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SITE SUPERVISORS' PERSPECTIVES ON SUPERVISION OF COUNSELOR TRAINEES IN INTEGRATED BEHAVIORAL HEALTH (IBH) SETTINGS: A Q METHODOLOGY APPROACH

by

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COUNSELOR EDUCATION AND SUPERVISION

August 2021

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ABSTRACT

COUNSELING SUPERVISORS' BEST PRACTICES IN INTEGRATED BEHAVIORAL HEALTH (IBH) SUPERVISION: A Q-METHODOLOGY APPROACH

Yeşim Giresunlu
Old Dominion University, 2021
Chair: Dr. Gülşah Kemer

Integrated Behavioral Health (IBH) is an integrated care approach where primary care and mental health providers work together to address the medical and behavioral health needs of the patients, or clients (Unützer et al., 2012). An increasing number of clinical mental health counselors are providing services in IBH settings and experiencing challenges with navigating unique aspects of their work in these complex systems. Clinical supervision in these settings appears as a critical resource for mental health counselor trainees (supervisees). However, we have very limited knowledge on clinical supervision provided to supervisees at IBH settings. An exploration of site supervisors' supervision practices in these settings appears to be crucial to inform clinical mental health practices as well as counselor training programs. Therefore, in the current study, I aim at understanding site supervisors' perspectives of counseling supervision in IBH settings through using a mixed-method approach, Q methodology (Watts & Stenner, 2005). Results of Q methodology procedures yielded a 2-factor solution, where Factor 1 focused on administrative supervision of IBH settings while factor 2 focused on process-oriented clinical supervision. Implications and recommendations for future studies are discussed.

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This dissertation is dedicated to my parents who taught me the value of education whose unconditional love, support and encouragement got me where I am today.

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CHAPTER ONE

Introduction

In this chapter, I will explain background of the problem, purpose of the current study, and significance of the study. Next, I will provide a brief overview of the theoretical framework and research design, including research questions. Lastly, I will conclude the chapter with the operational definitions for the terms used in this research.

Background of the Problem

Individuals with mental health concerns are often affected by other medical conditions as well (e.g., chronic diseases; SAMHSA, 2015). According to the American Hospital Association, in 2011, almost one in five Americans among a total of 34 million adults had co-morbid mental health and medical conditions (American Hospital Association, 2012). In addition, as many as 70% of primary care visits stem from psychosocial issues (Robinson & Reiter, 2007). Although physical and mental healthcare are inextricably linked (Miller et al., 2017), policymakers and health care professionals historically have conceptualized mental health care and primary health care separately (Schmit et al., 2018). Only recent initiatives enabled practices to start integrating behavioral health in primary care, although other mental health professionals (e.g., psychologists, family therapists) have long collaborated with primary care physicians (Hooper, 2014). Thus, clinical mental health counselors have been slowly recognizing the value of working in an integrated care setting (Aitken & Curtis, 2004).

Integrated care is a collaborative and comprehensive process involving a wide range of healthcare professionals (e.g., physicians, nurses). Attending patients' (clients') medical and mental health wellbeing in a single facility (Moe et al., 2019), integrated care has proven to be an effective way of caring for patients (Coleman & Patrick, 1976; Lanoye et al., 2017; Ratzliff et

al., 2017; Vickers et al., 2013). Clinical mental health counselors have been increasingly involved in integrated care settings through the Integrated Behavioral Health (IBH) delivery method. Therefore, as more counselors are practicing in IBH settings, we obtain further opportunities to describe and shape up clinical mental health counselors' place and practices in the integrated care. Moreover, according to Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) standards section A.3 of the Clinical Mental Health Counseling specialty, graduate programs "understand the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams" (p. 29). Yet, there are no guidelines established for training and practices in IBH settings for mental health counselors and supervision of their practices. Despite our increasing understanding of clinical supervision for counselor trainees (Bernard & Goodyear, 2019), IBH is one setting we have dearth knowledge and understanding for the content and practices of counseling supervision.

As one of the most frequently engaged professional activities, supervision is a vital component of clinical practice (Bernard & Goodyear, 2019; Hoge et al., 2011). Supervision promotes supervisees' learning and exploration within the areas of professional and personal development, while ensuring clients' welfare (Borders, 2006; Goodyear, 2014; Hoge et al., 2011). It is important to acknowledge that some aspects of supervision need to be adjusted based on the specific concerns of the setting, such as Integrated Behavioral Health (IBH; Goodyear et al., 2016). As counselor educators and supervisors, we are required to keep up with the evolving process of counseling. Even though the field of integrated care has been around for decades (Peek, 2013a) and other mental health professions have guidelines for trainees' supervision (e.g., *Handbook of Social Work Supervision*; Munson, 2012), evidenced-based guidelines for

counseling supervision in IBH settings are limited (Borders, 2014; Carpenter et al., 2012; Hoge et al., 2011).

Integrated behavioral health expected to be the norm for the near future (Curtis & Christian, 2012). Thus, training counselors and supervisors to provide services in this healthcare paradigm is crucial. We are informed more and more about the counselor's roles and responsibilities in IBH settings. However, we do not have an evidence-based understanding for supervisors' practices in these settings. To train future supervisors, we need first to understand the conceptual components of supervisors' practices with counselor trainees in IBH settings.

Purpose of the Study

The roles and responsibilities of today's mental health counselors in IBH settings are many and varied (e.g., therapy, consultation, health educations, advocacy). In these diverse settings, mental health counselors are required to perform in the roles of psychotherapists, consultants, administrators, and health educators (Nelson et al., 2000). Thus, IBH can be a complex setting for supervisees to navigate. Supervision that is tailored to supervisees' needs can provide a structure for the supervision process (e.g., communication with other healthcare providers, using medical software; Nate & Haddock, 2014). However, to date, researchers have not examined supervision of counselors in IBH settings from a counselor education angle. Intentional counseling supervision practices not only tailored to supervisees' needs but also based on the IBH settings' characteristics could provide structure and organization to the supervisory process, while promoting efficiency and effectiveness of counseling services (Pratt & Liamson, 2011). Thus, in this study, I aimed understand the in-depth experiences of counseling site supervisors who are currently providing supervision in IBH settings. I particularly examined site supervisors' self-reported knowledge and practices on the critical components of IBH

supervision with counselor trainees. This study has served as a preliminary exploration for the development of evidence-based best practices for counseling supervisors in IBH settings.

Significance of the Study

Findings from this study had offered us a baseline model for the components and processes of counseling supervision in IBH settings. Therefore, current study findings could further our efforts in supervisor training in counselor education programs, including ensuring ethical and professional practices and support for counselor trainees' learning and growth toward how to work as part of collaborative care teams to further provide appropriate services to the clients in their IBH setting. Findings may expand our knowledge on supervision needs of supervisors in IBH settings and addressing the training needs in doctoral programs (e.g., including IBH supervision guidelines). Furthermore, findings may increase knowledge for university supervisors to apply in their practicum/internship courses and help those with tailoring their supervision practices. Findings could also help bring awareness into counseling practices of supervisees in IBH settings as well as findings from this study could help us determining supervision needs of counselors in IBH settings. Similarly, via findings of current study, counselor education programs may include different components of IBH practices in their curriculum to train counselors in these settings. Finally, complementing Borders et al.'s (2014) *Best Practices for Clinical Supervisors*, the current study's findings have provided an initial understanding of creating guidelines for evidence-based counseling supervision practices in IBH settings. Determining these best practices could help supervisors to be better equipped in IBH settings, improving their supervisor skills and supervisory outcomes as well as counseling field’s presence and functions in integrated care.

Overview of Theoretical and Conceptual Framework

The theoretical framework of this study is embedded in the Integrated Care (IC). From a health system-based perspective, IC is defined as a person-centered comprehensive delivery service designed according to the multidimensional needs of the populations. This care model delivered by a coordinated multidisciplinary team of providers working across settings and levels of care (WHO, 2013). The concept of IC highlights the views and expectations of various stakeholders (e.g., physicians, nurses, primary care administration staff) in the health care system, centered around the needs of individuals and communities when delivering care. Similar to mental health counselors, supervisors are also part of this comprehensive care system. Thus, the delivery of counseling supervision not only centered around individual needs of supervisees, but also complementing the IC framework is crucial. Traditionally, supervision is tailored around the needs of the supervisees and their clients. In the IC framework, supervisors are part of the IC team, thus, tailoring their supervision practices not only for the needs of supervisees and their clients, but also for the functions of IC system.

The conceptual framework for the proposed methodology is embedded in both social constructivism and post-positivism (Hays & Singh, 2012). Social constructivism emphasizes knowledge created through interactions (Ancis & Marshall, 2010), where participants' social influences (i.e., culture and demand of IBH setting) are expected to shape their social interactions (i.e., supervision roles, responsibilities, and tasks; Hays & Singh, 2012). Social constructivism also highlights the subjective nature of actions, which I examined through each participant's supervision perspectives and processes. On the other hand, the postpositivist paradigm highlights the measurement of objective reality (Creswell & Creswell, 2018). In the postpositivist framework, the researchers seek the development of relevant and accurate statements of the situation, phenomenon, or interest (Phillips et al., 2000). There are overlaps in

both frameworks in which the view of the world is based on our perceptions of it, hence, objectivity is a social phenomenon (Moutinho & Hutcheson, 2011). In the current study, I explored IBH supervisors' subjective experiences and attempt to create an objective framework by explaining their shared views (objectivity).

Research Question

Based on the primary aim of the current study, I propose to address the following research question:

1. What are counseling site supervisors' perspectives on unique components and processes of supervision of counselor trainees in IBH settings?

Research Design

In this proposed study, I utilized a sequential mixed methods design, Q methodology, to address the research questions (Creswell & Creswell, 2018; Brown, 1993). Q methodology involved both qualitative and quantitative procedures to facilitate the measurement of subjectivity (McPherson et al., 2015). Q Methodology is also a good fit to explore similarities, patterns, and relationships between the categories of a specific phenomenon (Shinebourne, 2009). Specifically, in this study, the phenomenon being explored is site supervisors' perspectives of critical components of counseling supervision in IBH settings. This methodology is primarily used to explore personal experiences, opinions, and beliefs about the topic of interest using qualitative data collection techniques (McKeown & Thomas, 2013). Following the qualitative portion, the method seeks to find similarity in the viewpoints of the individuals using quantitative techniques (i.e., factor analysis). Thus, in the current study, supervisors' subjective input on their IBH supervision perspectives and practices produced objective structures through Q Methodology.

Definition of Terms Used in the Study

Behavioral Health

An umbrella term for the care of patients across mental health and substance abuse conditions, health behavior change, life stresses and crises, and stress-related physical symptoms (Crowley & Kirschner, 2015).

Behavioral Health Clinician (BHC)

Practitioners that includes mental health counselors, marriage and family therapists, psychologists, and social workers (Pratt & Liamson, 2011). In the current study, I used BHCs to specifically refer to mental health counselors.

Clinical Supervision

An intervention provided by a more experienced professional to a novice professional who usually are members of that same profession to monitor content learned and skills acquired while practicing gatekeeping to ensure that only qualified candidates enter the profession (Bernard & Goodyear, 2019).

Counselor Trainee/Supervisee

A counselor trainee is defined as a master's and/or doctoral level counseling student with a concentration in mental health who is in formal training to become a professional counselor at the field experience level (Heher, 2009). In the current study, counselor trainee is used interchangeably with the term *supervisee*.

Integrated Care

The unified and dynamic interaction of primary care providers (PCP) and behavioral health clinicians (BHC) within one agency to provide both counseling and traditional medical care (Glueck, 2015).

Integrated Behavioral Health

A care delivery system that includes a team of primary care providers (e.g., physicians, nurses) and behavioral health clinicians (e.g., mental health counselors) working together with patients and families and using a systematic and cost-effective approach to provide patient-centered care for a defined population (Korsen et al., 2013).

Integrated Behavioral Health Setting/Site

For a site to be considered Integrated Behavioral Health site, mental health counseling trainees and supervisors must be located in the same building as the primary care staff (i.e., hospitals, ambulatory care center) and providing services to the same clients with primary care staff (i.e., doctors, nurses).

Interprofessional Education (IPE)

Two or more professions learn from, with, and about each other to improve collaboration and quality of care (Thistlethwaite, 2012).

Patient

Individuals who interact with a clinician (e.g., physician, nurse) either because of disease or illness or for health promotion and disease prevention (Donaldson et al., 1996). The term *patient* implies the term of medicine portraying impairment, whereas the term *client* signifies the inclusion of biopsychosocial and/or humanistic terminology as the primary operating framework for clinical mental health counselors. In this study, mainly using the term *client,* I also referred to *patient* and *client* terms interchangeably in different sections based on the context.

Primary Care

Primary care "is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a

sustained partnership with patients, and practicing in the context of family and community" (Donaldson et al., 1996, p.31).

Primary Care Provider (PCP)

Practitioners that are providing services in primary care include physicians, nurse practitioners, and physician assistants (Sanchez et al., 2014).

Site Supervisor

For the purposes of the current study, an IBH site supervisor is defined as a qualified mental health professional with (1) a minimum of a Master's degree from a CACREP-accredited program, (2) at least two years of counseling experience in IBH settings, (3) didactic and experiential (supervision of supervision) supervision training in their background, (4) at least two years of experience with providing clinical supervision to counselor trainees in IBH setting, and (5) currently providing supervision or have provided supervision within the last year to master's and/or doctoral level practicum and/or internship students in an IBH setting (CACREP, 2016; Kemer et al., 2017).

CHAPTER TWO

Literature Review

In this chapter, I will first present a review of the literature on integrated care (IC), including levels and models of care as well as observed challenges in IC terminology. Next, I will discuss behavioral health and present the literature on Integrated behavioral health (IBH). Then, I will present clinical supervision including site supervision of counselor trainees and research on supervision practices in IBH settings. Lastly, I will conclude the chapter by informing on the current study and research questions.

Integrated Care

Mental health problems are among the most common problems encountered by primary care providers (PCPs; Arean et al., 2007). For example, chronic medical conditions often make depression difficult to diagnose, while medical concerns are difficult to treat due to the paralleling effects on the physical and psychological self (Schmit et al., 2018). PCPs may have difficulty with making referrals to mental health professionals when needed, the lack of mental health professionals in some areas, and patients' reluctance to see a second provider after being referred (Carey et al., 2010). Barriers to primary care and navigating through complex healthcare systems has been a significant obstacle to care (SAMHSA-HRSA Center for Integrated Care Solutions, n.d.). An increasing number of issues about detection and management of mental health concerns for patients has been drawing practitioners' attention to producing effective solutions in primary care settings (e.g., Aitken & Curtis, 2004; Coleman & Patrick, 1976; Dwinnels & Misk, 2017; Vickers et al., 2013).

IC has been the most effective approach for tackling these challenges (Cutis & Christian, 2012). The term *integrated care* appears to have many meanings and definitions in the literature

depending on what systems (e.g., horizontal, vertical, organizational, functional, providers, services) are integrated (Heeringa et al., 2020). However, the wide variety of these definitions also lead to lack of consensus on a standardized one (Peek, 2013a; Wolfe et al., 2020). In the context of this study, I conceptualize IC as the systemic integration of primary care and behavioral health care (Cutis & Christian, 2012; Coleman & Patrick, 1976). More specifically, "process and product of medical and mental health professionals working collaboratively and coherently toward optimizing patient health through biopsychosocial modes of prevention and intervention" (O'Donohue et al., 2005, p. 2).

IC has grown exponentially over the past decades (Martin, 2017), primarily, as a result of mental health and primary care coordination being promoted in 2003 report for the President's New Freedom Commission on Mental Health (Crowley & Kirschner, 2015). Programs in collaboration and integration were first developed in federally qualified health centers, settings like the Veterans Health Administration (VA). Park Place Medical Center in Norfolk, Virginia was one of the first of these centers in the Hampton Roads area. Passing of the Patient Protection and Affordable Care Act (ACA) in 2010 also initiated efforts to promote IC (Huang et al., 2016). Following legislative acts, primary care providers adapted the consolidation of the services. The cost-effectiveness of these shared practices has captured a trend in the implementation of IC practices (Heeringa et al., 2020). Thus, delivery models, competencies, and practices started and continue to develop still to this day.

Levels of Integration

As aforementioned, there are different conceptualizations for the IC in the literature. Goodwin (2013, 2016) highlights the complicated conceptualization of IC by reporting the different taxonomies for the ICs. These classifications include t*ypes of integration* (e.g.,

organizational), *breadth* of integration (e.g., vertical, horizontal), *degree of integration (e.g., fully integration)*, and *processes* of integration (e.g., structural and systemic; Goodwin, 2016). Valentijn and colleagues (2013) also introduced a unified framework by focusing on person-focused population-based care. In this framework, they specified macro- (system integration), meso- (organizational), and micro-level (clinical, service, and personal integration) integration as the guiding principles. Following the levels of integration, functional integration (e.g., communication) and normative integration (e.g., shared cultural values) ensure connectivity between the levels. Lewis and colleagues (2010) distinguished four types of integration that is adopted by the World Health Organization (WHO): organizational, functional, service, and clinical. Organizational integration refers to bringing organizations together through networks and mergers, while functional integration establishes multidisciplinary teams and service integration is adding clinical services through multidisciplinary teams. Clinical integration, on the other hand, integrates care into a single and coherent process across professions, and could be through using shared guidelines. Despite their overlaps, there is not a consensus on the conceptualization of integrated care among these IC frameworks. Lack of consensus in the literature appears to create confusion providers and organizations as well as researchers of IC, limiting the evidenced-based practices.

Similarly, terminology and standard definitions in IC literature are also diverse (Hunter et al., 2018; Peek, 2013a; Valentijn et al., 2013; Wolfe et al., 2020). For example, IC is often used interchangeably with collaborative care, Integrated Behavioral Health (IBH), Integrated Health Care, Integrated Primary Care, and Behavioral Health (Aitken, & Curtis, 2004; Curtis & Christian, 2012; Collins et al., 2010; Lenz et al., 2018; Peek, 2013b; WHO, 2016). Emerging from varying values, principles, and goals of implementation across different geographical,

organizational, and/or disciplinary models (Peek, 2013b), the field of IC has just begun to develop a standardized vocabulary. In order to facilitate this standardization, Peek (2013b) presented an illustration that shows the similarities in the terminology (Figure 1). Regardless of terminology, goals for the overall service delivery of all of these systems is to address the physical, psychological, and social healthcare needs of patients through comprehensive and collaborative practices.

Integrated Care Models

Similar to various definitions, there are a variety of models for integrating mental health treatment into primary care. According to the Canadian Collaborative Mental Health Initiative (CCMHI), "there are almost as many ways of 'doing' collaborative mental health care as there are people writing about it" (Macfarlane 2005, p. 11). Some of the most widely known models in the literature are chronic care model (CCM), patient-centered medical home (PCMH), four-quadrant clinical integration model (Mauer, 2009), Improving Mood-Promoting Access to Collaborative Treatment (IMPACT; Areán et al., 2005) and integrated behavioral health model (also known as Collaborative Care Model; Curtis & Christian, 2012).

Chronic Care Model (CCM) is one of the most well-known and applied IC models (WHO, 2016). CCM was developed in recognition of health system failures to meet the needs of people with chronic conditions and provide a comprehensive framework for the organization of health services to improve outcomes for people with chronic conditions (WHO, 2013). This model emphasizes preventative, community-based, and integrated approaches to care (Collins et al., 2010).

Patient Centered Medical Home (PCMH) is a physician-directed group practice that provides care that is a system-based coordinated health care system that is accessible and

delivered in the context of the patient's community (Jackson et al., 2013). The PCMH model "adopts a holistic approach to managing patients with chronic diseases and co-morbidities by offering an alternative individual model of primary care where patients are assigned to particular medical homes and physicians (WHO, 2013, p.8).

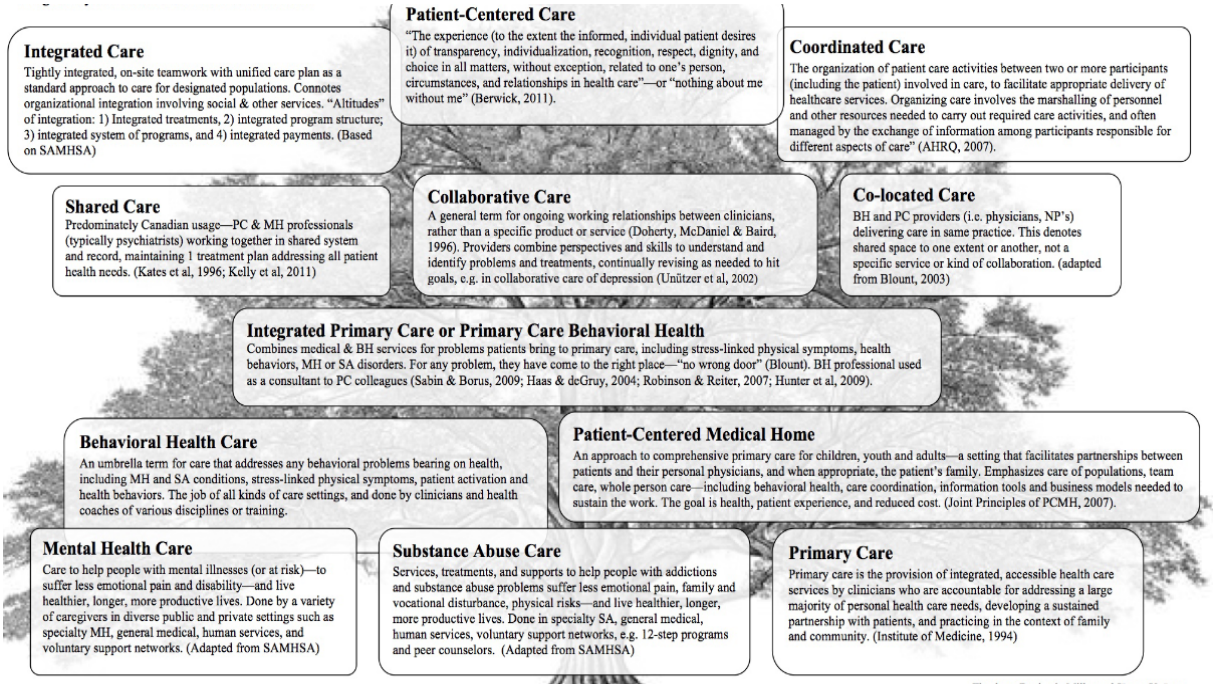
Four-Quadrant Model is a clinical integration model that specifies the types of services provided to meet patients' needs in different health care settings, such as primary care clinics and specialized medical units (Curtis & Christion, 2012). The model comprised of organizing care based on high or low behavioral and medical health problems. For example, Quadrant One includes patients with low behavioral and medical health problems whose needs can be met in a primary care setting, whereas Quadrant Four patients present with high medical and behavioral needs. Quadrant Four focuses on disease/condition specific conditions (Parks et al., 2005) provided through specialized units (e.g., palliative care unit, pain management; Mauer, 2009).

Improving Mood-Promoting Access to Collaborative Treatment (IMPACT), the longest running randomized trial study, is a collaborative care in which the individual's primary care physician works with BHC to develop and implement a treatment plan (Holden et al., 2014). This model is effective with older ethnic minority patients Results of the trials found that when a depression care manager (e.g., mental health counselor, psychiatrist) provided education, care management, medication or psychotherapy support, and problem-solving treatment, reduction of depressive symptoms were greater than in patients receiving usual care (Kohn-Wood & Hooper, 2014)

Finally, *Integrated Behavioral Health* (IBH) is an evidence-based approach for integrating primary care and behavioral health services (Unützer et al., 2013). There are different terminologies used to describe models of care which is addressed in the following section.

Figure 1

Tree of Definitions in IC from Peek (2013b)



Behavioral Health

Under the IC, behavioral health is an umbrella term that includes care for patients present with mental health and substance abuse conditions. Behavioral health care specifically addresses health behavior change (e.g., smoking cessation), life stressors and crises, and stress-related physical symptoms (Crowley & Kirschner, 2015). In the U.S., the predominant behavioral health delivery model is specialty behavioral health care and delivered in separate behavioral health clinics (Collins et al., 2010). According to the wide description of behavioral health, mental health counselors are considered as behavioral health clinicians (BHCs). Thus, the term BHC encompasses mental health counselors as well as substance abuse counselors and is used synonymously for mental health counselors (MHCs) in this study.

MHCs have been integrated into primary care settings (e.g., hospitals, primary care clinics) for decades (Martin, 2017; Peek, 2013a). With the passing of the Affordable Care Act (ACA), certain mental health counseling services became requirements for Federally Qualified Health Centers, well recognizing the presence of MHCs (Boland et al., 2019). However, fully integrating behavioral health in primary care may take time and specific training to have MHCs work efficiently within different health care teams. Behavioral health problems are common and significantly affect patients' health and quality of life (Ratziff et al., 2017). The two growing areas of MHCs practices were as "improving (a) the screening and treatment of mental health and substance abuse problems in primary care settings and (b) the medical care of individuals with serious mental health problems and substance abuse in behavioral health settings" (Collins et al., 2010, p.1). This combination of care can be achieved by the integration of medical and mental health services and a delivery system that focuses on addressing these challenges called *Integrated Behavioral Health (IBH)*.

Integrated Behavioral Health (IBH)

Integrated Behavioral Health (IBH) is an "integrated approach in which primary care and mental health providers work together to address medical and behavioral health needs" (Unützer et al., 2012, p.e41). While IC focuses on all aspects of the organization and delivery of work with a unified care plan including many professionals, IBH involves behavioral health working within and as a part of primary care (Strosahl, 1998). After the passing of ACA, other states and federal agencies have advocated for integrating the delivery of primary care and behavioral health services to improve the quality of patient care (Ede et al., 2015).

Both mental health illness and chronic diseases are common and can affect anyone, regardless of age, culture, race/ethnicity, gender, or income. Many associations exist between

mental illness and chronic conditions (e.g., cardiovascular disease, diabetes, obesity, asthma, arthritis, and hypertension; Celano et al., 2016; Collins et al., 2010; Halfon et al., 2013; Lu et al., 2016; Rozario et al., 2018; Wong et al., 2013). The need for integrated care arose when clients presented with mental health concerns while visiting emergency rooms and primary care settings (Aitken & Curtis, 2004; Coleman & Patrick, 1976; Dwinnels & Misk, 2017). Primary care providers reported feeling challenged by the identification and management of mental health concerns for clients (Vickers et al., 2013). Especially low-income, underinsured, and ethnic minority at-risk groups benefit from the IBH services the most (Aguirre & Carrion, 2012; Lanoye et al., 2017). IBH seeks to reduce stigma, improve access to care, lower the health care costs and improve the experience of care by inserting mental health professionals into the primary care setting (Bridges et al., 2014; Lanoye et al., 2017; Ratzliff et al., 2017). It is more effective when mental health counselors work in the same office as primary care physicians (Aitken & Curtis, 2004); however, there are different levels of integrated healthcare (Heath et al., 2013)

Levels of Service Integration

Levels of integration framework has changed over the years (Health et al., 2013). The most comprehensive framework for levels of service integration (used by SAMHSA) has three levels of integration: coordinated, co-located, and integrated care and two degrees of collaboration within each category, adding up to a total of six levels (Heath et al., 2013; Curtis & Christian, 2012).

Coordinated care refers to PCPs and MHCs working separately, offering services in separate settings. In the first degree, *minimal collaboration*, PCPs and MHCs work in separate facilities and rarely communicate, whereas in *basic collaboration at distance*, the second degree,

despite working in separate facilities, PCPs and MHCs communicate periodically about the clients. In coordinated care, service providers rely on a referral-base system and rarely communicate, thus, have little understanding of each other's professional premises and practices (Doherty et al., 1996).

In co-located integration, PCPs and MHCs are under one roof, providing services in the same facility, and engaging in a greater degree of collaboration and communication (Blount, 2003). In the third degree, *basic collaboration onsite*, PCPs and MHCs work in the same facility, they do not share same systems (e.g., information, administrative, financial) but they communicate regularly (e.g., email or phone call) about the client. In *close collaboration with some system integration*, fourth degree, both providers share the same space and system (e.g., information, management, financial), additionally providing consultation for one another when needed (Curtis & Christian, 2012).

The last level of integration, integrated care, involves enhanced communication between PCPs and MHCs. This proximity not only allows for shared clients but also for collaboration in the delivery of care (Schmit, 2018). In the fifth degree, *close collaboration approaching an integrated practice,* the providers function as a team with frequent personal communication understanding each other's roles when providing care. The sixth and last degree of integration, *full collaboration in a transformed/merged practice,* includes to the highest level of integration. PCPs and MHCs see the practice as a single health system treating the whole person (Health et al., 2013).

Research on IBH Outcomes

Regardless of the level of integration, previous studies with adult patients have shown significant improvement in physical, behavioral, and overall health, as well as cost savings for

patients served under IBH care delivery, including reductions in hospital stays (Carey et al., 2010; Unützer et al., 2013).

In one of those studies, Ede and colleagues (2015) examined provider, staff, and patient perceptions across five sites to describe perceptions and level of satisfaction with integrated care using three surveys (i.e., patient satisfaction survey, provider survey, and support staff survey). Researchers obtained high levels of satisfaction among all parties with the integration of primary and behavioral health services. The patients reported learning the skills needed to deal with their problems and continue to receive mental health services at the location where they receive medical care. Providers also reported the ability to manage 40% of their patients' psychiatric diagnoses without a referral, while support staff indicated behavioral health services being helpful and useful for their patients. Similarly, in an examination of IBH services provided by Veterans Administration and federally qualified healthcare centers, Grazier and colleagues (2016) reported increased access to MHC services, reduced stigma related to receiving MHC services, increased patient satisfaction, and improved clinical outcomes.

Several studies have noted the effectiveness of IBH programs on minority and underserved clients including access and improved care (Berge et al., 2017; Bridges et al., 2014; Moe et al., 2018). It is important to note, when many ethnic minorities enter treatment for mental health concerns, they are often exposed to inequalities in care (e.g., issues with diagnosis and treatment, lack of culturally competent services; Alegría et al., 2008). The IBH settings offer opportunities for patients with physical and mental health problems in elucidating their concerns (Holden et al., 2014). Berge and colleagues (2017), conducted a study on transforming a primary care clinic into a fully integrated clinic serving low socioeconomic and ethnic minority patients. The components of IBH services included creating interdisciplinary teams, increased use of

MHC services, and allocating more resources to MHCs. The results indicated significantly increased utilization of MHCs, especially therapy appointments, decreased no-show rates and increased satisfaction from the patients.

Bridges and colleagues (2014) explored whether IBH service referrals, utilization, and outcomes were comparable for Latinos and non-Latino White primary care patients. Results indicated while Latino patients had significantly lower self-reported psychiatric distress, significantly higher clinician-assigned global assessment of functioning scores, both groups had comparable utilization rates, comparable and clinically significant improvements in symptoms and high satisfaction with IBH services.

Moe and colleagues (2017) discussed the implications of IBH practices with lesbian, gay, bisexual, transgender, queer (LGBTQ) populations. The authors noted IBH practices could offer opportunities to overcome barriers that LGBTQ populations experience (e.g., discrimination, marginalization, lack of financial resources, co-morbid conditions) and provide effective and affirming treatment. Additionally, the authors highlighted the importance of advocacy and training for providers to maximize LGBTQ affirming services in IBH settings. Though IBH is effective with minority patients, providers must continue to be involved in advocacy for policy and organizational changes to allow for inclusion of care (Kohn-Wood & Hooper, 2014).

Substance use condition are part of the behavioral health paradigm (Crowley & Kirschner, 2015). Balkin and colleagues (2018) conducted a meta-analysis to evaluate the effectiveness of IBH for treating adults who were experiencing substance use disorders and receiving treatment in a primary care setting compared with treatment as usual (TAU) in primary care settings. TAU in the study refers to standard medication and referral protocols for the

treatment of substance use. The preliminary results indicate the effects of IBH compared to TAU were small, demonstrating limited effects of IBH in treating substance use.

In their review of collaborative care models, Archer and colleagues (2012) found that the team-based primary and behavioral care models significantly improved symptoms of depression and anxiety when compared to standard primary care model. Balasubramanian and colleagues (2017) also evaluated the effect of integrated care on depression severity and patients' experience of care using a mixed-method design. Over a four-year period in five different community mental health clinics, patients reported significant reductions in depression severity and positive experiences with behavioral health clinicians as well as learning new skills. In a quasi-experimental, pre–posttest study with 196 participants diagnosed with serious mental illness, Schmit and colleagues (2018) compared the effectiveness of an IBH treatment approach to a treatment-as-usual (TAU) approach over 12 months. The results stated participants receiving IBH experienced a 24-times greater improvement in overall functioning compared to TAU.

Wolfe and colleagues (2020) completed a meta-analysis on the effects of IBH on child health, health service use, health care quality, school absenteeism, and costs for children and young people. After reviewing 23 trials, researchers reported that IBH care indicated greater cost savings and improved quality of life when compared to usual care. Similarly, other researchers also highlighted the cost-effective nature of IBH services in their studies (Blount et al., 2009; Karapareddy, 2019; Kwan & Nease Jr., 2013; Unützer et al., 2008).

In a notable meta-analysis, Lenz and colleagues (2018) identified the degree of IBH paradigm effectiveness in decreasing commonly occurring mental health symptoms. Researchers review of 36 peer-reviewed articles revealed that the number of treatment team providers and the number of behavioral health sessions were the strongest predictors of treatment effectiveness

compared to TAU. As a critical study highlighting the position of counselors in IBH settings, Lenz and colleagues' study also suggested IBH as an evidenced-based effective delivery service. Additionally, mental health care delivered in an integrated setting can help to minimize stigma and discrimination while increasing opportunities to improve overall health outcomes (Collins et al., 2010; Funk, 2008). Across all of these positive outcomes of IBH, a common important factor ensuring effective delivery of the services is interprofessional education.

Roles and Responsibilities of Counselors in IBH Settings

According to ACA Code of Ethics (2014), counselors have an ethical obligation to their clients and must use treatment modalities that are empirically driven or grounded in scientific evidence. Counselors' roles in IBH teams vary depending upon the agency's philosophy, agency's needs, level of integration, behavioral and medical health problems, and the skills and qualifications of the counselors (Aitken & Curtis, 2004). Counselors are often referred to as MHCs, which appears to create confusion on roles and responsibilities from the get-go. Additionally, IBH paradigm necessitates counselors to exhibit knowledge and competencies (e.g., psychopharmacology, medical culture, co-morbidity of mental health and physical health conditions) that may not have been emphasized in their training curriculum (CACREP, 2016; Lenz et al., 2018). However, in the literature, there are established guidelines, such as core competencies developed by Substance Abuse and Mental Health Services Administration Center (SAMHSA) that the counselors can follow. In addition to core competencies, biopsychosocial approach to care is a vital part of IBH that defines the counselor's role in these settings. Lastly, there are various services that counselors can provide that are agency and client specific.

Core Counselor Competencies in IBH

There are numerous delivery competencies and clinical practice manuals that have been published for PCPs and BHCs. Of those, perhaps SAMHSA Center for Integrated Health Solutions (CIHS) and National Council for Behavioral Health core competencies are most prominent and widely used (Hoge et al., 2014). SAMHSA's core competencies highlight an effective delivery system for primary care and behavioral health services for the patients (clients; Hoge et al., 2014). These competencies were developed using interviews, literature reviews, and examining other competency sets. According to SAMHSA's core competencies, there are nine categories for effective delivery of care (1) interpersonal communication, (2) collaboration and teamwork, (3) screening and assessment, (4) care planning and care coordination, (5) intervention, (6) cultural competence and adaptation, (7) systems-oriented practice, (8) practice-based learning and quality improvement, and (9) informatics. *Interpersonal communication* highlights communicating effectively with other professionals, patients, and their families. *Collaboration and teamwork* focus on providers' ability to work together, understand each other's roles and responsibilities, and consult with each other when needed. *Screening and assessment* involve the ability to conduct an evidence-based assessment (e.g., substance use, cognitive impairment, depression). *Care planning and care coordination* include creating and implement integrated care plans for patients. For example, matching the type and intensity of services to the patient's needs. *Intervention* competency focuses on providers' ability to provide a range of interventions, such as motivational interviewing, health education, crisis intervention, and brief treatments for substance use and mental health conditions. *Cultural competence and adaptation* emphasize cultural sensitivity when providing services. For example, providers being sensitive to language preferences, culturally sensitive norms, promoting diversity among providers, and

addressing disparities in the system. *Systems oriented practice* underlines the organizational and financial structures of the local system. *Practice-based learning and quality improvement* focuses on continuous improvement of the services individually and as an interprofessional team. Lastly, *informatics* emphasizes the effective use of information technology (e.g., using electronic health records, telehealth services). Identifying and implementing evidence-based practices, patient outcomes and satisfaction as well as collaboration with other providers on the improvement of services are some of the examples for this competency area. In addition to SAMHSA's competencies, WHO and VA also created their competencies for the successful integration of behavioral health and primary care (Dundon et al., 2011; WHO, 2013). Similarly, each site/organization has its own competencies (e.g., University of Washington AIMS Center).

A notable training competency model developed by Strosahl (2005) focuses on six core competencies for the MHCs. The competencies are (a) clinical skills, (b) practice management skills, (c) consultation skills, (d) documentation skills, (e) team performance skills, and (f) administrative skills. These competencies are important for counselor education programs for furthering the training of the counselors and supervisors. Whether it is a federally funded organization or a local IBH site, the competencies provide suggestions on practical implementation strategies, which are critical to establishing the roles and responsibilities of providers. Counselors are often encouraged to follow the core competencies published by SAMHSA and follow ACA's code of ethics when delivering services in the IBH settings.

Biopsychosocial Approach in IBH

The biopsychosocial approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery (Engel, 1981; Engel, 2003). The biopsychosocial approach in counselor training

programs emphasizes the importance of understanding human health and illness in their fullest contexts. To apply the biopsychosocial approach to clinical practice, O'Donohue et al. (2005) suggested counselors to (a) understand the importance of relationships when providing care, (b) elicit the patient's history in the context of life circumstances, and (c) decide which aspects of biological, psychological, and social domains are most important to understanding and promoting the patient's health. This model is endorsed by most medical professionals yet seldomly practiced; however, it is considered the root of collaborative and integrated care (Collins et al., 2010). Embracing it as an important role, counselors must use and advocate for the use of the biopsychosocial approach in their IBH practices.

Agency and Client Specific Services in IBH

The agency that the counselors work determines the services they provide. For example, a counselor working in a primary care practice could be responsible for more case management type services than a counselor in an inpatient hospital palliative care setting.

In literature some of the roles counselors in IBH settings can provide individual therapy (30-60 minutes), group therapy, family support, consultation to the PCP and the clients, provide knowledge on chronic medical conditions (e.g., diabetes, asthma) and co-occurring conditions (Berge et al., 2017; O' Donohue et al., 2005; Ede et al., 2015; Hall et al., 2015). According to Peek (2013b), some of the functions of counselors in IBH settings are (a) behavioral activation, (b) psychological support and crisis intervention, (c) providing community resource connection, (d) mental health/substance abuse interventions, (e) providing follow-up on chronic/complex illness care, and (f) cultural and linguistic competency. Counselors in IBH settings see clients with one or more mental health or substance use conditions, relationship problems, stress linked to physiological issues (e.g., insomnia, headache), chronic medical conditions and clients with

complex symptoms (e.g., social determinants of health). As a vital part of IBH settings, counselors need to be ready to work with medical providers and deliver care (Clueck, 2015; Hooper, 2014; Peek, 2013b).

Counselors' Challenges with Performing Their Roles in IBH

Professionals from other backgrounds are not trained or familiar with mental health professionals' role or impact, thus, less inclined toward collaboration (Martin, 2017). There also seems to be confusion among mental health professionals. For example, social workers, psychologists, and psychiatrists have been involved in IBH services for a while. Gradually recognizing the need for them and importance of their role, counselors have recently started to acknowledge their place in providing services in IBH settings (Fowler & Hoquee, 2016; Johnson & Freeman, 2014; Johnson et al., 2015; Vickers et al., 2015). Social workers, for example, comprise the majority of behavioral health clinicians in IBH settings (Horevitz & Manoleas, 2013). However, each training program for these professions has different access to and involvement in health care settings based on scope of their practice (Pratt & Liamson, 2006). As a result, all professionals enter the IBH workforce with different levels of experience along a continuum of familiarity in how to provide integrated care services in a medical context and alongside medical providers. Therefore, it is inevitable for counselors to feel role confusion in IBH settings and further clarifications of their roles using supervision is warranted.

Interprofessional Education (IPE)

Addressing the complex needs of IC and successful implementation requires interdisciplinary education and collaboration (Johnson, 2019; Park, 2020). IPE is a process in which students and professionals from various professions learn from each other to move toward

a collaborative care practice (WHO, 2010). IPE is a competency that addresses the gaps in the integration of mental health into primary care.

Increased recognition that healthcare delivery involves several different healthcare professions, and that consumers often consult with different members of the healthcare team has led to the growth of IPE (Chong et al., 2013). To successfully execute IC competencies, all involved professions must acquire knowledge and receive training in interprofessional practice. According to Thistlethwaite et al., (2010), outcomes of IPE include (a) understanding roles and responsibilities of other professions, (b)creating awareness of the difference in professionals' language, (c) reflect critically on one's own relationship within a team, (d) demonstrate patient's central role in interprofessional care, and (e) understand one's own and others' stereotyping. Interprofessional education offers an ideal environment to learn about teamwork and can create a common platform and understanding for students to improve teamwork in practice (Bridges et al., 2011). IPE leads to interprofessional collaboration (IPC), the process of "developing and maintaining effective interprofessional working relationships with learners, practitioners, patients, clients, families and communities to enable optimal health outcomes" (Thistlethwaite, 2012, p.60). IPC is vital for the improvement of health care services as well as various health professionals' competencies when delivering services (Alavi et al., 2012).

American Counseling Association Code of Ethics (ACA CoE; 2014), section D highlights counselors' relationship with other professionals. More specifically, counselors are encouraged to develop and strengthen interdisciplinary relations with colleagues from other disciplines to best serve clients (D.1.b.). In addition to developing interdisciplinary relationships, "they participate in and contribute to decisions that affect the well-being of clients by drawing on the perspectives, values, and experiences of the counseling profession and those of colleagues

from other disciplines" (p.10). Counselor educators have recently started to broach the topic of interprofessional practice in their training of counselors; however, how counselor trainees are experiencing these newer services and practices have not been examined (Johnson, 2019). There is a need for health professionals, including counselors, to be prepared educationally for communicating and working in teams.

Implications of IPE for Counselor Training

Scholars have been broaching interprofessional education counselor education and training, however, how counseling students perceive interprofessional education is an area need further exploration (Johnson & Freeman, 2014). Counselors typically receive an encapsulated training in counseling terminal degree programs by counseling professors. Thus, they may not have had an exposure to other healthcare professionals during their graduate studies. According to CACREP (2016) standards section 3.d. of the Clinical Mental Health Counseling specialty, graduate programs must include “strategies for interfacing with integrated behavioral health care professionals” (p. 25) in their curriculums. Additionally, CACREP standard section 1.b. also emphasizes functions of counselors across specialty areas and their relationships with integrated behavioral healthcare systems. Then, it appears to be critical for counseling and counselor education programs to incorporate IPE as well as IBH practices in their curriculums.

Barriers with Integrating Mental Health into Medical Settings

According to a panel of international mental health experts in Collins et al.’s (2011) study, integrating mental health services into primary healthcare was one of the top five challenges in global mental health. Among the multiple challenges in delivering high-quality mental health care in primary care settings (Ayalon et al., 2007; Carey et al., 2010), the barriers were categorized as operational, cultural, and educational.

Malâtre-Lansac and colleagues (2020) reported the operational challenges as incomplete information flow between behavioral and primary care providers, billing difficulties, and lack of consistent quality performance measures. Additionally, implicating the operational integration of behavioral health clinicians into primary care settings, Grazier and colleagues (2014) emphasized networking community providers, screening obstacles, lack of incentives, and continuous quality improvement as organizational barriers.

Cultural challenges, on the other hand, were related to the attitudes of professionals in these settings. For example, Martin (2017) highlighted physicians being less inclined toward collaboration compared to other disciplines. According to WHO (2013), understanding of roles and responsibilities and willingness to work collaboratively was a barrier among the care team members. Interestingly, confidentiality rules for mental health providers was reported as one of the barriers (Gerrity et al., 2014).

Educational barriers included interprofessional education and collaboration (Lawlis et al., 2014). Thistlethwaite et al., (2010) suggested the need for interprofessional education to be included in students' training and continuing practice as qualified health providers. Beyond didactic training, scholars also reported lack of supervised practice as one of the major barriers to integrating mental health into primary care (Collins et al., 2011; Ventevogel, 2014). Without a system of competency-based supervision, training is considered to have limited impact.

Counseling programs are still in the process of initiating training modalities and practices for counselors in IBH settings (i.e., counselor and supervisor training, practice opportunities). Along with the lack of counselor training, limited understanding of supervision in IBH settings is another major barrier for integration. To better prepare counselors with a more clarified understanding of their roles and meet the demands of integrated care settings, it is critical to

enhance our understanding of counseling supervision in these settings (Abera et al., 2014; Hall et al., 2015; Ventevogel, 2014).

Clinical Supervision

Clinical supervision is one of the most important activity for the development of therapeutic competence and the provision of effective clinical practice for counselors in trainees (Bernad & Goodyear, 2019; Borders, 2006; Inman et al., 2016). Clinical supervision is a critical professional activity not only for counselor training but also to provide resources to practicing counselors. Scholars have emphasized the educational nature of clinical supervision as well as recognizing supervision as a learning process (Tangen et al., 2019). While ensuring client welfare, clinical supervision promotes counselor trainees' learning and exploration of professional and personal development activities (Bernard & Goodyear, 2019). Moreover, clinical supervision has been viewed as essential to mental health professionals across all mental health disciplines (Watkins, 2011).

Over the past decades, scholars have given attention to clinical supervision, publishing guidelines and best-practices (Bernard & Goodyear, 2019; Borders, 2014; Goodyear et al., 2014). Scholars have also published the roles and responsibilities of supervisors to promote standards for practices (Borders, 2006). Counselor education field has given much attention to developing supervision as unique to the profession by establishing best practices (Borders, 2006; Borders, 2014). Outcomes of clinical supervision include monitoring the quality of professional services, enhancing professional functioning, and serving as a gatekeeper (Bernard & Goodyear, 2019). There are also additional functions of supervision and supervisors, such as teaching, modeling, consulting, ensuring ethical practice, providing feedback, evaluation and forming self-

awareness (Bernard & Goodyear, 2019; Borders, 2006; Borders et al., 2014; Milne & Watkins, 2014). Clinical supervision promotes enhanced self-awareness, enhanced treatment knowledge, skill acquisition and utilization, enhanced self-efficacy, and strengthening of the supervisee-client relationship (Watkins, 2011), where clinical supervisors are the main responsible party for these goals. Supervisors of counselor trainees are required to have the necessary counseling and supervision training along with key clinical experiences (Borders et al., 2014). In addition to ensuring welfare of their counselor trainees' clients, supervisors operate from their knowledge (e.g., supervision theories, assessing supervisees developmental level, using appropriate interventions, evaluation, multicultural competency, advocacy; Rocha, 2020) and experiential training in the area of supervision. Among the supervisors of counselor trainees, site supervisors appeared to receive very little attention of the scholars.

Site Supervisors of Counselor Trainees

As a more focused group of supervision practitioners, site supervisors of counselor trainees usually hold at least a master's degree in counseling, have a counseling license and/or certification, and an accountable amount of practice experience in the specialty area that they are supervising (CACREP, 2016). As critical contributors of the development of counselor trainees to perform clinical services in their respected sites, site supervisors' responsibilities include, but not limited to, guiding and evaluating counselor trainees with their clients, providing administrative tasks (e.g., clinical documentation, caseload management), and gatekeeping (Bernard & Goodyear, 2019; Kemer et al., 2017). Per CACREP (2016) standards, site supervisors are expected to meet with the counselor trainees one hour each week to work on the goals they developed. Kemer and colleagues (2017) also highlighted that the site supervisors considered relationship and collaboration building as a critical intervention of supervisory work.

Bjornestad and colleagues (2014) described site supervision practices as preparation and networking, professional development, refining skills, and engaging in various supervisory roles, such as counselor, consultant, and teacher while promoting professional development. Storlie and colleagues (2019) also explored the leadership and advocacy practices of site supervisors and reported themes of modeling, involving, engaging, empowering, and pushing. In one of the limited studies on site supervisors in the counseling field, Kemer and colleagues (2017) reported the complex thought processes of site supervisors, such as demonstrating professional behaviors, administrative supervision (e.g., case management, policy and procedure adherence), evaluation, and gatekeeping. However, to date, despite few studies of IBH supervision in other fields, researchers have not focused on supervisors of counselor trainees at IBH settings.

Site Supervision of Counselor Trainees in IBH Settings

Since IBH is a unique setting that requires roles and skills different from traditional counseling setting, a supervisor with IBH experience and perspectives can help smooth the transition of trainees' mindset (Blount & Miller, 2009; Funderburk & Fielder, 2013). In IBH settings, supervisors have additional responsibilities comparing to traditional counseling settings. One of those tasks is the additional administrative tasks such as signing on notes, supervisees logs, reviewing treatment plans and biopsychosocial reports (Herbert, 2016). Edwards and Patterson (2006) also emphasized supervisors' role of helping supervisees maintain relationships with PCP for promoting better continuity of care, access to care, and patient satisfaction. Funderburk and Fielder (2013) further suggested supervisors to help address administrative issues, educate students about professional/cultural differences, and answer medically related questions about patients including medication management and medical terminology as part of their responsibilities. Additionally, supervisors function as part of the organizational leadership

(Peek, 2013b); thus, their effective leadership could influence the establishment of counseling practices in IBH settings.

Integrated Behavioral Health settings are becoming more permanent for counselor trainees to provide services. As the counseling practices continuing to evolve, supervisors need and required to have training focusing on IBH settings (Borders et al., 2014). Further understanding of supervisors' perspectives and practices could offer us a better planning for the scope of counselor and supervisor training in IBH settings. According to the ACA Code of Ethics (2014), section C highlights "counselors' practice in specialty areas new to them only after appropriate education, training, and supervised experience" (p. 8). Therefore, exploring the critical components of IBH supervision could further our training programs for supervisors, further supporting establishment of guidelines for supervisors' practices in IBH supervision and improvement of effective transitions for counselor trainees' practices and the positive outcomes of services.

Research on Supervision Practices in IBH Settings

A substantial amount of the literature focuses on the delivery models of IBH (Curtis & Christian, 2012; Pratt & Lamson, 2011). Current literature on clinical supervision in IBH settings is limited and only a few studies outlines supervision specific to IBH setting (Curis & Christian, 2012). The existing supervision literature on practices for different mental health professions is mainly from psychology and family therapy fields (Kilminster & Jolly, 2000). Strosahl (2005) emphasized supervision in the context of mentoring for behavioral health practitioners, where earning supervisee's trust, providing feedback, and enhancing supervisee's motivation were part of the mentor's responsibility. Moreover, Strosahl (2005) suggested that effective mentors

(supervisors) create performance expectations by modeling the desired behaviors and are able to modify the practice in the demands of primary care.

From the field of psychology, Hall and colleagues (2015) highlighted the limited nature of IBH supervision experiences. The researchers focused on identifying how organizations prepare clinicians to work together for IBH. Psychology interns described the supervision they received as "curbside consultations, second opinions, and assistance with challenging patients" (p. S47), highlighting the need for relevant training to work effectively as integrated care teams.

Doherty and colleagues (1996) introduced a five-step collaboration model for behavioral health psychology interns. The model has five levels ranges from minimal collaboration (Level 1) to close collaboration in a fully integrated setting (Level 5). In this model, supervision depends on the integration level of the setting. For example, in a Level 1 setting, referral-based, there is minimal contact between the BHC and PCP, thus the role of the supervisor is building clinical skills and strengthening relationships with PCP. In Level 2, coordinated care, BHC and PCP have more interaction and the supervision focuses on supervisor visiting the site and conducting live supervision. Level 3, colocation setting, supervisor is seen as a go-to member for site supervision and supervisor draws emphasis on ethical codes of the profession. Lastly, in Level 4 and 5 supervisor provides is on the site supervision, meeting with supervisees one hour/week.

In their seminal study, Edwards and Patterson (2006) reported that supervision for family therapy supervisees' focused on understanding; (1) medical culture, (2) location supervisees role in the treatment system, (3) how to investigate biological/health issues of the client, and (4) how to be attentive to self of the supervisee. Following Edwards and Patterson's suggestions, Curtis and Christian (2012) recommended adding the following elements in supervision in IBH

settings; (1) developing a detailed supervision contract between the supervisor and the supervisee, (2) documenting the practice model supervisees are using including its strengths and challenges and (3) structuring supervision according to the level of collaboration involved in clinical care. Beyond these limited number of studies from other fields, to date, researchers have not examined supervision of counselor trainees and counselors in IBH settings, further highlighting the need for evidence-based understanding of clinical supervision of counselors in IBH settings. Thus, exploring site supervisors' experiences in IBH settings could expand our knowledge on the tasks and duties of IBH counselors and supervisors, informing counselor education and supervisor training programs.

The Current Study

Supervision of counselor trainees in IBH settings are critical for trainees to develop skills on how to work as part of an interdisciplinary care team, navigate through healthcare setting protocols, and promote client welfare (Pratt & Liamson, 2011). Given these many functions and various duties, supervisors of counselor trainees need clear and concise guidelines that provide concrete direction regarding counselors' roles and the supervision process in IBH settings. In the current study, thus, I examined site supervisors' self-reported knowledge and practices on the critical components of IBH supervision with counselor trainees using the IC framework.

Chapter Summary

Integrated care is a collaborative and comprehensive process involving a wide range of healthcare professionals. Attending clients' medical and mental health wellbeing in a single facility, integrated care has proven to be an effective way of caring for patients. Clinical mental health counselors have been increasingly involved in integrated care settings through the Integrated Behavioral Health (IBH) delivery method. Therefore, as more counselors are

practicing in IBH settings, we obtain further opportunities to describe and shape up clinical mental health counselors' place and practices in the integrated care. Despite our increasing understanding on clinical supervision of counselor trainees, IBH is one of those settings we have limited knowledge and understanding for the content and practices of counseling supervision. As mentioned above, in the current study, I aimed at understanding self-reported experiences of site supervisors who are supervising mental health counselor trainees in IBH settings.

CHAPTER THREE

Methodology

In this chapter, I will propose the methodology of this study. First, I will restate the research questions for the study. Then, I will provide an overview of the Q methodology, including rationale for using this design, components of the research design (i.e., qualitative and quantitative), and procedures for the data analyses. Finally, I will conclude with limitations of the proposed study.

Research Question

Based on the primary aim of the current study, I propose to address the following research question:

1. What are counseling site supervisors' perspectives on unique components and processes of supervision of counselor trainees in IBH settings?

Conceptual Framework of the Current Study

In this study, following both ontological and epistemological philosophies of science, I came from the angles of social constructivist and postpositivist paradigms (Creswell & Creswell, 2018; Hays & Singh, 2012). Social constructivism is rooted in the belief that the voices of both participants and researchers within a research study are impacted by their cultural experiences and identities (Hays & Singh, 2012). According to the paradigm of social constructivism, knowledge is in large part created through interactions with others (Ancis & Marshall, 2010). Therefore, using this paradigm I addressed how site supervisors' experiences in IBH settings (i.e., culture and demand of IBH setting) reflected through their supervision practices (i.e., supervision roles, responsibilities, and tasks). Site supervisors’ perspectives in an IBH setting is unique to them (Durning, 1999; Prabakaran et al., 2012).

On the other hand, postpositivist paradigm is concerned about measurement of the objective reality (Creswell & Creswell, 2018), where measuring observations and studying the behavior of individuals are vital. According to postpositivism, researchers seek to develop relevant and true statements to explain the situations, phenomenon, or relationships of interest (Phillips et al., 2000). Postpositivism overlaps with constructivist paradigm in which view of the world is based on our perceptions of it; thus, objectivity is a social phenomenon (Moutinho & Hutcheson, 2011). Utilizing a merging perspectives of social constructivism and postpositivism, in the current study, I explored site supervisors' subjective experiences using by creating an objective framework explaining their shared views (objectivity) of components and practices of IBH supervision from the IC framework.

Q Methodology

In this proposed study, I aimed to understand in-depth experiences of site supervisors who are currently providing supervision to counselor trainees in IBH settings. Following the conceptual framework of the study and to complement the purpose of the study, I utilized an exploratory mixed-methods research design, called Q Methodology (McPheerson et al., 2015). Frequently used as a mixture of constructivist (qualitative) and postpositivist (quantitative) approach to measurement of subjectivity in research (Ramlo & Newman, 2011), Q methodology is ideal for exploring similarities, patterns, and relationships between the categories of a specific phenomenon, such as IBH components and practices (Shinebourne, 2009). This qualitatively dominant postpositivist methodology (Johnson & Onwuegbuzie, 2007; Watts and Stenner 2005) seeks to identify patterns of diversity and similarity in the viewpoints of individuals. Q Methodology is primarily an exploratory technique, used to assess personal experiences, opinions, and beliefs about the topic of interest such as supervisor’s supervision perspectives

(McKeown & Thomas, 2013). It is not used to prove hypotheses; however, it can bring a sense of consistency to research questions that have potentially complex and socially contested answers. Q Methodology is a research technique that emphasizes on the scientific and systematic exploration of subjectivity or personal viewpoints (Brown, 1993; McKeown & Thomas, 2013; Stainton Rogers, 1995).

Taking its roots in Charles Spearman's factor analysis, William Stephenson developed Q methodology in 1935 (Brown, 1980; Stephenson, 1993; Watts & Stenner, 2012). Q methodology reflects its contrasted theoretical analysis with the R methodology (traditional factor analysis). R methodology examines objective data, whereas Q methodology examines subjective data collected through Q sorts (Brown, 1980; Watts & Stenner, 2012). Dziopa and Ahern (2011) explained the unique purpose of Q method as "…using a Q-sort to measure a theorized process is R-methodology, while using a Q-sort to enable participants to express their holistic opinion is Q-methodology" (p. 41). In R methodologies, not reflecting differing personal perspectives of the individuals, traits or characteristics of the participants become the variables of the study. In Q methodology, on the other hand, participants of the study are the variables. Thus, in the current study, I aimed at producing objective structures from site supervisors' subjective input on their IBH supervision practices through Q methodology (Brown, 1993; McKeown & Thomas, 2013; Trepal et al., 2008).

Q methodology also centers on the range and diversity of the obtained views. Thus, this methodological approach is an appropriate method to study the complex constructs or phenomena in social sciences, such as IBH supervision. Exploration of subjectivity is particularly relevant to the field of counseling and counselor education (Stickl et al., 2018). Q methodology can be advantageous for counselor educators who are aiming to explore subjective

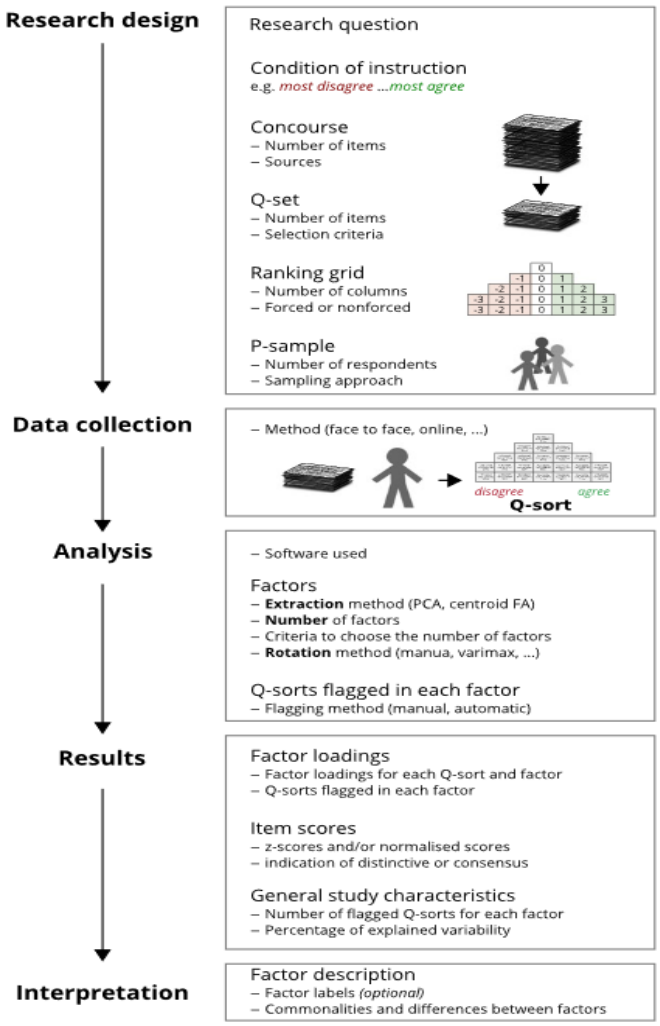
viewpoints, opinions, attitudes, and thoughts (Bang & Montgomery, 2013; Shinebourne, 2009; Stickl et al., 2018). Hence, to obtain an increased understanding of site supervisors' shared perspectives and, in turn, to enhance our knowledge on how we can best serve different stakeholders of the counseling processes (e.g., counselor trainees/supervisees, clients), Q Methodology appears as one of the ideal strategies to utilize in the current research study.

Research Design

In the current study, I followed five broad steps suggested for Q methodological studies (McKeown & Thomas, 2013; Purswell et al., 2019; Watts & Stenner, 2012): (1) determining the P set, (2) development of the concourse, (3) development of the Q set, (4) administration of the Q sort, and post-Q sort questionnaire, and (5) analysis and interpretation (Figure 2).

Figure 2

Research process of Q methodology from Zabala et al. (2018)



Step 1: The P Set (Participants)

This first step was part of the preparations for the second step, where I first defined the P set – participants of the study. The P set of the current study were site supervisors who are providing supervision to the mental health counseling trainees in IBH settings. To be eligible for participation in this study, the site supervisor must have (1) a minimum of a Master's degree from a CACREP-accredited program, (2) at least two years of counseling supervision experience in IBH settings, (3) didactic and experiential (supervision of supervision) supervision training in their background, (4) at least two years of experience with providing clinical supervision to

counselor trainees in IBH settings, and (5) currently providing supervision or have provided supervision within the last year to master's and/or doctoral level practicum and/or internship students in an IBH setting (CACREP, 2016; Kemer et al., 2017).

According to Watts and Stenner (2005), between 40 and 60 participants are recommended, even though there are examples of Q Methodology studies with fewer participants (e.g., Baltrinic & Suddeath 2020; Innes et al., 2018; Lai et al., 2007; Shinebourne & Adams, 2008). Therefore, due to targeting a very specific group of participants, I recruited five participants for statement generation and 16 participants for Q sort and post-Q sort questionnaire. Some participants involved in statement generation and Q sort were different to be mindful of the duplication of the responses (Creswell & Creswell, 2018). I utilized purposeful and convenience sampling for the recruitment of participants in this study. I contacted the local and nationwide IBH sites, announced the study in counseling listservs (e.g., CESNET) and contacted clinical directors for CACREP-accredited programs to distribute to their site supervisors in IBH (Appendices A and B).

Finally, I included demographic information questionnaire that focused on the participant as well as their IBH setting will also be included. The demographic questions specifically include information on gender, ethnic background, highest degree, clinical background in IBH, years of supervisory experience in IBH settings, supervision training, professional credentials, education levels of supervisees, current setting and unit of practice, level of integration and professional identities of other professionals in the current in IBH setting where the supervisor and their supervisees work practice. The same demographic questions will be used with the participants before the creating of concourse statements and before Q sort (Appendix C).

Step 2: Development of The Concourse

The concourse is "universe of statements for and about any situation or context" (Stephenson, 1986, p. 37). Methodologically, the concourse consisted the total number of statements created by the site supervisors before being synthesized (Ramlo, 2015; Watts & Stenner, 2012). Being derived by the research questions and including subjective viewpoints of the participants, in this study, concourse statements represented supervisors' perspectives regarding the components and processes of IBH supervision (Watts & Stenner, 2005). Since there are no specific literature on IBH supervision in the counseling field, I followed two different strategies to construct the concourse. First, to address the purpose and research questions of the study, I created a Qualtrics survey (www.qualtrics.com) with the following questions:

1. What are the unique aspects of your supervision practices with supervisees in your IBH setting? These unique aspects of your supervisory work in this IBH setting may include, but not limited to, unique focus areas, your unique roles and responsibilities as a supervisor, your supervisee's unique roles and responsibilities, etc. (Appendix D)

Second, ***upon*** creating their statements, the Qualtrics survey presented participants with 69 statements created by counselor trainees who have been supervised in IBH settings (Giresunlu et al., in progress). Site supervisors specifically asked to respond to each statement's "uniqueness/importance" to their IBH setting supervision practices with counselor trainees. Through this procedure, my goal was to increase the comprehensiveness of the final Q set. Initial P set of five supervisors completed this step.

Step 3: The Q Set

The Q set is the representative sample of items that site supervisors ranked (Q sort; Zabala et al., 2018). According to Watts and Stenner, (2012) the Q set includes between 40 to 80 statements. After gathering the statements and agreement of supervisees' statements from the site supervisors (e.g., a total of 110 statements), I reviewed the responses for language clarity and elimination of redundancy and consulted with my dissertation chair and an auditor for this editing and synthesis work.

Step 4: Q Sort

Site supervisors ranking of the Q set is called Q sort (Zabala et al., 2018). Purpose of Q sort is for site supervisors to express their viewpoints on components and process of IBH supervision in a modified rank-ordering way (McKeown & Thomas, 2013). Each site supervisor had their own Q sort as a result of ranking the statements. There are two considerations I decided prior to administration of Q sort to ensure expression of their viewpoints*: condition of instruction* and *ranking grid* of the Q sort.

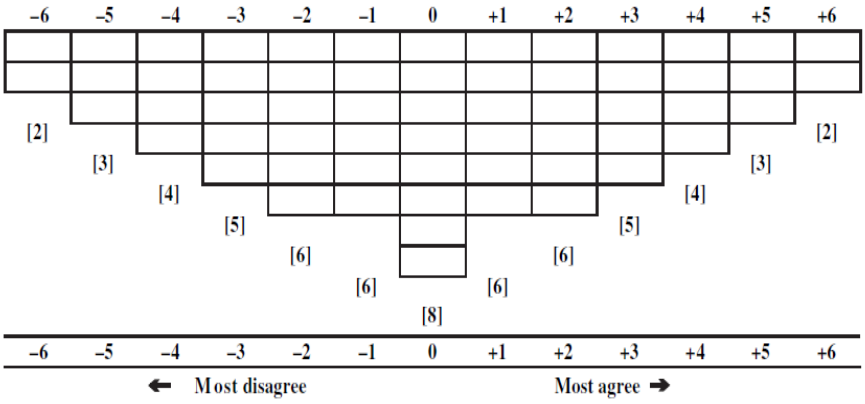
Condition of instruction. Condition of instruction refers to site supervisors' agreement with items, specifically the importance or closeness of the items to their beliefs about components and practice of IBH supervision (Zabala et al., 2018). In the current study, after the demographic questionnaire, I instructed site supervisors to rank each of the statements according to their opinion of *most significant* to *least significant* in their IBH supervision experience as a supervisor (Pruswell et al., 2019).

Ranking grid. Ranking grid refers to my decision of the type, range, and slope of the distribution for the Q set. I used a forced distribution method, a predetermined shape to assign a certain number of statements on each ranking value (Watts & Stenner, 2012). More specifically,

the shape I used is a quasinormal, inverted pyramid (Figure 3). Forced distribution provided more structured and convenient means of facilitating the item ranking process both for me and the site supervisors (e.g., ranking *from most significant* to *least significant*). I used the symmetrical grid to create factor arrays between the participants. It is important to note items placed in the same column receive the same ranking score (Watts & Stenner, 2012).

Figure 3

Example of a Quasinormal, 13-point, Shallow Uncompleted Q Sort from (Watts & Stenner, 2005)



The range and slope of the distribution depend on the number of statements and the experience level of the participants. According to Brown (1980), a nine point (-4 to +4) distribution is used for Q sets of 40 statements or less, an 11 point (-5 to +5) distribution for Q sets that has 60 statements and a 13-pont (-6 to +6) for Q sets of 60 statements or above.

The slope of the distribution reflects the expertise of the site supervisors (Watts & Stenner, 2012). Steeper distribution is for participants who are unfamiliar about the topic. A shallower distribution is for a group who particularly have expert level knowledge on the topic. I considered a shallower approach since site supervisors have knowledge, training, and experience in IBH supervision (Molenveld, 2020).

Step 4: Administration of Q Sort

The main purpose of this step is to collect quantitative data for the study. A different group of site supervisors responded to (1) a demographic information form, (2) the described procedures of Q sorting from Step 3, and (3) a series of open-ended questions (post-Q sort questionnaire).

Post-Q sort questionnaire. The purpose of post-Q sort questionnaire is to collect supporting information from site supervisors regarding their reactions about completing the Q sort and their decisions about the extreme value choices (Lundberg, 2020; Watts & Stenner, 2012). Following Q sort, site supervisors answered a series open-ended questions: (1) Please describe the items you placed as "most significant" and "least significant" to your IBH supervision practices and explain the reasons for the differences of their significance? (2) Are there any further items about which you would like to pass comment? (3) If there is any, please provide additional items you might have included at this point? (Watts & Stenner, 2005). Responses to these questions enriched the qualitative description of the factors, made factor interpretation easier, and improved the quality of the findings for the study (Lundberg, 2020).

Traditionally, Q sort and post-Q sort tasks are completed in person using item cards, ranking value cards, and a blank sorting distribution (Watts & Stenner, 2012). However, due to the current pandemic and the ease of date collection, I utilized Qualtrics to administer Step 4. Studies have shown with no difference in outcomes associated with changing the method of administration (Kelly et al., 2016).

Step 5: Analysis and Interpretation

In this step, I analyzed the quantitative data collected in the study. Quantitative data analysis in Q methodology involved the sequential application of three sets of procedures: (1)

correlation of Q sorts, (2) factor analysis, and (3) computation of factor scores (flagging; McKeown & Thomas, 2013). I used KenQ software to enter and analyze the quantitative data (Banasick, 2019).

Correlating Q sorts. The aim for this step was to correlate each site supervisors' Q sort with all other site supervisors' Q sort to determine how many different Q sorts are evident for factor analysis (Watts & Stenner, 2012). In Q methodology, each site supervisor becomes a variable (Walker et al., 2018) for correlation rather than the items (R methodology). Using KenQ software (Banasick, 2019), I calculated the correlation matrix of Q sorts, which represented the degree of similarity in the points of view between each site supervisor (Bartlett et al., 2015). Once again, different than correlation of variables in R methodology, and are correlated in order to interpret the relationships between them (Exel & Graaf, 2005; Walker et al., 2018). Those with similar views on IBH supervision, had high correlations.

Factor analysis. The purpose of factor analysis was to identify the number of groupings of Q sorts by virtue of being similar or dissimilar to one another (Brown 1993; Van Exel & Graaf, 2005). Following correlation analysis, I conducted a factor analysis for data reduction (Zabala, 2014). There are two main steps for data reduction, *factor extraction* and *factor rotation* (Zabala et al., 2018).

Factors in the Q methodology account for variance shared among observations rather than among variables (R methodology). In other words, grouping site supervisors who have similar views into factors where the views are captured in the form of Q sort (Ramlo, 2015). There are two methods of factor extraction in most of the Q method studies, Centroid or principal component analysis (PCA; Bartlett & DeWeese, 2015; Brown, 1980; McKeon & Thomas, 2013; Ramlo, 2016). Centroid factor analysis allows for deeper exploration of data

whereas PCA is mathematically simpler (Ramlo, 2016; Watts & Stenner, 2012). Supervisors with similar views on IBH supervision will share the same factor.

The purpose of *factor rotation* is to assist with determining what factors are significant to examine for the analysis. Factor rotation showed supervisors who have similar views. Rotation of the original set of factors, can be done either objectively or theoretically. Objective rotation, also called varimax rotation, is done according to statistical principle. In contrast, theoretical rotation also called manual rotation, is performed based on the researcher's prior knowledge, the aim and on the previous knowledge that the researcher (Akhtar-Danesh, 2016; Zabala & Pascual, 2016). Brown (1980) recommends rotating factors judgmentally in keeping with theoretical as opposed to mathematical. In most of the literature published using Q methodology, Varimax rotation complements PCA the most (Ramlo, 2015; Ramlo, 2016). In this study, I used PCA with Varimax rotation.

Computation of factor scores (Flagging). The purpose of *flagging* is to maximize the differences between factors, and it may be done either automatically or manually (Zabala, 2014). Flagging refers to "tagging" Q sorts (Zabala et al., 2018, p. 1189) that is representative of a factor view based upon factor loadings (Ramlo, 2015). Criteria for automatic flagging are the fact that the loading is (1) significantly high and (2) larger than the loadings of the same Q sort for other factors. In other words, the square loading for a factor is higher than the sum of the square loadings for all other factors (Ramlo, 2015; Zabala, 2014). It is important to note, some Q sorts maybe considered confounding for loading highly in more than one factor. Further flags can be manually added or eliminated after examining the loading (Watts & Stenner, 2012).

Validity and Reliability in Q Methodology

Validity and reliability in Q methodology do not have an emphasis as much as R methodologies do (Watts & Stenner, 2012). Since Q methodology explore the viewpoints of the participants, all results are considered as valid (Watts & Stenner, 2012). The Q sorting step is subjective and represents an individual's point of view; thus, there is no external criterion for evaluating site supervisors' rankings of the statements (Akhtar-Danesh et al., 2008; Bang, Montgomery, 2013; Brown, 1993; Watts & Stenner, 2012). However, I assessed and ensured validity of the results through certain internal processes. For example, to ensure content and face validity of the Q set statements, I elicited feedback from my dissertation char and an auditor, who is also a member form my dissertation chair. The delivery of counseling supervision not only centered around individual needs of supervisees, but also complementing the IC framework is crucial. Thus, when synthesizing the statements, I ensured the statements reflect the theoretical framework of the study (IC). I also pilot tested the Q sort with two participants prior to administering it to the large group of participants for content validity and face validity.

Ethical Considerations

I completed an Institutional Review Board (IRB) application prior to conducting the study. Once IRB approval was granted, I contacted the site supervisors. I provided the potential participants with a consent form that included the purpose and description of the study, exclusionary criteria, risks and benefits, confidentiality, withdrawal privilege, and the information of the researcher. The procedures adhered the anonymity of the participants. The data was be kept in a computer with two-step authentication access that only I had as the researcher. Furthermore, the current study is funded by Southern Association of Counselor Education and Supervision (SACES) Research Grant. I offered participants an incentive of $10

Amazon gift card for their participation in Part 1 and an additional $20 Amazon gift card for their participation in Part 2.

Chapter Summary

In this study, I used a mixed-methods research design, Q methodology to explore the counseling site supervisors' viewpoints of critical components and processes of IBH supervision. I aimed to produce objective structures from site supervisors' subjective input on their IBH supervision practices through Q Methodology. After the development of the concourse and the Q set, I administered Q sort to the participants. Following Q set, I analyzed the data using factor analysis procedures outlined in Watts and Stenner (2012), including the decision to rotation and flagging the factors.

CHAPTER FOUR

Results

In the current study, I aimed at examining supervisors' subjective input on their integrated behavioral health (IBH) supervision perspectives and practices that was obtained through Q Methodology (Watts & Stenner, 2012). To address this aim of the study, I pursued the following research question: What are counseling site supervisors' perspectives on unique components and processes of supervision of counselor trainees in IBH settings? Thus, in this chapter, I will discuss data collection and analysis methods followed based on the Q methodology.

Step 1: The P Set

The study's P set, participants, was site supervisors who were providing supervision to the mental health counseling trainees in IBH settings. Applying the same inclusion criteria for both, I had two P sets in the current study. The first P set included the participants to create statements for the Q set development, while the second P set completed the Q sort.

Step 2: Development of The Concourse

A total of six participants took the survey used to develop the concourse. Of those six, five of them completed the statements (n = 5). Four of the participants identified as female (80%), one identified as male (20%), while four of whom identified with Caucasian (80%) and one identified with Hispanic or Latinx (20%) backgrounds. Two of the participants did not specify their master's degree (40%), one participant completed their master's degree in Clinical Mental Health Counseling (20%), two in Community Counseling (40%). Three of the participants reported completing their doctoral degrees in Counselor Education and Supervision. One participant reported providing two and a half years of counseling in IBH settings (20%), one participant for four years (20%), one participant nine years (20%), and two participants over 20 years (20%). Participants who completed their doctoral degree reported completing a graduate didactic (content-based) course in clinical supervision and a graduate experiential course in

clinical supervision (60%; *n* = 3). In addition, four of the participants reported completing workshop training in clinical supervision. Participants reported taking supervision-related workshop trainings on counseling supervision at IBH settings (*n* = 1), Department of Medical Assistance Services (DMAS) training (*n* = 1), continuing education units (CEU; 20 hours) to provide clinical supervision (*n* = 1), and yearly and three-day trainings from an institution on supervising counseling residents (*n* = 1). In terms of participants' professional credentials, two participants reported having their Licensed Professional Counselor (LPC; (40%), two participants reported having their license as Certified Substance Abuse Counselor (CSAC; 40%), and one participant had National Certified Counselor (20%) credentials. Two of the participants reported supervising master's and doctoral level counselor trainees (40%), while three of the participants reported only providing supervision to the master's level counselor trainees (60%). Two participants reported providing supervision for two years (40%), one for four years (20%), one for 10 years (20%) and one for 15 years (20%).

Reporting on the professional identities of other professionals the participants have worked/are working with participants reported working with physicians (100%; *n*=6), physician's assistant (80%; *n* = 4), nurse (80%; *n* = 4), psychiatrist (100; *n* = 5), psychologist (40%; *n*=2), social worker (80%; *n* = 4), dieticians (40%; *n* = 2), nurse practitioners (20%; *n* = 2), health educator (20%; *n* = 1), case manager/care partner (40%; *n* = 2), and pastoral care (20%; *n* = 1). Two of the participants reported outpatient as their primary unit of practice (40%), two of the participants reported outpatient and inpatient as their primary unit of practice (40%), and one of the participants reported outpatient, inpatient, in home and telehealth as the primary unit of the practice 20%). When asked to report on the level of integration of their practice four participants reported co-location (80%) and one reported integrated (20%). Lastly, two of the

participants reported working at a private practice (40%), one on a non-profit agency (20%), one in a hospital (20%), and one in ambulatory care clinic, hospital, primary care/family practice clinic (20%) as the IBH setting they have been working at.

Six participants created a total of 128 statements (ranging from 20 to 40, *M* =25.6), reflecting on the unique aspects of their supervision experiences providing supervision to counseling trainees in IBH settings. While reviewing the statements, I removed five statements since they were not addressing the requested discourse. The final number of statements created by the participants totaled 123 statements. After they created the statements, I gave the participants a list of 69 statements created by counselor trainees who have been supervised in IBH settings in a previous study (Giresunlu et al., in progress). I asked participants to respond to each statement's "uniqueness/importance" to their IBH setting supervision practices with counselor trainees. I reviewed and discarded six statements that most participants (three out of five) disagreed with and integrated the agreed upon statements into the participants' original set of statements. The final set of statements for the concourse included 186 statements composing the Q set for the next step.

Step 3: The Q Set

The Q set included the total number of synthesized statements prior to Q sort. I reviewed the responses for language clarity and elimination of redundancy and consulted with my dissertation chair and an auditor for this editing and synthesis work. The dissertation chair is an associate professor, specialized in counseling supervision research and practice with extensive experience in mixed methods research. The auditor is a professor, specializes in university and college student adjustment, development, learning, and counseling, as well as diagnosis, case conceptualization, and treatment planning. The auditor has extensive experience in quantitative

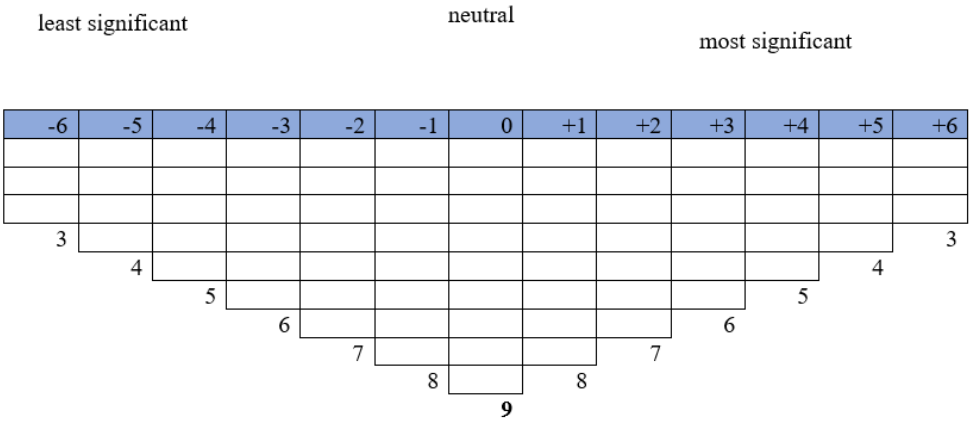
research. Dissertation chair and external auditor (dissertation committee member) reviewed the statements before Q sort. After synthesizing and consultation, the final Q set for the step 4 (Q sort; Appendix E) included 75 statements.

I decided the condition of instruction, type of the distribution and slope of the distribution prior to finalizing the preparations for Q set. For condition of instruction, I instructed site supervisors to rank each of the statements according to their opinion of *most significant* to *least significant* in their IBH supervision experience as a supervisor (Pruswell et al., 2019). In terms of the type of the distribution, I decided to use a forced distribution with an inverted pyramid shape prior to the administering the Q sort. The slope of the distribution reflected the site supervisors' expertise (Watts & Stenner, 2012). I considered a shallower approach since site supervisors had extensive knowledge, training, and experience in IBH supervision (Molenveld, 2020). Finally, I decided the range of the distribution after finalizing the number of statements in the Q set. The Q set included 75 statements; thus, I used a 13-point distribution. The final shape that I used in the distribution is shown in Figure 4.

Figure 4

Blank 13- point Quasinormal Q Grid Used in the Study

Step 4: Q Sort



I asked participants to rank statements according to their perspectives of *most significant* (+6) to *least significant* (-6) in their IBH supervision experience as a supervisor using the shape that I determined in chapter 3. I collected the data from October 2020 to February 2021. A total of 18 participants completed the Q sort. Of those 18, two were removed due to inclusion criteria and issues with the sorting making the total number of Q sorts to 16 (n=16). Out of 16 participants, 11 of the participants identified as female (68.75%), three as male (18.75%), one as non-binary (6.25%) and one as genderqueer (6.25%); while 11 identified as Caucasian (68.75%), two identified as Asian/Pacific Islander (12.5%), one Hispanic or Latinx (6.25%), one Black or African American (6.25%), and one as multiethnic (e.g., Caucasian and Hispanic or Latinx; 6.25%). Six of the participants reported completing their master's in Clinical Mental Health Counseling (37.5%), six of them reported their master's degree in counseling (37.5%), two in Community Agency Counseling (12.5%), one in counselor education (6.25%), and one in Counseling and Psychology (6.25%) all accredited by CACREP. Eight of the 16 participants reported completing their doctoral degrees in Counselor Education and Supervision (50%). While one participant did not report the number of years for their counseling practice in IBH settings, 15 participants' average years of practice was 8.2 years (n = 15) in IBH settings. In terms of participants' supervision training, eight of the participants reported completing a graduate didactic course in clinical supervision, a graduate experiential course in clinical supervision, and workshop training in clinical supervision (50%), five of them reported completing a graduate didactic course in clinical supervision and graduate experiential course in clinical supervision (31.25%), two reported receiving workshop training in clinical supervision (12.5%), and one reported completing a graduate didactic course in clinical supervision (6.25%). Participants are asked to provide information on the workshop they have completed. Workshop

information included topics, such as Counselor Trainees' and Supervisors' Roles and Responsibilities (*n* = 1), Counselor Trainees' and Supervisors' Needs in IBH Settings (*n* = 1), Counseling Supervision at Integrated Behavioral Health Settings (*n* = 1), Supervising Students with Disabilities: Raising Awareness and Cultural Competence (*n* = 1), Five Things to Think About Regarding Practicum, Internship, and Supervision in the Time of the COVID 19 Pandemic (*n* = 1). In addition, participants also reported attending workshops for site supervisors to provide licensure supervision (*n* = 2) from counseling organizations (e.g., Virginia Counseling Association; *n* = 1) or supervision professionals (*n* = 1).

In terms of participants' professional credentials, 13 participants reported having their LPC or state-specific professional license (e.g., LPCC; 81%), five participants reported having their license as CSAC or state-specific license as a substance abuse counselor (LICDC; 31.25%), four participants reported having/close to having their Approved Clinical Supervisor (ACS) credential or state-specific supervisor credential (e.g., LPCC-S CPCS; 31.25%) in addition to their LPC; two participants reported having their NCC credential (12.5%). Four participants reported supervising within the past year (25%) while 12 participants reported currently providing supervision in IBH settings (75%); 10 of the participants reported providing/have provided supervision to the master's level supervisees (62%) and six of the participants reported providing/have provided master's and doctoral level supervisees (37.5%). The average years of providing supervision for participants was 4.75 hours (*n* = 16).

Reporting on the professional identities of other professionals the participants have worked/are working with; participants reported working with physicians (62.5%; *n* = 10), physician's assistant (37.5%; *n* = 6), nurse (81.25%; *n* = 13), psychiatrist (81.25%; *n* = 13), psychologist (56.25%; *n* = 9), social worker (93.75%; *n* = 15), care manager/partner (12.5%; n =

2), pastoral care (6.25%; *n* = 1), physical therapist (6.25%; *n* = 1), nutritionist (6.25%; *n* = 1), crisis clinician (6.25%; *n* = 1), and Board Certified Behavior Analyst (6.25%; *n* = 1).

Seven of the participants reported outpatient as their primary unit of practice (43.75%), while seven reported inpatient and outpatient as their primary unit of practice (43.75%). Additionally, one participant reported inpatient as their primary unit of practice (6.25%) and one participant reported community-based services as their primary unit of practice (6.25%). When asked to report on the level of integration of their practice, eight participants reported co-location (50%), seven reported integrated (43.75%), and one reported minimal collaboration (6.25%). Lastly, the IBH settings the participants have been working at included the following: private practice (50%; *n* = 8), ambulatory care clinic (18.75%; *n* = 3), hospital (43.75; *n* = 7), primary care/family practice clinic (18.75%; *n* = 3), inpatient psychiatric facility (25%; *n* = 4), outpatient addiction clinic (6.25%; *n* = 1), non-profit agency (31.25; *n* = 5), and community services board (6.25%; *n* = 1). Following Q sort, all the participants completed the post-Q sort questionnaire. Please see Table 1 for the summarization of demographic information from both P sets.

Table 1

Demographic Information of the Participants

Characteristic	**Category**	**Number of Participants**
Gender	Female	15
	Genderqueer	1
	Male	4
	Non-binary	1
Ethnicity	Asian/Pacific Islander	2
	Black or African American	1
	Caucasian	14
	Hispanic or Latinx	2
	Multiethnic	1
Highest Degree	Master's	21
	Doctoral	11

Supervision Training	Graduate course in clinical supervision	11
	Graduate experiential course in clinical supervision	17
	Workshop training in clinical supervision	14
Professional License(s)	State Specific Professional Counseling License	13
	State Specific License as a Substance Abuse Counselor	7
	Approved Clinical Supervisor	4
	State specific supervisor credential	2
	National Certified Counselor	5
Education Levels of Supervisees	Master's	21
	Doctoral	9
Professional Identities of Other Professionals in the IBH Setting	Physicians	16
	Physician's assistant	4
	Nurse	17
	Nurse Practitioner	2
	Psychiatrist	18
	Psychologist	11
	Social worker	14
	Care manager/partner	4
	Pastoral care	2
	Physical therapist	1
	Nutritionist	3
	Crisis clinician	1
	Board Certified Behavior Analyst	1
	Health educator	1
Primary Unit of Practice	Outpatient	19
	Inpatient	11
	Other	2
Level of Integration	Minimal collaboration	1
	Co-location	12
	Integrated	8
IBH Setting that the Supervisors Practicing	Ambulatory care clinic	4
	Community services board	1
	Hospital	9
	Inpatient psychiatric facility	4
	Non-profit agency	6
	Outpatient addiction clinic	1
	Primary care/family practice clinic	4
	Private practice	10

Note. $N = 16$; some participants have multiple characteristics within the categories (e.g., a participant having both a master's and doctoral degree)

Step 5: Analysis and Interpretation

For the analysis and interpretation task, I followed the tree sets of procedures underlined in Chapter 3: (1) correlation of Q sorts, (2) factor analysis, and (3) computation of factor scores. I entered 16 completed Q sorts into a software program, KenQ, designed to conduct Q methodology analysis to examine the Quantitative data (Banasick, 2019).

Correlation of Q sorts

Correlation of Q sorts identified degree of similarity in the points of view between each site supervisor thereby representing the total variability present in the study (Watts & Stenner, 2012). The calculation of the standard error was also used for the determination of significant loadings. In all study components, I chose $p < 0.01$ as the significance level to have more statistically significant results (z-score for p-value of <.01 is 2.58). I used the formula from Brown (1980) "SEr = 1/√N", (p. 222) where SE is the standard error and N is the number of Q-sort statements. Since there were 75 statements in this study, the standard error calculated as: 2.58 (1/√75) =.30**.** Thus, f**o**r a correlation to be significant at the 0.01 level, it must have been equal to or exceed 0.30.

Table 2
Correlation Matrix
**p > .01, r ≥0.3 (Brown, 1980)*

Q Sort	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	1.00															
2	-.21	1.00														
3	.16	-.14	1.00													
4	.20	-.3*	.33*	1.00												
5	.32*	-.15	28	.32*	1.00											
6	.13	-.21	.48*	.39*	.27	1.00										
7	.07	.16	.22	.04	.25	.15	1.00									
8	-29	.17	0	.02	-.19	.29	.04	1.00								
9	.17	-.28	.01	.04	-.04	.16	-.01	.10	1.00							
10	.14	-.01	.34*	.35*	.23	.13	.15	.12	-.03	1.00						
11	.13	.15	.09	.02	-.01	-.02	0	-.06	-.04	.05	1.00					
12	-.22	.10	.39*	.24	-.09	.46*	.05	.51*	.16	.22	.06	1.00				
13	.04	.03	.22	.27	-.03	.15	.18	.12	-.05	.38*	.02	.23	1.00			
14	-.13	.24	.26	.24	-.01	.17	.15	.44*	-.09	.44*	.20	.43*	.56*	1.00		
15	.29	-.12	.17	.26	.45*	.25	.23	-.12	-.09	.46*	.07	.05	.19	.15	1.00	
16	-.19	.02	.18	.13	-.13	.35*	.10	.43*	.18	.18	.15	.52*	.28	.43*	.04	1.00

Each Q sort, other than Q sort 7, 9 and 11, had significant correlations with at least one other Q sort, demonstrating similarity across the viewpoints.

Factor analysis

I entered 16 Q sorts into KenQ software (Banasick, 2019). The data was subjected to a factor analysis for data reduction and highlighted any number of groupings of Q sorts that were similar or dissimilar to one another. Factor extractions were performed either through principal component analysis (PCA) or centroid factor analysis. As I mentioned in Chapter3, I concluded several factor analyses to find the most suitable fit for the data. I ran both methods to better understand the data and decided to utilize PCA because it was the most conceptually meaningful one to use in this dataset (Ramlo, 2015; Ramlo, 2016). The KenQ software output presented with eight factors that were unrotated (Table 3).

Table 3

Eight Factor Model of Unrotated Factor Loadings

Factor	Eigenvalue	% of Explained Variance	Cumulative % of Explained Variance	Two Highest Loadings in the Factor
1	3.639	23	23	0.691 0.666
2	2.538	26	49	0.676 0.667
3	1.698	11	60	-0.639 0.603
4	1.129	7	67	0.592 -0.36
5	1.1	7	74	0.827 0.317
6	0.969	6	80	0.58 0.447
7	0.832	5	85	-0.455 0.445
8	0.678	4	89	-0.379 0.327

To extract factors, I used two statistical measures and criteria to assess factors' statistical strength of the factors. First, the Kaiser-Guttman criterion suggests an eigenvalue of 1.00 or above as a cut-off point for an extracted factor (Watts & Stenner, 2012). Statistically, eigenvalues below 1.00 accounts for less study variance then a single Q sort (Lundberg, 2020; Watts & Stenner, 2005). Furthermore, according to Watts and Stenner (2012), an acceptable factor solution should account for more than 35 - 40% of the variance. Outlined in Lundberg (2020), a second parameter to determine the appropriate number of factors is Humphrey's rule, which "states that a factor is significant if the cross-product of its two highest loadings (ignoring the sign) exceeds twice the standard error" (Brown, 1980, p. 223), which is 2(SE*r*) = 0.6 in this study. As I applied this rule to the factors [factor 1, (.691)(.666) = 0.46, factor 2 (.676)(.667) = .451, factor 3 (.639)(.603) = .385, factor 4 (.592)(.36) = .213, factor 5 (.827)(.317) = .263, factor 6 (.58)(.447) = .259, factor 7 (.455)(.445) = .202, and factor 8 (.379)(.327) = .124], none of the factors was significant. Brown (1980) suggested less stringent use of Humphrey's rule: the cross-products exceed at least 1(SE*r*) = .30. According to this suggestion, factors 1, 2 and 3 qualified for extraction. Taking these criteria into account, a three-factor model could be extracted from the current dataset.

At first, I extracted three-factor model (i.e., factor extraction, rotation and flagging); however, there were not enough shared and/or distinguished viewpoints among the factors to interpret the data. I consulted with the dissertation chair and an external auditor (a political science faculty member who has extensive experience with Q methodology) to choose the right method of analysis. Additionally, Webler et al. (2009) suggested that "fewer factors is better, as it makes the viewpoints at issue easier to understand" (p. 31). Upon receiving consultation and reviewing suggestions from the literature, I decided to extract a two-factor model (Table 4).

Table 4

Extracted Factor Loadings

Q sort	Factor 1	Factor 2
1	-0.202	0.639*
2	0.147	-0.435*
3	0.454*	0.479*
4	0.363*	0.562*
5	-0.032	0.73*
6	0.526*	0.387*
7	0.218	0.263
8	0.642*	-0.385*
9	0.08	0.053
10	0.48*	0.438*
11	0.136	0.032
12	0.783*	-0.107
13	0.551*	0.164
14	0.775*	-0.031
15	0.172	0.655*
16	0.71*	-0.156
%Explained Variance	22	17

***** *p< 0.01*

Researchers utilized Q methodology commonly specified objective rotation, also called varimax rotation, as the most complementary to PCA (Ramlo, 2015; Ramlo, 2016). Thus, following the two factors extraction, I decided to use varimax rotation to maximize the differences between the factors. The two extracted factors accounted for 39% of the variance, adhering to the suggestion by Watts and Stenner (2012; shown in Table 4 with the factor loadings of each Q-sort). Following varimax rotation, I used Humprey's rule once again to ensure statistical strength of the factors [2(SE*r*) = 0.6, 1(SE*r*) = 0.3]; factor 1 (.783)(.775) = .6, factor 2 (.73)(.655) = .48; indicating both factors as significant.

Computation of Factor Scores (flagging)

The purpose of flagging was to maximize the differences between factors, and it may be done either automatically or manually (Zabala, 2014). I utilized auto flagging provided by KenQ software as well as manual flagging to ensure confounded sorts are not flagged (Table 5). I removed confounded sorts that loaded significantly on more than one factor (e.g., Q sort 3 and 10). My goal with excluding these sorts was to have a clearer presentation of the respective viewpoints and to reduce the correlation between the factors (Webler et al., 2009; Lundberg, 2020). Participant 3's loadings for factors 1 and 2 were 0.4543 and 0.479, while participant 10's loadings were 0.4795 and 0.4378, respectively. Lastly, as Webler et al. (2009) suggested, the correlation between the factors was significantly low in the current study (Table 6).

There are differences in the Q sorts that are flagged in Table 5 and marked (flagged) in Table 4. Table 4 has more marked Q sorts than flagged Q sorts. Unflagging helps reduce the correlation between the factors. In this case, the correlation levels between the factors were already lower than the significance level (.3). Thus, I made decisions about unflagging the Q sorts prior to interpretation. I unflagged the sorts that had <.05 difference between factor loadings (e.g., Q sorts 3 & 10) and kept the flagged sorts that had .>.1 difference between the factor, even though both factors are significantly loaded according to the significance level (e.g., Q sort 4 and 6).

Table 5

Flagged Factor Loadings

Q sort	Factor 1	Factor 2	
1	-0.2082	0.6389	flagged
2	0.1465	-0.4353	flagged
3	0.4543	0.479	
4	0.363	0.5622	flagged

5	-0.0318		0.7299	flagged
6	0.5264	flagged	0.3866	
7	0.2184		0.2625	
8	0.6419	flagged	-0.3851	
9	0.0795		0.0527	
10	0.4795		0.4378	
11	0.1358		0.0318	
12	0.7826	flagged	-0.1068	
13	0.5512	flagged	0.1643	
14	0.7748	flagged	-0.0305	
15	0.172		0.6551	flagged
16	0.7098	flagged	-0.1564	

Note. p >.01

Table 6

Correlations Between the Factors

	factor 1	factor 2
factor 1	1.00	
factor 2	.011	1.00

Interpretation

The KenQ output presented with factor arrays or composite Q sorts for each factor. Factor arrays are created represent and ideal Q sort representing each factor. (Appendix F). I used factor arrays to help me interpret the data within the factor (Table 5; Lundberg,2020). In addition to factor arrays, I used the crib sheet method outlined by Watts and Stenner, (2012) to interpret the viewpoints across factors. Crib sheet is a systematic approach to factor interpretation that includes guiding statements used to help understand and further explain the participants' viewpoints (Plummer, 2012). The crib sheets involve guiding statements such as *Top Two Statements, Statements Sorted Higher Than Other Factors, Statements Sorted Lower Than Other Factors, Bottom Two Statements and Other Possible Statements of Importance*. I completed crib sheets for each factor from the output generated by KenQ (Appendix G & H).

Lastly, I utilized participants' demographic data and answers to the post-sort questionnaires to assist with the interpretation of each factor.

In the description of the factors, I discussed the statements that are followed by numbers in brackets. The first of these refers to the number of the statement being emphasized, and the second to the position within the factor array, for example: Focusing on time limitations and management at the site (42: +3), meaning statement number 42, placed in position +3 (Plummer, 2012 & Watts & Stenner, 2012).

Factor 1: Mentoring Supervisees on Administrative and Interdisciplinary Work in IBH Settings

Factor 1 explained 22% of the variance in the model, with the highest Eigenvalue of 3.64 and the strongest statistical strength. The factor array for Factor 1 is shown in Appendix I. Six site supervisors significantly associate with this factor (participants 6, 8, 12, 13, 14, and 16).

This factor's viewpoint focuses on supervisor's mentorship of supervisee for the administrative tasks, and interventions of the IBH setting. The top three statements that all the supervisors sorted highly on were "Meeting with supervisees weekly" (75 +6), "Discussing resources to use and offer working with clients" (60 +6) and "Following and maintaining federal guidelines" (71 +6). Supervisors all agreed on the viewpoint on importance of "Focusing on treatment planning and need to incorporate health history and compounding issues" (41 +5). Q sorts loading onto this factor highlighted "Addressing administrative components of IBH setting" (61 +5).

Supervisors emphasized the relationship building/collaboration as an important intervention, in the following statements, "Collaborating with my supervisees in creating a safe space for our supervision experiences (65 +1) at the same time "Discussing ways to develop a

professional relationship with staff in other roles" (55 +4). Another important administrative components supervisors highlighted are "Responding challenges involving staff's engagement with clients (67 +4) and "Working with supervisees on providing various services, such as substance abuse services" (44 +3). Supervisors emphasized the importance of "Attending to supervisees' concerns related to professional identity in an interdisciplinary environment as a unique aspect of their supervision practices" (56 +3), as well as "Discussing ways to advocate for clients and causes that are important to supervisees' work such as collaborating with medical staff on medication" (62 +3). Lastly, "Developing an understanding each professional's perspective on mental health and specific client concern" (69 +3) loaded highly on this factor.

Statements that supervisors valued but less than the statements above focused on were "Helping counselor trainees understand mental health counselor's place and impact in the organization" (58 0) and "Attending medical vs. wellness model in supervision within the IBH setting" (57 0). Supervisors neither agreed nor disagreed in the significance of "Increasing familiarity with medical terminology in the supervision with counseling trainees "(34 0) and "Assisting with adjusting to environmental aspects of the site" (47 0). Lastly, supervisors highlighted "Focusing on the organizational structure in the IBH setting such as role hierarchy and working within the organization" as well as "Helping supervisees understand mental health counselor's place and impact in the organization/site" were also loaded in the middle of the factor array (68 +1) and (58 0) respectively.

In this factor, supervisors put less emphasis on "Discussing roles and responsibilities within the IBH setting (12 -4) and "Encouraging supervisees to advocate for their roles and responsibilities as mental health professionals" (4 -5) as a unique aspect of their supervision with counselor trainees. Additionally, "Observing warm-handoff strategies by shadowing supervisors"

loaded low in this factor (7 -4). Supervisors noted “Going over site documentation (e.g., supervision agreement, hour logs, site agreement)” is another least significant aspect of IBH supervision (19 -3). The least significant statements that the supervisors all agreed on were focusing on “Knowing and tracking clients' medications and lab work (2 -6), performing university specific administrative tasks such as meeting with faculty supervisor/s, completing evaluations” (18 -6) and “Focusing on care management to ensure coordination of services and continuity of care” (1 -6).

Looking at the demographic information of the supervisors who are loaded high in this factor offered more detailed information about the perceptions of IBH supervision. For example, supervisors who are loaded high in the factor have all completed their Ph.D. in counselor education, in addition, completed a graduate didactic (content-based) course in clinical supervision, has state-specific professional counseling licensure and has been providing counseling services in the IBH setting for over four years and supervision and over two years of supervision. Participant eight has the second-highest years of counseling experience, which is 16 years. Some supervisors in this factor have been providing supervision in the IBH setting for over seven years and the highest years of supervision experience is nine years. The majority of the supervisors (n = 4) are working in an integrated level of integration and are working with various medical providers. Majority of the participants were working in a hospital (n = 3), non-profit agency (n = 3) and private practice (n = 4). Some participants on factor 1 significantly share the same viewpoints. For example, participants 12 and 16 had a high inter-sorter correlation, r = .52 while participants 13 and 14 had a high correlation and r = .56.

Factor 2: Supervisee-focused and process-oriented supervision

Factor 2 explained 17% of the variance in the model with an Eigenvalue of 2.54. The factor array for Factor 2 is shown in Appendix J. Four site supervisors had significantly positive associations with this factor (participants 1, 4, 5, and 15) while participant 2 had negative associations. The viewpoint in this factor focused on supervisee and process-oriented supervision. Top three statements that all supervisors described as a unique aspect in their supervisory work were “Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (10 +6), “Helping supervisees develop clinical strategies and techniques to work with clients” (16 +6), and “Assisting with and modeling how to establish and maintain boundaries with clients” (51 +6).

Supervisors in factor 2 emphasized the viewpoints on “Helping supervisees develop clinical strategies and techniques to work with clients” (15 +5), “Encouraging supervisees to discover their own style of providing counseling” (43 +5) and “Identifying supervisees' developmental level and tailoring practices based on their developmental levels” (6 +5). In terms of process-oriented supervision, supervisors agreed on “Observing and processing supervisees' counseling sessions in supervision” (59 +5) and “Broaching culture and diversity within supervision to ensure cultural competency in supervisees work with clients (25 +4). Supervisors highlighted “Focusing on issues related to client's behaviors that are specific to the site” (53 +2) and attending their “Supervisees' emerging needs or critical clinical issues” as an important process-oriented aspect of IBH supervision (9 +3). Following client-focused statement, supervisors put less significance on modeling and encouraging collaboration and coordination of care with other providers at the site to address client needs and/or progress (27 +2). Supervisors put less emphasis on discussing their supervisees' roles and responsibilities within the IBH

setting (12 0), emphasizing different areas of conceptualization such as social determinants of health (33 +1) and including role play in supervision session (17 -1). Another statement that was loaded in the middle of the sort was “Assisting with adjusting to environmental aspects of the site such as working in medical exam rooms, different medical units, personnel” (47 0).

Supervisors in factor 2 all disagreed that “Focusing on the organizational structure in the IBH setting and working within the organization” (68 -4), “Discussing ways to advocate for counseling in an IBH setting to enhance the role of a mental health counselor” (48 -3) and “Assisting with adjusting to environmental aspects of the site such as working in medical exam rooms” (47 -4) as least significant aspect of their IBH supervision practices. The bottom three statements for factor 2 were “Providing homework for follow-up” (50 -6), “Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations” (66 -6), and “Focusing on knowing and tracking clients' medications and lab work was not of an important aspect” (2 -6).

Demographic information of the participants who were loaded highly on factor 2 indicated that, two participants completed their doctoral degree in counselor education. Of those two, one of them was negatively loaded in the factor. All participants had master's degrees as their terminal degree. Additionally, most of the supervisors completed graduate-level didactic and experiential courses in clinical supervision as well as workshop trainings in clinical supervision (n = 4 including participant 2). Participant 15 with the longest counseling practice (17 years) shared similar views with the rest of the factor 2 participants. For the years of supervision provided, participants in factor 2 are all less than four years except participant 15 who has been providing supervision for 14 years. Most of the participants had their state-specific professional counselor license (n = 4). Majority of the participants in factor two providing

services in private practice (n = 3), hospital (*n* = 3) and ambulatory care centers (*n* = 2). The majority of the supervisor's level of integration is co-location (*n* = 3) and working with various medical providers. In terms of sharing the same viewpoints, participants 4 and 5 were correlated somewhat high (*r* = .32) according to the study's significance level (*r* = .3). Participant 5 and 15 had the highest correlation score of *r* = .45. Participant 2, on the other hand, had low negative correlations with the rest of the participants.

Participant 2 was loaded negatively in this factor (*r* = -.44), indicating participant 2's disagreement with the viewpoint of other supervisors about the unique aspects of IBH supervision. However, that does not mean that the participant 2 should have been loaded in factor 1. Participant 2's coefficient for factor 1 was *r* = .147. Looking closely at participant 2's Q sort, the supervisor agrees with "Meeting with supervisees weekly" (75 +6), which is an important statement in factor 2's factor array that is similar to some of the highest loading participants in this factor (e.g., participant 1). Participant 2 stated significance disagreements in the second factor, such as focusing on supervisees' strengths and developmental milestones in their training in collaboration with them" (11 -5). This statement loaded as one of the top statements for factor 2's array (11 +6) and a lower statement in factor 1's array (11 -4). Like this statement, participant 2 stated "Helping supervisees develop clinical strategies" and techniques to work with clients is a lower aspect in the IBH supervision (16 -5), while factor 2 array highlights this statement as one of the statements of importance (16 +4). The statement "Discussing resources for supervisees' professional growth (e.g., licensure process, licensure exam, continuing education)" was sorted as +1 in both factors 1 and 2 but -6 in participant 2. Participant 2 has seven years of counseling experience and four years of supervisory experience in the IBH settings. Additionally, they hold a state-specific professional license and completed

their doctoral degree. Participant two has completed a graduate didactic and experiential course and completed workshops.

Consensus and Disagreed Statements

There are, of course, some viewpoints that all the supervisors agreed and disagreed. For example, half of the supervisors agreed on the significance of "Meeting with supervisees weekly" and sorted at +6 (n = 8). Supervisors all agreed that “Observing and processing supervisees' counseling sessions” in supervision is a unique aspect of IBH supervision (59 +5). Supervisors emphasized that paying attention to “Build and maintain working alliance using person-centered approach” as an essential aspect; (64 +4) factor 1 and (64 +3) factor 2. The statement “Assisting with and modeling how to establish and maintain boundaries with clients” was another significant viewpoint for all the supervisors (51 +4) for factor 1 and (51 +6) factor 2. On the other hand, supervisors all disagreed that “Focusing on knowing and tracking clients' medications and lab work is not a significant aspect of IBH supervision; (2 -5) for factor 1 and (2 -6) for factor 2. The statement “Observing warm-handoff strategies by shadowing me” was a less significant component of supervision in IBH settings for all supervisors (7 -4) and (7 -3).

Confounding Sorts

Participants 3 and 10 were considered confounding sorts, significantly loading in both factors. Participant 1's loading for factor 1 was r = .45 and for factor 2 was r = .48, while participant 10’s loadings on both factors were r = .48 and r = .44, respectively. I excluded these sorts from flagging, thus, excluding from the construction of the viewpoints, leading to a clearer presentation of the viewpoints (Lundberg, 2020). Their viewpoint can be seen as agreeing with both factors (Plummer, 2012). For example, participant 3 viewed discussing ways to develop a professional relationship with staff in other roles as a less significant aspect of supervision (55 -

4), which was one of the most agreed viewpoint in factor 1 and less agreed in factor 2. Participant 3 also viewed “Identifying supervisees' developmental level and tailoring practices based on their developmental level” as a less unique aspect of supervision (6 -3). This is a viewpoint that is process-oriented, sorted high in factor 2 array (6 +4) but less significant of importance in factor 1 (6 -3). For participant 10, however, both statements 55 and 6 are sorted the opposite than participant three (55 +3), (6 +2). This indicates participant 10 agrees with the viewpoint of organizational aspects of IBH as a unique aspect of supervision of counselor trainees and also agrees with process-oriented aspects of supervision as the uniqueness of IBH supervision. The demographic data for participants three and 10 shows that the average counseling practice is four years and supervision two years. Both participants completed their master's degree. Participant 3 has completed workshop training in clinical supervision and participant 10 completed a graduate didactic and experiential course in clinical supervision as well as workshop training in clinical supervision. Looking at their post-Q sort questionnaire gives more detail about their reasoning for why they sorted the statements as the way they did. Participant three reported that "I placed the clinical aspects in the most significant and the administrative or structural items in the least significant," while participant 10 indicated that "I like to focus on trainee growth and skill development, on the supervisory relationship, and on cultural competency and ethics."

CHAPTER FIVE

Discussion

In this chapter, I will first briefly revisit the purpose and significance of the study. Then, I will discuss the yielded results with respect to the existing research and literature. Upon discussion of the results, I will also discuss implications for clinical supervision and counselor education practices. Finally, I will highlight the limitations of the current study along with implications for supervision, counselor education, and future research.

Purpose and Significance of the study

In the current study, I aimed at understanding site supervisors' self-reported knowledge and practices on the critical components of Integrated Behavioral Health (IBH) supervision with counselor trainees. To date, researchers have not examined supervision of counselors in IBH settings from a counselor education angle. This study served as a preliminary exploration for the development of evidence-based best practices for counseling supervisors in IBH settings. Thus, the current study results addressed the following research question: What are counseling site supervisors' perspectives on unique components and processes of supervision of counselor trainees in IBH settings?

Discussion of Findings from the Factor Arrays

In the current study, a participant sample of site supervisors supervising counselor trainees at IBH settings completed the procedures. Overall findings yielded important functional aspects of IBH supervision, offering us detailed understanding of supervision practices with supervisees in these settings. Two factors describing supervisors’ supervision focus emerged, where Factor 1 was more focused on administrative supervision and factor 2 appeared to be associated with clinical supervision.

Factor 1: Mentoring Supervisees on Administrative and Interdisciplinary Work in IBH Settings

Overall themes observed in factor 1 focused on administrative tasks of supervision, modeling and mentoring relationship with supervisees, and professional identity development of counselors in an interdisciplinary environment.

One of the themes in this factor centered on administrative tasks of the IBH supervision, including documentation. Site supervisors' viewpoints emphasized important administrative tasks specific to IBH, including navigating healthcare regulations, training on informatics (e.g., EHR), and maintaining federal, ethical, and legal guidelines of supervisees' work. These findings were supportive of previous scholarly efforts focused on supervision in other settings and/or in general. For example, Herbert (2016) stated that administrative tasks and clinical focus were additional responsibilities of site supervisors. Scholars also emphasized maintaining ethical and legal guidelines as essential functions of supervision for gatekeeping and best practices (Bernard & Goodyear; Borders, 2014; Kemer et al., 2017). Current study findings also supported the literature on informatics as a Core Competency in IBH practices (Heath, 2013). In other words, site supervisors who participated in the current study appeared to value effective use of information technology and saw it as critical to improve documentation and client care.

Documentation in this theme included setting specific documentation (e.g., treatment plan) and site-related documentation required by trainees' academic program at their university (e.g., hours log, evaluation, supervisory agreement). The findings yielded that supervisors appeared to prioritize treatment plans focused on clients' health history more than hours log, site agreement, evaluations and supervisory agreement. This finding supports Doherty and colleagues' (1996) emphasis on documentation as one of the essentials of IBH supervision and

Herbert's (2016) emphasis on additional administrative parts if supervision (e.g., tasks such as signing notes and signing logs). Moreover, general supervision literature emphasized the importance of having a detailed supervision contract as well as evaluation being part of the site supervisor's tasks (Borders et al., 2014; Curtis & Christian, 2012; Doherty et al., 1996; Kemer et al., 2017). All site- and program-specific documentation site supervisors emphasized in this factor was supportive of the previous literature and best practices on supervisory contracts and documentation. However, unique to the study's findings despite being acknowledged from the supervisors, academic program-required documentation did not appear to be at the forefront of site supervisors' focus.

Another theme in this factor was supervisors' intentional practice of modeling and mentoring relationship with their supervisees. This relationship was specified as collaborating with their supervisees, supervisor's transparency about their experiences, and mentoring supervisee around IBH setting aspects (e.g., medical vs. wellness mode, staff's engagement with clients). A statement that supported the mentoring relationship appeared as assisting supervisees to communicate assertively and confidently with physicians/medical staff as mental health experts. This finding may suggest that supervisors were aware of the challenges supervisees experienced with other professionals at the IBH settings. By mentoring supervisees on these challenges, supervisors may have intended to help supervises adapt to the organization better. Kemer and colleagues (2017) reported that the site supervisors considered relationship and collaboration building as a critical intervention of the supervisory work. Thus, supervisors in this study also intentionally focused on mentorship to build the supervisory relationship, so that supervisees could benefit from such mentorship to navigate through different aspects of IBH settings. Similarly, participant 13 reported that "As a supervisor, most significant to me is

collaboration and how a person interacts when hands-on with clients and their presentation when collaborating with me. Focusing on strengths and weaknesses and processing both. Least significant is the book smarts and what they should be learning in their course work." Previous IBH supervision literature has not addressed drawn parallels between the supervisory relationship and mentoring in IBH settings, revealing this as a unique finding of the current study.

With its significance for the site supervisors in IBH settings, relationship building and collaboration findings in this study also supported the premises of Holloway's Systems Approach Model (1995). Holloway presented *the supervision relationship* as the core factor of seven dimensions of supervision*; organization, supervisor, client, trainee, the functions of supervision,* and *the tasks of supervision*. The most prominent finding in this study parallel to Holloway's model was related to the organizational factors, such as mission and values, organizational structure, culture and climate, professional standards and ethics. For example, from the clinical dimension of the model, IBH supervisors in this study agreed that issues related to clients' behaviors were specific to the site (53 +3). Moreover, as part of supervisor dimension, supervisors also reported that the interpersonal style of supervisor (65 +5; 38 +3) was an important context of supervision in IBH settings.

In this factor, two statements contributed to the overall factor, but it is critical to emphasize their interpretation due to their uniqueness per statistical results. In the first statement, all of the site supervisors presented the importance of weekly meetings with their supervisees as an important part of counselor trainees' training in IBH settings. This finding was in the same line with the clinical supervisors' best practices (Borders et al., 2014) as well as accreditation standards for counselor training programs (CACREP, 2016). In the other statement, supervisors

identified involving supervisees in administrative tasks such as interpersonal staff meetings as an important process of administrative supervision. This appeared as an important finding of the current study since exposing supervisees to administrative processes in the IBH settings has not been a critical presentation in the supervision literature. This finding may suggest that, by involving and orienting supervisees through staff meetings, supervisors intended to build improved communication between the mental health counselors and other healthcare providers as interprofessional teammates. Lastly, previous studies from other disciplines focusing on IBH supervision (e.g., Doherty et al., 1996; Edwards & Patterson, 2006; Hall et al., 2015) did not appear to identify the administrative necessities but not in such detail. Thus, this finding appeared as one of the specific aspects of counselor supervision practices in IBH settings.

When we look at the results of this factor, statements loaded in the middle of the Q sort suggested neutrality. Watts and Stenner (2012), on the other hand, emphasized middle statements as a "fulcrum for the whole viewpoint" (p. 155). A good example for this was, “Helping counselor trainees understand mental health counselor's place and focusing on the organizational structure in the IBH setting, including role hierarchy and working within the organization and helping supervisees understand mental health counselor's place and impact in the organization/site” (58 0). A plausible interpretation of this statement was the clear emphasis of administrative aspects with organizational focus as the center of the viewpoint within this factor, while supervisors highlighted the importance of IBH organizational-specific interventions slightly less than the supervisory relationship or supervisory work.

In another theme of this factor, participants whose views aligned with this factor perceived professional identity development of counselors in an interdisciplinary environment as an important concept of supervision. Supervisors acknowledged supervisees' concerns related to

professional identity development and emphasized modeling and encouraging collaboration and coordination of care with other providers as an important component. Moreover, supervisors appeared to find it necessary to develop an understanding of other professionals' perspective of the counselors, and professional boundaries with staff as part of identity development. It is no surprise that assertive communication with physicians was a significant part of identity development of counselor trainees in this study, since Martin (2017) also highlighted physicians being less inclined toward collaboration than other disciplines. This may contribute to counselors' challenges with performing their roles in the IBH settings. These findings also supported Edward and Patterson's (2006) reports on understanding the medical culture and locating the trainee in the medical system as part of IBH supervision. In addition, Doherty et al. (1996) reported that trainees' need for communicating relevant mental health information to the PCP as a component of IBH supervision that aligns with the findings of this theme. It appeared that site supervisors were aware of these concerns and assisting about counselor trainees' professional identity development. Developing relationships with non-counseling staff as part of IBH supervision of counselors was a unique finding of the current study. Thus, site supervisors in this study emphasized that their supervisory attention was not solely on the counseling practice-related professional development but also on the professional development challenges for counselor trainees in IBH settings.

Factor 2: Supervisee-Focused and Process-Oriented Supervision

When compared to Factor 1's emphasis on administrative supervision focus, Factor 2 provided specific points of view for the supervisee-focused and process-oriented supervision, representing clinical supervision. Themes observed in factor 2 focused on supervisee-focus of supervision, development of supervisory relationship in the dyad, focus on clinical skill

development and client care in supervision, and supervisor's mentorship of client care in an interdisciplinary environment.

First of the emerging themes in this factor was the supervisee-focused statements. Supervisors emphasized utilizing interventions and processes that were developmentally appropriate. In order to do so, supervisors all presented to identify their supervisee's developmental level and tailor their practices accordingly. Similarly, supervisors also highlighted discussing roles and responsibilities, attending emerging needs of the supervisee, supporting supervisee's development of their counseling style, processing supervisee's sessions, providing feedback on sessions and notes, broaching culture and diversity, reviewing and processing ethical and legal guidelines, and providing support for clinical behaviors. These focus areas appeared to reflect supervisor's intentions with developing self-awareness and competency by focusing on process and increasing supervisee's motivation. Supporting these perspectives, Participant 4 particularly stated that “I put items on the most significant that revolve around growth for the supervisee. The least significant revolves around aspects of administrative.” These findings also complemented best practices on providing feedback, forming self-awareness, and ethical practice and setting clear expectations as well as previous IBH supervision reports (Borders, 2006; Borders et al., 2014; Doherty et al., 1996; Strosahl, 2005). Similarly, Curtis and Christian (2012) also suggested supervisor's emphasis on supervisees' philosophy of therapy and self-awareness as essential parts of IBH supervision.

Another theme in this factor was development of supervisory relationship between the supervisor and supervisee. Different than Factor 1’s more intervention/administratively-oriented relationship-focus, in factor 2, supervisors emphasized collaborating with their supervisees to create a safe space, while building and maintaining working alliance with their supervisees as an

important concept. Other specific relationship behaviors in this factor were supervisor's openness, genuineness in their relationship with supervisees, being transparent about their experiences in IBH setting, paying attention to their role as a supervisor regarding quality and efficiency in the supervision session, and meeting weekly with their supervisees. These all pointed out the focus of supervisory relationship in this factor as the supervisory dyad. Supervisors' intentional behaviors as well as flexibility and initiatives impact the relationship between the supervisor and supervisee. These findings supported the general supervision literature as scholars pointed out intentional behaviors of supervisors to promote supervisory relationship as a best practice (Borders, 2014; Kemer et al., 2017). Similar to these findings, Stroahl (2005) also presented that earning supervisee's trust and modifying the supervisory practice based on the demands of the setting as an important component of IBH supervision. On the other hand, supervisor's transparency about their own experiences in IBH settings as a clinician and as a supervisor appeared to be a unique component of IBH site supervisors' practices in this study. This may be considered as a further support for the site supervisor's mentorship awareness in IBH supervision practices where supervisees may benefit from supervisor's experiences to navigate IBH setting better.

Another theme in this factor appeared to be supervisors' focus on clinical skill development and client care in supervision. Supervisors of this factor all agreed that clinical judgement, clinical strategies, techniques, and theories and providing resources to the clients were important components of their IBH supervision practices. In addition, accuracy in assessment (including crisis assessment) and diagnosis as well as cultural competency were presented as part of the clinical skills involved in IBH supervision. These findings were not surprising as supervision is essential for the provision of effective clinical practice (Bernard &

Goodyear, 2019). Statements on the ethical practice and utilization of evidence-based practices also supported the best-practices and accreditation standards in supervision (Borders 2014; CACREP, 2016). In addition to their general clinical practice and client care focus, supervisors also emphasized other unique aspects of IBH setting client profiles. Those involved specific client conceptualization considerations (e.g., social determinants of health, Maslow's Hierarchy of Needs, converging medical and mental health needs) and client behaviors. The findings also presented practice areas of supervisees in IBH settings, supporting the previous literature on the matter. Even though counselors' work is specific to their agency, the findings supported the counselors' functions outlined by the scholars. For example, Peek (2013b) emphasized some of counselor's functions as behavioral work, crisis intervention, providing resources, and cultural and linguistic competency. Moreover, clients with complex symptoms (e.g., social determinants of health) are vital to client care in IBH settings (Clueck, 2015; Hooper, 2014; Peek 2013b). Supervisors agreed that staff's engagement with clients, communicating assertively and confidently with physicians and coordination of care with other providers were critical components of IBH supervision. Therefore, supervisors appeared to pay attention to supervisees' adjustment to the IBH client profiles, client conceptualization as well as interprofessional team practices as the supervisee-focused process aspects of their supervision.

In this factor, another theme appeared to be supervisor's mentorship of client care in an interdisciplinary environment as a viewpoint agreed by all the supervisors. This finding seemed to be unique to the supervisees in IBH settings, different than traditional counseling settings. As these nuanced client care considerations could be overwhelming experience for supervisees, supervisors seem to be intentional with helping supervisees make this experience smoother.

Finally, Factor 2 with its process-oriented focus differed from Hall and colleague's (2015) conceptualization of IBH supervision as more of a curbside interventions and assistance with challenging clients. Similarly, Doherty and colleagues (1996) presented their model of supervision as parallel to the level of integration at the IBH site, neglecting the process orientation and supervisee focus, prominent aspect of the current study findings. On the other hand, factor 2 findings appeared to complement different dimensions of Holloway's Systems Approach Model (1995) than factor 1. Factor 2 included information on the supervisee's contextual factors and learning tasks of supervision. Supporting supervisee and supervisory relationship dimension of the Holloway's model, IBH site supervisors agreed on the importance of the supervisory relationship and supervisory dyad. Specifically, supervisors agreed on the crucial nature of contextual factors, such as boundaries, clinical strategies/techniques/assessments, supervisee's self-awareness, encouraging supervisees to discover their style, and self-evaluation as well as supervisor's contextual factors.

Discussion of the Demographic Data

I collected a considerable amount of demographic information from the participants that connect the viewpoints of the supervisors to their demographic information. All of the supervisors who were part of factor 1 reported that they had completed their Ph.D. degrees in counselor education and completed a graduate-level theoretical course in clinical supervision. All supervisors, except one, also completed an experiential supervision course where they provided supervision to master's level trainees. Supervisors in this factor also attended workshops for CE requirements. Kemer et al. (2014) and Kemer (2020) underlined the importance of supervision training to promote supervisors' comprehensive understandings of the supervisory practices. In

other words, the amount of didactic and experiential supervision training may be a critical information to interpret why these supervisors were associated with this factor.

Supervisors in Factor 2, on the other hand, reported receiving their Master's degree and appeared to have fewer years of counseling practice than factor 1 supervisors. The supervision training background of the supervisors in Factor 2 involved more workshop/training than graduate-level didactic and experiential training. Factor 2 supervisors' focus was more on the supervisee and their practice, and they were more supervisory relationship oriented. This is supported by Kemer and colleagues (2019) as they highlighted supervisees experience and supervisory relationship as a priority of counselor supervisors. It appears that there may be a connection between the supervisors' training background and their focus of IBH supervision. This could mean that supervisors with more supervision training and clinical background were more aware of the bigger picture (e.g., organizational aspects of IBH setting, interdisciplinary focus) of how counselors were integrated in these systems and how supervisees may be oriented to those. In contrast supervisors who have more workshop training focused on supervisees' processes and experiences related to client care and organizational components and, supervisory relationship.

The findings also pointed out some nuances of collaborative care practices across the supervisors loaded in two factors. The majority of the supervisors in Factor 1 reported their IBH setting being in an integrated level of practice, where collaboration and communication among PCP and mental health professionals are typically high. In Factor 2, majority of the supervisors were supervising in co-located settings. Communicating assertively and confidently with medical professionals perceived as an important component in supervision for both factors. This may suggest that supervisees feel not part of an interdisciplinary team or not ready to feel like a part

of a team. In addition, statements such as advocating for the mental health counselor's place in the organization seemed to show that interdisciplinary care may not be well-established between the counselors and medical staff. I interpreted this as a lack of emphasis and/or prioritization in the supervisors' focus on collaborating with the medical professionals. Additionally, not knowing how to/on what to collaborate and/or not knowing the scope of each other's profession could be potential reasons for this aspect of IBH literature.

Finally, in different factors, participants' demographic similarities and differences were unique to observe, in factor 1, even though participants 13 and 14, and 12 and 16 had similarities in their viewpoints, close review of these participants' demographic information showed more differences than similarities. For participant 13 and 14, the only demographic information the supervisors shared was over 10 years of counseling experience and less than 8 years of supervision experience. Participants 12 and 16 were both at settings with the same level of integration (co-located). Knowing majority of the supervisors in factor 1 were from an integrated setting, I observed that, even being in an integrated setting, their organizational structure appeared more co-located than integrated. Co-located model highlights that mental health professionals and PCPs provide services under the same roof with greater degree and collaboration (Blount, 2003), while providers share the same information, administrative and financial systems. The results in factor 1 yielded similarities with the co-located model rather than integrated, which involved everything co-located and shared treatment plan and interdisciplinary collaboration. This may mean that supervisors who had similar years of counseling and supervision practice could understand the different dimensions of the organization and how they integrate with one another, which brings the systemic view into supervision with counselor trainees. On the other hand, this may point out that supervisors' might

hesitate to collaborate with the medical professionals or not know how to do so, highlighting the importance of IBH supervisors continuing development of their own identity in the IBH settings.

For factor 2, participants 15 and 5 shared similar viewpoints comparing to the rest of the participants. Both supervisors had their highest degree in master's in counseling and completed a graduate didactic and experiential course in clinical supervision and workshop training in clinical supervision. Though their years of supervision was significantly different, they both had over 10 years of counseling experience. They provided supervision to only master's students. Thus, this might shed light on the developmental, supervisee-oriented focus in supervision that the supervisors agreed on. Furthermore, supervisors who shared similar perceptions for the second factor may be prioritizing clinical skills, client care, and supervisory relationships with their supervisees over the organizational considerations of IBH supervision. Supervisors may not have thought supervisees in this category were developmentally ready for more organizational components of IBH supervision.

Limitations

As in all research, the current study also presents with limitations. First, the sample size in this study was limited since I focused on recruiting a specific site supervisor profile. In addition, I strived for including a diverse national sample, even though majority of the participants were White, female and practicing in the state of Virginia. Thus, a larger group of participants with broader representation from the U.S. may have increased the generalizability of the results. Similarly, Q methodology is criticized for being limited to the range and quality of statements provided at the outset (Plummer, 2012) as well as for the forced-choice nature of Q sort to make discriminations and participants may not be otherwise inclined to make (Dziopa & Ahern, 2011), perhaps restricting the range of expressed viewpoints. To tackle with these

limitations in this study, I made an effort to make the concourse as broad as possible, while specially attending to the type of factor analysis, extraction, and rotation methods (Zabala & Pascual, 2016) and announcing the study through a range of outlets (e.g., listservs, clinical coordinators of CACREP-accredited programs). However, separate groups of supervisors in different IBH settings may have yielded different results, further limiting the current study results' generalizability. In addition, certain differences across the IBH settings (e.g., outpatient or inpatient services), different client profiles of these settings served (e.g., children, adolescents, adults) and counselor trainee developmental levels (e.g., practicum versus internship) may have created variations across their supervision focus and processes. Similarly, different integration levels (e.g., co-location, integrated) at supervisors' works settings may present with different service delivery practices, affecting supervision practices. As much as these characteristics added to our understanding of the nuances across participants' identification with the factors, they may also have created confounding effects on the results. Finally, researchers traditionally administered Q sort task in-person in previous studies. However, due to the Covid-19 pandemic, in this study we completed procedures virtually. In addition to creating challenges during the sorting process, online procedures may have affected the number of participants as well as their response in the study. I received feedback from the participants on starting the sorting but never able to finish due to the difficulty of the procedures, despite monetary incentives.

Implications

Implications for Supervisors of Counselor Trainees at IBH Settings

The results of this study provided implications for site supervisors as well as university supervisors. Factor 1’s focus was more on the various administrative tasks which are connected by a supervisory relationship and factor 2’s focus was on focusing on processes of supervisee’s

experiences and supervisory relationship between the supervisor and supervisee. Both factors yielded findings that are critical aspects of supervision of counselors in IBH settings. The findings highlighted many nuanced components of supervision, and supervisors appeared to play a critical role of navigating between these nuances. Administrative and clinical work can be overwhelming for supervisors and can lead to burn out and/or ineffective supervision. Thus, one of the most important implications for site supervisors may be to consider finding balance between administrative components and clinical components of supervision. Supervisors may consider creating a contract that outlines expectations and responsibilities of both the supervisor and supervisee to help with balancing administrative and clinical responsibilities. Another implication for supervisors may be considering initiating relationships with the medical professionals and prioritize supervisee's collaboration with them. Though results emphasized supervisors' awareness of identity development of supervisees in IBH settings, emphasis of interdisciplinary collaboration was lacking. Supervisors may benefit from enhancing relationships between the counselors and the medical professionals and also initiate and model the ways counselors can communicate with them. Supervisors can mentor counselor trainees to help them understand the organizational structure and mental health counselor's place in IBH settings, including role hierarchy and working within the organization. In doing so, supervisors may help counselors discover their role and use their role effectively and work as part of a team.

Based on the findings regarding site supervisors training level and implications of their training on IBH supervision, site supervisors may consider taking graduate-level courses in supervision. Supervisors took more didactic and experiential courses in counseling supervision seemed to have the ability to understand IBH supervision's organizational nuances. The results yielded not enough findings on attention to collaborate with the PCPs as part of the

organizational functions of IBH. Although there are no best practices established for supervisors in medical settings, utilizing the current results as well as the IBH supervision literature, effective counseling supervision strategies could be applicable in IBH settings.

In addition, university supervisors could further benefit from the findings of the study by first exploring supervisees' IBH site and organizational structure, and then incorporating the organizational aspects into the supervision such as biopsychosocial conceptualization of the client. They can also attend supervisee's challenges with professional development being part of an interdisciplinary team in supervision. University supervisors may also consider developing relationships and collaborations with site supervisors providing counseling/supervision practices in these settings to develop specific curriculum areas related to integrated care practices.

Implications for Counselor Educators

American Counseling Association Code of Ethics (ACA CoE; 2014), section D highlights the importance of different approaches to best serve clients (D.1.b.) and interdisciplinary teamwork (D.1.c). Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) standards, section 3.d. of the Clinical Mental Health Counseling specialty, also states that graduate programs include strategies for interfacing with integrated behavioral health care and emphasize counselors' functions across specialty areas and their relationships with integrated behavioral healthcare systems (section 1.b). Similarly, current study findings indicated that collaboration among various healthcare workers seems to be a continuous process. These flagship organizations may continue encouraging counseling programs and counselor education faculty to include IBH education and training into their programs. These organizations may be able to influence the number of ways for programs to collaborate with other healthcare programs as they implement the standards via

workshops/trainings for practitioners and program leaders to participate to start creating opportunities for collaboration at the academic settings.

As yielded in the current study results, and reported in the literature (Thistlethwaite et al., 2010), educational barriers appear to be one of the challenges results in lack of collaborative care and integration of mental health counselors into medical settings. In order to improve interprofessional collaboration, interprofessional education appears to be a vital component of counselor training. Participant 14 clearly articulated the need for such collaborations and curriculum development in counseling programs; "I think that students need to have a component added to their curriculum to understand IBH and residential settings. It is very different when the client lives somewhere 24/7 and sees the same people every day (residents, staff, social worker, counselor, nurse, doctor...) and the stresses that occur do to this." Findings of the current study also showed that lack of collaboration could be because of lack of education in this area. To address this challenge, counselor educators in counselor training programs may consider collaborating with health sciences programs to develop workshops/training programs to initiate interprofessional education and collaboration. Furthermore, counseling program faculty may also develop a dedicated course addressing counseling services in integrated care settings in their curriculums. Such a course may help counseling training programs further focus on integrated care practices as an evolving practice area of counseling. Participant 11 also pointed this out; “I put items in the most significant section because they are different from standard counseling issues received in most graduate counseling programs not specific to IBH settings. I put the least significant items there because they are items most commonly found and practiced in all counseling programs and not necessary to focus on in this kind of IBH setting if they have already received it in their practicum.” To address professional development challenges in IBH

settings experienced by counselor trainees/supervisees, counselor educators may also consider incorporating leadership training in their curriculum. to better equip counselor trainees as well as their supervisors to practice effectively in IBH settings.

Lastly, counselor education programs can develop supervision workshops for site supervisors that include some organizational and process considerations of IBH setting supervision practices. Workshops that include some components of these experiences could significantly improve supervision practices. Lastly, counseling programs can play part by delivering information related to scholarships that supports the integration of counselors into IBH settings (e.g., National Health Service Corps Loan Repayment Program and Behavioral Health Workforce Education Training Program for Professionals grant).

Implications for Future Research

This study was a preliminary effort to explore site supervisors' perspectives on supervision of counselor trainees in IBH settings. In the light of the findings and limitations of this study, there are several further research implications. Researchers may consider further understanding of organizational/administrative and clinical IBH supervision as the findings yielded unique components. Researchers may develop studies with qualitative and/or mixed method designs to explore administrative and clinical supervision components and processes of IBH supervision to further obtain in-depth understanding of the IBH supervision practices.

In this study, I specifically focused on mental health site supervisors, thus the findings are limited to the specific demographics of the participants. Researchers may consider replicating this study with a larger sample of supervisors, such as supervisors who are providing licensure supervision to IBH setting residents to explore the different processes as well as similarities and differences of supervision in IBH. In addition, researchers may replicate the current study with

other counseling professionals (e.g., substance abuse counselors, community mental health counselors). In doing so, the findings may offer the opportunity to compare findings and further our understanding of IBH supervision. Small sample size and specific inclusionary criteria (e.g., years of supervision practice) in the present study presented results reflective of such criteria. Future studies with larger and more diverse participant samples may yield different and similar results. In the current study, I focused on site supervisors of counselor trainees/supervisees in IBH settings. Further examinations including university supervisors' practices with supervisees doing their fieldwork experiences in IBH settings may offer us a more comprehensive understanding of supervision practices relevant to training of supervisors. Another focus for future studies could be explorations of supervision practices in IBH settings with different levels of integration. For example, researchers may examine supervision practices in an integrated setting versus a co-located setting. Furthermore, the current study findings may also be informative to create baseline for further explorations of similarities and differences between traditional supervision and interdisciplinary supervision processes. Lastly, these explorations of counseling supervision practices in IBH settings may lead to an instrument development that assesses the effectiveness of supervision practices in IBH settings. Validation of such an instrument through exploratory and confirmatory factor analyses could offer us an evaluation guideline for standardized, evidence-based counseling supervision in IBH settings.

Implications for Professionals from Different Disciplines Working with Mental Health Counselors in IBH Settings

In IBH settings, mental health counselors and counselor trainees work with professionals from different disciplines, such as social sciences, human movement sciences and health sciences. These professionals involved in the interdisciplinary teams may benefit from taking

some of the current study findings into consideration. For example, among those findings, counselor trainees' professional development, the importance of communication and collaboration among the interdisciplinary team members, and relationship development between the supervisory dyads appear to be included. Counselor trainees' challenges related to professional identity development while becoming part of an interdisciplinary team member may be an important consideration for the other professionals in the interdisciplinary team. Such challenges should not be unique to counselor trainees. In other words, trainees from other disciplines may also experience similar challenges, thus, helping trainees in interdisciplinary teams to work together and assist each other may contribute to all trainees' performances in the interdisciplinary teams. Perhaps, supervisors of the counselor and other disciplines' trainees may consider exploring such challenges to develop efficient training environments not only for promotion of individual professional development in each trainee but also for building better functioning interdisciplinary teams. Similarly, current study findings also yielded information on the lack of collaboration between the physicians and mental health counselors. Professionals from other disciplines, particularly physicians, may consider taking initiative on working with mental health counselors and counselor trainees. Supervisors of counselor trainees as well as other disciplines' trainees may also consider collaborating on building relationships among interdisciplinary team members as they model collaboration and effective communication to their trainees. Lastly, supervisors may also consider attending interdisciplinary workshops and educational sessions on interdisciplinary collaboration to collectively build the interdisciplinary culture in which all trainees could learn and grow.

Chapter 6

Manuscript

Site Supervisors' Perspectives on Supervision of Counselor Trainees in Integrated Behavioral Health (IBH) Settings

Abstract

Integrated Behavioral Health (IBH) is an integrated care approach where primary care and mental health providers work together to address the medical and behavioral health needs of the patients, or clients (Unützer, et al., 2012). An increasing number of clinical mental health counselors are providing services in IBH settings and experiencing challenges with navigating unique aspects of their work in these complex systems. Clinical supervision in these settings appears as a critical resource for mental health counselor trainees (supervisees). This study served as a preliminary understanding of site supervisors' perspectives of counseling supervision in IBH settings. Using Q methodology (Watts & Stenner, 2005), 2-factor solution explained the organizational and clinical viewpoints from the supervisors. Implications for supervision, counselor education and for future studies are discussed.

Keywords: integrated behavioral health, site supervisors, supervision practices, counselor education

Site Supervisors' Perspectives on Supervision of Counselor Trainees in Integrated Behavioral Health (IBH) Settings: A Q Methodology Approach

Introduction

Mental health problems are among the most common problems encountered by primary care providers (PCPs; Arean et al., 2007). Primary care providers reported feeling challenged by the identification and management of mental health concerns for clients (Vickers et al., 2013). An increasing number of issues about detection and management of mental health concerns for patients has been drawing practitioners' attention to producing effective solutions in primary care settings (e.g., Aitken & Curtis, 2004; Coleman & Patrick, 1976; Dwinnels & Misk, 2017; Vickers et al., 2013). Integrated care is a collaborative and comprehensive process involving a wide range of healthcare professionals (e.g., physicians, nurses). Attending patients' (clients') medical and mental health wellbeing in a single facility (Moe et al., 2019) has proven to be an effective way of caring for patients (Lanoye et al., 2017; Ratzliff et al., 2017). Clinical mental health counselors have been increasingly involved in integrated care settings through the Integrated Behavioral Health (IBH) delivery method. Therefore, as more counselors are practicing in IBH settings, we obtain further opportunities to describe and shape up clinical mental health counselors' place and practices in the integrated care. Moreover, according to Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) standards section A.3 of the Clinical Mental Health Counseling specialty, graduate programs "understand the roles and functions of clinical mental health counselors in various practice settings and the importance of relationships between counselors and other professionals, including interdisciplinary treatment teams" (p. 29). Yet, there are no guidelines established for training and practices in IBH settings for mental health counselors and supervision of their

practices. Despite our increasing understanding of clinical supervision for counselor trainees (Bernard & Goodyear, 2019), IBH is one setting we have dearth knowledge and understanding for the content and practices of counseling supervision.

Integrated Behavioral Health (IBH) is a delivery method where a team of primary care providers (e.g., physicians, nurses) and behavioral health clinicians (e.g., mental health counselors) working together with patients and families and using a systematic and cost-effective approach to provide patient-centered care for a defined population (Korsen et al., 2013). Counselors' roles in IBH teams vary depending upon the agency's philosophy, agency's needs, level of integration, behavioral and medical health problems, and the skills and qualifications of the counselors (Aitken & Curtis, 2004). IBH paradigm also necessitates counselors to exhibit certain knowledge and competencies (e.g., psychopharmacology, medical culture, co-morbidity of mental health and physical health conditions) that may not have been emphasized in their training curriculum (CACREP, 2016; Lenz et al., 2018). Furthermore, to deliver high-quality mental health care in IBH settings (Ayalon et al., 2007; Carey et al., 2010), mental health counselors face operational, cultural, and educational. Operational challenges were presented as incomplete information flow and lack of operational integration between behavioral health clinicians (counselor trainees) and primary care providers, while cultural challenges were related to the attitudes of professionals in these settings (Malâtre-Lansac et al., 2020). On the other hand, educational barriers included interprofessional education and collaboration (Lawlis et al., 2014). Thistlethwaite et al., (2010) suggested the need for interprofessional education to be included in students' training and continuing practice as qualified health providers. Scholars have been broaching interprofessional education counselor education and training; however, how counseling students perceive interprofessional education is an area need further exploration

(Johnson & Freeman, 2014). Beyond didactic training, scholars also reported lack of supervised practice as one of the major barriers to integrating mental health into primary care (Collins et al., 2011; Ventevogel; 2014). To better prepare counselors with a more clarified understanding of their roles and meet the demands of integrated care settings, it is critical to enhance our understanding of counseling supervision in these settings.

Site Supervision of Counselor Trainees in IBH Settings

As a unique setting, IBH requires roles and skills different from traditional counseling settings. Supervisors with IBH experience and perspectives can help smooth the transition of counselor trainees to practice in these settings (Blount & Miller, 2009; Funderburk & Fielder, 2013). Current literature on clinical supervision, though, is limited to a few studies outlining supervision specific to IBH setting (Curtis & Christian, 2012), and mainly from other mental health professions than counseling. In general, scholars suggested supervisors help address administrative issues (e.g., signing on notes, supervisees logs, reviewing treatment plans and biopsychosocial reports; Herbert, 2016), educate students about professional/cultural differences, and answer medically related questions about patients including medication management and medical terminology as part of their responsibilities (Funderburk & Fielder, 2013). Strosahl (2005) also emphasized supervision in the context of mentoring for behavioral health practitioners, where earning supervisee's trust, providing feedback, and enhancing supervisee's motivation.

From the field of psychology, Hall and colleagues (2015) highlighted the limited nature of IBH supervision experiences. Psychology interns described the supervision they received as "curbside consultations, second opinions, and assistance with challenging patients" (p. S47), highlighting the need for relevant training to work effectively as integrated care teams. Doherty

and colleagues (1996) introduced a five-step collaboration model for behavioral health psychology interns. The model has five levels ranges from minimal collaboration (Level 1) to close collaboration in a fully integrated setting (Level 5). In this model, supervision depends on the integration level of the setting. For example, in a Level 1 setting, referral-based, there is minimal contact between the BHC and PCP, thus the role of the supervisor is building clinical skills and strengthening relationships with PCP. Whereas, in Level 4 and 5 supervisor provides is on the site supervision, meeting with supervisees one hour/week.

In their seminal study, Edwards and Patterson (2006) reported that supervision for family therapy supervisees' focused on understanding; (1) medical culture, (2) location supervisees role in the treatment system, (3) how to investigate biological/health issues of the client, and (4) how to be attentive to self of the supervisee. Following Edwards and Patterson's suggestions, Curtis and Christian (2012) recommended adding the following elements in supervision in IBH settings; (1) developing a detailed supervision contract between the supervisor and the supervisee, (2) documenting the practice model supervisees are using including its strengths and challenges and (3) structuring supervision according to the level of collaboration involved in clinical care.

Beyond these limited number of studies from other fields, to date, researchers have not examined supervision of counselor trainees and counselors in IBH settings, further highlighting the need for evidence-based understanding of clinical supervision of counselors in IBH settings. Thus, exploring site supervisors' experiences in IBH settings could expand our knowledge on the tasks and duties of IBH counselors and supervisors, informing counselor education and supervisor training programs.

The Current Study

The roles and responsibilities of today's mental health counselors in IBH settings are many and varied (e.g., therapy, consultation, health educations, advocacy). In these diverse settings, mental health counselors are required to perform in the roles of psychotherapists, consultants, administrators, and health educators (Nelson et al., 2000). Thus, IBH can be a complex setting for supervisees to navigate. Supervision that is tailored to supervisees' needs can provide a structure for the supervision process (e.g., communication with other healthcare providers, using medical software; Nate & Haddock, 2014). Based on the primary aim of the current study the research question was: What are counseling site supervisors' perspectives on unique components and processes of supervision of counselor trainees in IBH settings?

Method

In this study, I aimed to understand in-depth experiences of site supervisors who are currently providing supervision to counselor trainees in IBH settings. Q methodology, as a mixed methods design, allowed me to understand in-depth experiences of site supervisors who were providing supervision to counselor trainees in IBH settings. Q Methodology emphasizes on the scientific and systematic exploration of subjectivity or personal viewpoints (Brown, 1993; McKeown & Thomas, 2013; Stainton Rogers, 1995). It was ideal for the purposes of the current study to explore similarities, patterns, and relationships between the categories of a specific phenomenon, such as IBH components and practices (Shinebourne, 2009).

P Set (Participant Sample)

The P set of the current study were site supervisors who are providing supervision to the mental health counseling trainees in IBH settings. To be eligible for participation in this study, the site supervisor must have (1) a minimum of a Master's degree from a CACREP-accredited program, (2) at least two years of counseling supervision experience in IBH settings, (3) didactic

and experiential (supervision of supervision) supervision training in their background, (4) at least two years of experience with providing clinical supervision to counselor trainees in IBH settings, and (5) currently providing supervision or have provided supervision within the last year to master's and/or doctoral level practicum and/or internship students in an IBH setting (CACREP, 2016; Kemer et al., 2017).

Once IRB approval was granted, I contacted the local and nationwide IBH sites, announced the study in counseling listservs (e.g., CESNET) and contacted clinical directors for CACREP-accredited programs to distribute to their site supervisors in IBH settings. According to Watts and Stenner (2005), between 40 and 60 participants are recommended, even though there are examples of Q Methodology studies with fewer participants (e.g., Baltrinic & Suddeath, 2020; Innes et al., 2018; Lai et al., 2007; Shinebourne & Adams, 2008). Applying the same inclusion criteria for both, I had two P sets in the current study. The first P set included the participants to create statements for the Q set development, while the second P set completed the Q sort. Some participants participated both in Q set development and Q sort (Creswell & Creswell, 2018). Due to targeting a very specific group of participants, five participants participated in Q set development, while 16 participants involved in Q sort and post-Q sort questionnaire, resulting a total of 21 participants in the current study.

Five supervisors participated in the creation of the concourse and 16 supervisors participated in Q sort and post-Q sort questionnaire, making the P set 21 (n = 21). 15 of the participants identified as female (71.4%), four as male (19%), one as non-binary (4.8%) and one as genderqueer (4.8%); while 15 of whom identified as Caucasian (71.4%), two identified as Asian/Pacific Islander (9.5%), and two identified Hispanic or Latinx (9.5%), one Black or African American (4.8%), and one as multiethnic (e.g., Caucasian and Hispanic or Latinx;

(4.8%) backgrounds. All participants completed their master's degree in a CACREP accredited program (*n* = 21). 11 of the participants reported completing their doctoral degrees in Counselor Education and Supervision (52.4%). While one participant did not report the number of years for their counseling practice in IBH settings, supervisors' average years of counseling practice in IBH settings (*n* = 21). In terms of participants' supervision training, 10 participants reported completing a graduate didactic course in clinical supervision, a graduate experiential course in clinical supervision, and workshop training in clinical supervision (47.6%), six of them reported completing a graduate didactic course in clinical supervision and graduate experiential course in clinical supervision only (28.6%), four reported receiving only workshop training in clinical supervision (19%), and one reported completing only a graduate didactic course in clinical supervision (4.8%). Participants are asked to provide information on the workshop they have completed. Workshop information included topics, such as counseling supervision at IBH settings (*n* = 2), Department of Medical Assistance Services (DMAS) training (*n* = 1), continuing education units (CEU; 20 hours) to provide clinical supervision (*n* = 3), and yearly and three-day trainings from an institution on supervising counseling residents (*n* = 1).

In terms of participant's professional credentials 15 participants reported having their LPC or state-specific professional license (e.g., LPCC, LPC; 71%) seven participants reported having their license as Certified Substance Abuse Counselor (CSAC) or state-specific license as a substance abuse counselor (LICDC; 33.3%), four participants reported having/close to having their Approved Clinical Supervisor (ACS) credential or state-specific supervisor credential (e.g., LPCC-S CPCS; 19%), three participants reported having their National Certified Counselor credential (14.3%). 17 participants reported currently providing supervision to trainees (81%), while four participants reported supervising within the past year (19%). 12 of the participants

reported providing/have provided supervision to the master's level supervisees (57%) and nine of the participants reported providing/have provided master's and doctoral level supervisees (42.9%). Participants reported average of 11.25 years of providing supervision to counselor trainees IBH settings (*n* = 21). Reporting on the professional identities of other professionals the participants have worked/are working with participants reported working with physicians (76.2%; *n* = 16), physician's assistant (47.6%; *n* = 10), nurse (81%; *n* = 17), psychiatrist (81%; *n* = 17), psychologist (52.4%; *n* = 11), social worker (90.5%; *n* = 19), nutritionists (14.3%; *n* = 3), nurse practitioners (9.5%; *n* = 2), health educator (4.8%; *n* = 1), care manager/care partner (19%; *n* = 4), and pastoral care (9.5%; *n* = 2), physical therapist (4.8%; *n* = 1), crisis clinician (4.8%; *n* = 1), and Board Certified Behavior Analyst (4.8 %; *n* = 1). Nine of the participants reported outpatient as their primary unit of practice (42.9%) while nine of the participants reported outpatient and inpatient as their primary unit of practice (42.9%), Additionally, one participant reported only inpatient as their primary unit of practice (4.8%), one participant reported community-based services as their primary unit of practice (4.8%) and one participant reported outpatient, inpatient, in home and telehealth as the primary unit of the practice (4.8%). When asked to report on the level of integration of their practice 12 participants reported co-location (57%), eight reported integrated (38.1%) and one reported minimal collaboration (4.8%). Lastly, the IBH settings the participants have been working at included the following: private practice (47.6%; *n* = 10), ambulatory care clinic (14.3%; n = 3), hospital (42.9; *n* = 9), primary care/family practice clinic (19%; *n* = 4), inpatient psychiatric facility (19%; *n* = 4), outpatient addiction clinic (4.8%; *n* = 1), non-profit agency (28.6; *n* = 6), and community services board (4.8%; *n* = 1).

Concourse and Q Set

The concourse consisted the total number of statements created by the site supervisors before being synthesized (Ramlo, 2015; Watts & Stenner, 2012). According to Watts and Stenner, (2012) the Q set includes between 40 to 80 statements. In this study, concourse statements represented supervisors' perspectives regarding the components and processes of IBH supervision (Watts & Stenner, 2005). Since there is no literature on counselor education field, I utilized two strategies to construct the concourse. First, I asked supervisors to create statements reflecting on the unique aspects of their supervision experiences providing supervision to counseling trainees in IBH settings. Second, upon creating their statements, I presented participants with 69 statements created by counselor trainees who have been supervised in IBH settings (Giresunlu et al., in progress). I asked participants to respond to each statement's "uniqueness/importance" to their IBH setting supervision practices with counselor trainees. Five participants created a total of 128 statements (ranging from 20 to 40, M =25.6). While reviewing the statements supervisors created, I removed five statements since they were not addressing the requested discourse. Then, I reviewed and discarded six statements that most participants (three out of five) disagreed with and integrated the agreed upon statements into the participants' original set of statements. The final set of statements for the concourse included 186 statements composing the Q set. Q set refers to the number of synthesized statements prior to Q sort. I reviewed the statements for language clarity and elimination of redundancy and consulted with my dissertation chair and an auditor for this editing and synthesis work. The dissertation chair is an associate professor, specialized in counseling supervision research and practice with extensive experience in mixed methods research. The auditor is a professor, specializes in university and college student adjustment, development, learning, and counseling, as well as diagnosis, case conceptualization, and treatment planning. The auditor has extensive experience in quantitative

research. Dissertation chair and external auditor (dissertation committee member) reviewed the statements before Q sort. After synthesizing and consultation, the final Q set for the Q sort process to 75 statements.

Q Sort and Post-Q Sort Questionnaire

I asked participants to rank-order 75 statements statements according to their perspectives of *most significant* (+6) to *least significant* (-6) in their IBH supervision experience as a supervisor.

Following Q sort, site supervisors answered a series open-ended questions: (1) Please describe the items you placed as "most significant" and "least significant" to your IBH supervision practices and explain the reasons for the differences of their significance? (2) Are there any further items about which you would like to pass comment? (3) If there is any, please provide additional items you might have included at this point? (Watts & Stenner, 2005). Responses to these questions enriched the qualitative description of the factors, made factor interpretation easier, and improved the quality of the findings for the study (Lundberg, 2020).

Data Analysis

I entered 16 completed Q sorts into a software program, KenQ, designed to conduct Q methodology analysis (Banasick, 2019). The data was subjected to factor analysis to for data reduction and highlight any number of groupings of Q sorts that were similar or dissimilar to one another. I concluded several factor analyses to find the most suitable fit for the data. I selected a 2-factor solution using the principle components analysis with varimax rotation, which was the most conceptually meaningful analysis to use in this dataset (Ramlo, 2015; Ramlo, 2016). Following factor analysis I utilized auto flagging provided by KenQ software as well as manual flagging to maximize the differences between factors, and also to ensure confounded sorts are

not flagged (Zabala, 2014). In all study components, I chose $p < 0.01$ as the significance level to have more statistically significant results. Thus, for a result to be significant it must have been equal to or exceed 0.30.

Results

Data analysis revealed two significantly different viewpoints seen in Appendix.. To interpret the data, I used factor arrays presented by KenQ output. Factor arrays are the ideal representation of each factor. In addition to factor arrays, I used the crib sheet method for each factor, introduced by Watts and Stenner (2012) to systematically understand each factor. Lastly, I utilized participants' demographic data and answers to the post-sort questionnaires to assist with the interpretation of each factor.

Factor 1: Mentoring Supervisees on Administrative and Interdisciplinary Work in IBH Settings

Factor 1 explained 22% of the variance in the model, with the highest Eigenvalue of 3.64 and the strongest statistical strength. This factor's viewpoint focuses on supervisor's mentorship of supervisee for the administrative tasks, and interventions of the IBH setting. Statements supervisors sorted as significant were "Meeting with supervisees weekly" (75 +6), "Discussing resources to use and offer working with clients" (60 +6) and "Following and maintaining federal guidelines" (71 +6; 49 +4). Moreover, importance of "Focusing on treatment planning and need to incorporate health history and compounding issues" (41 +5) was an area of importance.

Supervisors emphasized the relationship building/collaboration as an important intervention, thus, noted "Collaborating with my supervisees in creating a safe space for our supervision experience" (65 +5) and "Paying attention to build and maintain working alliance with my supervisees using person-centered approach" (64 +4). At the same, supervisors

highlighted “Discussing ways to develop a professional relationship with staff in other roles” (55 +4) as part of their mentorship tasks. Supervisors highlighted the importance of “Attending to supervisees’ concerns related to professional identity in an interdisciplinary environment” (56 +3), and “Developing an understanding each professional's perspective on mental health and specific client concern” (69 +3) in supervision. The least significant statements that the supervisors all agreed on were “Focusing on knowing and tracking clients' medications and lab work” (2 -6), “Performing university specific administrative tasks such as meeting with faculty supervisor/s” and “Performing university specific administrative tasks such as completing evaluations” (18 -6). Looking at the demographic information of the supervisors who are loaded high in this factor have all completed their Ph.D. in counselor education, in addition, completed a graduate didactic (content-based) course in clinical supervision, has state-specific professional counseling licensure and has been providing counseling services in the IBH setting for over four years and supervision and over two years of supervision. The majority of the supervisors (n = 4) are working in an integrated level of integration and are working with various medical providers. Majority of the participants were working in a hospital (n = 3), non-profit agency (n = 3) and private practice (n = 4).

Factor 2: Supervisee-focused and process-oriented supervision

Factor 2 explained 17% of the variance in the model with an Eigenvalue of 2.54. The viewpoint in this factor focused on supervisee and process-oriented supervision. Top three statements that all supervisors described as a unique aspect in their supervisory work were “Exhibiting openness, transparency, and genuineness in my relationship with the supervisees” (10 +6), “Helping supervisees develop clinical strategies and techniques to work with clients” (16 +6), and “Assisting with and modeling how to establish and maintain boundaries with clients

(51 +6)". Moreover, supervisors all agreed on providing process-oriented tasks such as "Encouraging supervisees to discover their own style of providing counseling (43 +5), "Observing and processing supervisees' counseling sessions in supervision" (59 +5) and "Broaching culture and diversity within supervision to ensure cultural competency in supervisees work with clients (25 +4)" while "Identifying supervisees' developmental level and tailoring practices based on their developmental levels" (6 +5). The least significant statements for factor 2 were "Providing homework for follow-up" (50 -6), "Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations" (66 -6), and "Focusing on knowing and tracking clients' medications and lab work" (2 -6).

Demographic information of the participants who were loaded highly on factor 2 indicated that, two participants completed their doctoral degree in counselor education. Of those two, one of them was negatively loaded in the factor. All participants had master's degrees as their terminal degree. Additionally, most of the supervisors completed graduate-level didactic and experiential courses in clinical supervision as well as workshop trainings in clinical supervision. Participants in factor 2 are all less than four years except participant 15 who has been providing supervision for 14 years. Most of the participants had their state-specific professional counselor license (n = 4). Majority of the participants in factor two providing services in private practice (n = 3), hospital (n = 3) and ambulatory care centers (n = 2). The majority of the supervisor's level of integration is co-location (n = 3) and working with various medical providers.

Discussion

The purpose of the current study was understanding site supervisors' self-reported knowledge and practices on the critical components of IBH supervision with counselor trainees.

Factor 1 was more focused on administrative supervision and factor 2 could be identified with clinical supervision.

In factor 1, site supervisors' viewpoints emphasized important administrative tasks specific to IBH, including healthcare regulations, training on informatics (e.g., EHR), and maintaining federal, ethical, and legal guidelines of supervisees' work. These findings were supportive of previous scholarly efforts focused on supervision in other settings and/or in general (e.g., Bernard & Goodyear; Borders, 2014; Herbert, 2016; Kemer et al., 2017). Supervisors appeared to prioritize treatment plans focused on clients' health history more than hours log, site agreement, and evaluations and supervisory agreement. On the other hand, despite being emphasized, academic program-required documentation did not appear to be at the forefront of site supervisors' focus. In other words, supervision focus is more on the counseling services and clients than the supervisees. Therefore, all site- and program-specific documentation site supervisors emphasized in this factor was supportive of the previous literature and best practices on supervisory contracts and documentation (Borders et al., 2014; Curtis & Christian, 2012; Doherty et al., 1996; Kemer et al., 2017). Supervisors identified involving supervisees in administrative tasks such as interpersonal staff meetings as an important process of administrative supervision. This appeared as an important finding of the current study since exposing supervisees to administrative processes in the IBH settings has not been a critical presentation in the supervision literature. This finding may suggest that, by involving and orienting supervisees through staff meetings, supervisors intend to build improved communication between the mental health counselors and other healthcare providers as interprofessional teammates. Lastly, previous studies from other disciplines focusing on IBH supervision (e.g., Doherty et al., 1996; Edwards & Patterson, 2006; Hall et al., 2015) did not

appear to identify the administrative necessities but not in such detail. Thus, this finding appeared as one of the specific aspects of counselor supervision practices in IBH settings.

Supervisors' intentional practice of modeling and mentoring relationship with their supervisees involved supervisor's transparency about their experiences, and mentoring supervisee around IBH setting aspects such as assisting supervisees to communicate assertively and confidently with physicians/medical staff as mental health experts. This might suggest that supervisors are aware of the challenges and by mentoring them on such challenges supervises might adapt to the organization better. Kemer and colleagues (2017) also highlighted that the site supervisors considered relationship and collaboration building as a critical intervention of supervisory work. Thus, mentorship could contribute to the building of supervisory relationship. Similarly, participant 13 reported that "As a supervisor, most significant to me is collaboration and how a person interacts when hands-on with clients and their presentation when collaborating with me. Focusing on strengths and weaknesses and processing both. Least significant is the book smarts and what they should be learning in their course work."

Supervisors' acknowledged supervisees' concerns related to professional identity development and emphasized modeling and encouraging collaboration and coordination of care with other providers as an important component. To collaborate and coordinate with the providers, supervisors find it necessary to assist supervisees in communicating assertively with physicians for counseling supervision. This is supportive of IBH literature as Martin (2017) highlighted physicians being less inclined toward collaboration than other disciplines which could contribute to counselors' challenges with performing their roles. Findings also supported Edward and Patterson's (2006) findings on understanding the medical culture and locating the trainee in the medical system as part of IBH supervision. Lastly, previous literature on IBH

supervision did not discuss developing relationships with non-counseling staff as part of IBH supervision of counselors. Thus, presenting this critical viewpoint, site supervisors in this study emphasized the professional development challenges for counselor trainees in IBH settings and their supervisory attention was not solely on the counseling practice-related professional development.

When compared to Factor 1's emphasis on administrative supervision focus, Factor 2 provided specific points of view for supervisee-focused and process-oriented supervision. Supervisors emphasized utilizing interventions and process that were developmentally appropriate. In order to do so, supervisors all presented to identify their supervisee's developmental level and tailor their practices accordingly. Similarly, supervisors also highlighted discussing roles and responsibilities, attending emerging needs of the supervisee, supporting supervisee's development of their counseling style, processing supervisee's sessions, providing feedback on sessions and notes, broaching culture and diversity, reviewing and processing ethical and legal guidelines and providing support for clinical behaviors. These focus areas appeared to reflect supervisor's intentions with developing self-awareness and competency by focusing on process and increasing supervisee's motivation. Supporting these perspectives, Participant 4 particularly stated that "I put items on the most significant that revolve around growth for the supervisee. The least significant revolves around aspects of administrative." These findings also complemented best practices on providing feedback, forming self-awareness, and ethical practice and setting clear expectations as well as previous IBH supervision reports (Borders, 2006; Borders et al., 2014; Doherty et al., 1996; Strosahl, 2005). Similarly, Curtis and Christian (2012) also suggested supervisor's emphasis on supervisees' philosophy of therapy and self-awareness as essential part of IBH supervision.

Results also yielded focus on supervisory relationship between the supervisor and supervisee. Different than Factor 1's more intervention/administratively-oriented relationship-focus, in factor 2, supervisors emphasized collaborating with their supervisees to create a safe space, while building and maintaining working alliance with their supervisees as an important concept. Other specific relationship behaviors in this factor were supervisor's openness, genuineness in their relationship with supervisees, being transparent about their experiences in IBH setting, paying attention to their role as a supervisor regarding quality and efficiency in the supervision session, and meeting weekly with their supervisees. These all point out the focus of supervisory relationship in this factor as the supervisory dyad and also supervisors' intentional behaviors impact the relationship between the supervisor and supervisee. The findings support the general supervision literature as scholars pointed out intentional behaviors of supervisors to promote supervisory relationship as a best practice (Borders, 2014; Kemer et al., 2017). Similar to these findings, Stroahl (2005) also presented that earning supervisee's trust and modifying the supervisory practice based on the demands of the setting as an important component of IBH supervision. On the other hand, supervisor's transparency about their own experiences in IBH settings as a clinician and as a supervisor appeared to be a unique component of IBH site supervisors' practices in this study. This may be considered as a further support for the site supervisor's mentorship awareness in IBH supervision practices where supervisees might benefit from supervisor's experiences to navigate IBH setting better.

Supervisors of this factor all agreed that clinical practices involving client care were important components of their IBH supervision practices. These findings were not surprising as supervision is essential for the provision of effective clinical practice (Bernard & Goodyear, 2019). Statements on the ethical practice and utilization of evidence-based practices also

supported the best-practices and accreditation standards in supervision (Borders 2014; CACREP, 2016). In addition to their general clinical practice and client care focus, supervisors also emphasized other unique aspects of IBH setting client profiles. Those involved specific client conceptualization considerations (e.g., social determinants of health, Maslow's Hierarchy of Needs, converging medical and mental health needs). The findings also presented practice areas of supervisees in IBH settings, supporting the previous literature on the matter. Lastly, supervisors appeared to pay attention to supervisees' adjustment to the IBH client profiles, client conceptualization as well as interprofessional team practices as the supervisee-focused process aspects of their supervision.

Findings supported supervisor's mentorship of client care in an interdisciplinary environment as unique to the supervisees in IBH settings, different than traditional counseling settings. As these nuanced client care could be overwhelming experience for supervisees, supervisors seem to be intentional with helping supervisees make this experience smoother. Finally, Factor 2 with its process-oriented focus differed from Hall and colleague's (2015) conceptualization of IBH supervision as more of a curbside interventions and assistance with challenging clients. Similarly, Doherty and colleagues (1996) presented their model of supervision as parallel to the level of integration at the IBH site, neglecting the process orientation and supervisee focus, prominent aspect of the current study findings.

Discussion of the Demographic Data

A considerable amount of demographic information from the participants also connected the viewpoints of the supervisors and their demographic information. Supervisors who were part of factor 1 reported more clinical experience and graduate-level supervision training (e.g., didactic and experiential course), while supervisors in factor 2 presented fewer years of clinical

experience and workshop training in supervision. Factor 1 supervisors emphasized administrative and systemic considerations of IBH supervision when compared to supervisee, their practice, and supervisory relationship dyad considerations of factor 2 supervisors. It appeared that there may be a connection between the supervisors' training background and their supervision focus at IBH settings. Supervisors with more clinical background and graduate-level supervision training were more focused on the bigger picture characteristics (e.g., organizational aspects of IBH setting, interdisciplinary focus) of how counselors were integrated in these systems and how supervisees may be oriented to those. In contrast, supervisors with less clinical experience and workshop-oriented supervision training were more zoomed in on supervisee's processes and experiences related to client care and organizational components and, supervisory relationship.

Lastly, certain demographic information also pointed out nuances of collaborative care practices. For example, supervisors of both factors deemed communicating assertively and confidently with medical professionals as critical in IBH supervision. Similarly, advocating for the mental health counselor's place in the organization were also critical in both factors. These nuances in the findings also highlighted the fact that counselor trainees/supervisees still seem to struggle with feeling a part of the interdisciplinary teams and interdisciplinary care still requires attention to be well-established between the counselors and medical staff.

Limitations

As in all research, the current study also presents with limitations. First, the sample size in this study was limited since I focused on recruiting a specific site supervisor profile. In addition, I strived for including a diverse national sample, even though majority of the participants were White, female and practicing in the state of Virginia. Thus, a larger group of

participants with broader representation from the U.S. may have increase the generalizability of the results. Similarly, Q methodology is criticized for being limited to the range and quality of statements provided at the outset (Plummer, 2012) as well as for the forced-choice nature of Q sort to make discriminations and participants may not be otherwise inclined to make (Dziopa & Ahern, 2011), perhaps restricting the range of expressed viewpoints. To tackle with these limitations in this study, I made an effort to make the concourse as broad as possible, while specially attending to the type of factor analysis, extraction, and rotation methods (Zabala & Pascual, 2016) as well as announcing the study through a range of outlets (e.g., listservs). However, separate groups of supervisors in different IBH settings may have yielded different results, further limiting the current study results' generalizability. In addition, certain differences across the IBH settings, different client profiles of these settings served, and counselor trainee developmental levels may have created variations across their supervision focus and processes. Similarly, different integration levels at supervisors' works settings may present with different service delivery practices, affecting supervision practices. As much as these characteristics added to our understanding of the nuances across participants' identification with the factors, they may also have created confounding effects on the results. Finally, researchers traditionally administered Q sort task in-person in previous studies. However, due to the Covid-19 pandemic, participants completed procedures virtually. Online procedures may have affected the number of participants as well as their response in the study, despite monetary incentives.

Implications for Supervision, Counselor Education and Future Research

The results of this study provide implications for site supervisors as well as university supervisors. Both factors yielded findings that are critical aspects of supervision of counselors in IBH settings. The findings highlight many nuanced components of supervision, and supervisors

play a critical role of navigating between these nuances. Thus, one of the most important implications for site supervisors is to consider finding balance between administrative components and clinical components of supervision. Another implication for supervisors is considering initiating relationships with the medical professionals and prioritize supervisee's collaboration with them. Though results emphasized supervisors' awareness of identity development of supervisees in IBH settings, emphasis of collaboration was lacking. Supervisors may benefit from enhancing relationships between the counselors and the medical professionals and also initiate and model the ways counselors can communicate with them. Based on the findings regarding site supervisors training level and implications of their training on IBH supervision, site supervisors may consider taking graduate-level courses in supervision. Lastly, university supervisors could further benefit from the findings of the study by first exploring supervisees' IBH site and organizational structure, and then incorporating the organizational aspects into the supervision. University supervisors may also consider developing relationships and collaborations with site supervisors providing counseling/supervision practices in these settings to develop specific curriculum areas related to integrated care practices.

American Counseling Association Code of Ethics (ACA CoE; 2014), section D highlights the importance of different approaches to best serve clients (D.1.b.) and interdisciplinary teamwork (D.1.c). CACREP (2016) standards, section 3.d. of the Clinical Mental Health Counseling specialty, also states that graduate programs include strategies for interfacing with integrated behavioral health care and emphasize counselors' functions across specialty areas and their relationships with integrated behavioral healthcare systems (section 1.b). Similarly, current study findings indicated that collaboration among various healthcare workers seems to be a continuous process. These flagship organizations encourage counseling

programs and counselor education faculty to include IBH education and training into their programs. These organizations may increase the number of ways for programs to collaborate with other healthcare programs as they implement the standards via workshops/trainings for practitioners and program leaders to participate to start creating opportunities for collaboration at the academic settings. As yielded in the current study results, and reported in the literature (e.g., Thistlethwaite et al., 2010), educational barriers appear to be one of the challenges results in lack of collaborative care and integration of mental health counselors into medical settings. To address this challenge, counselor training programs may consider collaborating with health sciences programs to develop workshops/training programs to initiate interprofessional education and collaboration. Furthermore, counseling programs may also develop a dedicated course addressing counseling services in integrated care settings in their curriculums. Such a course may help counseling training programs further focus on integrated care practices as an evolving practice area of counseling. Participant 14 clearly articulated the need for such collaborations and curriculum development in counseling programs [i.e., "I think that students need to have a component added to their curriculum to understand IBH and residential settings. It is very different when the client lives somewhere 24/7 and sees the same people every day (residents, staff, social worker, counselor, nurse, doctor...) and the stresses that occur do to this.]." Lastly, counselor education programs can develop supervision workshops for site supervisors that include some organizational and process considerations of IBH setting supervision practices.

This study was a preliminary effort to explore site supervisors' perspectives on supervision of counselor trainees in IBH settings. In the light of the findings and limitations of this study, there are several further research implications. Researchers may consider further understanding of organizational/administrative and clinical IBH supervision as the findings

yielded unique components. In doing so, the findings might further trainings of supervisors and counselor trainees. Researchers may consider replicating this study with a larger sample of supervisors, such as supervisors who are providing licensure supervision to IBH setting residents to explore the different processes as well as similarities and differences of supervision in IBH. Moreover, future studies with larger and more diverse participant samples may yield different and similar results. In the current study, I focused on site supervisors of counselor trainees/supervisees in IBH settings. Further examinations including university supervisors' practices with supervisees doing their fieldwork experiences in IBH settings may offer us a more comprehensive understanding of supervision practices relevant to training of supervisors.

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APPENDICES

Appendix A

Invitation to Participate E-mail to Supervisors

Subject: Counseling Supervisors' Perspectives on Supervision of Counselor Trainees in Integrated Behavioral Health (IBH) Settings: A Q Methodology Approach

Dear Integrated Behavioral Health (IBH) Site Supervisor,

I am a doctoral candidate in Counseling at Old Dominion University. I am contacting to invite you to participate in my dissertation study on counseling supervisors' perspectives on counselor trainees' supervision in Integrated Behavioral Health (IBH) settings. In this study, I am aiming to better understand the experiences of site supervisors providing clinical supervision in IBH settings. I will be using Q methodology (Watts & Steiner, 2005), a mixed methods approach, to systematically understand perceptions and attitudes of the supervisors. This study is approved by the Institutional Review Board at Old Dominion University (IRB Protocol STUDY 1662745-1).

If you (1) a minimum of a Master's degree from a CACREP-accredited program, (2) at least two years of counseling experience in IBH settings, (3) didactic and experiential (supervision of supervision) supervision training in their background, (4) at least two years of experience with providing clinical supervision to counselor trainees, and (5) currently providing supervision to master's and/or doctoral level practicum and/or internship students in an IBH setting.

About your participation:

Your participation in this study is completely voluntary. You can decide to withdraw from the study at any time. If you agree to participate in this study, you are agreeing to participate in ***at least one of the two parts***: (1) Completing an online questionnaire and (2) Q sort task followed by a series of questions.

Part1: You will present interest in participating in the study by clicking the following link and completing the demographic questionnaire. Once you complete the demographic questionnaire, you will be directed to a questionnaire that will request you to create statements reflecting your experiences in your IBH setting (15 minutes). Upon creating the statements, you will be given set of statements created by counselor trainees who have been supervised in IBH settings. You will be asked to respond to each statement's "uniqueness/specific importance" to your IBH setting supervision practices with counselor trainees. You will have two weeks to complete this task. For your participation in Part 1, you will **receive an incentive of $10 Amazon gift card.**

Part 2: The researcher will send the Q-sort statements (obtained from the online questionnaire), sorting instructions, and post Q sort questions to you via email. Per Q-sort protocol, you will sort the cards into a quasi-normal distribution with "most significant" on one end and "least significant" on the other (30 minutes). Following Q-sort, you will also answer a series of questions for supportive information (10 minutes). You will have two weeks to complete this task. For your participation in Part 2, you will **receive an incentive of $20 Amazon gift card.**

While I cannot compensate you for your time, I hope that you find the current study valuable to your practices. With its procedures, I hope that the study will also offer you an opportunity to reflect on your experiences and enhance your awareness on your supervision practices. I appreciate your time and value your input as I strive to understand more about supervisors' experiences in this unique clinical setting. If you have any questions or concerns regarding this study, please contact me at ygiresun@odu.edu, or Laura Chezan, current IRB chair at lchezan@odu.edu. I will greatly appreciate if you share your experiences with me!

Yesim Giresunlu
Doctoral Candidate
Old Dominion University
Counseling and Human Services
Ph: 757-683-3326

Gulsah Kemer, Dissertation Chair
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Appendix B

Informed Consent Document

PROJECT TITLE: Counseling Supervisors' Perspectives on Supervision of Counselor Trainees in Integrated Behavioral Health (IBH) Settings: A Q Methodology Approach

INTRODUCTION:

In this study, I aim to understand the in-depth experiences of site supervisors who are providing supervision in IBH settings.

RESEARCHERS:

Dissertation Chair: Dr. Gulsah Kemer, Department of Counseling and Human Services, College of Education and Professional Studies

Student Researcher: Yesim Giresunlu, M.S.Ed. Doctoral Candidate, Department of Counseling and Human Services, College of Education and Professional Studies

DESCRIPTION OF RESEARCH STUDY

A major barrier integrating mental healthcare into primary care is lack of supervision, as without a system of competency-based supervision, training will be limited in impact (Abera et al., 2014; Ventevogel, 2014). Current literature on supervision at Integrated Behavioral Health (IBH) settings consists of "curbside consultations, second opinions, and assistance with challenging patients" (Hall et al., 2015, p. e47) in mental health-related fields, yet we have no empirical evidence of counseling supervision. Counselor educators are responsible to keep up with the evolving process of counseling (Borders et al., 2014). Even though the field of integrated care has been around for decades (Peek, 2013), evidenced-based guidelines for clinical supervision in IBH settings is limited (Borders, 2014). To ensure best practices as supervisors, this study will be one of the very first efforts to explore, understand, and develop evidence-based understanding of IBH supervision from counseling site supervisors' experiences. This study is approved by Old Dominion University's Institutional Review Board (IRB Protocol STUDY 1662745-1).

Your participation in this study is completely voluntary. You can decide to withdraw from the study at any time. If you agree to participate in this study, you are agreeing to participate in ***at least one of the two parts***: (1) Completing an online questionnaire and (2) Q sort task followed by a series of questions.

Part1: You will present interest in participating in the study by clicking the following link and completing the demographic questionnaire. Once you complete the demographic questionnaire, you will be directed to a questionnaire that will request you to create statements reflecting your experiences in your IBH setting (15 minutes). Upon creating the statements, you will be given set of statements created by counselor trainees who have been supervised in IBH settings. You will be asked to respond to each statement's "uniqueness/specific importance" to your IBH setting supervision practices with counselor trainees. You will have two weeks to complete this task. For your participation in Part 1, you **will receive an incentive of $10 Amazon gift card.**

Part 2: The researcher will send the Q-sort statements (obtained from the online questionnaire), sorting instructions, and post Q sort questions to you via email. Per Q-sort protocol, you will sort

the cards into a quasi-normal distribution with “most significant” on one end and “least significant” on the other (30 minutes). Following Q-sort, you will also answer a series of questions for supportive information (10 minutes). You will have two weeks to complete this task. For your participation in Part 2, you **will receive an incentive of $20 Amazon gift card**.

INCLUSIONARY CRITERIA

(1) a minimum of a Master’s degree from a CACREP-accredited program

(2) at least two years of counseling experience in IBH settings

(3) didactic and experiential (supervision of supervision) supervision training in their background

(4) at least two years of experience with providing clinical supervision to counselor trainees in IBH settings

(5) currently providing supervision to master's and/or doctoral level practicum and/or internship students in an IBH setting

EXCLUSIONARY CRITERIA

Participants who did not get their highest degree from a CACREP institution, do not have a didactic and experiential supervision training, have been providing clinical supervision to counselor trainees less than two years and not currently providing supervision to students in IBH settings.

RISKS AND BENEFITS

There is minimal risk to participating in this study as your identity will be revealed to other participants. The researcher is ethically and legally bound to protect participants’ identities and responses.

NEW INFORMATION

If the researcher finds new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

The researcher is using an online software called Qualtrics to collect data. Qualtrics will provide full anonymity since no identifying information will be asked from the researcher. The researcher and dissertation chair (PI) will be the only ones who have access to the date collected using Qualtrics. The data will be stored in a password-protected computer with double log in for three years after the study is completed, according to the federal IRB regulations.

WITHDRAWAL PRIVILEGE

You have the right to refuse to participate or to withdraw from this study at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data that has been collected be destroyed unless it is in a de-identifiable state.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research

study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them. Please contact Yesim Giresunlu at ygire001@odu.edu and/or Dr. Gulsah Kemer at gkemer@odu.edu (dissertation chair).

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. Laura Chezan, the current IRB chair, at 757-683-7055 or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws and promise compliance. I have answered the subject's questions and have encouraged them to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	**Date**

Appendix C

Demographic Questionnaire

Instructions: Select and/or fill in the blanks for each question and the appropriate responses.

1. What is your gender?
    a. Female
    b. Male
    c. Non binary
    d. Prefer to self-describe: _____
2. What is your ethnic background? (Select all that apply)
    a. Black or African American
    b. Asian/Pacific Islander
    c. Caucasian
    d. Hispanic or Latinx
    e. Native American
    f. Other (please specify) _____
3. Please specify your master's degree:_____
4. Do you have a PhD?
    a. Yes
    b. No
5. If yes, please specify your PhD degree:

6. Have you had your fieldwork experience during your master's and/or doctoral program in an IBH setting?
    a. Yes
    b. No
7. If yes, how long have you provided counseling services in IBH settings in years _____
8. Please specify which of the following supervision trainings you have completed (Please check all that apply)?
    a. A graduate didactic (content-based) course in clinical supervision
    b. A graduate experiential course in clinical supervision (received supervision for my supervision of counselor trainees)
    b. Workshop training in clinical supervision
        Please describe briefly: _____
    c. Other (please describe briefly) _____
9. What are your professional credentials (check all that apply)?
    a. NCC
    b. LPC
    c. Approved Clinical Supervisor (NBCC credential)
    d. Other (please specify)

10. Are you currently providing site supervision to master's/doctoral-level counselor trainees in an IBH setting?
    a. Yes
    b. No

11. Please describe the educational level of your supervisees (circle all that apply):
    a. Master's-level counselor trainees
    b. Doctoral-level counselor trainees
    c. Other: _____

12. How long have you been providing site supervision to counselor trainees in IBH settings in years? _____

13. What are the professional identities of other professionals you have you been working with in your IBH setting? (circle all that apply)
    a. physician
    b. physicians' assistant
    c. nurses
    d. psychiatrist
    e. psychologist
    f. social worker
    g. other _____

14. What is the primary unit of practice client profile you have been working with in your IBH setting? (circle all that apply)
    a. inpatient
    b. outpatient
    c. other_____

15. What is the level of integration at your site?
    a. Minimal collaboration (e.g., referral-based care)
    b. Co-location (e.g., same location, shared EHR)
    c. Integrated (e.g., shared treatment plan)

16. What is the IBH setting you have been working at? (circle all that apply)
    a. private practice
    b. ambulatory care clinic
    c. hospital
    d. non-profit agency
    e. inpatient psychiatric facility
    f. primary care/ family practice clinic
    g. other _____

Appendix D

Step 2: Development of The Concourse Part 1

Dear IBH Site Supervisor,

I am conducting this study to explore the counseling site supervisors' viewpoints of critical components and processes of Integrated Behavioral Health (IBH) supervision. I value your experiences as a site supervisor in an IBH setting. To be efficient and effective, I would love to obtain an understanding of your supervision experiences in this unique setting. For each prompt, please provide AS MANY CONCRETE PHRASES/SENTENCES AS you need to describe and reflect the critical components and processes of your supervision experiences as IBH supervisor. Please be AS CLEAR AND CONCRETE AS possible. When you complete the task, you will be asked to provide your email address to receive your $10 Amazon gift card.

1. What are the unique aspects of your supervision practices with supervisees in your IBH setting? These unique aspects of your supervisory work in this IBH setting may include, but not limited to, unique focus areas, your unique roles and responsibilities as a supervisor, your supervisee's unique roles and responsibilities, etc.

Step 2: Development of the Concourse Continued

Below are the set of statements created by counselor trainees who have been supervised in IBH settings. Please respond to each statement's ***"uniqueness/importance" to your IBH setting supervision practices with counselor trainees***. If you think the statement is unique/important to your IBH counseling supervision, select "agree." If you think the statement is not unique/important in your IBH counseling supervision, select disagree.

Statements	**Agree**	**Disagree**
Clinical judgement in my work with clients		
Crisis assessment and intervention		
Communicating with other health professionals at my site		
Being assertive when communicating with staff at my site		
Writing progress notes within the IBH setting (e.g., SOAP, BIRP, theory based)		
Interprofessional collaboration (e.g., social workers, care managers, physicians, charge nurses, bed nurses, chaplains) to address client needs and/or progress		
Establishing boundaries with clients		
Maintaining boundaries with clients		
Establishing boundaries with other health professionals		
Maintaining boundaries with other health professionals		
Maintaining my professional identity while working in an interdisciplinary environment		
My competency concerns about respect/competence in an interprofessional team		
Clients' view of the leadership in our interprofessional team		
Medical model vs. wellness model (e.g., counseling is holistic and able to be incorporated within different practices in health care)		
My concerns about some other staff not viewing mental health in the same way as I do		
Case conceptualization and case review (e.g., exploring various factors that might affect clients' progress in counseling)		
Multicultural considerations in my work with clients		
My multicultural competence in my work with clients		
My knowledge of hospital protocols for clients in medical units (in-patient)		
Tentative recommendations provided on the progress notes		
Conveying plan of action with clients		
Expectations of me as a supervisee		
My disagreement on the conceptualization of a client seen by another mental health trainee		
Communicating with clients' family and/or caregivers		
Establishing rapport with clients		
Ways to handle aggressive clients in my setting (e.g., psychiatric unit)		
Recognizing and exhibiting counselors have unique ability to empathize and conceptualize		
Converging medical needs and mental health needs (e.g., integrating information from past medical concerns in explaining current functioning)		

Using Maslow's Hierarchy of Needs when working with clients		
Discussing ways for seeking referrals for new clients from physicians		
Planning for termination/discharge of clients (e.g., whether to discharge to a more acute care, planning a family session before discharge)		
Coordinating follow-up care upon termination/discharge		
Brainstorming ways to educate medical professionals about the importance of mental health		
Collaborating with medical professionals on clients' concerns (e.g., duration, frequency, type, note writing for substance abuse)		
My client's needs for other services at my site (e.g., medication management)		
Understanding and acknowledging the complexities of services provided by mental health counselors at my site (e.g., acute setting, non-traditional counseling, addressing trauma via short-term treatment)		
Time limitations and management at my site		
Enhancing therapeutic opportunities through designing and implementing other services for clients in the milieu (e.g., stress management support group in an outpatient modality)		
Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients)		
Discussing clients' challenges clients with lack of resources (e.g., financial, social)		
Ways to hold my clients accountable		
Organizational structure in the IBH setting (e.g., role equality, role hierarchy, counselor responsibility)		
Dynamics among healthcare professionals (e.g., working with staff, consulting with dismissive medical staff, comments that the medical staff make)		
Administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations)		
Distinguishing the roles and responsibilities among mental health and other health care professions (e.g., social work)		
Developing an understanding of each professional's perspective on mental health and the specific client concern (e.g., substance use)		
Developing a professional relationship not only with mental health professionals but also with staff in other roles		
Administrative issues unique to my site (e.g., inconsistency of staffing)		
Developmental milestone/s of my training		
Ethical and professional issues that I may foresee at my site (e.g., dilemmas, boundaries, burnout, HIPAA-related)		
Adhering to or revising treatment plans for the clients' benefit		
Treatment planning for my clients		
Treatment planning for clients with compounding issues due to low SES		
Assessment and diagnostic considerations and competencies unique to my site (e.g., v-codes, ruling out medical problems)		
Legal issues I may foresee working with clients (e.g., mandated reporting)		
Discussing specific approaches/interventions and theories to use with my clients		
Discussing resources to use and offer working with my clients (e.g., evidence-based approaches, medication interactions)		
Discussing referrals for my clients		

Discussing resources for my professional growth (e.g., licensure process, continuing education)		
Addressing the health professional's order needs (e.g., perform a mental status examination, PHQ-9) and client's emerging needs, respectively		
Mental health counselors' practices impacting various other professionals (e.g., nurses, physical therapists, medical students, dental hygienists)		
Validating and normalizing my personal feelings and self-care practices while working in the IBH setting		
Understanding medical terminology to add credibility to my counseling work within my setting		
Advocating for clients and causes that are important to my work as a counselor (e.g., collaborating with medical staff on medication)		
My supervisor's experiences in the IBH setting both as a supervisor and as a clinician		
Ways to advocate for my profession in an IBH setting to enhance the role of a mental health counselor to be more prominent, understood and recognized		
Getting exposed to administrative components at my site (e.g., attending interprofessional staff meetings)		
How to improve the quality of my services (e.g., receiving continuing training on IBH)		
Being supervised by other professionals from different fields		

Appendix E

Q Set

1. Focusing on care management to ensure coordination of services and continuity of care
2. Focusing on knowing and tracking clients' medications and lab work
3. Encouraging supervisees to advocate for the mental health aspects of cases and their roles and responsibilities as mental health professionals
4. Encouraging supervisees to advocate for their roles and responsibilities as mental health professionals
5. Focusing on case staffing (e.g., sharing conceptualizations, patient progress) among supervisees at the site
6. Identifying supervisees' developmental level and tailoring my practices based on their developmental levels
7. Observing warm-handoff strategies by shadowing me
8. Discussing the progress of the supervision sessions (e.g., asking supervisees what is going well/not going well, what I and they could do to improve the supervision experience)
9. Attending my supervisees' emerging needs or critical clinical issues
10. Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (e.g., owning my own growth areas, approaching with a non-judgmental approach)
11. Focusing on supervisees' strengths and developmental milestones in their training in collaboration with them
12. Discussing my supervisees' roles and responsibilities within the IBH setting
13. Explaining and encouraging the use of resources for mental health clinicians at the IBH site
14. Providing different modalities of supervision (e.g., individual, live) appropriate to the site
15. Providing support in using challenging or enhancing clinical behaviors (e.g., enabling vs. helping, transference, countertransference)
16. Helping supervisees develop clinical strategies and techniques to work with clients (e.g., listening, learning, being open-minded, skill building, establishing rapport)
17. Including role play in supervision session
18. Performing university specific administrative tasks (e.g., meeting with faculty supervisor/s, completing evaluations)
19. Going over site documentation (e.g., supervision agreement, hour logs, site agreement)
20. Discussion of providing different modes of counseling (e.g., telehealth, individual, SUD, group) that are appropriate to the site
21. Focusing on clinical judgement and higher symptom acuity in the IBH setting
22. Helping supervisees understand crisis assessment and intervention including suicide assessment
23. Discussing and modeling communication with other health professionals and members of the treatment team at the IBH site
24. Providing feedback on supervisees' progress notes to ensure accuracy (e.g., mental status exam) and benefit/tips for the other medical professionals (interprofessionalism)
25. Broaching culture and diversity within supervision to ensure cultural competency in supervisees work with clients

26. Offering training on program guidelines, policies (e.g., HIPPA, EHR)
27. Modeling and encouraging collaboration and coordination of care with other providers at the site to address client needs and/or progress
28. Focusing on different areas of supervisees' services (e.g., client centered services, training on intimate partner violence and co-occurring disorders)
29. Discussing specific approaches/interventions and theories to use with clients (e.g., DBT, CBT, MET, mindfulness, Motivational Interviewing)
30. Discussing how to complete referrals for the clients (e.g., to external agencies)
31. Discussing resources for supervisees' professional growth (e.g., licensure process, licensure exam, continuing education)
32. Developing goals of supervision as well as clarifying the expectations
33. Emphasizing different areas of conceptualization (e.g., social determinants of health, Maslow's Hierarchy of Needs, converging medical and mental health needs) when working with clients
34. Increasing familiarity with medical terminology to add credibility to the counseling work
35. Adhering to, reviewing, and revising treatment plans for the client's benefit
36. Assisting supervisees to explore issues outside of the counseling session that may be interfering their work
37. Planning for termination/discharge of clients and coordinating follow-up care
38. Being open about my experiences in the IBH setting both as a supervisor and as a clinician
39. Focusing on assessment and diagnostic considerations, competencies unique to the site (e.g., v-codes, ruling out medical problems, DSM 5)
40. Discussing other services/therapeutic opportunities in the milieu (e.g., stress management, medication management, support group in an outpatient modality)
41. Focusing on treatment planning/Individualized Service Plans and need to incorporate health history and compounding issues (e.g., low SES)
42. Focusing on time limitations and management at the site
43. Encouraging supervisees to discover their own style of providing counseling
44. Working with providing various services (e.g., Substance Abuse, Mental Health)
45. Paying attention to my roles as a supervisor regarding my supervisees' abilities (e.g., building confidence, understanding limits, encouraging learning)
46. Paying attention to my role as a supervisor regarding quality and efficiency in the supervision session (e.g., providing structure for the sessions, professionalism, boundaries, letting the supervisor know I would work as hard as they but never harder)
47. Assisting with adjusting to environmental aspects of the site (e.g., working in medical exam rooms, different medical units, personnel)
48. Discussing ways to advocate for counseling in an IBH setting to enhance the role of a mental health counselor to be more prominent, understood and recognized
49. Reviewing and processing ethical and legal guidelines (e.g., ACA, ASAM, mandated reporting) as well as cases that supervisees might foresee at the site (e.g., elder abuse, burnout)
50. Providing homework for follow-up
51. Assisting with and modeling how to establish and maintain boundaries with clients
52. Focusing on communicating with clients on plan of action, accountability as well as communicating with client's family and/or caregivers

53. Focusing on issues related to client's behaviors that are specific to the site (e.g., ways to handle aggressive clients, accountability)
54. Assisting supervisees with establishing and maintaining boundaries with other health professionals including attention to dynamics
55. Discussing ways to develop a professional relationship with staff in other roles
56. Attending to supervisees concerns related to professional identity working in an interdisciplinary environment
57. Attending to medical vs. wellness model in supervision as is pertains to the IBH setting
58. Helping sueprvisees understand mental health counselor's place and impact in the organization/site (e.g., services provided, unique abilities such as empathy)
59. *Observing and processing supervisees' counseling sessions in supervision*
60. Discussing resources to use and offer working with my clients (e.g., evidence-based approaches, medication interactions)
61. Addressing administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations)
62. Discussing ways to advocate for clients and causes that are important to supervisees' work (e.g., collaborating with medical staff on medication)
63. Assisting supervisees to communicate assertively and confidently with physicians/medical staff as mental health experts
64. Paying attention to build and maintain working alliance with my supervisees using person-centered approach
65. Collaborating with my supervisees in creating a safe space for our supervision experience
66. Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations
67. Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients)
68. Focusing on the organizational structure in the IBH setting (e.g., role equality, role hierarchy) and working within the organization
69. Developing an understanding each professional's perspective on mental health and specific client concern (e.g., substance use)
70. Paying attention to ways to increase comradery among supervisees
71. As a supervisor, following and maintaining federal guidelines (e.g., DMAS, COVID-19)
72. Discussing client's view of the leadership in our interprofessional team
73. Addressing the health professional's order needs (e.g., perform a mental status examination, PHQ-9) and client's emerging needs, respectively)
74. Exposing supervisees to administrative components of the IBH site (e.g., attending interprofessional staff meetings)
75. Meeting with supervisees weekly

Appendix F

Factor Arrays

Statement	Factor 1	Factor 2
1	-6	-2
2	-5	-6
3	-3	0
4	-5	-1
5	-3	-1
6	-4	5
7	-4	-3
8	-4	4
9	-1	3
10	-2	6
11	-4	6
12	-3	0
13	-6	2
14	-5	3
15	-2	3
16	-3	5
17	-2	-1
18	-6	-3
19	-3	-1
20	-5	-2
21	-1	0
22	-1	4
23	-4	-1
24	-1	0
25	-2	4
26	0	-2
27	-2	2
28	-2	-2
29	1	4
30	-1	-3
31	1	1
32	-1	-2
33	-1	1
34	0	-3
35	2	-1

36	-2	4
37	0	2
38	3	1
39	2	0
40	0	1
41	5	-1
42	3	-2
43	0	5
44	3	-2
45	2	1
46	1	2
47	0	-4
48	-1	-3
49	4	1
50	1	-6
51	4	6
52	1	0
53	3	2
54	1	2
55	4	-5
56	3	0
57	1	-3
58	0	-4
59	5	5
60	6	0
61	5	-4
62	3	-1
63	2	1
64	4	3
65	5	1
66	0	-6
67	4	2
68	1	-4
69	2	-4
70	0	-5
71	6	3
72	-3	-5
73	2	0
74	2	-5
75	6	3

Appendix G

Crib Sheet for Factor 1

Top Two Statements (most agree)
75. Meeting with supervisees weekly
60. Discussing resources to use and offer working with my clients (e.g., evidence-based approaches, medication interactions)
Statements sorted higher than other factors
65. Collaborating with my supervisees in creating a safe space for our supervision experience 5
61. Addressing administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations) 5
41. Focusing on treatment planning/Individualized Service Plans and need to incorporate health history and compounding issues (e.g., low SES) 5
67. Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients) 4
49. Reviewing and processing ethical and legal guidelines (e.g., ACA, ASAM, mandated reporting) as well as cases that supervisees might foresee at the site (e.g., elder abuse, burnout) 4
55. Discussing ways to develop a professional relationship with staff in other roles 4
44. Working with providing various services (e.g., Substance Abuse, Mental Health) 3
69. Developing an understanding each professional's perspective on mental health and specific client concern (e.g., substance use) 3
74. Exposing supervisees to administrative components of the IBH site (e.g., attending interprofessional staff meetings) 2
42. Focusing on time limitations and management at the site 2
68. Focusing on the organizational structure in the IBH setting (e.g., role equality, role hierarchy) and working within the organization 0
58. Helping sueprvisees understand mental health counselor's place and impact in the organization/site (e.g., services provided, unique abilities such as empathy) 0
Attending to medical vs. wellness model in supervision as is pertains to the IBH setting 0
70. Paying attention to ways to increase comradery among supervisees 0
34. Increasing familiarity with medical terminology to add credibility to the counseling work 0 -
Statements sorted lower than other factors
10. Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (e.g., owning my own growth areas, approaching with a non-judgmental approach) -2
15. Providing support in using challenging or enhancing clinical behaviors (e.g., enabling vs. helping, transference, countertransference) -2
16. Helping supervisees develop clinical strategies and techniques to work with clients (e.g., listening, learning, being open-minded, skill building, establishing rapport) -2
6. Identifying supervisees' developmental level and tailoring my practices based on their developmental levels -3
12. Discussing my supervisees' roles and responsibilities within the IBH setting -4
11. Focusing on supervisees' strengths and developmental milestones in their training in collaboration with them -4
8. Discussing the progress of the supervision sessions (e.g., asking supervisees what is going well/not going well, what I and they could do to improve the supervision experience) -4

14. Providing different modalities of supervision (e.g., individual, live) appropriate to the site -5
13. Explaining and encouraging the use of resources for mental health clinicians at the IBH site -6

Bottom two statements (least agree)

2. Focusing on knowing and tracking clients' medications and lab work
18. Performing university specific administrative tasks (e.g., meeting with faculty supervisor/s, completing evaluations)

Other possible statements of importance

62. Discussing ways to advocate for clients and causes that are important to supervisees' work (e.g., collaborating with medical staff on medication) 3
56. Attending to supervisees concerns related to professional identity working in an interdisciplinary environment 3
35. Adhering to, reviewing, and revising treatment plans for the client's benefit 2
66. Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations -1

Appendix H

Crib Sheet for Factor 2

Top Two Statements (most agree)

10. Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (e.g., owning my own growth areas, approaching with a non-judgmental approach)
16. Helping supervisees develop clinical strategies and techniques to work with clients (e.g., listening, learning, being open-minded, skill building, establishing rapport)

Statements sorted higher than other factors

10. Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (e.g., owning my own growth areas, approaching with a non-judgmental approach) -2
15. Providing support in using challenging or enhancing clinical behaviors (e.g., enabling vs. helping, transference, countertransference) -2
16. Helping supervisees develop clinical strategies and techniques to work with clients (e.g., listening, learning, being open-minded, skill building, establishing rapport) -2
6. Identifying supervisees' developmental level and tailoring my practices based on their developmental levels -3
12. Discussing my supervisees' roles and responsibilities within the IBH setting -4
11. Focusing on supervisees' strengths and developmental milestones in their training in collaboration with them -4
8. Discussing the progress of the supervision sessions (e.g., asking supervisees what is going well/not going well, what I and they could do to improve the supervision experience) -4
14. Providing different modalities of supervision (e.g., individual, live) appropriate to the site -5
13. Explaining and encouraging the use of resources for mental health clinicians at the IBH site -6

Statements sorted lower than other factors (see Factor 1)

65. Collaborating with my supervisees in creating a safe space for our supervision experience 5
61. Addressing administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations) 5
41. Focusing on treatment planning/Individualized Service Plans and need to incorporate health history and compounding issues (e.g., low SES) 5
67. Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients) 4
49. Reviewing and processing ethical and legal guidelines (e.g., ACA, ASAM, mandated reporting) as well as cases that supervisees might foresee at the site (e.g., elder abuse, burnout) 4
55. Discussing ways to develop a professional relationship with staff in other roles 4
44. Working with providing various services (e.g., Substance Abuse, Mental Health) 3
69. Developing an understanding each professional's perspective on mental health and specific client concern (e.g., substance use) 3
74. Exposing supervisees to administrative components of the IBH site (e.g., attending interprofessional staff meetings) 2
42. Focusing on time limitations and management at the site 2
68. Focusing on the organizational structure in the IBH setting (e.g., role equality, role hierarchy) and working within the organization 0
58. Helping sueprvisees understand mental health counselor's place and impact in the organization/site (e.g., services provided, unique abilities such as empathy) 0

Attending to medical vs. wellness model in supervision as is pertains to the IBH setting 0
70. Paying attention to ways to increase comradery among supervisees 0
34. Increasing familiarity with medical terminology to add credibility to the counseling work 0 -
Bottom two statements (least agree)
70. Paying attention to ways to increase comradery among supervisees
50. Providing homework for follow-up
Other possible statements of importance (see Factor 1)
62. Discussing ways to advocate for clients and causes that are important to supervisees' work (e.g., collaborating with medical staff on medication) 3
56. Attending to supervisees concerns related to professional identity working in an interdisciplinary environment 3
35. Adhering to, reviewing, and revising treatment plans for the client's benefit 2
66. Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations -1

Appendix I

Factor Array (Composite Q Sort): Factor 1

Composite Q sort for Factor 1

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
** 13. Explaining and encouraging the use of resources for mental health clinicians at the IBH site	** 20. Discussion of providing different modes of counseling (e.g., telehealth, individual, SUD, group) that are appropriate to the site	** 23. Discussing and modeling communication with other health professionals and members of the treatment team at the IBH site	** 16. Helping supervisees develop clinical strategies and techniques to work with clients (e.g., listening, learning, being open-minded, skill building, establishing rapport)	** 27. Modeling and encouraging collaboration and coordination of care with other providers at the site to address client needs and/or progress	33. Emphasizing different areas of conceptualization (e.g., social determinants of health, Maslow's Hierarchy of Needs, converging medical and mental health needs) when working with clients	** 34. Increasing familiarity with medical terminology to add credibility to the counseling work	** 50. Providing homework for follow-up	* 63. Assisting supervisees to communicate assertively and confidently with physicians/medical staff as mental health experts	38. Being open about my experiences in the IBH setting both as a supervisor and as a clinician	** 67. Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients)	** 65. Collaborating with my supervisees in creating a safe space for our supervision experience	** 75. Meeting with supervisees weekly
** 18. Performing university specific administrative tasks (e.g., meeting with faculty supervisor/s, completing evaluations)	** 14. Providing different modalities of supervision (e.g., individual, live) appropriate to the site	** 6. Identifying supervisees' developmental level and tailoring my practices based on their developmental levels	** 3. Encouraging supervisees to advocate for the mental health aspects of cases and their roles and responsibilities as mental health professionals	** 36. Assisting supervisees to explore issues outside of the counseling session that may be interfering their work	* 30. Discussing how to complete referrals for the clients (e.g., to external agencies)	37. Planning for termination/discharge of clients and coordinating follow-up care	* 29. Discussing specific approaches/interventions and theories to use with clients (e.g., DBT, CBT, MET, mindfulness, Motivational Interviewing)	** 74. Exposing supervisees to administrative components of the IBH site (e.g., attending interprofessional staff meetings)	** 62. Discussing ways to advocate for clients and causes that are important to supervisees' work (e.g., collaborating with medical staff on medication)	64. Paying attention to build and maintain working alliance with my supervisees using person-centered approach	** 61. Addressing administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations)	** 60. Discussing resources to use and offer working with my clients (e.g., evidence-based approaches, medication interactions)
** 1. Focusing on care management to ensure coordination of services and continuity of care	** 4. Encouraging supervisees to advocate for their roles and responsibilities as mental health professionals	** 11. Focusing on supervisees' strengths and developmental milestones in their training in collaboration with them	* 19. Going over site documentation (e.g., supervision agreement, hour logs, site agreement)	17. Including role play in supervision session	** 22. Helping supervisees understand crisis assessment and intervention including suicide assessment	** 43. Encouraging supervisees to discover their own style of providing counseling	** 68. Focusing on the organizational structure in the IBH setting (e.g., role equality, role hierarchy) and working within the organization	** 69. Developing an understanding each professional's perspective on mental health and specific client concern (e.g., substance use)	* 56. Attending to supervisees concerns related to professional identity working in an interdisciplinary environment	** 49. Reviewing and processing ethical and legal guidelines (e.g., ACA, ASAM, mandated reporting) as well as cases that supervisees might foresee at the site (e.g., elder abuse, burnout)	** 41. Focusing on treatment planning/Individualized Service Plans and need to incorporate health history and compounding issues (e.g., low SES)	* 71. As a supervisor, following and maintaining federal guidelines (e.g., DMAS, COVID-19)
	2. Focusing on knowing and tracking clients' medications and lab work	** 8. Discussing the progress of the supervision sessions (e.g., asking supervisees what is going well/not going well, what I and they could do to improve the supervision experience)	* 5. Focusing on case staffing (e.g., sharing conceptualizations, patient progress) among supervisees at the site	** 10. Exhibiting openness, transparency, and genuineness in my relationship with the supervisees (e.g., owning my own growth areas, approaching with a non-judgmental approach)	* 48. Discussing ways to advocate for counseling in an IBH setting to enhance the role of a mental health counselor to be more prominent, understood and recognized	** 58. Helping sueprvisees understand mental health counselor's place and impact in the organization/site (e.g., services provided, unique abilities such as empathy)	52. Focusing on communicating with clients on plan of action, accountability as well as communicating with client's family and/or caregivers	45. Paying attention to my roles as a supervisor regarding my supervisees' abilities (e.g., building confidence, understanding limits, encouraging learning)	** 44. Working with providing various services (e.g., Substance Abuse, Mental Health)	** 51. Assisting with and modeling how to establish and maintain boundaries with clients	59. Observing and processing supervisees' counseling sessions in supervision	
		7. Observing warm-handoff strategies by shadowing me	72. Discussing client's view of the leadership in our interprofessional team	** 25. Broaching culture and diversity within supervision to ensure cultural competency in supervisees work with clients	21. Focusing on clinical judgement and higher symptom acuity in the IBH setting	** 66. Brainstorming ways to educate medical professionals about the importance of mental health and counselors' capabilities and limitations	54. Assisting supervisees with establishing and maintaining boundaries with other health professionals including attention to dynamics	** 35. Adhering to, reviewing, and revising treatment plans for the client's benefit	53. Focusing on issues related to client's behaviors that are specific to the site (e.g., ways to handle aggressive clients, accountability)	** 55. Discussing ways to develop a professional relationship with staff in other roles		
			** 12. Discussing my supervisees' roles and responsibilities within the IBH setting	** 15. Providing support in using challenging or enhancing clinical behaviors (e.g., enabling vs. helping, transference, countertransference)	** 9. Attending my supervisees' emerging needs or critical clinical issues	40. Discussing other services/therapeutic opportunities in the milieu (e.g., stress management, medication management, support group in an outpatient modality)	** 57. Attending to medical vs. wellness model in supervision as is pertains to the IBH setting	* 73. Addressing the health professional's order needs (e.g., perform a mental status examination, PHQ-9) and client's emerging needs, respectively)	** 42. Focusing on time limitations and management at the site			
				28. Focusing on different areas of supervisees' services (e.g., client centered services, training on intimate partner violence and co-occurring disorders)	32. Developing goals of supervision as well as clarifying the expectations	* 26. Offering training on program guidelines, policies (e.g., HIPPA, EHR)	46. Paying attention to my role as a supervisor regarding quality and efficiency in the supervision session (e.g., providing structure for the sessions, professionalism, boundaries, letting the supervisor know I would work as hard as they but never treated	* 39. Focusing on assessment and diagnostic considerations, competencies unique to the site (e.g., v-codes, ruling out medical problems, DSM 5)				
					24. Providing feedback on supervisees' progress notes to ensure accuracy (e.g., mental status exam) and benefit/tips for the other medical professionals (interprofessionalism)	** 47. Assisting with adjusting to environmental aspects of the site (e.g., working in medical exam rooms, different medical units, personnel)	31. Discussing resources for supervisees' professional growth (e.g., licensure process, licensure exam, continuing education)					
						** 70. Paying attention to ways to increase comradery among supervisees						

Legend

* Distinguishing statement at P< 0.05

** Distinguishing statement at P< 0.01

Appendix J

Factor Array (Composite Q Sort): Factor 2

Composite Q sort for Factor 2

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
✳✳ 50. Providing homew ork for follow -up	✳✳ 55. Discussing w ays to develop a professional relationship w ith staff in other roles	✳✳ 68. Focusing on the organizational structure in the IBH setting (e.g., role equality, role hierarchy) and w orking w ithin the organization	✳✳ 18. Performing university specific administrative tasks (e.g., meeting w ith faculty supervisor/s, completing evaluations)	28. Focusing on different areas of supervisees' services (e.g., client centered services, training on intimate partner violence and co-occurring disorders)	✳✳ 41. Focusing on treatment planning/Individualized Service Plans and need to incorporate health history and compounding issues (e.g., low SES)	✳✳ 60. Discussing resources to use and offer w orking w ith my clients (e.g., evidence-based approaches, medication interactions)	38. Being open about my experiences in the IBH setting both as a supervisor and as a clinician	✳✳ 13. Explaining and encouraging the use of resources for mental health clinicians at the IBH site	✳✳ 14. Providing different modalities of supervision (e.g., individual, live) appropriate to the site	✳✳ 25. Broaching culture and diversity w ithin supervision to ensure cultural competency in supervisees w ork w ith clients	✳✳ 16. Helping supervisees develop clinical strategies and techniques to w ork w ith clients (e.g., listening, learning, being open-minded, skill building, establishing rapport)	✳✳ 10. Exhibiting openness, transparency, and genuineness in my relationship w ith the supervisees (e.g., ow ning my ow n grow th areas, approaching w ith a non-judgmental approach)
2. Focusing on know ing and tracking clients' medications and lab w ork	72. Discussing client's view of the leadership in our interprofessional team	✳✳ 69. Developing an understanding each professional's perspective on mental health and specific client concern (e.g., substance use)	✳ 30. Discussing how to complete referrals for the clients (e.g., to external agencies)	✳✳ 1. Focusing on care management to ensure coordination of services and continuity of care	✳✳ 62. Discussing w ays to advocate for clients and causes that are important to supervisees' w ork (e.g., collaborating w ith medical staff on medication)	✳ 56. Attending to supervisees concerns related to professional identity w orking in an interdisciplinary environment	40. Discussing other services/therapeutic opportunities in the milieu (e.g., stress management, medication management, support group in an outpatient modality)	✳✳ 27. Modeling and encouraging collaboration and coordination of care w ith other providers at the site to address client needs and/or progress	✳ 71. As a supervisor, follow ing and maintaining federal guidelines (e.g., DMAS, COVID-19)	✳✳ 36. Assisting supervisees to explore issues outside of the counseling session that may be interfering their w ork	✳✳ 43. Encouraging supervisees to discover their ow n style of providing counseling	✳✳ 11. Focusing on supervisees' strengths and developmental milestones in their training in collaboration w ith them
✳✳ 66. Brainstorming w ays to educate medical professionals about the importance of mental health and counselors' capabilities and limitations	✳✳ 74. Exposing supervisees to administrative components of the IBH site (e.g., attending interprofessional staff meetings)	✳✳ 61. Addressing administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations)	✳✳ 57. Attending to medical vs. w ellness model in supervision as is pertains to the IBH setting	✳✳ 42. Focusing on time limitations and management at the site	17. Including role play in supervision session	✳ 39. Focusing on assessment and diagnostic considerations, competencies unique to the site (e.g., v-codes, ruling out medical problems, DSM 5)	45. Paying attention to my roles as a supervisor regarding my supervisees' abilities (e.g., building confidence, understanding limits, encouraging learning)	37. Planning for termination/discharge of clients and coordinating follow -up care	✳✳ 9. Attending my supervisees' emerging needs or critical clinical issues	✳✳ 8. Discussing the progress of the supervision sessions (e.g., asking supervisees w hat is going w ell/not going w ell, w hat I and they could do to improve the supervision experience)	✳✳ 6. Identifying supervisees' developmental level and tailoring my practices based on their developmental levels	✳✳ 51. Assisting w ith and modeling how to establish and maintain boundaries w ith clients
	✳✳ 70. Paying attention to w ays to increase comradery among supervisees	✳✳ 47. Assisting w ith adjusting to environmental aspects of the site (e.g., w orking in medical exam rooms, different medical units, personnel)	7. Observing w arm-handoff strategies by shadow ing me	✳✳ 20. Discussion of providing different modes of counseling (e.g., telehealth, individual, SUD, group) that are appropriate to the site	✳✳ 35. Adhering to, review ing, and revising treatment plans for the client's benefit	✳✳ 12. Discussing my supervisees' roles and responsibilities w ithin the IBH setting	✳✳ 65. Collaborating w ith my supervisees in creating a safe space for our supervision experience	✳✳ 67. Responding to challenges involving staff's engagement w ith clients (e.g., staff not engaging therapeutically w ith clients)	64. Paying attention to build and maintain w orking alliance w ith my supervisees using person-centered approach	✳✳ 22. Helping supervisees understand crisis assessment and intervention including suicide assessment	59. Observing and processing supervisees' counseling sessions in supervision	
		✳✳ 58. Helping sueprvisees understand mental health counselor's place and impact in the organization/site (e.g., services provided, unique abilities such as empathy)	✳✳ 34. Increasing familiarity w ith medical terminology to add credibility to the counseling w ork	✳ 26. Offering training on program guidelines, policies (e.g., HIPPA, EHR)	✳✳ 4. Encouraging supervisees to advocate for their roles and responsibilities as mental health professionals	21. Focusing on clinical judgement and higher symptom acuity in the IBH setting	33. Emphasizing different areas of conceptualization (e.g., social determinants of health, Maslow 's Hierarchy of Needs, converging medical and mental health needs) w hen w orking w ith clients	46. Paying attention to my role as a supervisor regarding quality and efficiency in the supervision session (e.g., providing structure for the sessions, professionalism, boundaries, letting the supervisor know I would w ork as hard as they but never	✳✳ 15. Providing support in using challenging or enhancing clinical behaviors (e.g., enabling vs. helping, transference, countertransference)	✳ 29. Discussing specific approaches/interventions and theories to use w ith clients (e.g., DBT, CBT, MET, mindfulness, Motivational Interview ing)		
			✳ 48. Discussing w ays to advocate for counseling in an IBH setting to enhance the role of a mental health counselor to be more prominent, understood and recognized	✳✳ 44. Working w ith providing various services (e.g., Substance Abuse, Mental Health)	✳✳ 23. Discussing and modeling communication w ith other health professionals and members of the treatment team at the IBH site	✳ 73. Addressing the health professional's order needs (e.g., perform a mental status examination, PHQ-9) and client's emerging needs, respectively)	✳✳ 49. Review ing and processing ethical and legal guidelines (e.g., ACA, ASAM, mandated reporting) as w ell as cases that supervisees might foresee at the site (e.g., elder abuse, burnout)	✳✳ 54. Assisting supervisees w ith establishing and maintaining boundaries w ith other health professionals including attention to dynamics	✳✳ 75. Meeting w ith supervisees w eekly			
				32. Developing goals of supervision as w ell as clarifying the expectations	✳ 5. Focusing on case staffing (e.g., sharing conceptualizations, patient progress) among supervisees at the site	52. Focusing on communicating w ith clients on plan of action, accountability as w ell as communicating w ith client's family and/or caregivers	✳ 63. Assisting supervisees to communicate assertively and confidently w ith physicians/medical staff as mental health experts	53. Focusing on issues related to client's behaviors that are specific to the site (e.g., w ays to handle aggressive clients, accountability)				
					✳ 19. Going over site documentation (e.g., supervision agreement, hour logs, site agreement)	✳✳ 3. Encouraging supervisees to advocate for the mental health aspects of cases and their roles and responsibilities as mental health professionals	31. Discussing resources for supervisees' professional grow th (e.g., licensure process, licensure exam, continuing education)					
						24. Providing feedback on supervisees' progress notes to ensure accuracy (e.g., mental status exam) and benefit/tips for the other medical professionals (interprofessionalism)						

Legend

✳ Distinguishing statement at P< 0.05

✳✳ Distinguishing statement at P< 0.01

Yeşim Giresunlu, M.S.Ed., NCC, Resident in Counseling (VA)
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EDUCATION

Doctor of Philosophy, Counselor Education and Supervision **June 2021 (anticipated)**
Old Dominion University (ODU), Norfolk, Virginia CACREP accredited program

Master's of Science in Education, Clinical Mental Health Counseling **2018**
Old Dominion University, Norfolk, Virginia
CACREP accredited program

Master's of Arts in Clinical Mental Health Counseling **2015 - 2016**
University of Redlands, Redlands, CA

Bachelors of Science in Therapeutic Recreation **2015**
Old Dominion University Norfolk, VA

RESEARCH EXPERIENCE

Graduate Research Assistant **May 2020 - Present**
Health Resources and Services Administration (HRSA), Behavioral Health Workforce Education and Teaching (BHWET) Program
Supervisor: Dr. Mark Rehfuss

- Monitoring the BHWET Program grant through weekly administrative tasks, assist program director and research coordinator including data collection and analysis
- Assist with data reporting to HRSA
- Publicizing and track tasks students need to complete
- Collaborate with the clinical coordinator for ensure personal development opportunities for students

Graduate Research Assistant **August 2019-May 2020**
Supervisor: Dr. Kristy Carlisle

- Working on *Relationship between Adverse Childhood Experiences and Professional Quality of Life for Helping Professionals* manuscript including data collection and analysis

Graduate Research Assistant **August 2018-May 2020**
Supervisor: Dr. Gülşah Kemer

- Graduate research team member for Process and Outcome Research Laboratory
- Conducting high impact research utilizing innovative technology and advanced research designs to define how process contribute to effective outcomes in counseling and clinical supervision.

- Collaborate on publication and presentations with faculty, doctoral level and master's level research assistants.

Publications

Kemer, G., Rocha, J., Reiter, A., Dominguez, V., & **Giresunlu, Y.** (2021). A structured peer feedback exchange intervention in group supervision of beginning doctoral supervisors. *Counselor Education and Supervision.*

Lemich, G., Lund, S., **Giresunlu, Y.** (revise and resubmit). Connecting the university athlete's decision-making process to self-determination theory. *Journal of College Counseling.*

Giresunlu, Y., Sunal, Z., & Kemer., G. (manuscript in progress). Counselor trainees' experiences in integrated behavioral health supervision (IBH): A q-methodology approach.

Carlisle, K., **Giresunlu, Y**., & Hughes, K. (data collection in progress). Values impositions among human services students.

Kemer, G., **Giresunlu, Y.** (data collection in progress). Development of evaluation instruments for master's level practicum and internship courses.

National Peer-Reviewed Presentations

Giresunlu, Y., & Richards, T., Rehfuss, M. (2021, April). Design, Implications and Outcomes of an Interprofessional Course for Graduate Counseling Students. Poster presentation presented at biennual Interprofessional Care for the 21st Century, Virtual

Giresunlu, Y., & Richards, T., Rehfuss, M. (2021, March). Mental Health Counselor's Place in Collaborative Care Practices: Improving Services Through Interprofessional Discussion. Educational presentation presented at Annual Emswiller Symposium, Virtual

Giresunlu, Y., & Rehfuss, M. (2020, February). Integrating Counselors into a Free Medical Training Clinic: Collaborating for Patients Health. Poster presentation presented at Annual Emswiller Symposium, Richmond, VA

Giresunlu, Y. & Sunal, Z. (2019, October) Counseling Supervision at Integrated Behavioral Health Settings. Association of Counselor Education and Supervision bi-annual Conference Seattle, Washington

Kemer, G., Rocha, J., Reiter, A., Dominguez, V., **Giresunlu, Y**. (2019, October) A Structured Peer Feedback Exchange Intervention in Group Supervision of Beginning Supervisors. Association of Counselor Education and Supervision bi-annual Conference Seattle, Washington

Burgess, M., Sunal, Z., Li, C., **Giresunlu, Y.,** Killen, R., Kalafsky, S., & Kemer, G. (2017, October). Beginning Counselors and Supervisors: First Supervision Experiences. Oral presentation presented at Association of Counselor Education and Supervision bi-annual Conference Chicago, Illinois

State Peer-Reviewed Presentations

Giresunlu, Y., Rocha, J., & Orrison, B. (2020, February). Special Population in Academia: International Faculty. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Norfolk, VA.

Rocha, J., Orrison, B., & **Giresunlu, Y.** (2020, February). Application of the Integrated Developmental Model in Supervision. Oral presentation presented at Virginia

Association of Counselor Education and Supervision Annual Conference, Norfolk, VA.

Sunal, Z., & **Giresunlu, Y.** (2020, February). Let's Talk About Faculty-Student Mentorship in Counselor Education and Supervision. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Norfolk, VA

Giresunlu, Y., & Brown, K. (2019, October) Practicing Wellness Through Authenticity, Self-Care and Communication. ARDX Women's Wellness Conference, Chesapeake, VA

Giresunlu, Y., & Sunal, Z. (2019, February). Integrated Behavioral Health for Counseling Profession. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Hampton, VA.

Giresunlu, Y., Reiter, A. & Orrison, B., (2019, February). Mentorship in Counselor Education. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Hampton, VA.

Sunal, Z., & **Giresunlu, Y.** (2019, February). International Counselor Trainee's Counseling Self-Efficacy. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Hampton, VA.

Sunal, Z., & **Giresunlu, Y.** (2019, February). Tripartite Model Review of the Five Core Areas of Counselor Educator Identity. Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Hampton, VA.

Sunal, Z., **Giresunlu, Y.** & Li, C. (2019, February). An Example of Research Training Environment Includes Gelso's 10 Ingredients- Process and Outcome Research Lab (PORL). Oral presentation presented at Virginia Association of Counselor Education and Supervision Annual Conference, Hampton, VA.

Grants, funded

Giresunlu, Y. (August, 2020) Counseling Supervisors' Best Practices in Integrated Behavioral Health (IBH) Supervision: A Q-Methodology Approach. Grant Proposal to Southern Association for Counselor Education and Supervision ($500)

Grants, submitted

Giresunlu, Y., (2020, October). Counseling Supervisors' Best Practices in Integrated Behavioral Health (IBH) Supervision: A Q-Methodology Approach. Grant Proposal Submitted to Virginia Counselor Association Foundation ($1,000)

Giresunlu, Y. (July, 2020) Counseling Supervisors' Best Practices in Integrated Behavioral Health (IBH) Supervision: A Q-Methodology Approach. Grant Proposal to Association for Counselor Education and Supervision ($900)

Giresunlu, Y. (May, 2020) Counseling Supervisors' Experiences in Integrated Behavioral Health (IBH) Supervision. Grant proposal submitted to Assessment and Research in Counseling Donald Hood Student Research Grant ($500)

Giresunlu, Y. (2020, January) Counseling Supervisors' Experiences in Integrated Behavioral Health (IBH) Supervision: A Q-Methodology Approach. Grant Proposal to Virginia Association of Counselor Education and Supervision Graduate Student Development Grant ($500)

Giresunlu, Y. (2019, October) Supervisee Experiences in Integrated Behavioral Health Supervision: A Q-Methodology Approach. Grant Proposal Submitted to Virginia Counselor Association Foundation ($1,000)

Giresunlu, Y. (2019, August) Supervisee Experiences in Integrated Behavioral Health Supervision: A Q-Methodology Approach. Grant Proposal Submitted to Southern Association for Counselor Education and Supervision ($500)

Giresunlu, Y. (2019, July) Providing Educational Resources to Counselor-in-trainees at Ambulatory Care Clinic. Grant Proposal Submitted to American Counseling Association Foundation ($500)

Giresunlu, Y., Sunal, Z., Kemer, G. (2019, February). Supervision in Integrated Behavioral Health. Grant Proposal Submitted to Virginia Counselor Association Foundation. ($1,000).

Burgess, M. A., Kemer, G., **Giresunlu, Y**., & Reiter, A. (2017, August). *School counseling supervisors' supervision cognitions.* Grant proposal submitted to the Southern Association for Counselor Education and Supervision. ($500).

TEACHING EXPERIENCE

Undergraduate Human Services Courses

Instructor

HMSV 341: Introduction to Human Services **Spring 2019**

Co-Instructor

HMSV 339: Interpersonal Relations **Fall 2018**

HMSV 339: Interpersonal Relations Session 1 **Summer 2019**

HMSV 339: Interpersonal Relations Session 2 **Summer 2019**

Master's level Mental Health Counseling Courses

Co-Instructor

COUN 667: Internship in Mental Health Counseling **Spring 2021**

COUN 695: Integrated Care with Children and Youth **Spring 2021**

COUN 633: Counseling and Psychotherapy Techniques **Fall 2020**

COUN 695: Integrated Care with Children and Youth **Spring 2020**

COUN 670: Introduction to Counseling Supervision **Fall 2019**

CLINICAL SUPERVISION EXPERIENCE

University Supervisor **January 2020- present**

- Providing individual supervision to COUN 669 practicum master's level counseling students

Site Supervisor **August 2018 - present**

Sentara Ambulatory Care Center, Mental Health Clinic, Norfolk, VA

- Providing site supervision to master's level practicum and internship students in an integrated behavioral health setting

University Supervisor **January 2020 – August 2020**

COUN 868 Doctoral Internship Course

- Provided individual supervision to COUN 669 practicum master's level counseling students

Doctoral Level Supervisor **January 2019 - May 2019**

COUN 848 Advanced Supervision Course

- Provided individual, triadic and group supervision to COUN 634 Advanced Techniques students

SERVICE and ADVOCACY EXPERIENCE

Clinical Director **August 2018 - present**

ODU Mental Health Clinic at Sentara Ambulatory Care Center, Norfolk, VA

- Serve as the director of the mental health clinic in a community outpatient clinic
- Onboarding master's and doctoral level counselor trainees including interviewing, coordinating and leading the recruitment fairs
- Schedule and facilitate orientation in the beginning of each semester and provide further training on the topics relevant to the clinic
- Establish multidisciplinary collaboration and evaluate the effectiveness of the clinic each semester to enhance master's level counselor-trainees' experiences
- Create, modify, and enforce policies and procedures
- Provide 1-hour weekly site supervision to supervisees
- Participate in 1-hour weekly supervision of supervision meeting

Interprofessional Clinic Advisor **August 2019 - present**

Old Dominion University & Eastern Virginia Medical School

- Serve as an advisor representing mental health services in an interprofessional clinic focusing on clients' social determinants of health
- Collaborate with the faculty from various professionals (e.g., nursing, physical therapy) to enhance student-trainees' experiences working with various health care professionals in a client-centered environment
- Advocate for the counseling profession and clients' needs during bi-weekly advisor meetings
- Mentor master's level counselor-trainees on advocating for the profession and client's needs

Interprofessional Education Advisor **January 2020**

Old Dominion University

- Served as the mental health counseling advisor along with nursing, dental hygiene, physical therapy faculty
- Offered suggestions and guidance for the face-to-face and telehealth interprofessional visits to the students from various healthcare professions
- Provided feedback on interprofessional telehealth and in-person visit with standardized patient

Proposal Reviewer **January 2020**
Virginia Association for Counselor Education and Supervision Graduate Student Conference
- Served as a conference proposal reviewer for the conference

Peer Mentor **August 2019 - present**
Chi Sigma Iota – Omega Delta Chapter
- Serve as a mentor for a first-year doctoral student to help with adjustment to the program, support and professional needs

Guest Lecturer **October 2019**
COUN 655: Social & Cultural Diversity
- Sharing experiences of being a foreign-born counselor-trainee to enhance multicultural considerations for master's level counseling students

Guest Lecturer **April 2019**
Chi Sigma Iota- Omega Delta National Counselor Examination Review
- Reviewed research section of the exit exam for master's students

Community Engagement Chair **May 2018 – August 2019**
Chi Sigma Iota- Omega Delta Chapter (CSI)
- Plan and advertise community engagement events for the department
- Assist compiling and editing the CSI newsletter

Master's Student Team Member **September 2017- October 2017**
American Counseling Association Graduate Students Ethics Competition
- Participating in the annual team-based competition on analyzing a potential ethical scenario and creating an appropriate ethical decision mailing plan to respond to the dilemma

CLINICAL COUNSELING EXPERIENCE

Resident in Counseling in the Commonwealth of Virginia **February 2019- present**

Behavioral Health Clinician **October 2019 - present**
Chesapeake Regional Primary Care Clinic
- Providing outpatient individual counseling including biopsychosocial framework for care
- Consistent communication with the primary care providers for team-based care for clients
- Responsible for conducting intake, assessment, treatment planning, documentation, and referrals

Doctoral Practicum Intern **September 2019-December 2019**
Health Outreach Partnership of *Eastern Virginia Medical School* Students (H.O.P.E.S) Clinic
- Providing outpatient services to the underinsured/uninsured population
- Responsible for case conceptualization, treatment planning, and documentation

- Integrated care in a primary care setting

Master's Level Counseling Intern **August 2017 to May 2018**
ODU Mental Health Clinic at Sentara Ambulatory Care Center- Norfolk, VA

- Providing outpatient integrated behavioral health services to the underinsured/uninsured population.
- Responsible for case conceptualization, treatment planning, and documentation.
- Providing services for various clinical diagnoses in the individual and couples counseling settings

Practicum Student **January 2016- August 2016**
True Life Destinations, LLC- Hampton, VA

- Provided outpatient counseling services to adults with various mental health diagnosis
- Facilitated in a mental health skill building program
- Developed a 12-week Psychosocial Rehabilitation program for the agency

Counselor Trainee **September 2015 – April 2016**
Riverside Free Clinic- Riverside, CA

- Worked in an integrated care setting with second year master's students in providing crisis and counseling support to the Inland Empire's uninsured/underinsured population
- Assisted with integrating mental health services in student-run clinic's multidisciplinary system
- Provided clients with resources in the community, making appropriate referrals when necessary

HONORS, AWARDS AND NOMINATIONS

Awards

International Student Advisory Board Scholarship ($275)	**2021**
Chi Sigma Iota- Delta Omega Outstanding Doctoral Student Award	**2020**
Chi Sigma Iota- Delta Omega Outstanding Research Award	**2019**
Chi Sigma Iota- Omega Delta Chapter Outstanding Service to Chapter Award	**2018**
Chi Sigma Iota- Delta Omega Outstanding Master's Level Student Award	**2018**
Department of CHS's Doctoral Student Professional Development Award ($450)	**2019**
Darden College of Education Dean's Office Travel Fund ($300)	**2017 & 2019**

Nominations

Public Health Excellence in Interprofessional Education Collaboration Award	**2021**
Chi Sigma Iota- Delta Omega Outstanding Doctoral Student Award	**2020**
Chi Sigma Iota- Delta Omega Outstanding Research Award	**2019**
Chi Sigma Iota- Delta Omega Outstanding Service to Chapter Award	**2018**
Chi Sigma Iota- Delta Omega Outstanding Master's Level Student Award	**2018**
Chi Sigma Iota- Delta Omega Outstanding Master's Level Student Award	**2017**

PROFESSIONAL AFFILIATIONS

American Counseling Association	**2016 - present**
Association for Counselor Education and Supervision	**2017 - present**
Chi Sigma Iota- Omega Delta	**2017 - present**
Society of Student-Run Free Clinics	**2019 - present**