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Attitudes of Counselors Toward Collaboration with Healthcare Professionals

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Abstract

Counselors are experts in handling mental health issues, however many mental health issues are reported to primary care providers. Collaboration between counselors and healthcare providers is increasing yet little is known about counselors' attitudes toward this challenging practice. In this study 165 counselors completed surveys related to their attitudes and social anxiety levels toward interacting with healthcare professionals. Counselors in this study reported having slightly negative attitudes toward healthcare professionals. There was no significant relationship between attitudes and social anxiety. Social anxiety was inversely related to frequency of collaboration, however, only a few counselors reported social anxiety. More importantly, most counselors in this study reported collaborating to benefit clients which is promising considering the growing mental health needs. Implications for Counselor Educators and Supervisors for promoting collaboration as a standard of care are provided.

Keywords

Interprofessional collaboration, counselors, attitudes, social anxiety, healthcare

There is an increasing number of individuals with coexisting psychological and physical symptoms resulting from depression, substance use, and other conditions (Goodell et al., 2011). According to the National Institute of Mental Health (2022), an estimated 52.9 million adults experienced a mental illness in 2020. This number does not account for minors, individuals who do not report symptoms, and relational factors that may impact wellbeing. Individuals suffering with mental health concerns tend to seek medical help first, yet physicians are typically untrained to fully address mental health related issues beyond psychopharmacological interventions (Westheimer et al., 2008). Health rankings, which also include mental health related issues, are particularly low for southern states (United Health Foundation, 2022), which was the region included in this study. Complex conditions, also known as comorbidity or cooccurring disorders, was a primary reason for engaging in interprofessional collaboration and continues to be so (Johnson, 2019; Seaburn et al., 1996).

In general, interprofessional collaboration occurs when practitioners from different disciplines combine their expertise to provide patient or client care (Johnson et al., 2021; Vazirani et al., 2005). Although the idea of interprofessional collaboration is not new, growing mental health needs combined with significant policies created by the Patient Protection and Affordable Care Act (2010) have encouraged more interprofessional collaboration. In addition, the Substance Abuse and Mental Health Services (SAMHSA, 2014), has endorsed interprofessional collaboration over the last decade.

Despite counselors' expertise, they have been less visible than other professionals in collaboration efforts (Johnson et al., 2021; Sperry, 2013). With counselors' ability to bill Medicare and Medicaid, hopefully they will be more visible for interprofessional teams. Researchers have made it clear that more research is needed; particularly from local agencies that inform if and how

counselors currently collaborate with healthcare professionals (Johnson, 2016). Considering how little is known, this exploratory study focused on counselors' attitudes, emotions, and related factors regarding interprofessional collaboration. We asked counselors and related mental health professions to participate in this study because there are a limited number of professional counselors currently engaged in interprofessional collaboration.

Interprofessional Collaboration

For this article, we defined interprofessional collaboration as interactions between mental health professionals and healthcare professionals such as physicians, physician assistants, and nurse practitioners. We acknowledge that other medical professionals are relevant to the overall health of clients, however, we wanted to be clear in our definition considering the broad range of terms that have been used over the years including, but not limited to, interdisciplinary collaboration (Abraham & Mizrahi, 1996), multidisciplinary collaboration (McDaniel et al., 1992), integrated primary care (Beehlar & Wray, 2012), and integrated healthcare (Westheimer et al., 2008).

Although several models of collaboration exist, one particularly well-known model (Doherty et al., 1996) consists of six levels of collaboration. The first level, minimal collaboration, is where professionals work in separate locations, consult as needed, and maintain full autonomy. The second level, basic collaboration, consists of periodic communication, full autonomy, and passive knowledge of other professionals' expertise. The third level, co-located care, is where providers share a space, have limited knowledge of other professionals' expertise, yet share responsibility for overall client care. The fourth level, close collaboration, and the fifth level, also close collaboration, are both integrated care. The difference between the fourth and fifth level, is that at the fifth level professionals, clients, and family members share space, resources (i.e.,

documentation systems), and knowledge. The sixth and rarest level, full collaboration, consists of a new professional culture based on client-centered collaboration. All resources are shared, workflows are designed with collaboration in mind, and professionals are knowledgeable about the expertise that everyone holds. Although the benefits of the latter levels may seem obvious, so are the challenges. Regardless of the level of collaboration, effectiveness requires uninhibited and frequent communication (Foy et al., 2010; Rossen et al., 2008). Understanding the levels of collaboration can help counselors understand what is required for optimal collaboration with health care professionals.

Benefits of Collaboration

The benefits of collaboration for clients are well documented. With increases in collaboration, researchers have been able to document long held beliefs that counseling and medications combined are more effective than medications alone, especially for complex, comorbid, and serious mental illnesses (Lenz et al., 2018; Schmit et al., 2018). These findings, though not surprising, have been vital in further promoting the practice of interprofessional collaboration. Treating mental health conditions in tandem with physical conditions is linked to several benefits including improved treatment outcomes (Lenz et al., 2018; Schmit et al., 2018), increased access to mental health services (Kaur et al., 2022), reduced costs associated with overall treatment (McDaniel et al., 1992; Sperry, 2013), increased follow-through for clients attending and completing counseling (Bitar et al., 2009), lessening of ethnic disparities (Kohn-Wood & Hooper; 2014; Vogel et al., 2014), and quicker access to appointments (Haggarty et al., 2012). Unfortunately, clients can wait an average of one to 15 years prior to seeking help for mental health concerns (Goldberg et al. 2019) making access to care important. Furthermore, healthcare professionals reported more confidence in managing mental health concerns when they had access

to mental health professionals in their decision making (Staab, et al., 2022). Leveraging these benefits hinge upon professionals initiating collaborative practices.

Initiating Collaboration

Surprisingly, researchers found that both healthcare professionals and mental health professionals may be hesitant to initiate collaboration even when beneficial for clients due to lack of training, as well as their attitudes and emotions (Glueck 2015; Ruch & Murray, 2011). Counselors also have this hesitancy (Johnson & Freeman, 2014; Johnson et al., 2021; Sperry, 2013). Like any modality of care, professionals need valid reasons and some degree of comfort to engage in collaboration (Reiss et al., 2017). Not surprisingly, counselors reported having low confidence in developing an interprofessional identity (Klein & Beeson, 2022). Referral to mental health professionals is more streamlined when professionals implement higher levels of collaboration. For physicians, reasons to initiate collaboration included treating patients with depression, eating disorders (Bischoff et al., 2012), and specialized behavioral health concerns for kids (Schuster et al., 2011). Research indicated that counselors and other mental health professionals typically make the most accommodations when interacting with healthcare professionals (Beehlar & Wray, 2012; Biderman et al., 2005; Bischoff et al., 2012), which may be a barrier to initiating collaboration. As healthcare delivery becomes more collaborative, it is essential for counselors to be aware of their own attitudes toward embracing interprofessional collaboration.

Attitudes

Across professions, researchers widely agree that attitudes toward interprofessional collaboration and communication are important (Johnson & Mahan, 2019; Miers & Pollard, 2009). It is not surprising that for decades researchers considered attitudes as a cornerstone associated

with interprofessional collaboration, considering that an openness to new experiences is necessary in establishing effective practices, mindsets, or some combination thereof (Beehlar & Wray, 2012; Bischoff et al., 2012; Bruner et al., 2011; Chong et al., 2013; Gleuck, 2015; Patterson et al., 2021; Schadewaldt et al., 2013). For example, counselors would have to overcome significant barriers, such as having fewer than 50 minutes with clients, adjusting to the quick-paced workflow of medical settings, learning medical terminology, possibly receiving lower compensation for mental health services compared to other health care services, working with professionals who adhere to different codes of ethics, inadequate supervision, and dealing with restrictions of insurance companies (Fivecoat et al., 2017, Johnson et al., 2021; Kaur et al., 2022; Klein & Beeson, 2022; Zubatsky et al., 2020). Despite the noted challenges, most mental health professionals consistently reported neutral to positive perceptions toward collaboration with healthcare professionals (Bruner et al., 2011; Glueck, 2015, Johnson, 2016; Johnson et al., 2021; Korazim-Kőrösy et al., 2014). Unfortunately, determining attitudes of counselors is difficult because in most studies attitudes of counselors were examined along with attitudes of other mental health professionals, counselors were underrepresented, or counselors were excluded all together. Three studies add to the literature related to counselors. The first study (Johnson, 2016) found the attitudes of counselors to be similar to other mental health professionals in that counselors reported favorable attitudes toward interprofessional collaboration. The second study (Johnson & Mahan, 2019) interviewed counselors and other mental health professionals regarding attitudes toward interprofessional collaboration. A key finding was that participants reported interprofessional collaboration as beneficial to both clients and clinicians. The third study (Klein & Beeson, 2022) surveyed primarily counselors regarding their attitudes toward interprofessionalism. Participants in this study reported neutral to positive attitudes.

Credentialing, Race, Work Setting, and Experience

Interprofessional collaboration is a complex process potentially influenced by other factors in addition to attitudes such as professional credentials, race, workplace setting, and years of experience. The literature was not substantial, yet enough to be discussed considering the pivot that counselors would need to make to engage in collaboration, especially at higher levels. Bruner et al. (2011) reported differences in interprofessional collaboration activities based on both race and credentials. Hispanic providers reported the greatest level of collaboration, whereas African American providers reported the least level of collaboration. In the same study, participants credentialed as behavioral health practitioners held the least favorable attitudes toward interprofessional collaboration compared to other professional groups. Bruner et al. did not clarify the specific credentials of behavioral health practitioners. Other studies did not report racial differences, however, did suggest that future studies should consider diversity when recruiting as most participants identified as White (Johnson, et al., 2021; Klein & Beeson, 2022). Regarding credentials, counselors, compared to other professional groups reported less interprofessional engagement per week (Johnson, 2016).

Concerning work settings, researchers found counselors in educational, community, and private practice settings as avoidant or less available for collaboration (Carney & Jefferson, 2014), however more research is needed to substantiate those findings. Counselors reported some aspects of training in medical settings as *harsh and abrupt* (Cox et al., 2014), making it understandable why experts expect counselors from certain settings to be slow to transition to collaborative settings. Interprofessional training can help professionals to positively acclimate to interpersonal collaboration, however, to date, only a few counseling programs offer such training (Cox et al.,

2014; Johnson & Freeman, 2014) leaving counselors to learn about interprofessionalism on the job.

In general, research does not clearly define experience, yet experience seemed like a good variable to examine in this study considering that a part of professional expertise has do with one's years in a profession or specialized training. Zubatsky and colleagues (2020) found that participants with 10 years of experience related to interprofessional work, particularly those in higher levels of collaboration, reported higher levels of personal satisfaction related to their work. In additions, they believe professionals with unfavorable attitudes might care less about client care. Thus, it is important to fully explore attitudes and other perspectives that might influence professional groups in effectively collaborating.

Social Interaction Anxiety

Mental health professionals may experience a variety of feelings associated with interprofessional collaboration, with anxiety being one of them (Fox et al., 2012). Social anxiety can occur in specific situations in which individuals are exposed to real or perceived situations that are novel, judgmental in nature, or harmful (Mattick & Clark, 1998). Although most perceptions of mental health were favorable or neutral, a few mental health professionals held perceptions of healthcare professionals that were unfavorable due to perceived power differences known as one-down relationships (Chesluk & Holmboe, 2010). These power dynamics cannot be attributed to all healthcare professionals, however, if present, it is understandable how collaboration would be anxiety provoking (Mortensen, 2014; Naber et al., 2015; Nelson, 2016; Peek, 2015; Ruch & Murray, 2011). Ruch and Murray interviewed mental health professionals and found that those who experienced anxiousness tended to withhold information from other parties, even when that information could benefit clients. In a study by Cox et al. (2014), counselors also reported feeling

anxious about collaboration even if only initially. Furthermore, doctoral-level pharmacy students who reported higher levels of anxiety when collaborating with medical professionals also reported less favorable attitudes and less collaboration (LaRochelle & Karpinski, 2016). In the same study, African American students who reported less anxiety related to interprofessional collaboration held better attitudes than their counterparts. These findings support assumptions that emotions can impact attitudes and behavior related to collaborative practices (Laidlaw, 2009; Naber et al., 2015), however more research is needed regarding how counselors might experience social anxiety relate to communicating with other professional groups.

Rationale

This quantitative study explored the attitudes and social anxiety of counselors toward collaborating with healthcare professionals by gathering and analyzing their ratings using a scale for working with healthcare professionals. We defined interprofessional collaboration as counselors who interact with healthcare professionals and included the following research questions in this study:

RQ1: Are attitudes toward collaboration among counselors associated with their level of social interaction anxiety; and

RQ2: Do any of the following traits of counselors, individually or in combination with each other, predict attitudes toward collaboration between counselors with healthcare professionals: social anxiety; race; work setting; credentials; and years of experience?

In this study, we assessed the attitudes of counselors, then we hypothesized that:

H1: As social anxiety increased among counselors, attitudes toward collaboration with healthcare professionals would decrease; and

H2: One of more of the following factors, individually or in combination with each other, would predict attitudes toward collaboration between counselors and healthcare professionals: social anxiety level; race; work setting; type of credentials held; and years of experience.

Method

Participants

We recruited participants following approval from the Human Subjects Protection Review Committee and adhered to the *Code of Ethics* (American Counseling Association, 2014) while conducting the study. Participants were 165 members of counseling associations from US southern states. Of participants, 138 (83.6%) were women. The mean age was 42.62 (*SD* = 13.79). Also, 122 (73.9%) were Caucasian American, with 37 (22.4%) being African American, 4 (2.4%) were Hispanic, one (.6%) identified as Asian, and one identified as other ethnicities.

Participants had an average of 12.03 years of experience (*SD* = 9.82). Most participants had obtained a master's degree, (*n* = 128, 77.6%), or doctoral degree, (*n* = 22, 13.3%). Participants graduated from programs in clinical mental health (*n* = 59, 35.8%), school counseling (*n* = 41, 24.8%), marriage and family (*n* = 20, 12.1%), psychology (*n* = 16, 9.7%), counselor education (*n* = 7, 4.2%), and some (*n* = 22, 13.3%) from other programs or were students. Most participants held credentials as Licensed Professional Counselors (LPCs), (*n* = 138, 81.8%) or equivalent titles in their states. Some were dually credentialed as Licensed Marriage and Family Therapists (LMFTs) (*n* = 21, 12.7%), certified school counselors (*n* = 20, 12, %), and Nationally Certified Counselors (NCCs), (*n* = 11, 6.7%).

The frequency of collaboration reported by mental health professionals varied among occasionally (*n* = 81, 49.1%), very often (*n* = 49, 29.7%), and always collaborated with healthcare professionals (*n* = 12, 7.3%). Participants could select multiple responses and therefore

percentages do not total 100%. Collaboration was prompted by severe mental illness (*n* = 135, 81.8%), serious medical condition (*n* = 117, 70.9%), determination by the counselor that the client could benefit from medical examination or treatment (*n* = 121, 73.3%), initiation by a healthcare professional (*n* = 110, 66.7%), guardian belief that the client could benefit (*n* = 92, 55.8%), compliance with policy or procedure of an agency (*n* = 85, 51.5%), or other reasons (*n* = 16, 9.7%). One respondent would not collaborate.

Work settings of counselors varied among primary school (*n* = 49, 29.7%), mental health agency (*n* = 29, 17.6%), private practice (*n* = 26, 15.8%), university or college (*n* = 23, 13.9%), inpatient hospital or treatment center (*n* = 10, 6.1%), corrections (*n* = 5, 3.0%), substance abuse or rehabilitation (*n* = 3, 1.8%), and primary care office (*n* = 2, 1.2%), with counselors working in other settings, retired, students, or unemployed making up the remainder of the respondents (*n* = 18, 10.9%).

Participants were asked about years of experience as a mental health professional (*M* = 12.03, *SD* = 9.82).

Participants reported having a mean of 7.41 (*SD* = 15.14) friends, and a mean of 1.16 (*SD* = 1.19) close family members who are healthcare professionals. Over 75% (124) of participants socialized with friends and close family members who were healthcare professionals.

Instruments

The Interprofessional Interaction Scale (Pollard et al., 2004) is a 9-item scale that initially measured attitudes toward collaboration between health and social care students. With permission from the author, we replaced the term *social care* with *mental health.* Possible responses were scaled from 1 (*strongly agree*) to 5 (*strongly disagree*), with items such as, “Different health and mental health professionals have stereotyped views of each other.” In the original scale, cumulative

scores ranged from 9-45; indicating 9-22 (*positive attitude*), 23-31 (*neutral attitude*), and 32-45 (*negative attitude*) after reverse scoring for items 1, 3, 4, 7, 8, and 9. Among college students surveyed twice over about a 2-week period, the items were internally consistent (Cronbach alpha = 0.82). Internal consistency for this study was .83.

The Interprofessional Collaboration Scale (Kenaszchuk et al., 2010) is a 13-item 4-point Likert scale that ranges from 1 (*strongly disagree*) to 4 (*strongly agree*), with items such as, "<We> have a good understanding with <them> about our respective responsibilities." Three subscales included communication, accommodation, and isolation. When allied health professionals rated physicians, all three scales were internally consistent (alphas = .73, .79, and .79). The scales were also consistent when allied professionals rated nurses (alphas = .82, .88, .72). The instrument was designed to substitute the nouns in the brackets with the professional groups to be included such as physicians, nurses, or allied health staff. In this study <we> and <us> were substituted using mental health professionals, and <them> and <they> was substituted with healthcare professionals. In this sample, the scale overall was internally consistent (alpha = .80). We recoded the 4-point interprofessional collaboration scale into a 5-point scale to accommodate for the interval differences between the Interprofessional Interaction Scale and Interprofessional Collaborations Scale.

The Social Interaction Anxiety Scale-Short Form (SIAS-SF; Fergus et al., 2012; Fergus et al., 2014) is a 6-item scale from 0 (*not at all*) to 4 (*extremely*), in which higher scores indicate higher levels of social interaction anxiety. When completed by college students, answers were internally consistent (alpha = .80; Fergus et al., 2014). The Cronbach alpha for this study was .87.

Procedure

Out of five counseling associations contacted in southern states, three agreed to participate in this study. One association later decided not to participate, leaving two associations. The Louisiana Counseling Association and the Mississippi Counseling Association emailed their members inviting them to participate in the research study using a hyperlink to the survey. These associations sent a follow-up email approximately 2 weeks later, and a second follow-up email approximately 6 weeks later. A total of 205 participants responded. However, 40 were excluded because of insufficient or missing data (for example, answered demographic information only), leaving a final sample of 164 or 165 for some calculations. One participant had missing, yet sufficient data.

Results

We created a composite score by combining the Interprofessional Collaboration Scale (Kenaszchuk et al., 2010), and the Interprofessional Interaction Scale (Pollard et al., 2004). The mean for this composite score was 2.29 (N = 165, SD = .35), which indicated slightly unfavorable attitudes toward collaborating with healthcare professionals. The Pearson correlation of the combined measures for this study was statistically significant, r (164) = .62, p = .000, which is moderate to strong.

The Interprofessional Interaction Scale alone had a mean of 33.49 (N = 165, SD = 4.85), indicating negative attitudes toward interprofessional collaboration. The mean for the Interprofessional Collaboration Scale-Recoded was 43.1538 (N = 164, SD = 7.15), indicating neutral to mildly disagreeable interprofessional collaboration practices.

The mean for the SIAS-SF was 4.18 (SD = 4.12). The mode was 0 (n = 32, 19.4%). Among participants, 149 (90.3%) fell below the cutoff score, and only 16 (9.7%) met or exceeded the cutoff score of 10. There was no significant relationship between attitudes toward collaborating

with healthcare professionals and social interaction anxiety using Pearson's correlation, r (165) = -.049, p = .536.

A correlation test, Pearson's product-moment was used to determine if a relationship existed between years of experience and attitudes toward collaboration. No significance was found, r (151) = -.03, p = .723. When grouped by race, 122 (73.9%) participants indicated Caucasian and 43 (26.1 %) indicated either African American, Hispanic, Asian, or Other. The one-way ANOVA, F(1, 162) = 1.78, p =.18, demonstrated no differences. When grouped by credentials, either LPC or non-LPC. A total of 135 (81.8%) of participants were LPC and 30 (18.2%) were not LPC's. The one-way ANOVA, F(1, 162) = .87, p =.35, demonstrated no differences. For work setting, participants were grouped as School n = 72, (43.6%), Clinical Mental Health n = 68, (41.2%), or Other n = 25 (15.2%). The one-way ANOVA, F(2, 162) = 2.43, p =.09, demonstrated no differences Analysis of variance tests for race, credential, and work setting indicated that these demographic variables were not related to their attitudes toward collaboration, or that different groups were not different in their attitudes toward collaboration.

Participants reported that they occasionally collaborated, with an average of 2.30 on a scale where 1 = *never* and 4 = *always*. Frequency of collaboration between counselors and healthcare professionals was not associated with attitudes, Pearson's product-moment correlation was, r (164) = .088, p = .264. However, frequency of collaboration between counselors and healthcare professionals was related to levels of social interaction anxiety, r (164) = -.174, p = .026. Participants collaborated more frequently when they had lower levels of social interaction anxiety.

Discussion

Surprisingly, hypotheses of this study were not supported, thus no correlations existed among the defined variables: attitudes, social anxiety, years of experience, race, credentials, and

work setting. Overall, these counselors possessed slightly negative attitudes toward interprofessional collaboration. The mildly negative attitudes of counselors in this study were inconsistent with the attitudes of other mental health professionals. In previous studies of attitudes toward collaboration, counselors and other mental health professionals held positive to neutral attitudes toward interprofessional collaboration (Bruner et al., 2011; Glueck, 2015; Johnson, 2016; Klein & Beeson, 2022). Only one study had participants who reported slightly negative attitudes in a small sample of social work students (Pollard et al., 2004). The researchers, although not favorable of the possible explanation, questioned if their findings were due to one state having previous policies that required collaboration and other factors discussed later. Furthermore, the attitudes of counselors toward collaborating with healthcare professionals and social anxiety were not related.

The lack of relationship between attitudes and other variables were also inconsistent with previous literature. Race, credentials, work setting, and social interaction anxiety level made no difference on the attitudes of counselors toward collaborating with healthcare professionals. As expected, the frequency of collaboration decreased as levels of social anxiety increased, which supports the theory that social anxiety perpetuates avoidance behavior (Mattick & Clark, 1998). Although the social interaction anxiety theory was supported, only a few counselors in this study reported high levels of social anxiety 16 (9.7%).

Several possibilities exist for these findings, such as the homogeneity of this group, level of collaboration among the participants, the ambiguity of studying attitudes, or location. First, the training homogeneity of this group may have contributed to the lack of differences as suggested by previous research (Bruner et al., 2011; Carney & Jefferson, 2014; LaRochelle & Karpinski, 2016) as most of the participants in this study were counselors or were dually credentialed as a

counselor and marriage and family therapist. Second, attitudes are (a) not synonymous with behavior, (b) defined differently by various researchers, and (c) rely on self-reported measures, which can be distorted, skewed, and misrepresented (Chaiklin, 2011). It can be difficult to isolate and define interprofessional collaboration consistently, especially considering the differing levels, models and reasons for interprofessional collaboration. In an attempt to isolate the variable, in this study we utilized two scales to assess for collaborative attitudes in which one measured thoughts and the other measured actual behavior. The two scales were moderately correlated, suggesting that they were adequate for measuring attitudes toward interprofessional collaboration in the participants of this study. In addition, in this study we recruited professional counselors from Southern United States. Klein and Beeson (2022) counselors reported neutral to positive attitudes, and they noted unusual representation from three states, with two being in the South. However, states named in their study were different than states used for recruitment in this study; therefore, not eliminating the possibility of geographical differences. Emerging science, known as geographical psychology or psychological clustering might provide some insight to findings in this study. According to Rentfrow (2020) psychological clustering explains that geographical areas can be uniquely characterized in terms of attitudes, personalities, and other phenomena. Furthermore, arguments have been put forth that full consideration of immediate environmental influences has been ignored for too long in the health of populations (McLaughlin, 2017). This line of thinking also makes sense considering the growing research linking geography to social determinants (i.e., housing, food security, etc.) and health impacts (Dai et al., 2017). In addition, most search features for peer reviewed articles have the option to identify articles by geography. The role of geography cannot be ruled out.

In contrast to Bruner et al. (2011) and LaRochelle and Karpinski (2016), who found some race differences in attitudes toward collaboration, we found no such differences. Bruner attributed differences to professional status, noting that some participants may have been impacted by the hierarchy found in medical settings. LaRochelle and Karpinski attributed racial differences to having a greater number of one race in the population in general that might lead to a sense of working together than races that were less representation. Our findings suggest that race was not a factor in attitudes nor social interaction anxiety.

Furthermore, according to their credentials, nurses, behavioral health practitioners, pharmacy level doctoral students, and dentists were specific professionals who held less favorable attitudes toward collaboration than other professionals (Bruner et al., 2011). The credentials of the participants for this study were LPCs or Non-LPCs, which was a more homogenous group. It was not possible to compare these two groups because there was a small number of Non-LPCs.

For the present study, years of experience was not significantly related to attitudes of counselors toward collaboration. Note, specific training in interprofessional collaboration may differ from years of experience practicing counseling, and we recommend asking about specific training in collaboration in future studies.

Our findings that anxiety was related to less favorable attitudes toward collaboration is similar to that of LaRochelle and Karpinski's (2016) pharmacy students. Efforts to reduce anxiety about collaboration may promote collaboration.

Social anxiety was studied in medical students (Laidlaw, 2009), resulting in some similarities and differences from the findings in this study. Our small subsample (about 10%) that indicated high social anxiety was similar to Laidlaw (2009), where only 8% of medical students

scored high in social interaction anxiety. Both studies suggest that only a few professionals within these groups possess high anxiety about social interactions.

When looking at social anxiety only, the findings of this study were consistent with Mattick and Clark's theory (1998) for a very few and inconsistent with Ruch and Murray (2011) who suggested that higher levels of social anxiety was associated with less collaboration. For most counselors in this study, social interaction anxiety was unrelated to collaboration. This finding suggests that social interaction anxiety is not likely a barrier for counselors collaborating with healthcare professionals.

Overall, the findings related to the attitudes of counselors were surprising based on previous research regarding the importance of attitudes for interprofessional collaboration. Another explanation of these finding may be the level of collaboration. The previous research represented a balance between mental health professionals who worked in all levels of collaborative care, including in the same settings as healthcare professionals. In this study, only two counselors indicated primary care as a work setting, which was not enough to detect differences. Johnson (2016) reported that only a small percentage of counselors work at the highest level of collaboration and less than half or their weekly duties was directly related to collaborating. In addition, researchers used different scales to measure attitudes making it harder to make comparisons.

Interprofessional collaboration across all levels and professionals will continue to be implemented in healthcare. Despite the lack of significant results, we were pleased to know that counselors in this study, regardless of their slightly negative beliefs, either collaborated or would collaborate when reasonable for improving client care. Findings in this study can help inform counselors about situations that are considered reasonable for initiating collaboration with

healthcare professionals. We found that few counselors are working in higher levels of collaboration, which implies that they may need training or opportunities for continued learning. Most counselors reported collaborating occasionally. We cannot say for sure why participants in this study responded differently than participants in previous research yet would like to share one additional perspective. According to Mellin et al. (2011) counselors in professional organizations are typically different, which include an openness to holistic perspectives. Perhaps the willingness for counselors to collaborate has to do with the interpersonal training counselors receive, but we cannot conclude this with certainty. Klein and Beeson (2022) provided recommendations for future research to focus on differences among counselor and specifically invited professional associations to assist in research. It could be helpful to determine difference among counselors who belong to associations versus those who do not as well as differences among specialty groups since membership to professional associations is encouraged. This study relied on professional associations for recruitment, yet also want to emphasize the inclusion of counselors regardless of their membership with professional counseling associations.

Implications for Counselor Educators and Supervisors

Interprofessional collaborations at various levels is growing in popularity in counseling, even by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2020). The results of this study provide implications for furthering that practice, particularly among counselor educators and supervisors who have a vital role in training emerging counselors. Counselor educators and supervisors are in ideal positions for helping trainees navigate interprofessional collaboration by sharing reasons to collaborate, helping trainees assess their attitudes and manage any anxiety, and helping them understand that they have valuable contributions. Although, social anxiety was only reported by a few counselors in this study, it

might be helpful to know that researchers suggest regulation and self-compassion for helping manage social anxiety (Gorinelli et al., 2022). A full discussion of regulating anxiety is beyond the scope of this article, however, interprofessional interactions can consist of perceived negative feedback, personality differences, and differences from healthcare professional which might prevent those with higher levels of social anxiety from effectively collaborating and participating in course work (Archbell & Coplan, 2022). Typically, counselors have opportunities to work through anxieties during training programs. It makes sense that some social anxiety might be experienced considering the lack of exposure to interprofessional collaboration. Researchers debate whether the use of digital means mitigates anxiety, however the research in inconclusive (Doorley et al., 2020). Because of this debate, researchers should continue to determine the relevance of technology and teleservices related in interprofessional collaboration as suggested by Johnson (2019).

In fact, researchers recommend additional training for those supervisors and educators because interprofessional collaboration work is much different than traditional mental health (Johnson, 2021). Mattison et al. (2017) further encouraged programs to recruit faculty with experience in interprofessional collaboration. The immersion component is considered more valuable than coursework alone (Greidanus et al., 2020). Furthermore, counselor educators and supervisors have key roles in helping trainees develop specialty skills, such as screening for elder sexual abuse (Shamaskin-Garroway et al., 2017). This study provides clarity on when collaboration is considered reasonable, which can aid educators, supervisors, and counselors in ethical and clinical decision making for initiating collaboration with other professional groups regardless of setting. Also, interprofessional collaboration is a standard of care that can be taught and modeled regardless of the complexity of client concerns or the varying levels of care. Training

that promotes collaboration could include multidisciplinary mock experiences (Quealy-Berge & Caldwell, 2004) and courses that introduce students to medical culture, as serious medical conditions was highly recognized as a reason to collaborate for participants in this study. Helping trainees screen and recognize for complex and co-morbid conditions is paramount. Counselor educators and supervisors can also help develop curriculums for learning collaboration during practicum and internship courses, where educators and supervisors can closely monitor students' attitudes and practices (Klein & Beeson, 2022). More specifically, creating formal partnerships for training counselor in medical settings is another option (Johnson, 2019). Not surprisingly, medical programs recognize the potential benefits of cross training (Ghassemi, 2017; Margolies et al., 2018). We recommend both.

Limitations

Several limitations of this study may affect the generalizability of the findings. First, the counselors in this study may not be representative of all counselors. We recruited counselors from professional organizations in the south using email. There was no way to assess the number of recipients who had access to the survey. In addition, one professional organization was in a state that had previous laws (later repealed) mandating counselors to consult or collaborate with a healthcare professional when assessing, diagnosing, or treating clients or when treating clients with severe mental illnesses. Initially, we wanted to compare results of participants in this state to participants in other states considering the possible impact of policy on integrated practices (Kaur et al., 2022), however the responses were too low for such a comparison. More variance could have been obtained by recruiting other professional groups such as social workers, psychologists, and psychiatrists, or expanding the geographical location to include national agencies as suggested by Johnson (2016).

This study also relied on multiple self-report measures, which can lead to response bias, inflation of results, and the problems with the interpretation of terms. The Interprofessional Interaction Scale reduces social desirability by asking participants to report attitudes about other groups (Pollard et al., 2004). Using multiple self-reported and web-based measures can also inflate results. Also, there may be differences in terms of participants who participate in web-based surveys and those who do not. The construct of interprofessional collaboration may have been interpreted differently by various participants. Participants may have assigned different meanings to the construct of interprofessional collaboration as well as to the scales associated with this study. Not utilizing instruments that were designed to measure the attitudes of counselors who work in various work settings was another limitation. Future studies could be enhanced by asking counselors to actively engage in collaboration, such as a simulation or natural environment.

Future Research and Suggestions

Future research should explore counselors' experiences and perceived effectiveness of interprofessional collaboration at various levels (low to high). This can be done by using simulations for counselors, observing counselors in settings with higher levels of collaboration, or by interviewing counselors with interprofessional experiences as was done by Johnson et al. (2021). Further research will become more important as health systems and clients continue to seek whole-person healthcare. Lastly, it would be valuable to know why the counselors is this study reported slightly negative attitudes toward interacting with healthcare professionals. The negative attitudes may impact laws and policies ranging from the state to agency level that require collaboration and are also worthy of future inquiry (Kaur et al., 2022). Considering the vast expression of emotions, further research should continue to explore the role of emotions, both positive and negative (Waber et al., 2021) in communicating with healthcare professionals. It is

also important to recognize the debate of conducting research that is generalizable versus geographically relevant. Again, we recommend both for the sake of helping clients with complex conditions that might be further complicated by regional phenomena and policies. Lastly, researchers can consider developing or using common definitions and scales related to interprofessional collaboration so more relevant comparisons can be made among future studies. Previously mentioned studies in this article relied on different scales.

Conclusion

This study explored the perspectives of counselors toward collaborating with healthcare professionals. Based on this study, we think that attitudes, and other factors are difficult to measure, yet warrant further investigation. On one hand, it was surprising that years of experience, work setting, race, credential, and social anxiety were unrelated to attitudes toward collaboration. On the other hand, we acknowledge that this study was exploratory and attempted to replicate variables that were found significant in other studies and included newer variables that seemed to make sense considering the limited literature for counselors. We must also consider the possibility that we underestimated the uniqueness of this population. We are confident that social anxiety is not related to attitudes, except for a small portion of individuals who we suspect exhibit social anxiety across a variety of situations. Many questions remain concerning attitudes toward interprofessional collaboration. Perhaps the most encouraging data to report was the willingness and reasons to collaborate indicated by counselors. This data is promising because counselors indicated reasons that is consistent with ethical obligations to promote client welfare (Bischoff et al., 2012, Goodell et al., 2011). Moving forward, counselors, counseling programs, educators, and supervisors should encourage training and practice at all levels and across multiple systems

considering that interprofessional collaboration might be the future standard of care for some clients whether counselors fully embrace it or not (Johnson & Freeman, 2014; Sperry, 2013).

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