, 2017; Wall, 2009). While it is not surprising that endorsing negative impact of trainers who were exhibiting PPC was related to decreased valuing and identifying with their chosen professions, this is the first study that has confirmed that relationship.

Decreased professional commitment could manifest as lowered involvement in mental health fields, including lack of membership in professional organizations, little interest in serving in leadership positions, limited emphasis on volunteer and advocacy work, and professional isolation (Austin, 2002; Beddoe, 2016; Reiser & Milne, 2017). Mental health professions strive for active engagement in professional organizations, such as various divisions of the American Psychological Association or American Counseling Association. It is possible that after experiencing potentially numerous trainers with PPC, graduates of those programs might become disillusioned and less invested in participation in their professional organizations. Future research might directly examine this relationship.

These findings confirm the need to improve current processes related to training on how to respond to PPC and continued competency development for professionals in the field regardless of how long they have been practicing independently (Donovan & Ponce, 2009). Other trainers in the programs need to be more active in addressing PPC in their colleagues. Brown-Rice and Furr (2015) described that peers of problematic faculty have a duty to hold one another accountable for correcting or addressing concerns so they do not affect the program environment. The findings from this study suggest that effects from trainers with PPC can reach beyond the immediate program environment. If there is anything positive in these results, it might be that the correlations between trainer PPC and professional commitment, although significant, were still quite small. This would suggest there are many other variables that are also related to professional commitment and trainees who encounter trainers with PPC can still be strongly committed to their professions.

The associations between having trainers with PPC and trainee self-efficacy in addressing PPC in trainers and their peers contain cause for both concern and hope. On the concern side, trainees endorsing trainer PPC impact, program disruption, and uncertainty about addressing PPC had decreased self-efficacy for addressing PPC broadly – in peers or trainers. The literature already indicates that students report reluctance in either directly addressing peers with competency concerns or sharing their concerns about their peers with their faculty (Jacobs et al., 2011; Nicholson et al., 2017; Rosenberg et al., 2005). While there are many reasons for this reluctance, findings from the current study suggest that a lack of self-efficacy might play a role and that concerns around trainer PPC, including discomfort and lack of information for how to address it, shape

self-efficacy for addressing issues with peers, too. In the Rosenberg et al. study, students did not feel they had a space or procedure put in place to learn how to effectively address a peer with problems of professional competence. Students reported they wanted to see efforts from faculty to address fellow trainees with PPC and acknowledgment of the issues along with guidance and support on how to address the issue as a peer (Rosenberg et al., 2005). It appears they trainees would also like this information in reference to trainers with PPC. In the current study, the strongest correlations were between ‘lacking information’ about how to address trainer PPC and lower self-efficacy for addressing PPC in trainers or peers.

The hopeful aspect is the positive correlations between having awareness of program policies and how to intervene and greater self-efficacy for addressing PPC. There is a growing recognition of the need for clear policies and procedures around PPC and frequent discussions with trainees on recognizing and intervening when they encounter PPC (Forrest et al., 2013; Shen-Miller et al., 2011). A considerable amount of progress has been made in this area with most programs have policies about remediation in their handbooks so that this information is available to students (Vacha-Hasse et al., 2019). However, the mere presence of policies is not sufficient if discussions around professional competence are not integrated into the life of a training program (Johnson et al., 2012). Furthermore, most policies do not address trainers’ PPC. This is a glaring oversight as Johnson et al. (2012) noted that colleagues often avoided initiating difficult discussions when they saw their psychologist peers exhibiting problems of professional competence. Their reluctance to intervene was fueled by uncertainty about their ethical duty to intervene, fear that they did not have sufficient evidence to intervene, or concern

about any resulting negative outcomes for their colleagues. Having clear policies about expectations for trainer competency behaviors and how to address problems could mitigate some of the reluctance.

Current trainees will become future trainers. Kaslow and Ammirati (2020) highlighted the need for training psychologists to “self-reflect accurately, and neither over-nor underestimate their performance” (p. 4). Drawing on competency development in other professions (Tsingos et al., 2015), Kaslow and Ammirati suggested balancing the formal instruction of trainees with experiential learning, direct observation, and the opportunity to engage in feedback and discussion of the learning process, including summative or strategically placed competency checks to teach the process of self-reflection throughout the training and post training process.

The training in reflective practices suggested by Kaslow and Ammirati (2020) could prevent some of the experiences participants identified in our current study. The 233 participants in the study identified 529 trainers they perceived as having problems of professional competence. Considering that the sample from this study is small relative to the number of trainees in mental health training programs, this is a cause for grave concern. While 27% of participants indicated encountering only one trainer with problems of professional competence, 52% reported two or three trainers with PPC and 13.4% reported four or five. An alarming 7% indicated they had encountered more than five trainers with PPC. The literature (references? I feel like they used to be here, but got lost somewhere in the edits) also notes that minority trainees are likely to encounter microaggressions, discrimination, and other problematic encounters with their trainers; the current sample did not contain many racial or ethnic minority trainees so a more

diverse sample might have yielded even larger numbers of trainers exhibiting PPC. While no formal definition of problems of professional competency was provided to participants, many of the items on the measure of PPC listed specific behaviors of trainers (i.e., inadequate supervision skills, unprofessional behaviors of dishonesty or class absences, inappropriate boundaries), which provided participants with examples of problematic behaviors used to define PPC. It is possible that providing a definition of PPC might have reduced the number of trainers identified as struggling, but it is also important to recognize the negative impact of struggling trainers on trainees even if the trainers would not have met a predefined definition for PPC.

Training Implications

As previously noted, there is a lack of literature addressing trainer PPC. These results indicate the need for training programs and individual trainers to be more proactive regarding how trainer PPC is addressed so it does not impact students during their training years and influence their future in mental health fields. One way this can be addressed is by changing the focus of competence from an individualistic viewpoint to a communitarian training culture. Johnson et al. (2014) described a need for the field to transition to a culture emphasizing a shared community responsibility for competency in professionals and members of the field. By establishing a communitarian training culture from the beginning of trainees' careers, competence constellations can be created (Johnson et al., 2014) that support the development and maintenance of competence throughout one's career. Training during graduate programs allows trainees to be given feedback from others focusing on missed blind spots, bringing awareness to decision

making, and increase trainees' ability to provide and receive feedback from other professionals throughout the entirety of their career (Vazire & Carlson, 2011).

It is important to recognize that modeling coming from trainers with unaddressed PPC increases the likelihood those behaviors will continue in future professionals. When trainers are silent or avoidant in addressing PPC in their trainees or their peers, trainees do not learn how to use their community to address competency concerns (Johnson et al., 2012). In addition to policies regarding trainee competence, programs should be explicit in having and disseminating policies on how to address trainer PPC and be more transparent with how those issues are addressed, without violating any individual's privacy. The current study highlighted an interesting finding regarding how few trainees knew that their reported trainer with PPC had actually been addressed (44 of the 192 responses). It takes courage to report trainers due to the complex nature of the trainer-trainee relationship. Providing information to trainees is important as there is obviously value in closure of the feedback loop related to trainer PPC concerns. Trainers, programs, and professional organizations need to expand on what can be done to close the feedback loop while respecting the privacy and confidentiality of a complex situation. These discussions should also acknowledge the power dynamics that exist in training that not only make it difficult for trainees to address trainers with PPC but also recognize that trainers might be protected by the systems they are in and that problem resolution must work within those systems.

Finally, it is important to recognize the distinction between guidelines set up for trainees with PPC concerns and trainers with PPC concerns. Specifically, organizations that participate in training, like internship and practicum sites, do not currently have

guidelines to ensure trainers are competent. Which is vastly different than the clearly defined competency concerns for trainees. We also recognize a similar lack of guidelines for faculty in mental health training programs as their evaluations do not focus on competences outside of teaching, research, and some areas of professionalism.

Ultimately, we recognize mental health fields are relying on levels of professionalism to address PPC concerns that may not exist. This leaves a gap in having definitive or formal guidelines to determine if TPPC does exist or how to address it if it does. This highlights the need for more formal policies and procedures regarding the process of reporting concerns about trainers in a more structured capacity. Specifying what reporting TPPC concerns are and the proper reporting process while giving follow up information if concerns are identified while respecting the confidentiality and legal rights of trainers is part of the information necessary to improve the impact of TPPC in the future.

Limitations and Future Research

Although the current study provided important information regarding ways in which trainees' experiences with trainers who had problems of professional competence impacted them, there were some limitations to the study. As with all self-report data, the information only reflects the experiences that the participants perceived and felt comfortable disclosing. Since there was no objective identification of trainers with PPC or single definition of PPC, the study relied on trainees' perceptions of PPC in their trainers.

The majority of the sample identified as white, females. Although this identity is representative of the current demographics of trainees in graduate mental health programs, it reduces the generalizability of the results to racial or gender minority or

male populations. Even though there were not significant differences on the trainer problems with professional competency scales by racial group, the small number of diverse trainees necessitated having to combine them into one group. This might have obscured important differences by racial group. Current research surrounding minority individuals' training experiences confirms negative experiences with trainers impacting that career development. Bautista-Biddle et al. (2020) reported evidence that students and trainees who encountered repeated microaggressions throughout supervisory relationships were "actively harmed" by the experience in ways that negatively impacted their ability to provide the best quality care to their patients and stay actively engaged in their educational process. It would be beneficial for future research to focus on gathering responses from a larger number of racially and ethnically diverse trainees to obtain a better understanding of the different experiences of minority trainees with trainers who have problems of professional competence.

Similarly, the sample was not large enough to conduct fine-grained analyses among different types of doctoral programs or different categories of trainers. The data collection for this study began in March 2020 when the COVID-19 pandemic began. This might have limited the ability to obtain a larger sample as the population targeted for the study was transitioning to new educational practices and might have had reduced mental capacity to engage in research projects.

A minor limitation was the omission of a response option for participants who had not had any interaction with trainers with issues of PPC. While two participants wrote in that they had not encountered trainers with PPC, one still responded to the satisfaction with how the concerns were addressed question and 232 of the 233 participants reported

experiencing one or more trainers with PPC. It is likely that respondents who had not experienced trainer PPC were among those who discontinued participation prior to completing the survey. Additionally, participants were not asked the length of time they had worked with the trainer with PPC or how much time had elapsed (if any) since they had contact with the trainer. Including that information in future research would provide additional information about the lasting effects of trainer PPC.

Future research should focus on expanding the literature surrounding trainers who have problems of professional competence. The American Psychological Association and researchers report the need for ongoing literature in trainer competency and ethical decision-making (APA, 2018; Bent et al., 1999; Cox & Grus, 2019; Hatcher et al., 2013). It would also be beneficial to expand literature on the overall impact of trainers with PPC; utilizing qualitative research methods could gather more detail on different ways in which trainees were affected by trainer PPC and if there were some types of trainer PPC that were more damaging than others. Further research should also engage fellow trainers and gauge their perceptions of peers with PPC and how they can help protect trainees when they experience problematic situations. Lastly, there needs to be an open dialogue, discussion, and research regarding the institutional barriers for holding trainers with problems of professional competence accountable for their actions.

Conclusion

The competency literature emphasizes gatekeeping and ensuring trainees with competence concerns have remediation and other protocols in place to address concerns while in training. The results of this study highlight the need for continued research and policy on addressing PPC in trainers in mental health professions. This study expands

upon previous literature recognizing the overall disruptions of the training experience related to trainer PPC by identifying relationships between experiencing trainers with PPC and decreased professional commitment and self-efficacy for addressing PPC in others. However, trainees who were aware of procedures for addressing trainer PPC had higher self-efficacy for discussing PPC in others. This finding reinforces the need for the presence and dissemination of policies and procedures, a process that would be facilitated by competence constellations and a communitarian training culture.

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