

Defining the boundaries of professional competence: Managing subtle cases of clinical incompetence.

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Abstract:

Flagrant cases of professional incompetence are often identified and corrected through formal remediation procedures. However, many subtle cases exist that can go undetected and uncorrected. This article describes a 5-component schema for categorizing the elements of competence necessary to provide quality psychological services: factual knowledge, generic clinical skills, orientation-specific technical skills, clinical judgment, and interpersonal attributes. Case examples are used to illustrate the types of problems that are likely to occur in these different areas. Peer education and supportive confrontation are suggested as appropriate means of addressing subtle cases of incompetence. Also, suggestions are made for system changes (graduate training, licensure requirements, and continuing education) designed to promote competence among clinicians.

Keywords: mental health services | professional competence | psychology | psychology education | professional standards

Article:

Professional competence plays a prominent role in the guidelines established by all disciplines involved in psychotherapy, whether psychology (American Psychological Association [APA], 1981a, 1990), psychiatry (American Psychiatric Association, 1981), counseling (American Association for Counseling and Development, 1981), or social work (National Association of Social Workers, 1980). Although varying in their level of specificity, these different ethical codes show a high degree of similarity in the issues they cover. Minimal levels of competence have been established to protect consumers of psychological services (Claiborn, 1982). Instances when professionals do not perform in a competent manner are detrimental for consumers and can result in a loss of trust in the field in general (Jensen, 1979). In addition,

incompetence poses a risk for professionals because negligent behavior often lays the foundation for malpractice lawsuits (Hogan, 1979).

The Ethical Principles of Psychologists (APA, 1990) state that psychologists must “recognize the boundaries of their competence and the limitations of their techniques” (p. 390), only providing services for which they have been adequately trained. Although this is certainly a basic prerequisite for competence, the APA guidelines fall short of fully delineating the multidimensional nature of professional competence.

Competence is a multidimensional construct incapable of being assessed by any one method (Bernstein & Lecomte, 1981; Neufeld, 1985). Professional competence has been defined as the provision of quality services through the application of professional knowledge, skills, and abilities (McNamara, 1975). In evaluating competence, it is important to distinguish ability from performance. Simply possessing a particular ability does not ensure competent performance (Jensen, 1979). Also, performance is best viewed on a continuum, ranging from highly competent to clearly incompetent (Koocher, 1979). On the basis of these notions, incompetence occurs when professionals continue to provide services that they are not fully capable of performing (Keith-Spiegel & Koocher, 1985).

On the basis of a review of the literature pertaining to competence in the health care professions, Norman (1985) proposed a categorization schema of clinical competence describing the five domains of professional activities deemed essential to competent performance: knowledge and understanding, clinical skills, technical skills, problem solving and clinical judgment, and personal attributes. Norman's schema provides a useful framework for delineating the domains of professional competence, compatible with the four factors of perceived competence identified by Peterson and Bry (1980). The present article describes these domains as they apply to assessment and psychotherapy and will use several case descriptions to illustrate subtle forms of incompetence. Because psychologists who provide clinical services often work in interdisciplinary settings, many of the cases involve collaborative relationships with professionals from other fields. Thus, mental health professionals must be prepared to manage problematic situations that arise during such collaborative work.

Incompetence Due to Lack of Knowledge

Knowledge and understanding refer to clinically relevant factual information acquired through various educational activities. Psychologists are expected to attain and maintain adequate levels of knowledge regarding the scientific basis of the services they provide. This is probably the most easily evaluated domain of professional competence because factual information can be assessed through written examinations (Neufeld, 1985) and deficits can be corrected through continuing education programs (Jensen, 1979). This is also the aspect of competence most clearly emphasized in the APA (1990) guidelines. Unfortunately, one survey study (Peterson &

Bry 1980) found that incompetent supervisees were most likely to be described as lacking in knowledge and “intellectually dense.”

A clinician's knowledge base should include information pertaining to basic psychological processes, assessment and diagnosis, psychotherapy, ethics, and other specialty areas relevant to the services provided. During graduate training, the APA accreditation process helps to ensure that psychologists receive training in these areas. However, many individuals become licensed psychologists after graduating from programs not approved by APA or from disciplines outside of psychology (Keith-Spiegel & Koocher, 1985).

Although relatively easy to attain adequate knowledge, it is much more difficult to maintain it over time. It has been estimated that approximately one half of a psychologist's knowledge base will become obsolete within 10–12 years (Dubin, 1972). As such, it is particularly important that mental health professionals know, understand, and use the published literature that pertains to a particular diagnosis and its treatment (Sheldon-Wildgen, 1982). Unfortunately, many practicing psychotherapists underutilize the published literature (Morrow-Bradley & Elliott, 1986). Because therapists have an ethical responsibility to remain abreast of new advances in the field (APA, 1981b, 1987, 1990), it is more important for graduate training programs to promote an interest in lifelong learning than to advocate simple memorization of the facts of the current state of the field. As noted by Flexner (1925) so many years ago, training programs must promote an interest in the processes of learning and methods of science rather than specific facts or techniques.

One aspect of professional knowledge involves the ability to recognize the limitations of one's knowledge and expertise (APA, 1981b). This is difficult because of a lack of clear-cut criteria for expertise in a particular area (Keith-Spiegel, 1977). A clinician is never competent in all areas but can display competent behavior in certain domains of professional functioning (Koocher, 1979). Thus, it becomes vital for clinicians to recognize and limit their practice to areas for which they have sufficient expertise to perform in a competent manner.

Another aspect of professional knowledge involves respecting the limitations of clinical techniques. Not all approaches are equally effective for all disorders (Beutler, 1979). Novice therapists may become overzealous in the successful application of particular techniques and lose sight of the delimiting boundaries of these procedures. Together, therapist and client should identify the most appropriate treatment from a variety of possible approaches (Frances & Clarkin, 1981). This process relies on the therapist's knowledge of different interventions relevant to the client's problems.

Case Example 1

A 30-year-old, single, White man was referred by his primary therapist for adjunctive therapy to help him overcome his driving phobia. He had initially entered individual psychotherapy with his primary therapist 2 years earlier to deal with this specific problem, but no progress had been

achieved. Instead, they had spent much time exploring an assortment of developmental issues. In contrast, the adjunct therapist used behavioral techniques such as relaxation training, cognitive therapy, and in vivo exposure to overcome the client's irrational fear. After 12 sessions, he was able to drive in several difficult areas either alone or with the adjunct therapist. He was then referred back to his primary therapist for continued psychotherapy.

At the start and end of the behavioral treatment, the adjunct therapist telephoned the primary therapist to discuss the treatment of this client. The primary therapist described the client as dependent and overly reliant on psychotherapy for support and guidance. Rather than addressing the presenting problem (driving phobia), she decided to focus on various developmental issues. During the discussion it became apparent that the primary therapist was unaware of the literature describing the procedures or efficacy of exposure-based treatments for phobic disorders. Her slow and indirect therapeutic approach was not optimal for a simple phobia. The adjunct therapist politely explained what he had found effective in working with this client and strategies that may be useful in promoting autonomy in the client.

It is the responsibility of the therapist, in collaboration with the client, to evaluate the progress that has been made, and if deemed inadequate, to change modalities or terminate therapy and refer the client elsewhere (Keith-Spiegel & Koocher, 1985). Although this therapist did not change her therapy approach, she did refer the client elsewhere when she saw no progress was being achieved.

Incompetence Due to Inadequate Clinical Skills

Generic clinical skills refer to basic interviewing skills necessary to assess and treat clients. These skills typically develop through supervised experience, after appropriate didactic material has been learned. At the most basic level, clinicians must have the ability to foster a productive therapeutic relationship for assessment and therapeutic purposes. In addition, psychologists must use these generic skills to integrate assessment information into case formulations and treatment plans.

For assessment, clinical skills are necessary to develop adequate levels of rapport with clients (Anastasi, 1988). In addition, clinicians must be aware of the subtle ways that their own personalities, needs, and concerns can influence both the administration of tests and their interpretation (Schafer, 1954). Adequate assessment skills are a prerequisite for effective treatment because many problems cannot be appropriately treated until properly diagnosed (Sheldon-Wildgen, 1982).

In psychotherapy, adequate levels of empathy, warmth, and genuineness are often considered important for positive therapeutic outcome regardless of theoretical orientation (Egan, 1986; Ivey & Authier, 1978; Marziali, 1984; Rogers, 1961; Woodward & Gerrard, 1985). These qualities promote understanding, trust, and compliance in the clinical setting (Woodward & Gerrard, 1985). Other relevant skills include composure and sensitivity, the ability to

communicate with a variety of clients, and the ability to maintain an appropriate professional relationship with clients. These generic skills provide the foundation for the use of other, more specific clinical techniques.

Incompetence in the area of generic clinical skills can arise in a number of areas. For illustration, three areas are briefly described: (a) Informed consent may be inadequately obtained. This is important because consent is critical before assessment or psychotherapy begins (Everstine et al., 1980; Sheldon-Wildgen, 1982). (b) Advice-giving can be overused. Such directive approaches may produce rapid but short-lived changes in behavior (Rachman, 1976) or may evoke noncompliant behavior from clients (Patterson & Forgatch, 1985). In addition, giving advice can render clients dependent on their therapists for additional direction and guidance (Thompson, 1983). (c) Therapist self-disclosure can be excessive. Appropriate levels of disclosure promote a sense of genuineness in the clinical setting and may increase the effectiveness of the therapist as a role model. However, if carried to excess, therapist self-disclosure can confuse clients by blurring distinctions between the roles of professional and friend.

Case Example 2

A 28-year-old, single, White woman was seen for outpatient psychotherapy. She was self-referred after a recent move and had been in therapy for several years with a psychotherapist in a different city. During the course of therapy, the client frequently asked questions about the therapist's personal life. Unless the questions were relevant to therapy, the therapist politely refused to answer. After several refusals, the client revealed that her previous therapist shared “everything” with her. The client reported that in her sessions with her former therapist, they would often talk about personal issues and problems experienced by the therapist. The client described her former therapist as a friend with whom she could discuss anything. She was feeling rejected by her current therapist because this same friendship was not developing.

In this case, assuming the accuracy of the client's report, the former therapist failed to maintain an appropriate distance in the therapeutic relationship. This resulted in a confusion of personal and professional roles that bordered on the establishment of a dual relationship. This role ambiguity carried over into therapy with the new therapist and almost disrupted therapy again. The former therapist's level of self-disclosure seemed excessive. Therapist self-disclosure should match the client's needs (Hendrick, 1988) and should be done only after evaluating its probable impact on the client.

In an attempt to resolve this situation, the therapist discussed with the client potential problems arising from unclear boundaries in the therapeutic relationship and the need for objectivity on the part of the therapist. The therapist then drafted a letter to the client's former therapist. The letter described how therapy with this client was found to be more effective when clearly identified boundaries between personal and professional roles were maintained. Such boundaries helped

the client to focus on her own problems. The client was offered the opportunity to read the letter, and her consent was obtained to mail it. In this way, both client and former therapist were sensitively educated about the appropriate roles each party should play in a therapeutic encounter.

Incompetence Due to Deficient Technical Skills

Technical skills refer to the ability to use special procedures or techniques in the clinical setting. This may involve special assessment procedures or treatment techniques specific to a particular theoretical orientation. These highly focused skills are developed through specific, focused training experiences. Ideally, technical skills are fully blended with the generic clinical skills of the therapist (Strupp, 1978).

The competent use of specialized assessment instruments (e.g., Rorschach, MMPI, TAT, Bender-Gestalt, Luria-Nebraska) requires expertise in the assessment process itself, as well as knowledge of the norms, administration, scoring, interpretation, and appropriate uses of the specific instrument (Haynes, Sackett, & Tugwell, 1985). Test users should know the psychometric properties of the tests they use (APA, 1985) and should maintain current knowledge of the strengths and limitations of the tests (Weiner, 1989). In addition, clinicians should use assessment instruments that are cost effective and capable of critically evaluating specific diagnostic hypotheses (Haynes et al., 1985).

Specialized therapy techniques (e.g., hypnotherapy, biofeedback, aversion therapy, paradoxical intervention, marital and group therapy) require specialized training in the theory and application of such interventions. For example, many issues pertaining to communication and confidentiality not often seen in individual psychotherapy become prominent in marital and group therapy (Margolin, 1982). The use of specialized therapy techniques can be problematic because many specialty areas (e.g., sex therapy, hypnotherapy) do not provide adequate criteria to specify what constitutes expertise in that domain (Keith-Spiegel, 1977). Furthermore, the specialized titles (e.g., sex therapist, hypnotherapist) are usually not protected by law.

Technical skills can involve clinical work with special populations. Such special populations can be based on demographic variables (e.g., age, race, socioeconomic status) or clinical issues (e.g., forensic settings, medical patients, battered women). For example, it is unclear whether therapists trained in the treatment of adult psychopathology are adequately trained to treat children (Goggin & Goggin, 1979) or the elderly (Steuer, 1982). Likewise, the new field of behavioral medicine has opened many possibilities for assisting medical patients. Such work requires knowledge about standard medical procedures in order to ensure effective collaboration among an interdisciplinary treatment team. Psychologists should openly acknowledge the limits of their expertise and, in many cases, should refer clients elsewhere to receive the specialty skills possessed by professionals from other fields.

Case Example 3

A 45-year-old man sought outpatient psychotherapy for claustrophobia. His therapist initially attempted systematic desensitization procedures, but the client was noncompliant with assignments to practice relaxation twice a day. The therapist felt this would interfere with desensitization procedures and changed the intervention to a flooding approach. The client was to be exposed to an enclosed space until his emotional reaction subsided. Because the therapist feared the client might attempt to flee the situation, it was negotiated that the therapist would tie the client to a chair, turn off the lights in the therapy room, and leave the client alone in the small office until the emotional reaction had subsided. In this way, the therapist felt he could use flooding to extinguish the claustrophobia. After treatment, the client reported that the technique had been successful, and the therapist presented this case at a grand rounds discussion. A graduate student attending the presentation discussed the case with her faculty supervisor. The supervisor then attempted to clarify some of the issues involved in this case by talking directly with the therapist.

When the therapist was asked why physical restraint was used, he provided a concise, plausible treatment rationale, conceptualizing the client's problems as a fear of restraint and of intense emotional reactions. He described the precautionary measures he had taken, which had included using peer consultation, obtaining informed consent, encouraging the client's active participation, performing a recent medical evaluation, and planning procedures to be followed during the actual exposure session. Also, several sessions were used to prepare the client prior to the actual implementation of the exposure and to develop coping strategies for managing the expected emotional reactions.

The consent form used by the therapist contained much detail about the procedures to be used during the exposure session. However, it explicitly stated that there were no risks inherently involved in being tied to a chair. Therapists should discuss all risks relevant to the client's informed decision about whether or not to participate in a novel treatment (Glenn, 1974). Failure to disclose these risks can lay the foundation for a malpractice claim should those risks materialize (Glenn, 1974). This therapist failed to examine the full range of potential risks involved in the use of physical restraint. He seemed to lack the technical skills necessary to appreciate the possible ramifications of his treatment approach.

Another complicating factor was that the therapist had minimal training in behavioral approaches, thus possibly practicing beyond his expertise. Not all psychotherapists who use behavioral techniques have been adequately trained in the principles of learning theory or have sufficient training in behavioral interventions (Keith-Spiegel & Koocher, 1985). This issue is particularly salient in this case because it involved a novel technique whose effectiveness had not been empirically demonstrated. The choice of treatment should be based on the published literature, or if unavailable, on generally accepted practices (Association for Advancement of Behavior Therapy, 1977). This case illustrates inadequate technical skills because he was not aware of the literature that shows that relaxation is not an essential component of systematic

desensitization (Osberg, 1981; Sue, 1972) and that physical restraint reduces the effectiveness of exposure treatments (Marshall, Gauthier, & Gordon, 1979).

Incompetence Due to Poor Judgment

Problem solving and clinical judgment refer to the ability to apply knowledge and clinical skills to assess or treat a particular client. Such skills can apply to case conceptualization, treatment planning, or judgment in crisis situations. These skills are more sophisticated than generic clinical ones because they require the ability to plan for and manage a variety of clinical problems (Schoon, 1985). Despite similarities across clients in their clinical presentation, they often differ in important ways and require individualized treatment plans. Thus, therapists must remain flexible to adapt to the unique demands of each clinical encounter (Hadley & Strupp, 1976; Loveland, 1985).

For both assessment and treatment, these skills typically involve a problem-solving approach (D'Zurilla, 1986, Nezu, Nezu, & Perri, 1989) to develop, test, and refine hypotheses regarding the nature of the presenting problem and appropriate treatment strategies. The process involves the development and refinement of a case conceptualization that facilitates the choice of appropriate therapeutic strategies (Persons, 1989). Problems can arise if the professional maintains an inaccurate or narrow perception of the client's difficulties or maintains a rigid and inflexible approach to psychotherapy.

Clinical judgment is also important for managing a variety of crisis situations that require immediate decisions and action. These crises include instances when clients are suicidal, threatening to harm others (i.e., Tarasoff situations), or are aggressive toward therapists. Responding well to such situations requires knowledge of relevant legal and ethical guidelines, training in how to manage them, and judgment regarding effective ways to respond.

Case Example 4

A 28-year-old, single, White woman was in treatment for chronic depression. There was also evidence of a borderline personality disorder as displayed by labile moods, frequent crises, and repetitive but vague suicide threats (without any prior attempts). She was referred for group therapy by her primary therapist to facilitate her ongoing psychotherapy. After the second group meeting, the client stayed late to tell the group leaders that she had been feeling depressed and suicidal. She refused their recommendation to be evaluated for a brief hospital stay because she lacked the insurance coverage, vacation time, and sick leave, thus posing serious financial risks. After discussing her distress, the client suggested that the group leaders telephone her primary therapist to inform her of the current situation. The primary therapist reported that the client called her at home and talked for several hours almost every day. The client seemed overly reliant on her therapist. Unfortunately, the therapist did not see this as a problem and viewed her supportive therapy as the treatment of choice. At the suggestion of the primary therapist, the client agreed to drive directly and safely home and to call her therapist on arrival.

After the sixth group session, the patient again stayed late and discussed her suicidal urges with the group leaders. Although behaving in an empathetic manner, the group leaders were aware that their attention could reinforce suicide threats as a coping strategy (Wilmotte & Fontaine, 1982). It seemed more important to help the client learn to confront life's problems in a more constructive way (Rachlin, 1984). Suggestions were made for helping the client through the current crisis, and the patient agreed to discuss any future suicidal urges in the group therapy sessions instead of privately afterwards.

In an attempt to resolve this situation, the group leader called the client's primary therapist and discussed the evaluation and treatment of this client. A cautious approach would recommend quickly and seriously responding to any mention of suicidal ideation. However, this may reinforce the use of suicidal threats as a means of obtaining support and attention (Wilmotte & Fontaine, 1982). A different approach involves evaluating the client's lethality and providing the minimal intervention necessary to prevent a genuine suicide attempt (Fine & Sansone, 1990). Therapists should distinguish between acute and chronic suicidal tendencies, especially when working with borderline patients (Fine & Sansone, 1990). This client was chronically depressed, a pattern noted in many borderline individuals who use depression and suicidal behavior as a routine mode of adaptation (Guthiel, 1985; Schwartz, Flinn, & Slawson, 1974). Knowledge of this chronic dysphoria may assist psychotherapists in not overreacting to relatively minor increases in emotional distress.

The group leader discussed with the primary therapist strategies found effective in the group setting. For example, although the patient tended to focus on her problems to the exclusion of other events in her life, she seemed responsive to suggestions that she stabilize her emotional displays, focus on the task at hand, and retain a rational and constructive approach to problems. The group leader found it beneficial to focus on her strengths instead of her weaknesses, and whenever possible, to ignore her negativistic and complaining style. The group leader also suggested that it might be useful to schedule frequent sessions for support on a regular schedule instead of on an "as needed" basis and for the primary therapist to try reinforcing behavior incompatible with her negative focus. In this way, each crisis would not be treated in isolation, but a comprehensive treatment plan could be formulated.

This case illustrates poor judgment because the primary therapist displayed a narrow focus on short-term crisis management in lieu of long-term progress. Such a limited perspective represents inadequate case conceptualization and poor management of crisis situations. Although acknowledging that this client was at risk for suicide, little progress was being made by focusing on her emotional distress and suicide threats. No school of psychotherapy would support crisis intervention as a treatment to be used repeatedly on an extended basis.

Incompetence Due to Disturbing Interpersonal Attributes

Interpersonal attributes refer to personality characteristics, social skills, and emotional problems that may affect the ability to function in a professional capacity. Many of these qualities are presumably established prior to graduate training, but some aspects can be modified.

Professional demeanor includes one's appearance and attire as well as a calm and confident manner, all of which play a role in therapy. Therapists who appear anxious, uncomfortable, or uncertain are unlikely to instill confidence or hope in their clients.

Personality factors play a role in the type and style of therapy used by the therapist (Strupp, 1978). Thus, when disturbances of personality exist, the therapy process may be disrupted. Incompetent supervisees have been described as defensive and poorly motivated (Peterson & Bry, 1980). Other problematic attributes include the overuse of intellectualization, inability to tolerate silence or aggression in the client (Buckley, Karasu, & Charles, 1979), coldness, hostility, seductiveness, pessimism, narcissism (Hadley & Strupp, 1976), argumentativeness, passive-aggressiveness (Stone, 1975), feelings of loneliness, insecurity, or low self-esteem.

Kovacs (1974) has provided a gripping example of how a therapist's masochistic tendencies repeatedly interfered with his ability to view the clinical situation objectively. When the repetitive nature of the problems becomes apparent, clearly exceeding discrete incidents of poor judgment, the therapist may need professional help (Stone, 1975). Problems arise when therapists attempt to satisfy their own needs for affection and approval (Buckley et al., 1979), occasionally by going to inappropriate extremes in caring for their clients (Ellis, 1978).

Recent concern over the incidence of impaired practitioners (Wood et al., 1985) has served to raise sensitivity to personal and emotional problems that may interfere with effective professional functioning. As many as 19% of clinicians admit to having suffered from frequent psychological problems during the past year (Thoreson, Miller, & Krauskopf, 1989), and 74.3% admit to having had such problems during the previous 3 years (Guy, Poelstra, & Stark, 1989). Unfortunately, the work conditions of many psychologists complicate the identification and treatment of their psychological problems (Thoreson, Nathan, Skorina, & Kilburg, 1983).

Although it is not a sign of incompetence for professionals to suffer from emotional problems, it is considered incompetence if they continue to provide services when unable to function adequately (Keith-Spiegel, 1977), perhaps becoming apathetic toward their clinical work (McGee, 1989). When this happens, clinicians must recognize that their professional performance has been disrupted and must refrain from these activities until the problems can be resolved (APA, 1987). Unfortunately, 60% of psychologists admit to occasionally working when too distressed to perform effectively (Pope, Tabachnick, & Keith-Spiegel, 1987). Furthermore, one recent survey estimated that 38.5% of respondents knew of a colleague whose work had been affected by drugs or alcohol, 39.5% were aware of sexual misconduct, and 63.0% knew of depression or burnout in colleagues (Wood et al., 1985). Unfortunately, mental health professionals often decide not to seek treatment for their problems because of various

complications (e.g., damage to professional reputation) that might arise when one professional seeks assistance from another in the same field (Deutsch, 1985; Hurwitz et al., 1987).

Case Example 5

A 35-year-old, married, White woman presented with symptoms of a major depressive episode. She was referred to an outpatient social skills group by her primary therapist. During the group discussions, she revealed that she had been sexually abused as a child. The group members offered support and encouraged her to discuss this with her primary therapist. A week later she reported that she had discussed it with her therapist. As she told him the details of her abuse, she had been crying very hard and holding her head in her lap. When she looked up, she found her therapist had fallen asleep in the session. She quietly waited until he woke up. When he awoke, he acted as if nothing had happened, and she did not confront him about this. During the next group session, she discussed her intentions to directly confront her therapist. When she finished discussing her plans, another group member spontaneously commented that “We must have the same therapist because mine falls asleep on me too.” The group leader was aware of the accuracy of this statement. At that time, the client also reported that she had recently spoken with a friend whom she had met in the hospital, another client of this same therapist, and the friend spontaneously asked the patient if her therapist had ever fallen asleep on her. With encouragement from the group members, the patient eventually confronted her therapist about him sleeping in the session. He reportedly responded by avoiding the issue, stating “Maybe I did, and maybe I didn't.” The client was extremely upset over this incident.

In attempting to resolve this problem, the group leader followed a sequence of steps. First, the group leader and group members offered support for the emotional distress experienced by the client. Second, because directly confronting her therapist had been ineffective in changing his behavior, it seemed important for an independent party to intervene. The group leader offered to discuss the issue with her therapist. After obtaining the patient's consent, the group leader contacted her therapist to discuss this issue. Her therapist admitted that he had been having family problems and had not been sleeping well. It was suggested that he get help if this problem continues. Throughout all stages of this discussion, a supportive rather than accusative manner was maintained.

Although boredom or sleepiness in the therapist could be due to countertransference (McLaughlin, 1975) or a defensive withdrawal from overstimulation (Altshul, 1977), when occurring repeatedly, the problem probably originates in the therapist. It is certainly natural for an occasional patient with an aversive style of communication to evoke boredom in a clinician (Taylor, 1984), but when this happens on a regular basis over time or across clients, it represents incompetence.

Management of Professional Incompetence

Many subtle cases of incompetence go undetected, and even when detected, often go unreported (Claiborn, 1982). Subtle forms of incompetence are important because they are unlikely to come to the attention of state or national regulatory boards. Whether working as part of an interdisciplinary treatment team or accepting referrals as part of a private practice, a therapist will be exposed to the professional activities of other mental health professionals. Thus, psychologists must attempt to manage specific cases as they occur and take steps to prevent or reduce the frequency of incompetent behavior.

When confronted with specific cases of incompetence, professionals should be prepared to deal with these issues on an informal basis. A useful initial strategy involves reviewing the ethical guidelines and consulting a colleague to determine whether the other clinician's behavior has crossed the boundaries into incompetence (Keith-Spiegel & Koocher, 1985). Should peer confrontation be necessary, it must remain supportive, educational, and nonthreatening, so that peer relationships can be maintained that offer help to the fellow professional (Claiborn, 1982; Keith-Spiegel & Koocher, 1985). Although not an easy task (Levenson, 1986), such supportive confrontation should increase the likelihood that peers will be receptive to the input. Also, it is important to respect the diverse array of therapeutic strategies that have been developed because the psychotherapy outcome research literature cannot indicate precisely which approaches are most effective for which types of clients (Kazdin, 1983). If professionals can retain a tolerant and understanding attitude, the inevitable cases of disagreement can remain constructive (Hunt, 1965).

The problem of professional incompetence may be reduced through several preventative steps. First, graduate training programs should promote an interest in learning because professional development is a lifelong process (Dubin, 1972). Furthermore, the acquisition of knowledge is less important than the development of skills that are necessary for integrating, evaluating, and applying such knowledge (Stern, 1984). These skills are most appropriately developed through a variety of clinical experiences (Bradley & Olson, 1980). Also, mental health professionals from all fields should be encouraged to know and follow their respective ethical codes.

Second, although licensure exams can be useful in assessing factual knowledge, they do not assess the ability to apply the knowledge in a skillful manner (Bernstein & Lecomte, 1981). The additional use of secondary credentials (e.g., ABPP status) and actual work samples (e.g., videotaped interviews, written reports) may help overcome some of these limitations. Nonetheless, it is very difficult to assess psychotherapy skills in a reliable manner (Liston, Yager, & Strauss, 1981).

Third, because continuing education is needed to prevent the obsolescence of a professional's knowledge (Jensen, 1979), a growing number of professionals have recommended that it become mandatory for licensure renewal (Blau, 1983; Rodgers, 1989). However, only 19 states require continuing education (APA, 1989), and none have required formal reexamination for psychologists to renew their licenses (Keith-Spiegel & Koocher, 1985). Fortunately, the

decision to pursue continuing education is affected more by its availability than by any formal requirement (Brown, Leichtman, Blass, & Fleisher, 1982), suggesting an interest in learning is already present and just needs to be fostered.

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