CO-WORKER SUPPORT, SUPERVISOR ALLIANCE, AND PSYCHOLOGICAL DISTRESS AS PREDICTORS OF COUNSELING SELF-EFFICACY AMONG MENTAL HEALTH PROFESSIONALS IN MEDICAL SETTINGS

by

Andrew R. Melton

Dissertation Presented to the Graduate Faculty

of Trevecca Nazarene University

in partial fulfillment of the requirements

for the degree of

Ph.D. in Clinical Counseling

July 2018

_____ _____

Susan Lahey, Ph.D. (Dissertation Chair/Director of Graduate Counseling)

_____ _____

James Schut, Ph.D. (Committee Member)

_____ _____

Steve Stride, Ph.D. (Committee Member)

ACKNOWLEDGEMENTS

Completing this project has proven to be one of my most challenging and transformative experiences. Though cultivating a greater working knowledge related to research methods and technical writing, this process often brought to the surface previously unrecognized flaws and apprehensions. Giving up seemed a realistic option on more than one occasion. I am truly grateful to God, my wife, my kids, my committee, my parents, my in-laws, my siblings, my friends, and my church family for their persistent encouragement.

God: Any good there is in me, it is because of you. Thank you for hearing my prayers and providing the needed diligence and concentration to finish. Crystal: I cannot express how grateful I am for you. You were my minute-by-minute companion during this rigorous, multi-year journey. Thank you for your aptly timed enthusiasm, tenacity, and compassion. Love you, Love. DeLaney & McCabe: You guys have been so patient. You never have to hear "Dad's gone working on his dissertation" again. Thank you for cheering me on, even when you didn't feel like it. I love you both so much. Dr. Lahey: Thank you for your leadership and support. On several occasions, it was our phone conversations that prompted momentous stretches of progress. Thank you for taking time to talk things through. Dr. Schut: Thank you for your expertise and willingness to meet early or late to complete this project. Dr. Stride: Thank you for getting me started.

So many others have aided me at different seasons of this process. I cannot thank everyone enough. Psalm 46:1 states, "God is our refuge and strength, an ever-present help in trouble." May God show all of you the same kindness and strength that you have shown me during the ups and downs of this experience.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

This dissertation explores the perceptions of mental health professionals working in medical settings, also known as behavioral health consultants (BHCs). BHC perceptions were evaluated as predictors of counseling self-efficacy as measured by co-worker support, supervisor alliance, and psychological distress in the current study. Measures that assessed population characteristics, counseling self-efficacy, co-worker support, supervisor alliance, and psychological distress were completed by 49 BHCs. Analysis revealed support from certain types of co-workers within medical settings predicted self-efficacy among BHCs. Significant covariates included graduate education level, location of supervisor, and perceived diversity of workplace. Support from a licensure supervisor predicted self-efficacy under certain circumstances. Psychological distress and self-efficacy were adversely related. This study confirmed prior findings that co-worker support, supervisor support, and psychological distress are linked to counselor self-efficacy BHCs. The results further emphasized the importance of multidisciplinary collaboration and support among mental health professionals working in integrated settings. Future research directions include increased sample size, broadening sample to include fully licensed clinicians, efficacy of specialized supervision for BHCs, and distress related to integrating mental health and healthcare professionals.

CHAPTER I

REVIEW OF THE LITERATURE

Introduction

The mental health profession in the United States is growing at a rapid rate. According to the Bureau of Labor Statistics (2016), employment of mental health professionals in the United States is projected to grow 20% over the next 10 years—a significantly faster rate than the average occupation growth. Mental health professionals (i.e., licensed professional counselors, marriage and family therapists, and licensed clinical social workers) are filling positions in a variety of workplace settings, including agencies, private practices, treatment facilities, and schools (Gale & Austin, 2003).

For the past 30 years, researchers have examined the need for integrating mental health professionals into primary care settings (Blount, 2003). Recent studies have shown growth in support for this type of integration among patients and providers (A. J. Bridges et al., 2015; Torrence et al., 2014), indicating potential for increased patient access to mental health services (Pomerantz, Kearney, et al., 2014). Integrating these services has shown improved medical and mental health treatment outcomes (Peek, Cohen, & deGruy, 2014; Woltmann et al., 2012). In 2012, the U.S. government implemented health care reform that emphasizes and supports the integration of mental health professionals into primary care delivery, the effects of which are now being seen throughout primary care systems across the country (Ader et al., 2015).

Mental health professionals filling these positions, also known as behavioral health consultants (BHCs), offer services within primary care to help meet psychosocial and behavioral needs of patients, including assessment, intervention, individual, family,

group counseling, and collaboration with medical providers (Davis et al., 2015; Hall et al., 2015). BHCs work as part of a provider team that attends to patients' physical and mental well-being—from preventative services to chronic disease management (Cummings & O'Donohue, 2011). The need is growing for adequately trained, self-efficacious mental health professionals to work as BHCs and provide this type of service within a primary care setting.

Working as a mental health professional in a primary care setting presents unique challenges to the clinician (Dickinson, 2015) and requires particular competencies (B. Miller et al., 2016). Mental health professionals with proper training and support from supervisors and co-workers may experience less distress and maintain adequate self-efficacy to complete their work as a BHC. Counselor self-efficacy has been used to indicate a mental health trainee's perceived ability to work with patients and complete work-related responsibilities (Larson & Daniels, 1998). In the face of many professional challenges, mental health professionals' perceived self-efficacy can serve as an indication of beliefs and abilities to practice effectively and to persevere in the field (Iarussi et al., 2013). Higher levels of perceived self-efficacy have been associated with higher work performance (Bandura, 1986) and may indicate how mental health professionals perceive their own ability to work effectively and avoid distress within an integrated system. Without proper training, mental health professionals in primary care may experience psychological and emotional distress that affects professional functioning (Glueck, 2015).

Adequate support from supervisors and co-workers may also impact how a mental health professional approaches an integrated working environment. Supervisor support, also described as the alliance between a supervisor and supervisee, refers to mental health

professionals' perceived level of quality of alliance with the clinical supervisor. The supervisor uses the alliance to support the mental health professional through implementation of knowledge and skill (Efstation, Patton, & Kardash, 1990). Perceived supervisor support may impact self-efficacy and distress of BHCs working in primary care. Furthermore, perceived co-worker support may be a factor in integrated settings due to the various disciplines represented in the same facility. Co-worker support has been described as the information, understanding, feedback, and assistance co-workers may extend to one another (O'Driscoll, Brough, & Kalliath, 2004). Support from co-workers and supervisors may influence perceived levels of self-efficacy and distress among BHCs. A better understanding of BHC perceptions, support, and training needs may contribute to further development of the BHC role to meet workforce demands.

Statement of Problem

As the utilization of mental health professionals in primary care continues to grow, a workforce deficit has become apparent (Blount & Miller, 2009). "There is an anticipated national workforce need for qualified licensed behavioral health clinicians to work in integrated primary care settings" (Blount & Miller, 2009, p. 113). Burke et al. (2013) posited that over 27,000 full-time mental health professionals will be needed over the coming years to meet the demands of the U.S. health care expansion—an increase of 400%. The Affordable Care Act (ACA) implemented in 2012 an expansion of health insurance coverage that allowed master's-level clinicians to more efficiently fill these integrated behavioral health positions (Beronio, Po, Skopec, & Glied, 2013).

Even with the expansion of insurance coverage for master's-level clinicians to meet the growing workforce demands, it has been suggested that mental health

professionals are not properly trained to work with patients in an integrated primary care setting (Commings & O'Donohue, 2009; Hall et al., 2015). Blount and Miller (2009) indicated that a different set of skills is needed for integrated behavioral health than what is offered in more traditional counseling and therapy training settings. For example, unlike traditional therapy, BHCs are expected to provide patients with brief assessments, interventions, and follow-up within the swift pace of a primary care system. BHCs are expected to engage patients in 15- to 30-minute consultations, as opposed to the traditional 50-minute clinical session (Blount & Miller, 2009). In addition, BHCs are expected to engage patients and families to address a wide spectrum of mental and emotional needs that present in primary care (Davis et al., 2015). It is unclear if the master's-level education and training in these disciplines are appropriate for the demands of integrated behavioral health positions (Glueck, 2015).

Furthermore, it remains unclear if mental health professionals receive the necessary training to work side by side with providers (e.g., physicians, nurses, etc.) in a medical environment (Hall et al., 2015). When physical and mental health providers are unable to interact, both sides are less effective (Cohen, Davis, et al., 2015) and experience decreased satisfaction in their roles (Torrence et al., 2014). This reality leads to a greater urgency to better understand how primary care and mental health providers work together. Currently, the majority of mental health providers and primary care providers (PCPs) receive training unique to their own discipline, which can keep them isolated. Few clinicians are provided training to help bolster their collaborative partnerships when serving patients (Hall et al., 2015).

Lack of adequate support from supervisors and co-workers in integrated settings may affect mental health professionals' self-efficacy to perform clinic duties (Kozina, Grabovari, Stefano, & Drapeau, 2011) and increase psychological and emotional distress (McLean, Wade, & Encel, 2003). Mental health professionals working in primary care may find co-worker and supervisor support challenging due to the multidisciplinary environment and blending of separate practice cultures (Ader et al. 2015). Lower levels of perceived support may influence mental health professionals' psychological distress and self-efficacy (Hefner & Eisenberg, 2009). Lower levels of perceived self-efficacy may impact clinicians' overall job performance and satisfaction (Betz, 2004; Daniels & Larson, 2001). Further understanding of what factors correlate with higher levels of self-efficacy in mental health professionals working in primary care may give insight as to the appropriateness of training received along with the support and development of clinicians fulfilling these new positions.

Purpose of the Study

In an effort to better understand factors that contribute to self-efficacy in mental health professionals working in primary care settings, the current quantitative study attempts to determine if relationships exist between self-efficacy, co-worker support, supervisory working alliance, and psychological distress. This study will assist administrators and supervisors in better understanding the experiences of mental health professionals now working in primary care settings. Results will inform counselor, therapist, and social work educators as to an emerging workplace setting and assist educators in constructing proper training for such positions. The results of this study will

increase awareness of integrated forms of care, giving educators additional options to offer trainees heading into the workforce.

The research questions investigated in this study follow:

RQ1: Is there a relationship between the BHC perceived co-worker support and levels of counselor self-efficacy?

RQ2: Is there a relationship between the BHC perceived supervisor support and levels of counselor self-efficacy?

RQ3: Is there a relationship between the BHC perceived levels of work stress and levels of counselor self-efficacy?

Multiple regression techniques are used to analyze if relationships exist between the four variables.

Background and Significance

Mental Health Professionals in Primary Care

Mental health professionals working in traditional mental health settings (e.g., mental health agencies, group practices, etc.) maintain a variety of on-the-job responsibilities. For example, many mental health professionals attend to large caseloads, accommodate managed care systems (Ross, Altmaier, & Russell, 1989), and experience high levels of distress from working with clients in crisis (McLean, Wade, & Encel, 2003). Effective mental health professionals develop a unique skill set with which to actively listen, build rapport, and implement effective strategies toward the growth of each patient (Galassi & Akos, 2004). They maintain cultural competence, produce evidence-based results, provide advocacy, consistent self-evaluation, and are capable of

exhibiting leadership (Henderson & Montplaisir, 2015; Kazdin & Blase, 2011; Meany-Walen, Carns-Holt, Barrio Minton, Purswell, & Pronchenko-Jain, 2013).

Researchers have recognized the need for mental health professionals to be placed in primary care settings, referring to primary care as the *de facto* system for mental health (Pace, Chaney, Mullins, & Olson, 1995). Recent estimates show that 70% of primary care patients present with problems involving psychosocial or behavioral issues (Ray-Sannerud et al., 2012). In addition, 50-70% of psychological disorders are managed in primary care, and 67% of all psychotropic medications are prescribed by physicians in the primary care setting (Gatchel & Oordt, 2003; James, 2006). Primary care has been widely considered the most common entry point for mental health services (Angantyr, Rimner, Norden, & Norlander, 2015; deGruy, 1997). Depression and anxiety are the most common referral needs for BHCs in primary care (Funderburk et al., 2010). Therefore, a need exists for mental health professionals to be on site in primary care to work with patients and family and collaborate with medical providers.

Mental health professionals (i.e., BHCs) working in primary care require a unique skill set related to symptom reduction, consistent collaboration with PCPs, and organizational skills needed for managing referrals and documentation (McGough et al., 2015). BHCs tend to be tolerant, flexible, and enjoy a fast-paced environment. Privacy, quiet, and comfort are not typically found in this nontraditional counseling environment (Nash, McKay, Vogel, & Masters, 2012). BHCs are challenged to remain accessible and responsive to collaborating with PCPs within the time constraints of an active primary care facility (Glueck & Foreman, 2014). In the BHC role, clinicians prepare to "incorporate myriad interventions routinely to address behavioral medicine issues,

including chronic illness management, modification of disease risk through health behavior change, and adherence to prescribed medical and behavioral regimens" (Beacham, Kinman, Harris, & Masters, 2012, p. 18).

To better define the BHC role, Hall et al. (2015) described differences between traditional mental health professionals and BHCs. Traditional mental health professionals maintain 50-minute appointments, interventions focused on mental health, and documentation that is narrative and in story form. BHCs maintain 15- to 30-minute appointments, interventions are focused on several areas (e.g., substance use, adherence to health care treatment, life stressors, etc.), and documentation is brief and focused on the patient's problem, intervention, and plan. Traditional mental health communicates with other providers via referral forms, phone calls, and emails. According to Hall et al. (p. S43), BHC communication is immediate and often within a shared medical record. Traditional mental health assigns a clinical diagnosis in order to bill, whereas BHCs resist or delay a clinical diagnosis to avoid labeling the patient. In traditional mental health, patients are discharged when care is completed. BHCs retain the patient in the medical record as long as the patient continues to receive primary care. Finally, traditional mental health professionals build a therapeutic relationship through a thorough knowledge of the patient. BHCs help develop patients' relationship with their PCP and clinic team.

Various terms have been used to describe the use of BHCs in primary care (e.g., integrated behavioral health, integrated primary care, primary care behavioral health, etc.; Blount, 2003; Peek, 2013). Blount (2003) defined behavioral health integration in health care as "care that combines medical and behavioral health services to more fully address the spectrum of problems patients bring to their primary medical care providers" (p. 121).

Dickinson (2015) described integration as patient-centered care provided by a team of behavioral health providers and PCPs, working together in a systematic and cost-effective way. Peek (2013) defined integrated behavioral health as "the care that results from a practice team of primary care and behavioral health clinicians working together for patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population" (p. 2).

Mental health professionals began filling behavioral health positions in the mid-1970s (Blount & Bayona, 1994); however, the BHC role just began to emerge nationwide in the 2010s (A. J. Bridges et al., 2015; Glueck, 2015). Definitions of responsibilities and competencies have recently been formulated to help advance the position and meet workforce needs (Miller et al., 2016; Robinson & Reiter, 2016). An overview of the emergence of the BHC role in primary care leads to a discussion of how BHCs benefit health care in the United States.

Emergence of Behavioral Health Consultants

Eighty percent of the U.S. population visits a primary care clinic every year (Strosahl, 1998). Primary care has been defined as 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" (Institute of Medicine, 1994, p. 23). People with health care concerns will often visit primary care before any other community service, and many of those patients seek help with problems specifically related to mental and emotional health (Cohen, Davis, et al., 2015).

Robinson and Reiter (2016) found that one third of all primary care visits relate directly to mental health disorders such as anxiety, depression, substance use, sleep disturbances, and other behaviorally based factors. Other researchers have reported that approximately 70% of primary care visits are psychosocial in nature (Bryan, Morrow, & Appoloino, 2009), and nearly 70% of all psychotropic medications are written in the primary care environment (Hunter and Goodie, 2010). For clinics serving low-income populations, up to 50% of patients seen will present with mood or anxiety problems (Wang et al., 2005). Many primary care patients, though they are not seeking psychological treatment, are experiencing poor daily functioning due to behaviorally based problems (e.g., diabetes, chronic pain, obesity, and coronary problems; Angantyr et al., 2015; Hunter et al., 2009). When behavioral health problems are coupled with other chronic medical conditions, one's physical health can be significantly affected (Ader et al., 2015).

Because people with mental health concerns often seek out the health care system first, PCPs have the opportunity to observe and treat the problems early in the process (Ader et al., 2015). McGough, Bauer, Collins, and Dugdale (2015) reported that PCPs are more aware than ever before of mental health issues such as depression and anxiety, but the awareness does not necessarily lead to effective diagnoses and treatment. Rush et al. (2004) found less than 20% of patients treated with antidepressant medications in primary care showed significant improvements, even with referrals being made to mental health treatment in the community. The problem, according to Rush et al., is a lack of competent mental health professionals involved in the primary care system and that traditional mental health treatments are too focused on individual therapy. The authors

supported a movement toward a more effective approach to treating depression in primary care, which may include increased patient and family psycho-education, brief solution-oriented therapy provided by an on-site mental health professional (i.e., BHC), as well as attention to concurrent mental health and substance use issues.

PCPs have traditionally treated depression and anxiety with a problem-focused, visit-based approach (McGough et al., 2015). PCPs often report a lack of competence and a lack of time to adequately provide mental health services for patients (Hooper, 2014). A common approach for PCPs is to refer challenging patients to mental health professionals in their community. Poor coordination, separate health records, and varying care philosophies make collaboration arduous. In addition, many communities lack sufficient numbers of mental health professionals; and those who do exist are often hard to access in a timely manner (McGough et al., 2015). In the United States, an estimated 26% of adults struggle with a mental health disorder, many of which are not diagnosed or treated. When mental health problems are identified and referred, over 50% of patients do not attend the first appointment (Fisher & Ransom, 1997). Kazdin and Blase (2011) called for significant changes in the way mental health concerns are addressed in primary care and posited a growing need for "evidence-based psychosocial interventions" (p. 22).

McDaniel, Hepworth, and Doherty (1992) described the practical differences between the medical and mental health paradigms when working with patients. PCPs use a medical language and a biopsychosocial approach, whereas mental health professionals use a humanistic or psychoanalytic language and a family systems approach. PCPs are action-oriented, frequently use medications, and work from a basic understanding of the patient's history. Mental health professionals are process-oriented, infrequently use

medications, and work from an extensive understanding of the patient's history. PCPs are used to giving advice and can be too fixated on somatic symptoms. Mental health providers avoid giving advice and can be too fixated on psychosocial symptoms. Finally, PCPs are used to working all hours and shifts, whereas mental health professionals are used to scheduled sessions, unless for emergencies (McDaniel et al., 1992).

Various models of integrated care have used the BHC role in different ways. McGough et al. (2015) described one approach named the Behavioral Health Integration Program (BHIP), a collaborative approach in which a PCP, BHC, and a psychiatric consultant work together within the primary care system. In the BHIP model, the BHC (a position usually filled by a social worker, registered nurse, or psychologist) contributes to the care team by providing comprehensive assessments, patient education, brief evidenced-based interventions, and follow-up. The team meets weekly to review cases and coordinate treatment plans and needed referrals. The BHC maintains a caseload of 50-100 patients. McGough et al. found the BHIP model to exhibit positive outcomes for patients with depression and anxiety that exceeded clinical trial rates.

Angantyr et al. (2015) and Vogel, Malcore, Illes, and Kirkpatrick (2014) described another example of integration named primary care behavioral health (PCBH). Started in the United States in the 1990s, the PCBH model set out to increase patient access to mental health services and increase overall knowledge of mental health factors to primary care staff members. In this model, BHCs (a position usually filled by a psychologist) act as consultants for the PCP, as well as engage clients and collaborate with practice staff. PCBH is typically nontargeted in that it is open to various presenting problems. PCBH focuses on population health through full integration, seeking to

incorporate BHCs into all aspects of primary care (Strosahl, 1998). In 2014, 14 of the nation's largest health care associations launched an initiative to begin implementing the use of BHCs at every level of the organization (e.g., Kaiser Permanente in Northern California, Group health Cooperative of Puget Sound in Washington State, Institute of Medicine in North Carolina, and the U.S. Veterans Administration; Ader et al., 2015; Glueck, 2015).

Biopsychosocial model. Until the last few decades, the health care delivery system in the United States was built on the biomedical model of care (Engel, 1996). The biomedical model focuses on the diagnosis of an illness or disease based on a patient's presenting physical symptoms. This model postulates that the human mind and body are two separate entities and that health care providers need only focus on the latter to promote health and wellness.

More recently, growing support exists for the biopsychosocial model of health care (Glueck, 2014), which holds that there is no divide between the mind and body but considers a patient's physiological, psychological, and social factors together and how the three interact (Engel, 1996). The biospychosocial model emphasizes a more holistic approach to health care, broadening the health care provider's view of the patient's presenting problems.

During his time as a physician at the University of Rochester, Engel (1996) published multiple articles purporting his view that health care move toward a more integrated approach (McDaniel, 1993). Engel's biopsychosocial model believes in a greater connection between the mind and body, and that one cannot be observed or influenced without the other. Engel recommended significant changes to the health care

delivery system, including a shift in the basics of how physicians interact with their patients. "The doctor's task is to account for the dysphoria and the dysfunction which lead individuals to seek medical help…weigh[ing] the relative contributions of social and psychological as well as of biological factors" (Engel, 1977, p. 130). This model acts as part of the foundation for today's developing integrated health care practices.

Patient-centered medical home. The ACA was signed into U.S. law in 2012 to help redesign the nation's health care system. Promoting a more biopsychosocial approach to primary care, the patient-centered medical home (PCMH) was presented as a model of primary care purposed to decrease health care expenses and improve patient experience and population health (Ader et al., 2015). PCMH is based on a model of health care that encompasses the whole person and provides an integrated approach across needed health care services (Beacham et al., 2012; Levant & Heldring, 2007). The use of this model has expanded considerably in what has been described as a "substantial redesign" of primary care (Ader et al., 2015, p. 911).

PCMH seeks to provide care that is coordinated, comprehensive, accessible, patient-centered, and consistently improving in safety and quality (Hunter & Goodie, 2010). The PCMH model may benefit patients more than traditional models in access to care, lower health care costs, comprehensive care, and the treatment of chronic health disorders (Nelson et al., 2014; Soman & Larson, 2009). At the core of this model is the usual provider (i.e., clinic, PCP, and multidisciplinary team) who provides preventive or chronic disease treatments, patient-centered treatment plans, and community referrals as needed. Support for PCMH is based on the idea that "patients fare better when they have a usual source of care, often defined as a routine place of care or personal physician"

(Jones et al., 2015, p. 1830). Studies have also shown that patients who maintain a usual provider report higher levels of satisfaction and trust with their PCP (Carpenter et al., 2009), have fewer unmet needs (DeVoe, Tolliston, & Wallace, 2009), and have a greater likelihood of receiving screeners and preventative interventions (Ahmed, Pelletier, Winter, & Albatineh, 2013).

Integrating BHC services into the primary care environment is a vital part of the PCMH model, often referred to as behavioral health, integrated behavioral health, or integrated primary care. Behavioral health has been described as care that addresses behavioral, emotional, and substance use issues (Cohen, Davis, et al., 2015). The term *behavioral health* and the term *mental health* have been used interchangeably. BHC refers to mental health generalists who serve as part of the primary care team. BHCs provide culturally competent care to patients with a wide variety of mental health and substance use problems, as well as the management of behaviorally based medical diagnoses (Kessler et al., 2010).

Benefits of Behavioral Health Consultants to Health Care

The existence of mental health professionals has brought about many positive changes to the primary care environment. The presence of mental health professionals contribute to an increase in the quality of overall care and utilization, especially with high-risk populations (Felker et al., 2004). Blount (2003) reviewed over 60 integrated care studies to find that the use of mental health professionals generally improved clinical outcomes, decreased health care costs, and increased patient and PCP satisfaction rates. Ader et al. (2015) indicated that integration increases primary care's ability to see more patients and focus on the whole person.

According to Gallo et al. (2004), the use of mental health professionals as BHCs improves treatment outcomes for physical and mental health conditions, lowers health care costs, increases prevention efforts, and increases family involvement. In addition, researchers have observed evidence that patients prefer to receive BHC services within primary care (Brody et al., 2010 Hemmings, 2000), feel less negative stigma related to mental health services when a BHC is present, and report increased confidence knowing that the PCP is involved in the process (Aitken & Curtis, 2004). The use of BHCs is a growing strategy to improve collaboration between physical and mental health providers, improved patient outcomes, and lower health care costs in primary care (A. J. Bridges et al., 2015). Researchers have shown mental health professionals working in BHC roles to be beneficial to providers and patients alike. Patient outcomes, patient access to care, and patient health care costs are all benefited by the presence of BHCs (Angantyr et al., 2015; A. J. Bridges et al., 2015; Dale & Lee, 2016; Davis et al., 2015; Hooper, 2014; McFeature & Pierce, 2012; McGough et al., 2015; Pomerantz, Corson, & Detzer, 2009; Skillman, Snyder, Frogman, & Patterson, 2016; Vera et al. 2010; Vogal et al., 2014.

Improved patient outcomes. Although integrated behavioral health research is "in its infancy," many populations, outcomes, interventions, and programs have been examined within the context of integration (Blount, 2003; Vogel et al., 2014, p. 132). A large number of studies have demonstrated support for the effectiveness of BHCs for the treatment of depression and anxiety (Bower, Gilbody, Richards, Fletcher, & Sutton, 2006). For example, the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study examined 18 primary care clinics and over 1,800 older, depressed patients. Some participants were assigned to an IMPACT intervention group in which a

BHC provided psycho-education on late-life depression, follow-up for 12 months, and use of an antidepressant or psychotherapy. Other participants were treated with usual primary care interventions and referrals to traditional mental health services. Results showed the IMPACT group to be more satisfied with care, adherence to treatment at high levels, and lower levels of depressive symptoms.

The DIAMOND project (Depression Improvement Across Minnesota: Offering a New Direction; Solberg et al., 2013 studied a high number of depressed patients at primary clinic across Minnesota over a 12-month period. The project used BHCs, the PHQ-9 depression screen, an on-call psychiatrist for PCPs, and a track system across clinics. Results showed a decrease in symptoms by five times compared to control. Twelve-month follow-ups showed over half of patients continued to see improvement. Another study examined the use of BHCs in 179 depressed primary care patients (Vera et al., 2010). The integration group was offered no-cost treatment through a BHC, a resource coordinator, and PCP. The control group was offered standard treatment options through insurance. Ninety-seven percent of patients in the integrated group had received depression treatment compared to 57% in the other group. The integration group showed a greater improvement in depressive symptoms.

Roy-Byrne et al. (2010) studied anxiety treatment of over 1,000 patients in 17 primary care clinics. Some of the patients also presented with comorbid depression. Some patients were part of the Coordinated Anxiety Learning and Management (CALM) group, which provided a BHC using cognitive behavioral treatment, medication, or both. The CALM group showed a significant decrease in anxiety symptoms. Ray-Sannerud et al. (2012) showed a sustained reduction of depressive and anxious symptoms after 1.5

and 3 years when a BHC was a part of the primary care team. Participants with the most severe initial symptoms reported the greatest effect. These results match a similar study in which the use of BHC services helped to increase anxiety-free days for patients struggling with panic disorder (Katon, Russo, et al., 2002).

Older adults who received BHC services reported decreased depressive symptoms and increased quality of life (Unutzer et al., 2002). In a study done in military primary care clinics, Bryan, Morrow, & Appolonio (2009) showed that the use of BHCs helped to reduce problematic symptoms related to a wide range of conditions, many times involving as few as three appointments. In addition, evidence exists to show that BHCs can help to reduce general stress, mental health needs, psychological concerns (Bryan, Morrow, et al., 2009; Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006, Kates, Crustolo, Farrar, & Nikolaou, 2002), as well as more severe symptoms (Bryan, Corso, Corso, et al., 2012). The use of BHCs has also been positively associated with the reduction of harmful substance use (Whitlock et al., 2004).

Finally, studies have shown that brief therapy approaches used by BHCs can help to decrease the stigma patients feel related to mental health services (Strosahl, Robinson, & Gustavsson, 2012) and that brief interventions are preferred by most patients (Brown & Jones, 2005). Molenaar et al. (2011) found that the effectiveness of mental health interventions is not associated with the duration of the interventions. Using BHCs in primary care is "about doing intervention differently, not faster" (Vogel et al., 2014, p. 139).

Bryan, Corso, Neal-Walden, & Rudd (2009) investigated the clinical outcomes of 338 primary care patients who met with a BHC as part of their health care team. The

patients were referred by their PCP to the BHC for a variety of medical and emotional problems (e.g., anxiety, depression, pain, and insomnia). Approximately 66% of the patients met only one time with the BHC, 23% met with the BHC two times, 7% met three times, and 2% met four times. Patients with higher levels of distress met more often with the BHC. Most patients in the study showed significant clinical improvements taking place within the first few sessions. These findings are consistent with similar studies that that have shown the most significant amount of changes happens within the first few sessions (Barkham et al., 2006; Cigrang et al. 2006). Researchers have posited that the rapid response to BHC interventions may predict reduced recidivism and long-term functional improvement for patients (Bryan, Corso, et al., 2009; Strosahl et al., 2012), along with increased patient access to physical and mental health care.

Improved access to care. The use of BHCs has been demonstrated as a way to address the barriers related to patient access to mental health care. When BHCs maintain an *open access* approach to scheduling, it gives patients the opportunity to *drop in* or call the BHC as needed. Barber, Frantsve, Capelli, and Sanders (2011) found that over half of patients referred to a BHC in primary care were seen the same day or within 2 weeks—a significant decrease of average wait times for traditional mental health, which can range from 2 weeks to over 1 month. Another study showed a significant increase in attendance rates for Medicaid patients when referred to the BHC in a primary care setting (Guck, Guck, Brack, & Frey, 2007). Davis et al. (2015) posited, "Higher BHC-to-PCC staffing ratios, multiple BHCs on staff, and short BHC appointments with open, flexible schedules enabled primary care clinics to engage BHCs in patient care at the point of care" (p. S33).

Studies have shown that over half of patients who are referred outside the clinic fail to follow through with the referral (Gary, Dunbar, Higgins, Musselman, & Smith, 2010). Cummings & O'Donohue (2011) posited only 10% of patients follow through with mental health referrals. The low success rate of referrals can be attributed in part to the negative stigma often associated with mental health referrals, patients often feeling that their concerns are being dismissed, and the inconvenience of traveling to a different location (Corrigan, 2004; Haley et al., 1998).

When a BHC is present, referrals within primary care look and feel different to the patient. A *warm hand-off* takes place when a PCP invites the BHC into the exam room and introduces the BHC as part of the patient's care team (Torrence et al., 2014). The PCP and BHC communicate briefly about the referral need. The BHC then engages the patient by briefly describing the BHC role, assesses the patient's current situation, and works with the patient to construct a relevant intervention. The BHC finishes by documenting the visit in the medical record and follow-up with the PCP about what was seen, done, and the plan moving forward (Hall, 2015). According to Cummings, O'Donohue, & Commings (2009), same-day referrals to BHCs significantly increase the success of mental health referrals, with 85-90% of patients entering into treatment. Along with increased access to care, the presence of BHCs in primary care is making an impact on the financial aspects of health care.

Improved health care costs. DeGruy (1997) emphasized higher health care costs associated with distressed patients due to more frequent primary care and emergency room visits and a higher number of procedures and tests that could be unnecessary. Other researchers have discussed the significantly higher cost of treating

chronic medical issues when patients also struggle with comorbid anxiety and depression (Patterson, Peck, Heinrich, Bischoff, & Scherger, 2002). When a BHC is present, PCPs can "hand off time-consuming and less reimbursable behavioral health issues" (Vogel et al., 2014, p. 136). Prevention, symptom reduction, early detection and intervention, and rapid treatment all contribute to lower health care cost. The BHC role can affect patient well-being in all of these areas as a contributing member of the primary care team (Blount, 2003).

Monson, Sheldon, Ivey, Kinman, & Beachem (2012) showed positive effects related to financial viability when a BHC is present, including direct revenue generation, clinician efficiency, health outcomes, and offsetting other more intensive medical costs (i.e., emergency room visits, frequent primary care visits, etc.). In addition, Kates et al. (2001) found that BHCs help to decrease impatient psychiatric admissions.

A current limitation to an integrated primary care system is the reimbursement of mental health services. O'Donnell, Williams, and Kilbourne (2013) explained that offering BHC services in primary care can be challenging if the use of health and behavior codes is the only system for reimbursement. The authors proposed that other forms of reimbursement (i.e., capitation, bundled, etc.) may increase financial benefits for integrated clinics. Capitation refers to a pay structure in which a set amount is paid to providers based on enrolled patients over a period of time, regardless if those patients seek care or not. Bundled payments are reimbursements payed to providers based on the expected costs of services.

Furthermore, the co-located level of integration has demonstrated a variety of health care benefits and cost benefits and is often the best option for clinics that are not

ready for full integration or are not prepared to hire and maintain BHCs (Ader et al., 2015). Using this model, primary care organizations can partner with mental health agencies to bring in needed personnel. Federally qualified health care centers are not-for-profit health care centers located across the United States that receive federal funding to meet the needs of underserved populations and provide care for those who cannot afford care (Torrence et al., 2014). A co-located partnership can benefit federally qualified health care centers that may not have the operating budget to hire mental health professionals.

BHCs provide a variety of benefits to primary care systems and patients and the demand for mental health professionals in primary care is growing (Burke et al., 2013). Therefore, it is vital for mental health professionals to properly train for such roles and develop needed competencies to work in integrated settings.

Training Mental Health Professionals for Integrated Care

In a recent report by the Center for Health Workforce Studies, Skillman, Snyder, Frogner, and Patterson (2016) posited that a clear pathway for the education and training of mental health professionals to work in primary care is not yet available. The authors reported that the emergence of the BHC role is still a "relatively recent development" and that PCPs and BHCs alike are currently being "retrained" for work within an integrated setting (p. 8). Due to the recent emergence of the BHC role, literature pertaining to BHC competencies and training is limited.

In a phenomenological study of 10 BHCs across eight integrated primary care settings across North Carolina (Glueck, 2015), all participants reported they received no training to work in an integrated setting during their graduate programs. All participants

in the study reported that they are learning on the job and recommended increased medical training and the inclusion of courses and internships within graduate programs pertaining to working in an integrated primary care setting.

Behavioral health competencies. In recent years, researchers have worked to better define the competencies needed in the BHC role. For instance, Miller et al. (2016) delineated a set of eight core competences for BHCs, including (a) identify and assess behavioral health needs as part of a primary care team; (b) engage and activate patients in their care; (c) work as a primary care team member to create and implement care plans that address behavioral health factors; (d) help observe and improve care team function and relationships; (e) communicate effectively with other providers, staff, and patients; (f) provide efficient and effective care delivery that meets the needs of the population of the primary care setting; (g) provide culturally responsive, whole-person and family-oriented care; and (h) understand, value, and adapt to the diverse professional cultures of an integrated care team (p. 4; Kaslow, Dunn, & Smith, 2008).

One of the vital competencies for the BHC is the ability to quickly engage the patient while simultaneously assessing and identifying the patient's needs. This can be a challenging process for mental health professionals who are used to more traditional mental health environments. Twenty to 30 minutes is the average amount of time a BHC spends with each patient. During this span, BHCs are expected to engage the patient, assess the patient's needs and goals for treatment, and implement co-constructed brief interventions (Strosahl, 1998).

Proficient BHCs exhibit strong interpersonal skills with patients of various ages and work to consider each patient's biological, emotional, cognitive, and social context.

Proficient BHCs implement a wide scope of clinical knowledge, including developmental issues, chronic illnesses, familial and relationship problems, high-risk clinical situations (e.g., suicidality, homicidality, and psychosis), chronic pain issues, and co-occurring disorders (A. J. Bridges et al., 2015). In addition, BHCs learn to recognize names, uses, and side effects of medications common in primary care (McDaniel et al., 1995).

Competent BHCs maintain open communication and collaboration with clinic providers and staff. Torrence et al. (2014) posited that mental health professionals and PCPs face unique challenges of integrating multiple disciplines within the same clinic. Integrated care is "fast-paced and team-based" (Vogel et al., 2014, p. 138) and requires reciprocity of support from providers and clinicians (Davis et al. 2015). Fully integrated practices include BHCs as part of the medical team, positioning behavioral health as a valued service in primary care (Torrence et al., 2014).

BHCs face the challenging task of expanding their knowledge and application of mental health and chronic disease management within the primary care context. Prevalence rates of certain medical issues continue to rise exponentially, including chronic pain, obesity, heart disease, and diabetes. It is necessary for BHCs to be familiar with these medical issues and how they may exacerbate comorbid medical conditions or appear like mental health symptoms (Roberts, Kiselica, & Fredrickson, 2002).

Furthermore, BHCs take into account the patient's cultural and spiritual factors. For example, competent BHCs consider the patient's beliefs related to behavioral and medical health stigmas and treatment (Miller et al., 2016). BHCs train to quickly adapt assessments and brief interventions to the patient's cultural experience. Glueck (2015) posited that a benefit of the BHC role is to engage in preventative services, provide

increased opportunity for patients to access services, and lower the stigma of mental health across multicultural populations (Glueck, 2015).

Behavioral health training. Even with a better understanding of the skills needed, it remains unclear how mental health professionals train to become competent BHCs. With the recent growth in demand for BHCs in the workforce (Blount & Miller, 2009), researchers have indicated a need for mental health professionals to receive more specific training. For example, the U.S. Department of Defense recently released a report outlining the need for training specific to integrated care (Davis et al., 2015). The report indicated the training of BHCs is critical and is intensified by the substantial lack of financial support and personnel to meet integrated care needs across the nation. Davis et al. (2015) stated that primary care clinics are doing what they can to train mental health professionals on the job, but that it is not enough. Thus, the U.S. Military has begun to train BHCs to work integrated settings using a 1-month practice and supervision program (Corso et al., 2009).

To better understand BHC training needs across the United States, Hall et al. (2015) studied a group of 19 integrated practices that included clinics participating in the Advancing Care Together program and the Integrating Workforce Study. The authors found a *significant gap* between the workforce need and competent, trained professionals to fill the positions. They reported that clinics who were new to integrative practices struggled to find knowledgeable and experienced clinicians to fill positions. Inexperienced BHCs "struggled to appreciate their teammates' work, clinical perspectives, pace of care, and patient needs in integrated settings" (Hall et al., 2015, p.

S49). Hall et al. concluded that few training programs administer the necessary training for PCPs and BHCs to work in an integrated care setting.

These results are consistent with other studies that have identified a significant need for more specific training for BHCs (Blount & Miller, 2009; Bluestein & Cubic, 2009; Dickinson, 2015). Glueck (2015) purported that coursework on chronic disease management and BHC lifestyle issues are "noticeably missing" from graduate programs (p. 175). Dickinson (2015) highlighted the need for further training for BHCs in meeting needs of a primary care population; providing brief, solution-focused therapies; and adapting to the pace of primary care.

Burke et al. (2013) found that in 2010, federally qualified health care centers had very little access to BHCs to meet their population need. Burke et al. found that over 2.5 million patients with mild or moderate mental health diagnoses, including nearly 400,000 with a diagnosable substance use disorders, had no BHCs available to them. The authors added that it would have taken over 11,000 full-time BHCs to serve this number of people. Burke et al. also suggested 90% of high-need primary care facilities in their study had no have access to behavioral health services. The authors estimated over 27,000 full-time BHCs will be needed over the coming years to serve in these roles—an increase of 400%.

According to Vogel et al. (2014), mental health training programs are beginning to offer tracks and degrees specifically suited for integrated care settings (e.g., University of Massachusetts, Fairleigh Dickinson University, University of Michigan, etc.). Textbooks and guidebooks are becoming more readily available for BHCs in training (Hunter et al., 2009; Robinson & Reiter, 2007). Researchers have recommended that this

trend continue. For example, Aitken and Curtis (2004) suggested that master's-level training programs include certain information to help prepare interested trainees, even if the programs do not offer specific integrated care training. The authors recommended that the program's assessments course include the use of brief screening instruments (e.g., PHQ9 depression screen and GAD7 anxiety screen). Glueck (2015) recommended that training programs increase coursework related to coping skills and stress regulation skills that increase trainees' understanding of patient health, immunity, and disease management. Blount and Miller (2009) proposed that training programs offer curriculum related to multidisciplinary teamwork in health care settings. Furthermore, Aitken and Curtis (2004) urged mental health educators to include training related to psychopharmacology, medical environments and culture, and primary care based internships.

Challenges to Behavioral Health Consultant Role

Mental health professionals filling BHC roles require particular competencies and training to face the various challenges related to multidisciplinary integration and collaboration (Ader et al., 2014; Dickinson, 2015). Health care and mental health education have been criticized in recent years for an inadequate scope of training related to collaboration within a multidisciplinary environment (Johnson & Freeman, 2014; McClelland & Kleinke, 2013). The emergence of integrated care has led multiple policy organizations (i.e., World Health Organization, Substance Abuse and Mental Health Services Administration, Interprofessional Education Collaborative, etc.) to include specific training standards for trainees to increase multidisciplinary team awareness and effectiveness (Hoge, Morris, Laraia, Pomerantz, & Farley, 2014). For example, the

Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2016) produced a standard (2:F:1:b) that states that mental health trainees will understand "the multiple professional roles and functions of counselors across specialty areas, and their relationships with human service and integrated behavioral health care systems, including interagency and interorganizational collaboration and consultation" (p. 8).

Even with the call for interdisciplinary training, researchers have suggested mental health professionals in primary care may experience a "clash of professional cultures" in a primary care setting (Cox, Adams, & Loughran, 2014, p. 117) and the need for BHCs to maintain a strong professional identity when collaborating with other disciplines (Garcia-Shelton & Vogel, 2002; McDaniel et al., 1995). D. R. Bridges, Davidson, Odegard, Maki, and Tamkawiak (2011) posited that mental health and primary care clinicians working together within integrated settings concurrently gain understanding of their own professional identity as well as the roles of others, which may suggest that professional identity comes with on-the-job experience and increased familiarity.

Cox et al. (2014) studied the experiences of a small number of doctoral mental health trainees (four) interning in a primary care setting. Cox et al. found that the trainees felt overwhelmed and anxious in the primary care setting due to lack of exposure to medical care systems, unclear role expectations, the fast pace of the clinic, and the lack of contact with primary care staff. Cox et al. reported that the trainees desired increased understanding of integrated policies and procedures and support from clinic staff.

Understanding the different levels of primary care integration and practicing at the same level are a couple of the more difficult challenges mental health and physical

health providers face (Ader et al., 2015; D. R. Bridges et al., 2011). According to Pratt and Lamson (2012), mental health professionals enter into primary care settings with various levels of health care experience and can have difficulty understanding at what level of integration they are expected to function. To better define the levels of integrated care, Blount (2003) distinguished three categories: (a) coordinated, (b) co-located, and (c) fully integrated. Vogel et al. (2014) adapted a report by Heath, Wise Romero, and Reynolds (2013) to describe these same differences between the three levels. Similar descriptions of these levels of integration can also be found in Cohen, Davis, et al.'s (2015) article.

A coordinated level of integration maintains a minimal approach to collaboration using separate systems and facilities with periodic communication driven by specific patient issues. In coordination, mental health professionals and PCPs have little appreciation for the other's roles and refer to the other on an as-needed basis. This is a common approach for private practitioners and small agencies with define specializations. A co-located level of integration maintains a moderate approach and assumes some physical proximity, which can be shared space and systems within the same facility. Communication is in person and based on need for consultation with difficult patients. Providers who are co-located have a basic understanding of each other's roles and may feel part of a large, yet ill-defined care team (Vogel et al., 2014). Although PCPs and BHCs do practice in the same facility, limitations remain in this level of integrated care due to both disciplines maintaining different scheduling processes, reimbursement procedures, and separate medical records (Ader et al., 2015).

A fully integrated level of integration refers to clinics that have likely experienced a culture shift and change in practice that has transformed all roles. Clinic systems and workflows are aligned and space is shared within the facility. Communication is consistently shared at the system, team, and individual levels. Providers from both disciplines have an in-depth understanding of each other's roles as cultures blend together for the care of the patient (Vogel et al., 2014, p. 132). Full integration provides an interprofessional, team-based environment that promotes trust among clinic providers as they learn each other's roles and contributions to care. Clinic personnel can develop an understanding of a team-based, patient-centered, and cost-effective approach to primary care (Dickinson, 2015). Fully integrated practices include BHC as part of the medical team, positioning behavioral health as a valued service in primary care (Torrence et al., 2014).

Significant barriers exist to a fully integrated level of care and can be challenging for mental health professionals to fill BHC roles. Ader et al. (2015) posited that full integration "demands a complete system redesign, including the blending of separate practice cultures, shared medical records, introduction of new workflows, an integrated, team-based approach to treatment, and consideration of available reimbursement options" (p. 910). Primary care practices preparing to transition to full integration must be willing to modify care approaches and clinic processes at every level of the organization (Dickinson, 2015).

Furthermore, full integration can be a difficult task for BHCs when PCPs are not supportive of the collaborative efforts. Beacham et al. (2012) found a lack of support among medical providers for the use of BHCs. The authors indicated the lack of support

was due to limited knowledge of mental health treatment, barriers to referrals, and a perceived stigma that exists related to psychological disorders. The authors also noted that none of the medical providers in the study had worked in a fully integrated primary care system.

Conversely, several studies have shown PCPs to have an open, enthusiastic attitude toward the use of BHCs (Levine et al., 2005). For example, using an online, anonymous survey, Serrano and Monden (2011) found that the majority of the medical providers they surveyed maintained positive attitudes toward collaboration with BHC, along with the viewpoint that BHCs improve patient care. In a similar study, medical providers within diverse health care environments (i.e., Veterans Affairs) reported favorable attitudes toward working with BHCs (Funderburk et al., 2010). Torrence et al. (2014) surveyed 45 PCPs working in a large fully integrated federally qualified care health centers in the state of Colorado. They indicated the PCPs were highly favorable with 73-100% endorsing either that they strongly agree or agree with the use of BHCs in clinic. Torrence et al. reported that the PCPs believed the BHCs to be "valuable members of integrated teams, improved their ability to deliver care, and enhanced their ability to address their patients' physical problems and behavioral health problems" (p. 430).

Supervisor support. Lack of supervisor support can be a challenge to mental health professionals working in BHC roles. For years, researchers have described the importance of supervisor support for mental health professionals (Kozina et al., 2010; Watkins, 2014). Reese et al. (2009) contended the supervisory relationship is the *sine qua non* of effective training and development of mental health professionals. Clinical

supervision provides a supportive, structured, dyadic environment in which the supervisee continues to develop clinical skills and effectiveness with patients (Ladany, Ellis, & Friedlander, 1999). The supervisor's role promotes ethical and competent practice among his or her supervisees (Reese et al., 2009).

Supervisory working alliance has been defined as the relationship between a supervisor and supervisee by which "social influence occurs" and "the supervisors act purposefully to influence supervisees through their use of technical knowledge and skill and in which supervisees act willingly to display their acquisition of that knowledge and skill" (Efstation et al., 1990, p. 322). Efstation et al. (1990) studied over 175 supervisory relationships across the United States in order to develop an instrument that captured the supervisor and supervisees perception of the quality of the supervisory relationship. The study found the supervisory alliance to be a predictor for other clinician constructs (e.g., self-efficacy). A review of literature showed that the supervisory alliance has been used primarily with mental health trainees and their supervisors.

Maslach, Schaufeli, and Leiter (2001) found a "strong body of evidence" negatively associating supervisor support and job burnout among mental health professionals (p. 407). Job burnout was described as ongoing emotional and interpersonal stress on the job. More importantly, the authors emphasized that lack of support from supervisors exhibited a more dramatic effect on job burnout than did co-worker support. Laschober, de Tormes Eby, and Kinkade (2013) found significant negative correlations between supervisor support and job strain among substance use counselors. In a meta-analysis of 40 studies, Watkins (2014) found supervisory alliance to be positively linked to many variables related to mental health professionals, including

higher self-efficacy, job satisfaction, well-being, and perceived effectiveness. Watkins also found significant negative correlations with supervisory alliance, including perceived stress, role ambiguity, and role conflict.

Mental health professionals in primary care may require more specialized supervision to face the unique challenges in integrated care, including resistance to practice changes, adaption to medical models of care, and interaction with diagnoses not a part of the BHC's education or clinical training (Dale & Lee, 2016; Pratt & Lamson, 2012). Edwards and Patterson (2006) outlined the need for BHCs to receive supervision specifically designed for integrated care. The authors recommended BHC supervision focused on medical culture, collaboration with medical teams, increased awareness and understanding of medical diagnoses, and attention to person-of-the-therapist issues.

Pratt and Lamson (2012) described a multilevel integrated care supervision model based on Doherty, McDaniel, and Baird's (1996) five levels of integrated care. Pratt and Lamson purposed that supervisor support will vary based on different levels of integration. For example, Level 1 supervision would likely take place off site and focus on collaborating with other services outside of the BHC's facility, including releases of information, referral methods, and maintaining contact with other providers. Level 2 supervision would include regular on-site visits from a *profession-based* supervisor who would assist the BHC in collaborating with other disciplines and considering the various ethical and procedural codes. Level 3 entails on *on-site* supervisor who may be from a different professional discipline who works with the BHC and others as a unit. This level would include particular guidance for the BHC on emergency situations present in a medical setting. Supervisees in Levels 4 and 5 would benefit from an on-site supervisor

from the supervisee's same profession who meets regularly to discuss approaches to collaboration, patient outcomes, shared documentation, and other aspects of the medical environment (Pratt & Lamson, 2012).

Co-worker support. Social support has been defined as the perceived level of support an individual receives from family members, friends, and significant others (Zaleski, Levey-Thors, & Schiaffino, 1998). Social support can range from simple physical resources to more complex emotional or mental health resources (House, Umberson, & Landis, 1998).

In recent years, social support has been linked to a high number of cognitive and behavioral constructs, including resilience (Gloria, Castellanos, Lopez, & Rosales, 2005; Wilks, 2008), coping mechanisms (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012), burnout (Jacobs & Dodd, 2003; Maslach et al., 2001), communication (Macgeorge, Samter, & Gillihan, 2005), and optimism (Karademas, 2006). Social support has been found to be significantly related to overall mental health (Caron, Latimer, & Tousignant, 2007; Kawachi & Berkman, 2001; Leung, Chen, Lue, & Hsu, 2007). For example, higher levels of psychological distress are reported from individuals who report higher levels of social isolation (Kawachi & Berkman, 2001), feelings of loneliness, lack of confidant, or lack of friendships (Durden, Hill, & Angel, 2007; Stravynski & Boyer, 2001)—all of which signify an actual or perceived lack of social support (Hill, Ross, & Angel, 2005). Even more, researchers have found social support to have more effect on distress than impoverished conditions (Caron et al., 2007).

Specifically, co-worker support has been described as the exchange of assistance, knowledge, support, expertise, and encouragement when needed between individuals in

the workplace (Zhou & George, 2001). O'Driscoll, Brough, & Killiath (2004) referred to co-worker support as the giving and receiving of assistance, information, feedback, understanding, and advice between co-workers. Haines, Hurlbert, and Zimmer (1991) studied relationships between co-worker support, occupational stress, and strain (health or physical problems on the job). The authors found that participants who experienced a high level of co-worker support were less likely to develop physical or health problems due to job stress.

Chiaburu and Harrison (2008) observed co-worker support and co-worker antagonism. The authors defined co-worker support as co-workers receiving desired communication from another worker (e.g., assistance and kindness), whereas co-worker antagonism was defined as co-workers receiving undesired communication (e.g., verbal abuse and incivility). Co-worker support was positively correlated with organizational commitment and job satisfaction. Chiaburu and Harrison also showed a negative correlation between co-worker support and absenteeism, effort reduction, and turnover. In addition, the authors found co-worker support to be positively correlated with task performance and citizenship behaviors.

Leiter and Maslach (1988) studied the impact of co-worker support on a group of health care workers in California. Fifty-two health care professionals in an emergency room environment were surveyed. Higher levels of co-worker support correlated with high levels of personal accomplishment and lower levels of burnout. Co-worker support was shown to be positively related to organizational performance (Joiner, 2007), work–life balance (Thompson & Prottas, 2006), and organizational commitment (Raabe & Beehr, 2003).

Adversely, Ng and Sorenson (2008) theorized that co-worker support could have negative effects for the worker. For example, the authors suggested that co-worker support could be motivated by self-promotion or by political gains (Ferris & Kacmar, 1992). They suggested co-worker support may indicate a lack of independence or incompetence (Peeters, Buunk, & Schaufeli, 1995). Ng and Sorenson found that other types of support (e.g., supervisor and organizational) were more strongly related to employees' work attitudes than co-worker support. Still, evidence appears to demonstrate that co-worker support has more positive than negative effects for workers (Hefner & Eisenbert, 2009; Leiter & Maslach, 1988).

Even with compelling research emphasizing the advantages of co-worker support, BHCs may find integrating into primary care systems challenging. Integrating physical and behavioral treatment in primary care requires a paradigm shift for all involved and "interaction between described ideals, locally available resources, and decisions regarding resource deployment" (Davis et al., 2015, p. S34). BHCs "should not expect the primary care environment to adapt in response to their presence" (Hunter et al., 2009, p. 18) and are expected to "bridge the gap" between different disciplines within the culture of primary care (Glueck & Foreman, 2014, p. 169). It is important that BHCs make themselves useful to providers and patients, especially in clinics that are not used to an integrated culture.

Improving the workflow and communication in an integrated clinic involves "training programs, training manuals, an initial process of having clinicians shadow each other, ongoing mentoring, and ongoing interprofessional team meetings" (Dickinson, 2015, p. S103). Clinic administrators can develop integrated training programs and

resources, collect and disseminate best practices, and provide mentoring opportunities. Competent BHCs will remain open to ongoing training and consistent collaboration across multiple disciplines (McDaniel et al., 2014). Supervisor and co-worker support may impact BHCs' experiences on the job and perceived levels of stress.

Psychological distress. Integrating BHCs into medical settings requires a paradigm shift to which some physical and mental health providers may be resistant (Kessler, 2010). In addition to the professional demands that exist within traditional mental health settings, BHCs learn to work closely with medical providers, clinic staff, and administrators, as well as engage patients presenting with a variety of medical issues (Glueck, 2015). Mental health professionals in primary care may experience work stress related to the daily care of others who might be significantly distressed (Sabin-Farrell & Turpin, 2003). Figley (1995) emphasized the "cost to caring" mental health professionals may experience as a result of listening and caring for those who are suffering with fears or pain (p. 5).

Psychological distress is a term used to describe an individual's perceived mental stress that may influence emotional or physical functioning (Vernon & Roberts, 1981). Emotional impairment among mental health professionals has been described as difficulty completing professional duties due to conflict, mental illness, or chemical dependency (Laliotis & Grayso, 1985), whereas emotional distress among mental health professionals may involve anxiety, frustration, confusion, discouragement, and anger (Skovholt, 2011). Psychological distress has been associated with individuals who provide social support to traumatized individuals (Adams, Boscarino, & Figley, 2006); however, limited research has focused on professionals providing care to traumatized

patients (i.e., therapists, nurses, social workers, etc.; Figley, 2002). Researchers have posited that taking care of such individuals can be highly gratifying (Ohaeri, 2003) but it can also increase levels of psychological distress (Sabin-Farrell & Turpin, 2003).

Smith, Robinson, and Young (2007) found psychological distress to be adversely related to overall wellness in mental health professionals during training. In the sample of mental health professionals, 47.8% of the participants reported experiencing significant levels of psychological disturbance during training in at least one of the construct areas: interpersonal relationships, symptom distress, and social roles. Over 10% (10.7%) of Smith et al.'s participants indicated significant disturbance in all three areas. Lambie, Smith, and Ieva (2009) reported that between 9-16% of mental health trainees ($N = 111$) indicated high levels of psychological distress. de Vries and Valadez (2006) performed a study in which between 5.8-22.1% of mental health trainees indicated significant distress, impairment, or negative attitudes during training. Mallinckrodt and Wei (2005) found psychological distress to be positively associated with anxiety and avoidance and negatively associated with social competency and social support among mental health trainees.

Self-Efficacy

Mental health professionals preparing to work in primary care settings prepare themselves to face the unique challenges of the BHC role and to work with patients from a wide variety of ages, backgrounds, and presenting issues. An important factor when considering how well prepared BHCs are to work in primary care is the concept of self-efficacy. Self-efficacy refers to one's belief that one can perform certain duties or achieve certain goals (Luszczynska & Schwarzer, 2005).

According to Bandura (1977), self-efficacy is a critical factor in training competent mental health professionals (Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Lent et al., 2006). Self-efficacy is one of the primary constructs behind social cognitive theory, which postulates that human development is not based solely on either environmental or biological factors but rather complex interactions between an individual's behavior, personal factors, and environment (Bandura, 1986). Social cognitive theory postulates that individuals control their own development, interpreting information from both personal and environmental factors, which then alters their behaviors. Self-efficacy is central to social cognitive theory in that it helps individuals determine what behaviors they will pursue and with what intensity (Bandura, 1986).

Bandura (1977) defined outcome expectancy as "a person's estimate that a given behavior will lead to certain outcomes," whereas an efficacy expectation or self-efficacy is "the conviction that one can successfully execute the behavior required to produce the outcomes" (p. 191). Bandura posited that outcome and efficacy expectations are different in that individuals may believe that certain behaviors may lead to desired outcomes, but they may have doubts as to their ability to produce those behaviors. Chen et al. (2006) described self-efficacy as "an important mediator of performance and involves the degree to which people are capable, diligent, and committed in their work" (p. 211).

For the past three decades, the construct of self-efficacy has been discussed in regard to individual motivation and confidence building in specific areas of behavior. Researchers have studied self-efficacy in relation to research interest (Bard, Bieschke, Herbert, & Eberz, 2000), career counseling (Betz, 2004), AIDS prevention (O'Leary, 1992), athletic performance (Vargas-Tonsing & Bartholomew, 2006), job satisfaction

(Caprara, Barbaranelli, Steca, & Malone, 2006), job-seeking skills (Strauser & Berven, 2006), ability to cope (Ozer & Bandura, 1990), physiological effects (Bandura et al., 1982), and parenting (Teti & Gelfand, 1991). Studies have linked self-efficacy with human development factors such as personality, social interactions, life satisfaction, and stress (Luszcynska, Gutierrez-Dona, & Schwarzer, 2005).

Self-efficacy has been shown to be an important factor in predicting an individual's motivation, performance, and resilience. For example, Zajacova, Lynch, and Espenshade (2005) found that self-efficacy was the single strongest predictor of academic performance (grade point average) among first-year college students and that academic stress and self-efficacy were negatively correlated. Chemers and Garcia (2001) found that individuals with high self-efficacy make better use of coping skills when dealing with stress than those with lower self-efficacy. Bandura (1982) found that individuals with lower self-efficacy are more vulnerable to anxiety and those with higher self-efficacy possess greater "staying power" when experiencing stressors (1982, p. 88). In addition, Stajkovic and Luthans (1998) conducted a meta-analysis of 114 studies that showed self-efficacy to be positively correlated with work-related performance. Also prominent is literature relating self-efficacy to mental health professionals.

Counselor self-efficacy. Within Bandura's theories related to social cognition exists the more focused construct of counselor self-efficacy, which refers to a mental health professional's "beliefs or judgments about his or her capacities to effectively counsel a client in the near future" (Larson et al., 1998, p. 180). Counselor self-efficacy has been described as a primary difference between understanding how to assist a patient and assisting a patient effectively (Greason & Cashwell, 2009). "Equally critical as

academic and clinical accomplishment in determining future success as a counselor is affirmation of the interpersonal readiness of the [mental health professional] to work with clients and colleagues" (Homrich, 2009, p. 2). Similar to Bandura's (1977) original self-efficacy construct, counselor self-efficacy attempts to link a mental health professional's perceived abilities with actual abilities. Counselor self-efficacy assumes self-efficacy is a critical mechanism by which mental health professionals practice effectively and persevere through difficult professional situations (Iarussi et al., 2013).

Greason and Cashwell (2009) found that mental health professionals who reported higher levels of counselor self-efficacy also experienced higher levels of job performance due to the elevated levels of motivation. The authors posited that self-efficacy and competence are similar, and that mental health professionals with high self-efficacy see professional difficulties as challenging rather than overwhelming. Counselor self-efficacy has been related to attachment, career counseling, mindfulness, emotional intelligence, performance, anxiety and stress, and mental health professional training and supervision (Barnes, 2004; Betz, 2004; Cashwell & Dooley, 2001; Daniels & Larson, 2001; Easton, Martin, & Wilson, 2008; Friedlander, Keller, Peca-Baker, & Olk, 1986; Iarussi et al., 2013; Larson, Clark, et al., 1999; Marmarosh et al., 2013; O'Leary, 1992).

Larson and Daniels (1998) conducted a meta-analysis of 32 self-efficacy studies and found that counselor self-efficacy significantly correlated with patient treatment expectancies and mental health professional self-evaluations. Larson and Daniels (1998) also found higher levels of self-efficacy related to higher levels of mental health professional performance and negatively correlated with levels of anxiety. Self-efficacy's influence on mental health professionals has been discussed in literature for

years (Friedlander, Keller, Peca-Baker, & Olk, 1986; Kozina et al., 2010; Leach et al., 1997) and has been significantly associated with effectiveness of treatment outcomes (Larson & Daniels, 1998; Lent et al., 2006).

In addition, studies have been done to better define correlations between supervisor support and self-efficacy among mental health professionals and trainees. For example, Daniels and Larson (2001) studied the connection between counselor self-efficacy, supervisor feedback, and anxiety among mental health trainees. They used the Counselor Self-Estimate Inventory (COSE) and State Trait Anxiety Inventory to measure participants' perceptions regarding supervisor feedback. They found that positive feedback from supervisors decreased anxiety and increased counselor self-efficacy. A negative correlation was found between negative feedback from supervisors and trainee anxiety. Using a pre-/posttesting design, COSE scores were increased significantly by positive feedback, while scores were decreased significantly by negative feedback. Barns (2004) found that higher levels of self-efficacy are associated with a mental health trainee's ability to value and respond to supervisor feedback during a training process. These studies seem to suggest that mental health trainees with higher levels of self-efficacy are increasingly open to supervisor evaluation and guidance, making adequate use of their supervisory experience.

However, Ladany, Ellis, and Friedlander (1999) found that changes in supervisory working alliance did not positively correlate to self-efficacy. Ladany et al. used a revised version of the Supervisory Working Alliance Inventory (SWAI) and the Self-Efficacy Inventory (SEI) to pretest and posttest 107 mental health supervisees. In this longitudinal study, the authors found significant links between counselor self-efficacy and

satisfaction; however, no significant correlations existed between supervisory working alliance and self-efficacy. Both Efstation et al. (1990) and Ladany et al. (1999) called for further study in the area of supervisory alliance and self-efficacy and more rigorous examination of the measures. Even with some adverse findings, the majority of related studies have found higher levels of supervisor support linked to higher levels of self-efficacy (Cashwell & Dooley, 2001; Kozina et al., 2010; Reece et al., 2009).

Stetz, Stetz, and Bliese (2006) studied the interactions between self-efficacy, supervisor support, co-worker support, and stress. Stetz et al. recruited 96 military police officers from the U.S. National Guard and Army Reserve to complete pre-/posttesting during a 3-month period. The authors found a strong connection between self-efficacy and co-worker support when attempting to minimize the effect of certain stressors. Stetz et al.'s results may suggest that co-worker support can positively impact one's belief (self-efficacy) that he or she can perform occupational duties. Hefner and Eisenberg (2009) reported similar results—that higher levels of social support have been shown to positively influence self-esteem and self-efficacy and negatively influence psychological stress. The studies highlighted here appear to be part of a small number of studies that have examined the links between social support and self-efficacy.

In addition, researchers have studied the effects of psychological distress and self-efficacy. Namely, Bandura (1986) contended that higher levels of self-efficacy were adverse to higher levels of stress, anxiety, and depression. Wiedenfeld et al. (1990) studied the effects of coping self-efficacy and immune system. The authors found that high levels of stress can contribute to an individual's fatigue and stress-related disorders. Wiedenfeld et al. found "perceived self-efficacy to exercise control over stressors is a

modulator of immunological system status" (p. 1089). These results seem to suggest that self-efficacious individuals may experience less overall psychological and physical stress.

Self-efficacy and mental health training. Leach, Stoltenberg, McNeil, & Eichenfield (1997) surveyed 142 mental health trainees to consider if counselor self-efficacy levels differed depending on the trainee's developmental level. The authors found significant differences between first-year and second-year trainees and that more clinical experience positively correlated with higher levels of counselor self-efficacy. Melchert, Hays, Wiljanen, and Kolocek (1996) surveyed 138 licensed mental health professionals and found significant relationships between perceptions of counselor self-efficacy and higher levels of experience. Larson, Clark, et al. (1998) found self-efficacy to increase as trainees gain more educational experience, professional experience, and experience as a supervisee. Larson et al. also found positive correlations between self-efficacy, experience, problem-solving efficacy, and self-concept. Findings appeared to suggest that increased training and experience positively influence self-efficacy.

Lent et al. (2006) made the distinction between general and patient-specific counseling self-efficacy. The authors hypothesized that self-efficacy scores would change significantly over time due to experience in treating specific presenting problems. One hundred mental health professionals and their patients were recruited to be pre- and posttested throughout the treatment process. Patients were recruited specifically for the study from a pool of undergraduate students from the same university. The Counselor Activity Self-Efficacy Scale (CASES) was used to assess self-efficacy. Results indicated that CASES scores increased over time and reflected a trend toward linear growth in self-efficacy as treatment progressed. Lent et al. suggested that novice counselors do tend to

grow in self-efficacy with more experience in each treatment situation. These authors suggested that growth in self-efficacy may be based on the mental health professional's increased experience with particular clients, presenting issues, or patient factors, rather than increased professional experience overall.

Tang et al. (2004) examined the relationship between self-efficacy and training background by surveying 116 mental health trainees from six different programs in the U.S. midwest. The authors found that the trainees with more experience related to clinical instruction, coursework, and internship hours positively correlated with higher self-efficacy. Trainees from accredited programs had higher self-efficacy scores in the areas of counseling adjustment reactions, counseling affective disorders, and clinical interview skills. Similarly, Larson, Clark, et al. (1999) found a link between trainees' perceptions of self-efficacy and specific interventions (i.e., role play, videos, etc.) used during the training process. The results may suggest that the specificity of training received may influence mental health professionals' beliefs in their abilities to work in primary care settings.

Conclusion

A growing workforce need exists for mental health professionals to work in primary care settings across the United States (Blount & Miller, 2009; Burke et al., 2013). Mental health professionals with inadequate training and support may struggle to meet demands of working in unfamiliar behavioral health roles (Commings & Commings, 2009). Many mental health professionals learn to perform BHC duties while on the job as few educational and training programs are available for this emerging position (Vogel et al., 2014). Additional challenges exist for mental health professionals

working in integrated care settings, including lack of training related to working in multidisciplinary settings (Johnson & Freeman, 2014), lack of collaboration with medical providers in medical settings (Dickinson, 2015), inadequate supervisor and co-worker support (Davis et al. 2015; Edwards & Patterson, 2006), and increased levels of psychological distress (Adams et al., 2006). Increased understanding of what factors impact self-efficacy may contribute to the proper training and competencies of mental health professionals working in primary care settings.

Working Hypotheses

H1: Mental health professionals working in medical settings who report higher levels of co-worker support will report higher levels of counseling self-efficacy.

H2: Mental health professionals working in medical settings who report higher levels of supervisory working alliance will report higher levels of counseling self-efficacy.

H3: Mental health professionals working in medical settings who report lower levels of distress will report higher levels of counseling self-efficacy.

H3a: Psychological distress and supervisory working alliance will interact to predict self-efficacy such that participants who report the least distress and the strongest supervisory working alliance will report the highest counselor self-efficacy.

H3b: Psychological distress and co-worker support will interact to predict self-efficacy such that participants who report the least distress and the strongest co-worker support will report the highest counselor self-efficacy.

CHAPTER II

METHOD

Research Design

The goal of the study was to examine the experiences of mental health professionals working in integrated healthcare settings. Chapter 3 is divided into four sections. The first section contains a description of the participant characteristics. Study measures are described in the second section. The third section discusses the study covariates. Finally, a summary of the results of the four hypotheses and additional analyses are given in section four. A series of multiple regression analyses was employed to examine co-worker support, supervisor support, and psychological distress as predictors of counseling self-efficacy. In summary, positive associations were found between counselor self-efficacy and co-worker support, specifically nurse and doctor support. Negative associations were found between psychological distress and all counselor self-efficacy subscales. In addition, interactions between certain variables also predicted higher levels of self-efficacy among clinicians working in healthcare settings.

Population and Sampling

Forty-nine mental health professionals currently working in integrated health care settings (i.e., primary care, hospital, etc.) participated in the current study by completing an online survey. Master's-level mental health professionals working in full-time and part-time positions were included. Participants were currently engaged in an ongoing licensure supervision process, meeting with a supervisor on a weekly or bimonthly basis. In addition, participants with 3 months or less experience meeting with their licensure supervisor were excluded from the study.

This nonrandom, convenience sample of mental health professionals was invited to participate via online social media and electronic mail promotion. Permission to access these mental health professionals was requested from multiple integrated primary care facilities and post-master's behavioral health training programs across the United States. Further, permission to access participants was requested by state licensure supervisors across the United States. If the mental health professional was not currently working within an integrated health care setting, he or she was excluded from the study.

Measures

Demographic Questionnaire

A background questionnaire was used to collect the following demographic information: age, gender, race/ethnicity, and current or intended professional license. Data regarding age, gender, and race/ethnicity were collected for descriptive purposes. Professional license options included (a) licensed professional counselor, (b) licensed marriage and family therapist, (c) psychologist, (d) licensed clinical social worker, or (e) other. In addition, participants were surveyed for the following information: years of experience in primary care environment, involvement and frequency of supervision meetings, and nature of training received to perform behavioral health duties. Years of experience options included (a) 0-1, (b) 1-2, and (c) 2 or more. Frequency of supervision meetings options included (a) weekly, (b) two times per month, and (c) less than two times per month. The nature of training received to perform behavioral health duties options included (a) master's-program coursework, (b) post-master's training, and (c) on-the-job training.

Counselor Self-Estimate Inventory

The COSE was used to measure the construct of counselor self-efficacy defined as "a counselors' beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson et al., 1992, p. 180). The COSE's 37 Likert-type items lead to an overall self-efficacy score and five subscale scores, which include process, microskills, cultural competence, difficult client behaviors, and awareness of values. Each item is rated using a 6-point Likert scale (1 = *strongly disagree* to 6 = *strongly agree*), yielding a range of possible scores from 37-222. Higher scores suggest higher levels of self-efficacy. For the purposes of this study, the cultural competence and awareness of values subscales were excluded. Subscales process, microskills, and difficult client behaviors were used to assess participant perceived levels of counselor self-efficacy.

Larson et al. (1992) reported the total score reliability coefficients for the COSE was alpha .93. Internal consistencies for subscales included .87 for process, .88 for microskills, .78 for cultural competence, .80 for difficult client behaviors, and .62 for awareness of values. Martin, Easton, Wilson, Takemoto, & Sullivan (2004) also reported internal consistencies for COSE subscales, including .87 for process, .83 for microskills, .67 for cultural competence, .81 for difficult client behaviors, and .55 for awareness of values. They reported that the lower internal consistence scores on the cultural competence and awareness of values subscales could be due their brevity (four items compared to seven to 12 items in other subscales). Test–retest reliability proved adequate with r = .87 for the total score (Larson et al., 1992).

Validity measures for the COSE have shown a positive correlation with other counselor constructs, including problem-solving behavior, performance expectations, self-concept, and counselor performance (Larson et al., 1992). Minimal correlations were found between the COSE and personality type, achievement, and aptitude (Larson et al., 1992). Larson et al. (1992) found significant positive relationships between the COSE and counselors level of training, $F(2,314) = 4.17$, $p < .001$, and years of experience, $F(2,314) = 53.75$, $p < .001$. Gender was not positively correlated ($p > .05$). Convergent validity was indicated with positive correlations found between the COSE and the Tennessee Self Concept Scale (Fitts & Roid, 1964) and the Problem Solving Inventory (Heppner, 1982; Larson et al., 1992). Discriminate validity was indicated with negative correlations found between the COSE and aptitude (Sternberg & Williams, 1997), personality type (Myers-Briggs Type Indicator; Myers, McCaulley, & Most, 1985), and social desirability (Social Desirability Scale; Crowne & Marlowe, 1960).

The process subscale of the COSE (10 items) considers the counselor's repeated actions during a session (e.g., definition of the problem and goal development). An example process item is "I am certain that my interpretation and confrontation responses will be concise and to the point." The microskills subscale (12 items) measures a counselor's expectancy to use microcounseling skills in session (e.g., clear responding and tracking the client). An example microskills item is "When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point." The cultural competence subscale reflects the counselor's ability to work with clients from other cultures. An example cultural competence item is "In working with culturally different clients, I may have a difficult time viewing

situations from their perspective." The difficult client behaviors subscale considers the counselor's abilities with at-risk or noncooperative clients. An example difficult client behavior item is "I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals." The awareness of values subscale reflects the counselor's held values and biases. An example awareness of values item is "I am likely to impose my values on the client during the interview."

Outcome Questionnaire 45.2

The Outcome Questionnaire 45.2 (OQ-45.2; Beckstead et al., 2003) was used to measure mental health professionals' psychological distress. The term *psychological distress* has been used to describe an individual's perceived mental stress that may influence emotional or physical functioning (Vernon & Roberts, 1981). The OQ-45.2, a baseline and ongoing screening tool, was designed to assist clinicians in tracking client progress by measuring critical areas of mental health functioning, distress, relationships, social role, and quality of life (Lambert, Burlingame, et al., 1996). This 45-item questionnaire encompasses a total score of psychological distress and three subscales of symptom distress, social role, and interpersonal relationships. Symptom distress refers to the symptoms found in the most common psychological difficulties, including anxiety, affective, adjustment, and stress-related difficulties. Interpersonal relations involves the difficulties of loneliness, conflicts with others, family and marriage problems. Social role refers to the extent to which difficulties in the social roles of worker, stay-at-home parent, or student are present, including conflicts at work, overwork, distress, and inefficiency. The subscales symptom distress and social role was used in this study to assess the participant's perception of current, personal level of distress.

The OQ-45.2 was designed to be repeatedly administered, providing the counselor with ongoing information regarding the client's mental health status. Each item is rated using a 5-point Likert scale (0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *frequently*, 4 = *always*), yielding a range of possible scores from 0-180. Quality of life items (nine) are evenly distributed within the three subscales. Example questions include "I blame myself for things" and "I feel loved and wanted."

Internal consistency for the OQ-45.2's total score and symptom distress subscale were excellent at .93 and .92, respectively. The interpersonal relations and social role subscales were .74 and .70 (Lambert et al., 1996). Test–retest reliability for the total score was .84, whereas the symptom distress was .78, interpersonal relations was .80, and social role was .82. Beckstead et al. (2003) found the OQ-45.2's total score concurrent validity to be significant at the .01 level, ranging from .55-.85, in correlations found between the OQ-45.2 and the Symptom Checklist 90-Revised (SCL-90; Derogatis, 1979), Zung Self-Rating Anxiety Scale (Zung, 1976), Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Social Adjustment Scale (Weissman & Bothwell, 1976), Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), Taylor Manifest Anxiety Scale (Taylor, 1953), and the State-Trait Anxiety Inventory (Spielberger et al., 1970).

Umphress, Lambert, Smart, Barlow, and Clouse (1997) found moderate to high concurrent validity with a number of similar measures. For example, the authors reported .82 to .92 correlations between the SCL-90-R (Derogatis, 1979) and the symptom distress subscale and .54-.73 correlation between the Social Adjustment Rating Scale (Weissman & Bothwell, 1976) and the social role subscale (Umphress et al., 1997). Normative

information has been discussed on data collected nationwide (Lambert & Finch, 1999). In addition, Boswell, White, Sims, Harrist, and Romans (2013) tested for correlations between the OQ-45.2 and a client's presenting problems (e.g., anxiety, family issues, and substance abuse). Strong positive correlations were found between the OQ 45.2 total score, symptom distress subscale, participant anxiety, depression, and stress, which may suggest adequate validity of the measure.

Supervisory Working Alliance Inventory

The SWAI-Trainee Version (SWAI-T; Efstation et al., 1990) was used to assess mental health professionals' perceptions of the quality of the alliance with their clinical supervisor. The supervisory working alliance addresses the supervisor's impact on the trainee and the trainee's reciprocity of the knowledge and skill imparted by the supervisor. Efstation et al. (1990) believed that researchers need a more sensitive tool with which to measure rapport and focus within the supervisory alliance.

In the developmental study of the SWAI, Efstation et al. (1990) assessed 185 supervisors and 178 trainees from 42 states and Canada. Results indicated acceptable reliability and validity, and proved to measure three supervisor domains (rapport, client focus, and identification) and two supervisee domains (rapport and client focus). Rapport refers to the bond that can develop between the supervisor and supervisee, therefore forming an alliance. Client focus refers to the mutually agreed-upon plans and actions to be taken by the supervisee to help meet treatment goals specific to each client. Identification refers to the supervisor's perception of how well the supervisee identifies with the supervisor. The authors found positive correlations between the SWAI and the

SEI, giving the authors reason to suggest that supervisory working alliance may positively correlate of self-efficacy.

The SWAI-T, the trainee portion of the SWAI, is a 19-item instrument that measures the trainee's perception of the supervisory working alliance in two factor areas: rapport and client focus. Items are rated on a 7-point Likert-type scale ranging from *almost never* (1) to *almost always* (7). The rapport subscale (Items 1-12) measures the trainee's perception of the supervisor's efforts to build a bond within the supervision process. The trainee portion of the SWAI were used for the purposes of the current study to assess the supervisee's perception of the quality of the supervisory relationship. An example item from this subscale is "My supervisor is tactful when commenting about my performance." The client focus subscale (Items 13-19) measures the trainee's perception of the efforts by the supervisor to work toward specific goals and tasks that benefit the client. An example from this subscale is "My supervisor encourages me to formulate my own interventions with the client." Scores in the rapport and client focus subscale can range from 12-84 and 7-49, respectively, with higher scores reflecting perceptions of higher rapport between the supervisor and trainee and higher client focus during the supervision process.

Using Cronbach's alpha, Efstation et al. (1990) found the SWAI-T's internal consistency was .95 for the total score, .90 for the rapport subscale, and .77 for the client focus subscale. Correlations for the SWAI-T ranged from .44-.77 for the rapport scale and .37-.53 for the client focus scale. Convergent and divergent validity was found to be adequate when using the Supervisor Styles Inventory (Efstation et al., 1990; Friedlander & Ward, 1984).

Social Support Scale

Co-worker support has been referred to as the giving and receiving of assistance, information, feedback, understanding, and advice between co-workers (O'Driscoll, 2000). O'Driscoll (2000) developed a brief, four-question scale to assess perceived social support of co-workers called the Social Support Scale. The Social Support Scale was used in this study to measure co-worker support among mental health professionals in primary care settings.

Previous studies have shown the Social Support Scale's reliability (alpha coefficient) to range between .89-.91 (O'Driscoll et al., 2004). The scale is made up of four Likert type items that assess participants' perceptions of coworker practical assistance, helpful information or advice, clear and helpful feedback, and sympathetic understanding and advice (e.g., "My coworkers provide me with practical assistance"). Responses range from *strongly disagree* to *strongly agree*. Total scores range from 4-24 with higher scores indicating a higher perception of social support.

O'Driscoll's (2004) Social Support Scale has been used in multiple studies to measure co-worker support. Brough and Kelling (2002) surveyed 1495 workers from 23 large organizations in New Zealand representing a variety of industries. They found a negative association between perceived levels of co-worker support and the presence of a partner in the life of the participant. Brough and Kelling suggested that, when a significant other is present, individuals tend to rely less on co-worker support. The Social Support Scale was used to study a group of police personnel in India (Rathi & Barath, 2013). The study found that co-worker support significantly affected participants' work-to-family conflict and family satisfaction. Ibrahim (2014) used the Social Support Scale

to observe the interactions of co-worker support, job stress, and organization-based self-esteem. Ibrahim found co-worker support to be positive associated with organization-based self-esteem and that individuals who experience higher levels of social support also perceive themselves to be a valued member of the organization. In addition, the Social Support Scale has been used in the development of other larger measures, including the New Job Stress Scale (Shukla & Srivastava, 2016).

Procedures

Participants for this study were recruited from multiple integrated health care facilities and post-master's behavioral health training programs from across the United States. Permission to access mental health professionals in health care settings was requested from administrators and supervisors of health care facilities via phone, email, and face-to-face interaction, beginning in the Nashville, Tennessee area. Program directors from post-master's behavioral health training programs (i.e., Arizona State University, East Tennessee State University, University of Massachusetts, Fairleigh Dickinson University, University of Michigan, etc.) were contacted via phone and email to request permission to contact trainees with email survey links. Once access was granted, emails were sent by administrators and program directors to several hundred potential participants. Invitations for participation were also listed on behavioral health online distribution lists (e.g., Collaborative Family Healthcare Association). In addition, permission to access participants was requested by state licensure supervisors across the United States by use of associations' membership listings (e.g., Tennessee Licensed Professional Counselors Association).

Individuals interested in participating were directed to follow an address link where they accessed the online survey. The survey screened each participant for demographic factors, including age, gender, race/ethnicity, and current or intended professional license. Participants who met the study requirements agreed to participate through an informed consent (an agreement indicated by clicking on text reading "I have read this page, and I would like to take the survey"). Participation in the study was voluntary, and participants were free to refuse to participate or withdraw from the study at any time. No penalties or unfair treatment resulted for those who choose not to take the survey. This study was not in any way connected with the participant's place of employment.

An informed consent informed participants of their rights and delineated potential risks of taking the survey. Participants were alerted that they may experience new awareness or insights related to self-efficacy, supervisor or co-worker support, or survey questions related to current distress. Participants were alerted that they may experience positive emotions related to the understanding that they are contributing to behavioral health research. In addition, participants were alerted that they may experience discomfort related to answering questions about lived experiences in their behavioral health role. No foreseeable risks existed associated with the survey other than the emotions that may have arisen from the experience of taking the survey. Participants had the option of skipping questions. The online survey included an informed consent by which individuals accepted or declined participation.

The survey consisted of 33 OQ-45.2 items, four Social Support Scale items, 19 SWAI-T items, 28 COSE items, and a short demographic information form. No

identifying information was collected. Participants were given the option of including their email address if they wished to be entered in to a drawing for incentives (multiple $25 Visa gift cards). Participants interested in incentives were directed to another secure website in order to provide email address information. Once the data were collected, a few of the participants who provided their email addresses were randomly selected to receive a gift card.

Forty-nine participants completed the online survey. If any of the participants filled out the survey more than once, the duplicate copies were discarded. A *validity check* item was included to recognize individuals who were either inattentive or randomly responding to survey items. The item was "Please do not respond to this item."

SurveyMonkey was used in this study to survey participants from any Internet-connected device. For the data to remain confidential, participants followed a link to an online survey website. Neither participants' email address nor their computer IP address was attached to survey responses. This allowed survey data to remain anonymous. SurveyMonkey used data encryption methods to help ensure confidentiality of participants' information and survey answers. Participants were able to take the survey anonymously, providing their email address only if they were interested in being entered into a drawing for incentives. The use of SurveyMonkey minimizes data entry errors as each participant directly entered his or her data, which was then held and accessible to the investigator.

The researcher could not guarantee absolute confidentiality of data due to the limited protections of online access. Participants were reminded to close their Internet browser when the survey was complete to help with overall confidentiality. Collected

survey data were stored on the researcher's computer and password-protected at all times. Data will be maintained for 2 years following the completion of the study, at which point they will be erased. Data collected for this study will remain confidential unless revelation is required by law.

Analytical Strategy

The data were analyzed using SPSS 21.0. Prior to performing analyses to address study hypotheses, a series of bivariate analyses was conducted examining relationships between potential covariates and the dependent variables of interest in this study. Selected covariates were then entered into a series of multiple regression analysis, along with the independent variables of interest in this study. The covariates of graduate education, location of supervisor, and workplace diversity was entered along with supervisor support, co-worker support, and distress as predictors of counselor self-efficacy. Correlation analysis was used observe relationships between co-worker support and self-efficacy, supervisor support and self-efficacy, and psychological distress and self-efficacy. Multiple regressions was used to analyze relationships between self-efficacy and dependent variables. *T* tests were used to analyze the differences in gender and predictors of counselor self-efficacy. Regression analyses were used to determine if meaningful interactions exist between psychological distress and supervisory working alliance and between psychological distress and co-worker support—both in relation to counselor self-efficacy. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were calculated to gain a comprehensive picture of participant characteristics.

CHAPTER III

RESULTS

Overview of the Data

The goal of the study was to examine the experiences of mental health professionals working in integrated health care settings. This chapter is divided into four sections that discuss the following: participant characteristics, study measures, study covariates, and results of the four hypotheses and additional analyses. A series of multiple regression analyses was employed to examine co-worker support, supervisor support, and psychological distress as predictors of counseling self-efficacy. In summary, positive associations were found between counselor self-efficacy and co-worker support, specifically nurse and doctor support. Negative associations were found between psychological distress and all counselor self-efficacy subscales. In addition, interactions between certain variables also predicted higher levels of self-efficacy among clinicians working in health care settings.

Participant Characteristics

Convenience sampling was used to recruit prelicensed mental health professionals working in integrated health care settings. Of the 225 clinicians to access the survey, 114 indicated that they were fully licensed in their state and were therefore excluded from the study. Forty-three respondents were not currently working in an integrated health care settings and were removed. Eighteen respondents had been meeting less than 3 months with their licensure supervisor and were excluded from the study. One respondent was removed due to not yet starting the process of pursing state licensure. The sampling goal

for this study of 100 participants was not obtained. A total of 49 participants were included in the data analysis.

Mental health professionals who met the following criteria were included in the study: currently working in an integrated setting, currently pursuing state licensure, and having met with state licensure supervisor for at least 3 months. Initial recruitment efforts involved soliciting integrated health care clinics across the United States, beginning with the State of Tennessee. Using this strategy alone proved insufficient due to low numbers of prelicensed professionals currently working in integrated care settings. Efforts solicited state license supervisors across the United States to recruit supervisees who were also working in integrated health care settings.

Of the final sample, 86% identified as female (n = 42) and 82% as Caucasian/non-Hispanic (n = 40). Mean age of participants was 35.51 (SD = 9.7) with a range of 25-63 (see Table 1). Nearly two thirds ranged in age from 25-34 years. All had completed a master's degree, whereas 26.5% of the sample were pursuing a doctorate degree or had completed a doctorate degree. The majority of participants graduated from programs focusing on either clinical mental health counseling (n = 20) or clinical social work (n = 15). Sixty-seven percent (67.3%) indicated they had received specific training during their master's program related to working in integrated health care settings.

Table 1

Participant Characteristics ($N = 49$)

Variable	*n*	%
Current age		
25-34	31	63.3
35-44	10	20.4
45-54	5	10.2
55-64	3	6.1
Sex		
Female	42	85.7
Male	7	14.3
Race/ethnicity		
Caucasian	40	81.6
Minority race	9	18.4
Graduate education status		
Completed master's degree	36	73.5
Pursuing or completed doctorate degree	13	26.5
Focus of graduate education		
Clinical mental health counseling	20	40.8
Clinical social work	15	30.6
Psychology	8	16.3
Marriage and family therapy	6	12.2
Training received related to integration		
Coursework specific to integration	33	67.3
Post-master's training/on-the-job training	16	32.6
Perception of workplace diversity		
No diversity at all	1	2.1
A little diversity	17	34.7
A moderate amount of diversity	11	22.4
A lot of diversity	10	20.4
A great deal of diversity	10	20.4
Location of supervision meetings		
Onsite face-to-face	33	67.3
Offsite face-to-face	10	20.4
Online/phone	5	10.2

Respondents were also asked about the location of their supervision meetings and perceived level of diversity in their workplace. Sixty-seven percent (67.3%) of those surveyed reported that they met with their licensure supervisor face-to-face at their workplace. The remaining participants reported they either met with their licensure supervisor off site (20.4%) or by phone/online (10.2%). As for workplace diversity, 34.7% of the sample perceived their site to have "little diversity," 22.4% perceived a "moderate amount of diversity," with 40.8% reporting "a lot of diversity" or "a great deal of diversity" in the workplace.

Scale Descriptives

The current study utilized counselor self-efficacy, psychological distress, supervisor support, and co-worker support along with participant characteristics data in an attempt to better understand the experiences of mental health professionals working in integrated settings. The COSE (Larson et al., 1992) was used to assess participant counseling self-efficacy. Perceived counseling self-efficacy was assessed across the three subcategories of microskills, counseling process, and working with difficult clients. Internal consistencies for the COSE subscales were excellent for microskills (a = .96) and counseling process (a = .94) and marginally acceptable for difficult client (a = .62). Larson et al. (1992) reported internal consistencies at .88 for microskills, .87 for counseling process, and .80 for difficult client. Mean scores included 4.99 for microskills, 4.67 for counseling process, and 4.69 for difficult client (range 1-6).

The OQ-45.2 (Beckstead et al., 2003) was used to assess participant psychological distress in the areas of personal distress and workplace distress. Lambert, Burlingame, et

al. (1996) reported internal consistencies for the OQ-45.2 subscales included .92 for symptom distress and .70 for social role. Internal consistencies were comparable in the current study with .86 for symptom distress and .65 for social role. Mean scores included .92 for symptom distress and 1.01 for social role (range 0-4).

Supervisor support was determined by using the SWAI-T (Efstation et al., 1990). Subcategories for supervisory alliance were supervisor rapport and supervisor focus. Efstation et al. (1990) reported internal consistencies for SWAI-T subscales included .90 for rapport and .77 for client focus. Internal consistencies in the current studies were excellent for rapport (a = .91) and good for client focus (a = .88). Mean scores for the SWAI-T were 6.06 for rapport and 5.58 for client focus (range 1-7). Finally, the Social Support Scale (O'Driscoll, 2000) was used to assess perceived co-worker support.

Table 2

Scale Descriptives and Cronbach's Alphas

Scale	Range	*M*	*SD*	α
COSE	1-6			
Microskills		4.99	.86	.96
Counseling process		4.67	1.04	.94
Difficult clients		4.69	.75	.62
SWAI-T	1-7			
Rapport		6.06	.88	.91
Client focus		5.58	1.05	.88
OQ 45.2	0-4			
Symptom distress		.92	.39	.86
Social role		1.01	.46	.65
Social Support Scale	1-5			
Doctor support		3.32	.96	.88
Provider support		3.63	.78	.87
Nurse support		3.56	.91	.90
Staff support		3.55	1.04	.90

Working in an integrated health care setting often requires mental health professionals to interact with professionals from a variety of medical disciplines. Therefore, co-worker support was assessed across four categories: doctor (i.e., MD, DO, Dr. Med, etc.), midlevel provider (i.e., physician assistant, nurse practitioner, etc.), nurse (i.e., registered nurse, licenses practical nurse, etc.), and staff (i.e., front desk workers, administrators, etc.). The positions of doctor, midlevel provider, nurse, and staff identify the most common disciplines found within a primary care environment (Hall et al., 2015). Internal consistencies in the current study included .88 for doctor support, .87 for provider support, .90 for nurse support, and .90 for staff support. O'Driscoll et al. (2004) reported a similar internal consistency range between .89-.91. Mean scores for the Social Support Scale included 3.32 for doctor support, 3.63 for provider support, 3.56 for nurse support, and 3.55 for staff support (range 1-5).

Covariates

T tests, analysis of variance, and correlations were used to test for relationships between covariates and variables. No significant relationships were evident between the dependent variable and covariates of sex, race, focus of graduate education, and training received related to integration. Significance was found between the dependent variable and the covariates of graduate education status, location of supervision meetings, and perception of workplace diversity. Therefore, the three covariates of education, supervision location, and workplace diversity were considered for all further analyses.

Major Findings

Co-Worker Support and Counselor Self-Efficacy

Hypothesis 1 stated that mental health professionals working in primary care settings who report higher levels of co-worker support will report higher levels of counseling self-efficacy. Twelve separate simultaneous multiple linear regression analyses were used to examine co-worker support (e.g., support from doctors, providers, nurses, and staff) predicted counselor self-efficacy (e.g., microskills, counseling process, and working with difficult clients). Final models included the covariates of graduate education, location of supervision, and workplace diversity. Covariates were removed from models one by one until a final model was selected.

Three of the 12 models were found to be significant. Initial analysis found that BHCs who reported more nurse support scored higher on microskills self-efficacy. The overall model was significant, $F(2, 46) = 3.43$, $R^2 = .13$, $p = .041$. For every unit increase in nurse support, microskills self-efficacy increased .29 units (see Table 3).

Table 3

Co-Worker Support Predicting Counselor Self-Efficacy

Model	B	*SE*	β	*t*	*p*
Predicting microskills					
Nurse support	.29	.13	.31	2.19	.034
Off-site supervision	.26	.26	.14	.99	.324
Predicting counseling process					
Nurse support	.49	.15	.37	2.84	.0070
More diverse workplace	-.26	.11	-.29	-2.27	.028
Predicting difficult client					
Doctor support	.29	.12	.37	2.66	.011
More diverse workplace	-.17	.09	-.27	-1.99	.053

Additionally, results showed that nurse support predicted counseling process self-efficacy, $F(2, 46) = 6.83$, $R^2 = .23$, $p = .003$. This effect was stronger with a beta of .49. In this model, the workplace diversity covariate was also significant, indicating that more diversity was associated with lower counseling process self-efficacy. More support from nurses increased clinician confidence to engage in the counseling process with patients. Finally, BHCs with more doctor support reported more confidence working with difficult clients, $F(2, 46) = 4.59$, $R^2 = .17$, $p = .015$. For every unit of doctor support, difficult client self-efficacy was .29 units higher.

Supervisory Alliance and Counselor Self-Efficacy

Hypothesis 2 posited that a stronger supervisor alliance would be positively associated with counselor self-efficacy. Hypothesis 2 was analyzed using six regressions to determine the association between supervisor alliance and counselor self-efficacy. Examination of results revealed that neither of the two supervisor alliance variables (e.g., supervisor focus and rapport) predicted self-efficacy, failing to provide support for Hypothesis 2. Probability values for overall F tests ranged from .17-.87. The microskills, supervisor rapport model was not significant, $F(2, 46) = 1.43$, $R^2 = .058$, $p = .339$. The microskills, supervisor focus model was not significant, $F(2, 46) = .957$, $R^2 = .040$, $p = .868$. The counseling process, supervisor rapport model was not significant, $F(2, 46) = 3.48$, $R^2 = .132$, $p = .166$. The counseling process, supervisor focus model was not significant, $F(2, 46) = 2.88$, $R^2 = .111$, $p = .348$. The difficult client, supervisor rapport model was not significant, $F(2, 46) = 2.53$, $R^2 = .099$, $p = .629$. The difficult client, supervisor focus model was not significant, $F(2, 46) = 2.55$, $R^2 = .100$, $p = .610$.

In addition, the covariates of graduate education, supervisor location, and workplace diversity were nonsignificant in all six regression models.

Psychological Distress and Counselor Self-Efficacy

Hypothesis 3 examined the relationship between psychological distress and counseling self-efficacy. Specifically, an inverse relationship between psychological distress and counseling self-efficacy was hypothesized. Psychological distress was measured using the subcategories of symptom distress and social role. Full models included the covariates of graduate education (masters vs. more than masters), location of supervision (on-site vs. off-site), and workplace diversity. Covariates were removed from models one by one until a final model was selected.

Three of the six regression models used to analyze relationships were significant (see Table 4). Results indicated significant inverse relationships between symptom distress and microskills, counseling process, and difficult client self-efficacy. For example, mental health professionals who reported less symptom distress reported more microskills self-efficacy, $F(2, 46) = 8.25$, $R^2 = .264$, $p = .000$. In addition, respondents who reported lower levels of symptom distress reported higher levels of counseling process self-efficacy, $F(2, 46) = 7.67$, $R^2 = .25$, $p = .001$, and difficult client self-efficacy, $F(2, 46) = 7.08$, $R^2 = .24$, $p = .006$. In both of these models, participants with doctoral education reported more counseling self-efficacy. On average, participants with doctoral education scored .61 and .62 points higher on counseling process self-efficacy ($B = .264$, $p = .047$) and difficult client self-efficacy ($B = .372$, $p = .007$), respectively. Results for multiple regressions focusing on social role were not significant.

Table 4

Psychological Distress Predicting Counselor Self-Efficacy

Scale	B	*SE*	β	*t*	*p*
Predicting microskills					
More symptom distress	-1.13	.28	-.52	-4.01	.000
Some or completed doctoral education	.32	.25	.17	1.30	.202
Predicting counseling process					
More symptom distress	-1.25	.34	-.47	-3.64	.001
Some or completed doctoral education	.61	.30	.26	2.04	.047
Predicting difficult client					
More symptom distress	-.72	.25	-.38	-2.91	.006
Some or completed doctoral education	.62	.21	.37	2.84	.007

Psychological Distress/Supervisory Alliance and Counseling Self-Efficacy

Regression analysis was used to analyze relationships between the potential predictor interactions and dependent variables. Hypothesis 3a posits psychological distress and supervisory working alliance would interact to predict self-efficacy such that participants who report the least distress and the strongest supervisory working alliance would report the most counselor self-efficacy. Graduate education, location of supervision, and workplace diversity were removed one by one until a final model was selected.

Results demonstrated that the interaction between psychological distress and supervisory alliance variables indicated higher levels of counseling self-efficacy, supporting the hypothesis. Specifically, participants who reported lower levels of symptom distress and higher levels of supervisor rapport and supervisor focus also reported higher levels of difficult client self-efficacy (see Table 5).

Table 5

Interaction Between Psychological Distress/Supervisory Alliance Predicting Counseling Self-Efficacy

Scale	B	*SE*	β	*t*	*p*
Predicting difficult client					
Symptom distress	-4.35	1.45	-2.29	-2.99	.004
Supervisor rapport	-2.61	.74	-3.08	-3.52	.001
Symptom distress + supervisor rapport	.83	.24	4.50	3.54	.001
Some or completed doctoral education	.55	.20	.33	2.79	.008
Symptom distress	-1.24	1.01	-.65	-1.23	.224
Supervisor focus	-1.11	.55	-1.55	-1.99	.052
Symptom distress + supervisor focus	.36	.18	2.03	2.01	.050
Some or completed doctoral education	.62	.22	.37	2.85	.007

No significant relationships were found between the interaction and microskills and counseling self-efficacy. Additionally, the covariate of graduate education was significantly correlated in the models displayed in Table 6. More education contributed to increased self-efficacy in clinicians who were also experiencing lower distress and higher alliance with a supervisor. The difficult client, symptom distress/supervisor rapport interaction model was significant, $F(4, 44) = 7.50$, $R^2 = .405$, $p = .000$, as was the difficult client, symptom distress/supervisor focus interaction model, $F(4, 44) = 4.72$, $R^2 = .300$, $p = .003$. Clinicians were more confident to work with challenging patients when also experiencing lower distress and higher alliance with a supervisor.

Table 6

Interaction Between Psychological Distress/Co-Worker Support Predicting Counselor Self-Efficacy

Scale	B	*SE*	β	*t*	*p*
Predicting microskills					
Social role	-3.05	1.32	-1.63	-2.31	.026
Provider support	-2.33	1.11	-2.12	-2.11	.041
Social role + provider support	.84	.37	3.0	2.27	.028
More workplace diversity	-.12	.10	-.16	-1.14	.263
Predicting counseling process					
Social role	-3.91	1.64	-1.74	-2.39	.021
Nurse support	-2.63	1.29	-2.31	-2.03	.049
Social role + nurse support	1.02	.44	3.5	2.37	.022
More workplace diversity	-.28	.11	-.32	-2.56	.014
Predicting difficult client					
Social role	-4.12	1.21	-2.55	-3.42	.001
Nurse support	-2.96	.96	-3.62	-3.10	.003
Social role + nurse support	1.08	.32	5.01	3.3	.002
More workplace diversity	-.15	.08	-.24	-1.9	.069

Psychological Distress/Co-Worker Support and Counselor Self-Efficacy

Hypothesis 3B posits psychological distress and co-worker support will interact to predict self-efficacy such that participants who report the least distress and the strongest co-worker support will report the highest counselor self-efficacy. Regression analysis was used to examine interactions between the two psychological distress scales and the four support scales as predictors of the three counseling self-efficacy scales for a total of 24 regression models. As with previous hypotheses, the covariates of graduate education, location of supervision, and workplace diversity were included in full models and removed incrementally until a final model was chosen.

Examination of results revealed three significant interactions between variables (see Table 6). Only three of the 24 models showed a significant reaction. Symptom distress and co-worker support interactions were not significant. Three of the 12 social role and co-worker support interactions were significant. Mental health professionals who reported higher levels of social role and provider support also reported high levels of microskills self-efficacy, although the overall model was not significant $F(4, 44) = 1.73$, $R^2 = .136$, $p = .161$. Additionally, interactions between social role and nurse support positively associated with higher levels of counseling process self-efficacy, including a significant correlation with the workplace diversity covariate. The same interactions also predicted higher levels of difficult client self-efficacy. The counseling process and social roles/nurse support model was significant, $F(4, 44) = 5.13$, $R^2 = .318$, $p = .002$, along with the difficult client, social role/nurse support model, $F(4, 44) = 4.34$, $R^2 = .285$, $p = .004$.

CHAPTER IV

DISCUSSION

The purpose of this study was to better understand the experiences of mental health professionals working in integrated health care settings. Most mental health professionals involved in this study were Caucasian/White/non-Hispanic females under 35 years of age. Clinicians who reported higher levels of counselor self-efficacy also reported higher levels of perceived co-worker support from nurses and doctors. Clinicians who reported higher levels of counselor self-efficacy also reported lower levels of perceived psychological distress. In contrast to what was hypothesized, higher levels of alliance with a licensure supervisor did not increase counselor self-efficacy among clinicians. Significant relationships, however, were found when supervisor support interacted with other variables as predicted.

Summary of Findings

Participant Demographics

The present study examined the relationships between participant demographic characteristics and their perceived self-efficacy, supervisor support, co-worker support, and psychological distress. The findings indicated no relationships between participants' age, gender, or ethnicity and their reported self-efficacy, support, or distress. Tang et al. (2004) found similar results that identified no relationship between age and counselor self-efficacy. Results may suggest that a BHC's age is not related to his or her perceived confidence to perform professional duties and that counseling self-efficacy may relate more with clinicians' level of education than age.

The current study found a positive association between participant education and counseling self-efficacy. Specifically, respondents who reported higher levels of education also reported higher levels of difficult client self-efficacy. These results are similar to Tang et al.'s (2004) study, which found positive associations between completed coursework and counseling self-efficacy among counselor trainees. The association between education, experience, and self-efficacy is also consistent with Bandura (1977) who found a strong relationship between self-efficacy and performance accomplishments. All current study participants had completed a master's program, whereas 26% of participants had also began or completed a doctoral program. Participants with more education reported more self-efficacy, which may suggest that BHCs who pursue doctoral-level education may feel more confident when working with difficult clients. This position is consistent with Melchert et al. (1996) who suggested that extended graduate training of doctoral programs may provide increased self-efficacy and competence that "cannot be gained solely through acquiring additional clinical experience with bachelor's or master's level training" (p. 642). Current findings may imply that working effectively in an integrated medical setting requires clinicians to pursue higher levels of education that bridge the medical and mental health environments.

Eighty-four percent of study participants were under the age of 45, and 63% of participants were under the age of 35. The younger ages represented in the sample may be a result of the study including only clinicians who are in the process of obtaining state licensure. Another explanation for the majority of younger clinicians in the sample may be the "relatively new development" that is integrated behavioral health (Skillman et al.,

2016, p. 8). Still emerging in the mental health profession (A. J. Bridges et al., 2015; Gleuck, 2015), the BHC role has just begun to gain momentum and may be more appealing to clinicians who are in the beginning stages of their career. The large number of younger participants may imply that the BHC role is an entry-level position for master's-level clinicians working in integrated health care settings. With increased experience, mental health professionals in integrated settings may transition to positions of clinical supervision or administrative leadership.

Of the study sample, 86% of participants were female, which is a slightly higher representation than the population of mental health professionals (Hollis, 2013). According to recent workforce, females represent 69% of psychologists, 72% of counselors, and 83% of social workers (Bureau of Labor Statistics, 2018). The numbers are consistent with medical positions within integrated settings. For example, 93% of nurses (i.e., registered nurse, licensed professional nurse, etc.) within primary care in the United States are female (Budden, Zhong, Moulton, & Cimiotti, 2013). Of midlevel providers, females represent three quarters of physician assistants, whereas females make up 95% of nurse practitioners (Hooker, Brock, & Cook, 2016). In both instances, gender characteristics within the BHC population are similar to their medical counterparts. The high numbers of females in the current sample appear to compare adequately to gender representation amongst medical and mental health professionals.

No significant relationships were found between the covariate of supervisor location and other variables, specifically supervisor support. The majority of participants (67%) reported that they met with their licensure supervisor face-to-face and on site at the integrated setting. Other participants indicated supervision meetings took place face-to-

face and off site (20%) or via online/phone meeting (10%). Results may imply that clinicians can feel supported or nonsupported by their supervisor regardless of the location of the meetings. This implication differs from a number of studies that have called for on-site supervision for BHCs (Dale & Lee, 2016; Pratt & Lamson, 2012). For example, Edwards and Patterson (2006) emphasized the need for BHCs to receive on-site supervision specific to medical culture, chronic disease management, and collaboration with medical personnel. However, nonsignificant findings in the present study may suggest that clinicians in integrated settings can feel adequate support from off-site supervisors.

Co-Worker Support and Counselor Self-Efficacy

Hypothesis 1 asserted that mental health professionals working in primary care settings who report higher levels of co-worker support will report higher levels of counseling self-efficacy. This assertion was based on previous studies concerning the importance of counselor self-efficacy among mental health professionals (Greason & Cashwell, 2009; Iarussi et al., 2013; Larson et al., 1992), as well as the need for collaboration and support between mental health professionals and medical professionals within integrated health care settings (Davis et al. 2015; Dickinson, 2015; Edwards & Patterson, 2006). The results of this study indicated that higher levels of support significantly associated with higher levels of counseling self-efficacy and align with previous studies related to support and self-efficacy.

For example, Hefner and Eisenberg (2009) found that higher levels of social support positively influence self-efficacy among college students. Stetz et al. (2006) found a connection between self-efficacy and support among military personnel.

However, less is known about the effects of co-worker support within a multidisciplinary medical setting. Findings from the current study may suggest that support from a medical co-worker may positively influence a BHCs confidence to perform mental health duties within an integrated setting.

The current study attempted to better understand co-worker support from the various medical disciplines represented in an integrated health care setting and how that support may or may not predict counselor self-efficacy. Therefore, co-worker support was assessed across four categories: doctors (i.e., MD, DO, Dr. Med, etc.), midlevel providers (i.e., physician assistant, nurse practitioner, etc.), nurses (i.e., registered nurse, licensed practical nurse, etc.), and staff (i.e., administrators, front desk workers, etc.). The four categories represent common professional disciplines found in primary care or similar health care settings (Hall et al., 2015). This study found significant relationships between the support of nurses and doctors and counselor self-efficacy. For example, when mental health professionals in integrated medical settings perceived more support from nurses, they also felt more confident to use basic counseling microskills (i.e., active listening, clear responding, tracking the client, etc.) and engage in the counseling process (i.e., definition of the problem, goal development, strength finding, etc.).

A higher number of positive associations were identified between nurse support and counseling self-efficacy than with the other discipline (e.g., doctors, midlevel providers, and staff) represented in the study. Associations between nurse support and counselor self-efficacy, specifically microskills and counseling process, may suggest that higher levels of support and collaboration between nurses and mental health professionals increase clinician confidence when working with patients. Greater nurse support seemed

to positively effect BHC interactions with patients. Collaboration within integrated settings promotes teamwork among co-workers (Rout et al., 2011) and increases likelihood of positive patient outcomes (McGough et al., 2015). The positive effects of multidisciplinary collaboration between nurses and mental health professionals may increase their belief in themselves to carry out professional duties.

The results may also be explained by the understanding that, of all of the disciplines represented in integrated settings, nurses and mental health professionals spend the most time engaged in direct care with patients. It should be noted that the term *nurses* refers only to bachelor's-level providers (i.e., registered nurse, licensed practical nurse, etc.). The term does not to refer to nurse practitioners, as they are considered *midlevel providers* in an integrated health care setting (Bishop, 2012). Nurses spend an average of 45.8% of their time providing direct patient care (Philipsen et al., 2014), whereas doctors spend an average of 27.5% of their time providing direct patient care (Ammenwerth & Spotl, 2009). Mental health professionals in the BHC role spend 15-30 minutes in direct contact with each patient they encounter (Hall et al., 2015; James, 2006). Of the disciplines represented in an integrated environment, nurses and BHCs spend the most time engaging in direct patient care and the two positions may, therefore, experience a high level of support and collaboration. This support and collaboration may help explain why nurse support is positively associated with counseling self-efficacy among clinicians in the study.

Another finding within the scope of Hypothesis 1 is related to doctor support and self-efficacy. The study found that increased doctor support positively correlated with increased counseling self-efficacy when dealing with difficult clients. More co-worker

support from doctors predicted more confidence for clinicians to work with challenging patients. Associations between doctor support and self-efficacy may theoretically imply that mental health clinicians are more confident working with difficult patients when the patient's doctor is present and involved in the collaborative care. Within an integrated care approach, the primary care physician retains control of the patient's care (Robinson & Reiter, 2016), hence the use of the term *consultant* for the BHC. Clinicians may maintain more self-efficacy when they know they have the support of the care team leader for the patient.

Conversely, counseling self-efficacy may be negatively affected when doctors are not supportive of the BHC role. Beacham et al. (2012) found that primary care physicians may not support the integration of the BHC role into the care system, especially when the physicians have a limited knowledge of mental health treatment. Lack of support from the care team leader may negatively impact clinician confidence to work with difficult patients. Despite the implication, it seems more studies have found strong support from doctors toward the BHC role and multidisciplinary collaboration (Funderburk et al., 2010; Levine et al., 2005; Serrano & Monden, 2011; Torrence et al., 2014).

Co-worker support of nurses and doctors were both found in the study to impact counseling self-efficacy. However, the study found no significant associations related to support from midlevel providers or staff. The lack of significance with these two categories may indicate a difference in perceived co-worker support between the various disciplines represented. For example, clinicians may feel less supported by clinic staff (i.e., administrators, front desk workers, etc.) than they do by nurses and doctors. This

implication is supported by Glueck's (2015) qualitative research in which the author examined barriers to BHCs carrying out professional duties. According to Glueck, BHCs expressed concern due to a lack of support and collaboration with administrative staff. Glueck posited that more training is needed for staff and BHCs to increase collaboration related to mental health treatment in an integrated setting. Other studies have highlighted the need for similar multidisciplinary training (Dickinson, 2015; Hall et al., 2015).

Supervisor Support and Counselor Self-Efficacy

Hypothesis 2 posited that higher levels of support from a licensure supervisor would be associated with higher levels of counselor self-efficacy. The current sample showed no significant relationships between the supervisor support and counselor self-efficacy. Neither the focus of the supervision nor the rapport of the supervisory relationship predicted counseling self-efficacy. Findings are consistent with a study by Ladany et al. (1999), who found no significant correlations between supervisory working alliance and counseling self-efficacy among mental health supervisees. The authors called for further examination of the measures and methods of studying supervisory alliance. The findings for Hypothesis 2, however, are contrary to a number of studies in which the two constructs are significantly correlated (Barns, 2004; Cashwell & Dooley, 2001; Daniels & Larson, 2001; Kozina et al., 2010; Reese et al., 2009). For example, Watkins (2014) conducted a meta-analysis of 40 studies related to supervisory alliance and found that a strong supervisor relationship was predictive of higher levels of counseling self-efficacy.

Findings that do not support the hypothesis may be explained by the lack of specialized supervision available for the BHC role. According to A. J. Bridges et al.

(2015), the BHC role is still a recent development—emerging nationwide in the early 2010s. Novice BHCs may find it difficult to find a supervisor who is knowledgeable and experienced in integration. Moreover, BHCs receiving licensure supervision from a clinician who is not familiar with integrated settings may find the supervision experience deficient. Pratt and Lamson (2012) emphasized the need for supervision specific to behavioral health consultation, which includes focused guidance related to medical culture and processes, treating patients with chronic diseases, and collaboration with medical personnel.

Most of the participants in the current study (67.3%) indicated meeting on site and face-to-face with their licensure supervisor. The remaining sample (30.6%) indicated meeting off site or online/phone with their licensure supervisor. Results are not clear as to if the participants perceived their supervision experience to be specialized to integrated care. Previous studies have highlighted the lack of adequate supervision for the BHC role (Dale & Lee, 2016; Edwards & Patterson, 2006). The lack of appropriately specialized supervision may have contributed to the lack of support found for the hypothesis.

Psychological Distress and Counselor Self-Efficacy

Hypothesis 3 asserted that mental health professionals working in primary care settings who report lower levels of distress will report higher levels of counseling self-efficacy. As asserted by the hypothesis, lower levels of psychological distress were adversely associated with higher levels of counseling self-efficacy. Less distress predicted more self-efficacy among clinicians in integrated settings. The study findings support prior research related to the effects of distress on mental health professionals

(Figley, 1995; Lambie et al., 2009). The findings also support prior research related to distress in a medical environment. For example, when considering the effects of distress on primary care clinicians, Fortney, Luchterhand, Zakletskaia, Zgierska, and Rakel (2013) noted that clinicians experienced high levels of emotional distress. The authors found lower distress correlated with higher positive professional attributes.

Unlike the results of Fortney et al. (2013), participants in the current study consistently reported low levels of distress. Results are contrary to several previous studies related to mental health professionals working in integrated settings (Cox et al., 2014; Hall et al., 2015; Kessler, 2008). For example, Cox et al. (2014) found that novice mental health professionals can experience high levels of distress in medical settings due to unfamiliarity to medical culture, unclear role expectations, and the fast pace of the clinic. The authors reported that to decrease distress, clinicians desired increased understanding of integrated procedures and support from clinic staff. Conversely, the vast majority of mental health professionals in the current study reported low distress scores.

Low distress scores may be a result of more education. The current study found that higher levels of education (e.g., master's degree and doctorate degree) contributed to lower levels of distress and higher levels of self-efficacy. More educational experience may increase clinician confidence to preform professional duties (Larson et al., 1992; Melchert et al., 1996). Moreover, low distress scores may be due to more adequate education. The majority of study participants (67.3%) indicated that they had received specific coursework related to working in a medical setting during their graduate education program. This result was unexpected given the deficit of behavioral health

integration education posited by multiple researchers (Blount & Miller, 2009; Bluestein & Cubic, 2009; Davis et al., 2015; Dickinson, 2015; Vogel et al., 2014) and may suggest that the existence of such graduate coursework has grown in recent years.

In addition, low distress scores may be due to fear of appearing distressed. For instance, the online surveys used to collect responses were often distributed to participants by the participant's licensure or organizational supervisor. Though participants were informed that all survey responses were confidential, answers related to psychological distress may have been influenced by fear of evaluation by a supervisor, should the supervisor ever see the participant's responses. Additionally, low distress scores may be due to fear of appearing unsuccessful or incapable of performing professional duties. Participants may have had difficulty answering questions such as "I feel I am not doing well at work" or "I'm not working as much as I used to." Such questions may have prevented participants from giving honest answers, especially if participants doubted the confidentiality of their answers or feared that respondents could be identified.

Psychological Distress, Supervisor Support, and Counseling Self-Efficacy

Hypothesis 3a examined the interactions between psychological distress and supervisor support as predictors for counseling self-efficacy. Though no significant associations were found between supervisor support and counseling self-efficacy in Hypothesis 2, support was found for Hypothesis 3a when supervisor support interacted with distress to predict self-efficacy. More supervisor support and less distress interacted to predict more counselor self-efficacy when working with difficult patients. Study

results align with prior research related to the positive effects of maintaining strong supervisory relationships (Ladany et al., 1999; Reece et al., 2009; Watkins et al., 2014).

Results indicated that clinicians in integrated settings are less distressed and more confident working with difficult patients when supervisor support is present. According to Larson et al. (1992), the term *difficult* refers to patients who are unmotivated, nonverbal, indecisive, and noncommittal. Study results may suggest that, though the supervisor is not always present, clinicians feel more confident and less distressed when they perceive strong supervisor support. Such support may increase the clinicians' self-efficacy to work autonomously with a difficult patient. The term *difficult* also refers to patients presenting in crisis with problems related to suicidality, substance use, or physical abuse (Larson et al., 1992). Perceived supervisor support may also increase clinicians' confidence to make more effective decisions in the midst of a patient's crisis experience.

Mental health professionals' ability to maintain appropriate levels of personal distress may also contribute to their self-efficacy to work patient's in crisis. Distress management among mental health professionals has been emphasized by prior research (Adams et al., 2006; Sabin-Farrell & Turpin, 2003). Additionally, results for Hypothesis 3a found that participants who reported higher levels of education also reported less distress and more supervisor support, which then predicted more counseling self-efficacy when working with difficult patients. Results add to the importance of adequate education and training for mental health clinicians in integrated settings (Cohen, Davis, et al., 2015; Davis et al., 2015).

Psychological Distress, Co-Worker Support, and Counseling Self-Efficacy

Hypothesis 3b supposed psychological distress and co-worker support would interact to predict self-efficacy such that participants who report the least distress and the strongest co-worker support would report the highest counselor self-efficacy. Hypothesis 3b is the only instance in the current study of which support from midlevel providers (i.e., physician assistant, nurse practitioner, etc.) is significantly associated with counselor self-efficacy. More support from midlevel providers and less distress interacted to predict more microskills self-efficacy among clinicians. Microskills self-efficacy refers to clinicians' belief in their ability to use learned counseling skills with patients. Health care in the United States has experienced a sharp rise in the use of midlevel providers since the implementation of the ACA in 2012 (Liu et al., 2017). Therefore, mental health providers in integrated settings are collaborating more and more with physician assistants and nurse practitioners. The current study results may suggest that increased collaboration and support between BHCs and midlevel providers contributes to higher levels of confidence to perform duties.

Similar to Hypothesis 1 results, nurse support also associated with higher levels of self-efficacy. Results indicated that more nurse support and less distress interacted to predict more self-efficacy among clinicians to engage patients in the counseling process. Furthermore, the same interaction predicted increased clinician confidence to work with difficult patients. Results suggest that the collaboration between nurses and mental health professionals in integrated settings is important to the development of self-efficacy among an integrated team of providers. Study findings support multiple studies that have highlighted the importance of multidisciplinary collaboration, including nursing, in the quality of integrated care (D. R. Bridges et al., 2011; Cohen, Davis, et al., 2015; Dale &

Lee, 2016; Levey & Miller, 2012; McGough et al., 2015). One result from the study indicated results related nurse support and workplace diversity. Participants who reported working in a less ethnically diverse workplace also reported more nurse support and less distress. Results seem to suggest that working in a less diverse environment may contribute to increased counselor self-efficacy under certain circumstances. Findings may be related to a clinician's ability to adapt to a multidisciplinary and ethnically diverse environment.

Implications

The goal of the current study was to better understand the experiences of mental health professionals working in integrated health care settings. Specifically, this study considered possible predictors of counseling self-efficacy among BHCs, including co-worker support, supervisor support, and perceived psychological distress. Study participants indicated higher levels of counseling self-efficacy when supported by nurses and doctors in clinic. As nurse support increased, so did clinicians' confidence in their own counseling skills. As doctor support increased, so did clinicians' confidence to work with challenging patients. Mental health professionals in medical settings may find it advantageous to cultivate positive relationships with clinic nurses and doctors, as it may improve their perceived ability to work effectively with patients (Blount, 2003; Rout et al., 2011; Vogel et al., 2014). Increased support from nurses may increase BHCs' perceived ability to engage medical patients using counseling skills and processes. Doctor support may aid BHCs when providing care for crisis patients or those resistant to medical or mental health care.

Nonsignificant relationships found between supervisor support and counseling self-efficacy may imply that more specialized supervision is needed for mental health professionals in integrated settings (Dale & Lee, 2016; Edwards & Patterson, 2006; Pratt & Lamson, 2012). The BHC role may require that supervisors understand medical environments and systems in order to provide adequate support. Additionally, study results may indicate that on-site supervision is not as important to the supervision process as the supervisor's scope of knowledge and familiarity with integrated health care systems.

Participants in the study who reported lower levels of distress also reported higher levels of counseling self-efficacy, suggesting the importance for mental health professionals to maintain appropriate levels of personal and professional distress (Lambie et al., 2009). Working regularly with distressed patients in medical settings may contribute to higher levels of distress among clinicians (Figley, 1995; Sabin-Farrell & Turpin, 2003). Furthermore, integrating mental health professionals into medical settings requires clinic-wide changes that providers may find challenging (Kessler, 2008). Responsibilities of the BHC role are continuing to be developed (Hall et al., 2015). Therefore, managing distress is important for mental health professionals serving in BHC roles. Although supervisor support alone did not associate with self-efficacy in the current study, higher supervisor support and lower distress together significantly predicted self-efficacy. In addition, mental health professionals with more educational experience, less distress, and more supervisor support also reported increased self-efficacy in integrated settings. Similar positive associations were also found related to

co-worker support. Managing distress and cultivating support appear part of the process of self-efficacy development among BHCs.

Professional counselors have an opportunity to be a part of a growing movement toward mental and physical health integration in the United States. Health care systems are shifting toward a *one-stop shop* approach to health care, and the workforce need for mental health professionals to serve in medical settings is considerable (Blount & Miller, 2009; Burke et al., 2013). For example, the latest major reform to health care in the United States (Rak & Coffin, 2013) provided the opportunity for professional counselors to fill mental health roles in primary care and other medical settings—roles previously reserved only for psychologists (Beronio et al., 2013). These changes to health care have created a workforce shortage (Burke et al., 2013) that professional counselors can help solve. Professional counselors represented 41% of the mental health professionals in the present study, followed by social workers (31%), psychologists (16%), and marriage and family therapists (12%). Though participants were part of a convenience sample, the numbers may suggest that professional counselors are part of the solution to meet mental health needs in integrated settings across the United States.

Researchers have suggested that master's-level clinicians (e.g., professional counselors, social workers, marriage and family therapists) are not properly trained to work with patients in medical settings (Commings & Commings, 2009; Hall et al., 2015). Nearly a third (32%) of participants in the current study reported that they had not received training specific to integrated behavioral health during their master's programs. Furthermore, the results of the current study indicated positive associations between support and self-efficacy among BHCs with more educational experience. Mental health

training programs across the United States are introducing degrees and elective courses specific to behavioral health integration (Vogel et al., 2014). Counselor educators and supervisors may further contribute to this trend by providing graduate and other training opportunities for professional counselors.

Adequate supervision is another important implication for counselors working in medical settings. The current study found positive associations between supervisor support, low distress, and counselor self-efficacy. Professional counselors in medical settings may benefit from a supervisor familiar with behavioral health integration, including patient health, brief screening instrumentation, chronic decease management, medical culture, and working within multidisciplinary teams (Aitken & Curtis, 2004; Blount & Miller, 2009; Glueck, 2015; Robinson & Reiter, 2007). CACREP (2016) standards include the responsibility for counselors to better understand integrated behavioral health care systems and "interorganizational collaboration" (2:F:1:b, p. 8). Increased understanding in areas of integration may provide counselors opportunities within another lesser known track within the profession.

Finally, results from the present study imply the need for counselors to be aware of their self-efficacy and factors that contribute of higher levels of self-efficacy. The concept of counseling self-efficacy has been considered a useful tool to help counselors develop from simply believing they can work effectively to practicing effectively (Larson et al., 1992). The present study found positive associations between certain types of co-worker and supervisor support and increased self-efficacy. Implications exist for professional counselors such that counselors may find it advantageous to cultivate supportive relationships with clinic nurses and doctors. The current study indicated

several positive associations between nurse support and doctor support and counselor self-efficacy among BHCs. Additionally, the current study found that low distress contributes to increased self-efficacy. Managing distress can improve professional counselors' confidence to carry out daily professional activities. Counselor self-efficacy has been positively associated with client outcomes (Larson et al., 1992) and, therefore, may be integral to the development of effective counselors.

Limitations

The purpose of the current study was to better understand the experiences of mental health professionals working in medical settings. Multiple limitations were found during the research process. The present study only reflected the experiences of a small sample of mental health professionals working in integrated settings. Convenience sampling limited the study by underrepresenting or overrepresenting particular groups within the sample. Under/overrepresentation limited a study's ability to be generalized to a population and resulted in low external validity (Price & Murnan, 2004). In addition, the majority of participants in this study were Caucasian/White/non-Hispanic females under the age of 35. The lack of ethnic differences in the sample hindered the ability to generalize this study's results across diverse populations. Convenience sampling limited the possibility that the study participants would represent a diverse section of cultural, biological, or perceptual differences.

Limitations existed related to accessing adequate sample numbers of mental health professionals in integrated health care environments. Attempts by the researcher to access participants in health care facilities or within post-master's behavioral health training programs were hindered due to unforeseen factors related to each particular

facility or program. Facilities and programs research participation policies created challenges for researchers outside of the organization to access mental health professionals working in medical environments. The BHC role is still emerging across the United States, and challenges for the researcher existed when attempting to access adequate numbers of mental health professionals working in integrated health care settings.

Moreover, limited numbers of prelicensed (in process of obtaining state licensure) mental health clinicians working as BHCs were available. This limitation may be due in part to the challenges medical organizations face when attempting to bill insurance companies for mental health services provided by prelicensed clinicians (Mauch, Kautz, & Smith, 2008). For example, of the 225 participants to take the study survey, only 49 were included in the sample. The limited sample was due in large part to the lack of prelicensed professionals working in medical settings.

The following instruments were used to assess participant perspectives: counseling self-efficacy (COSE; Larson et al., 1992), supervisor support (SWAI; Efstation et al., 1990), co-worker support (Social Support Scale; O'Driscoll, 2000), and psychological distress (OQ-45.2; Beckstead et al., 2003). A limitation for this present study was the use of the SWAI to assess supervisor support. Although the SWAI has been an effective tool to measure supervisee/supervisor alliance (Efstation et al., 1990; Ladany et al., 1999), the use of this instrument required that participants be in the beginning stages of their career. Use of a more general instrument to measure supervisor support may be a more effective method to involve clinicians at different stages of their career.

Additional limitations existed related to the internal validity of instrumentation. Participants' self-efficacy responses may have been impacted by temporal events. For example, if recent events were positive (e.g., positive interactions with patients, supportive feedback from a supervisor, and positive collaboration with clinic staff), participants may have inflated counselor self-efficacy scores on the survey. Conversely, if recent events were negative (e.g., non-improvement of a patient, critical feedback from supervisor, and poor collaboration with clinic staff), participants may have understated counseling self-efficacy scores. Additionally, perceptions of psychological distress may have been influenced if participants feared that scores would be made known to clinical or administrative supervisors.

Threats to statistical conclusion validity in this study existed, including Type I errors and assumption violations. The predictor variables of co-worker support, supervisor support, and psychological distress were included as having been supported by previous empirical studies in order to meet statistical assumptions. Instrument reliability and validity of the COSE, OQ 45.2, SWAI-T, and Social Support Scale were considered to limit measurement error. Certain subscales of the measures were discarded due to poor reliability. Additionally, data-gathering floor effects limited the range of subscale analyses (Vogt & Johnson, 2015). For example, analysis related to the psychological distress instrument was limited due to the bunching of similar scores.

Future Directions for Research

Future research related to the experiences of mental health professionals working in integrated settings can begin with assessing larger numbers of BHCs. Reconfiguring measures and data collection methods can increase the sample and include a larger swath

of clinicians, specifically participants who are fully licensed in their state. Utilization of a supervisor support measure with a broader focus is suggested that would include licensed and experienced clinicians relations with their organizational and/or clinical supervisors. The current study's sample collection was hindered by only including prelicensed clinicians. By including licensed clinicians, researchers can further define the experiences of clinicians working in medical settings and, thereby, improve understanding of how these clinicians develop professionally.

Future studies could further clarify differences of relations between BHCs and other disciplines represented in a medical setting. For example, researchers may wish to investigate how BHCs interact differently with doctors than nurses or midlevel providers. The current study examined perceived support related to practical assistance, advice, feedback, and sympathy. Future researchers may concentrate on collaborative interactions between mental health personnel and medical personnel, including multidisciplinary teamwork, professional identity, and patient outcomes (Ader et al., 2015; Bartles et al., 2004; Blount, 2003). A better understanding of how BHCs interact with medical providers may also improve training processes.

Researches may also explore the efficacy of specialized supervision for BHCs. For instance, BHCs receiving licensure supervision from a supervisor unfamiliar with behavioral health integration may find the supervision process incomplete. Previous studies have emphasized the importance of clinicians engaging in a supervision process specific to integrated health care (Dale & Lee, 2016; Pratt & Lamson, 2012). The current study's results were mixed as to the importance of supervisor support to BHC

development of self-efficacy. A pre- and posttest design may provider stronger support for the need for specialized supervision.

Additional studies related to the psychological distress levels among BHCs are needed. Participants in the current study indicated very low levels of distress, which is contrary to previous studies describing the challenges BHCs face when transitioning to medical settings (Beacham et al. 2012; Davis et al., 2015; Hall et al., 2015; Hunter et al., 2009). Future researchers may consider focusing less on overall psychological distress and more on stress specific to the workplace and, even more specific, stress related to working in a multidisciplinary environment. According to Glueck (2015), BHCs have felt ill-prepared for the transition of working in a medical setting. Further understanding of BHC distress levels may improve behavioral health education and training efforts.

Conclusion

This study confirmed prior findings that co-worker support, supervisor support, and psychological distress are linked to counselor self-efficacy among mental health professionals. This study focused on the experiences of BHCs and discovered significant relationships between co-worker support from nurses and doctors and counseling self-efficacy. The results further emphasized the importance of multidisciplinary collaboration and support among mental health professionals working in integrated settings. Counseling self-efficacy has been connected to patient outcomes (Larson & Daniels, 1998; Lent et al., 2006) and is therefore an important factor in the development of BHCs.

REFERENCES

Abel, H., Abel, A., & Smith, R. L. (2012). The effects of a stress management course on counselors-in-training. *Counselor Education and Supervision*, *51*(1), 64–78.

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: a validation study. *American Journal of Orthopsychiatry*, *76*(1), 103.

Ader, J., Stille, C. J., Keller, D., Miller, B. F., Barr, M. S., & Perrin, J. M. (2015). The medical home and integrated behavioral health: advancing the policy agenda. *Pediatrics*, *135*(5), 909–917.

Ahmed, N. U., Pelletier, V., Winter, K., & Albatineh, A. N. (2013). Factors explaining racial/ethnic disparities in rates of physician recommendation for colorectal cancer screening. *American Journal of Public Health*, *103*(7), e91–e99.

Aitken, J. B., & Curtis, R. (2004). Integrated Health Care: Improving Client Care while Providing Opportunities for Mental Health Counselors. *Journal of Mental Health Counseling*, *26*(4), 321–331.

Aliyev, R., & Tunc, E. (2015). Self-efficacy in counseling: The role of organizational psychological capital, job satisfaction, and burnout. *Procedia-Social and Behavioral Sciences*, *190*, 97–105.

Alvarez, K., Marroquin, Y. A., Sandoval, L., & Carlson, C. I. (2014). Integrated health care best practices and culturally and linguistically competent care: Practitioner perspectives. *Journal of Mental Health Counseling*, *36*(2), 99.

Ammenwerth, E., & Spötl, H.-P. (2009). The time needed for clinical documentation versus direct patient care. *Methods of Information in Medicine*, *48*(01), 84–91.

Angantyr, K., Rimner, A., Nordén, T., & Norlander, T. (2015). Primary Care Behavioral Health model: Perspectives of outcome, client satisfaction, and gender. *Social Behavior and Personality: An International Journal*, *43*(2), 287–301.

Arria, A. M., O'Grady, K. E., Caldeira, K. M., Vincent, K. B., Wilcox, H. C., & Wish, E. D. (2009). Suicide ideation among college students: A multivariate analysis. *Archives of Suicide Research*, *13*(3), 230–246.

Arroll, B., Goodyear-Smith, F., Crengle, S., Gunn, J., Kerse, N., Fishman, T., … Hatcher, S. (2010). Validation of PHQ-2 and PHQ-9 to screen for major depression in the primary care population. *The Annals of Family Medicine*, *8*(4), 348–353.

Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P. L., Ahmed, K., & Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT) toward a public health approach to the management of substance abuse. *Substance Abuse*, *28*(3), 7–30.

Baird, M., Blount, A., Brungardt, S., Dickinson, P., Dietrich, A., Epperly, T., … others. (2014). Joint principles: integrating behavioral health care into the patient-centered medical home. *The Annals of Family Medicine*, *12*(2), 183–185.

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist*, *37*(2), 85–89.

Bandura, A. (1986). The explanatory and predictive scope of self-efficacy theory. *Journal of Social and Clinical Psychology*, *4*(3), 359–373.

Barber, J. A., Frantsve, L. M., Capelli, S., & Sanders, K. A. (2011). Implementation and evaluation of an integrated care program in a VA medical center. *Psychological Services*, *8*(4), 282.

Bard, C. C., Bieschke, K. J., Herbert, J. T., & Eberz, A. B. (2000). Predicting research interest among rehabilitation counseling students and faculty. *Rehabilitation Counseling Bulletin*, *44*(1), 48–55.

Barkham, M., Connell, J., Stiles, W. B., Miles, J. N., Margison, F., Evans, C., & Mellor-

Clark, J. (2006). Dose-effect relations and responsive regulation of treatment duration: the good enough level. *Journal of Consulting and Clinical Psychology*, *74*(1), 160.

Barnes, K. L. (2004). Applying Self-Efficacy Theory to Counselor Training and Supervision: A Comparison of Two Approaches. *Counselor Education and Supervision*, *44*(1), 56–69.

Barrett, M., & Warren, T. F. (2012). Becoming the Behavioral Health Expert. *Integrated Care: Applying Theory to Practice*, 21.

Beacham, A. O., Kinman, C., Harris, J. G., & Masters, K. S. (2012). The patient-centered medical home: Unprecedented workforce growth potential for professional psychology. *Professional Psychology: Research and Practice*, *43*(1), 17.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. K. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, *4*(6), 561–571.

Beckstead, D. J., Hatch, A. L., Lambert, M. J., Eggett, D. L., Goates, M. K., & Vermeersch, D. A. (2003). Clinical significance of the Outcome Questionnaire (OQ-45.2). *The Behavior Analyst Today*, *4*(1), 86.

Beehler, G. P., Funderburk, J. S., Possemato, K., & Vair, C. L. (2013). Developing a measure of provider adherence to improve the implementation of behavioral health services in primary care: a Delphi study. *Implementation Science*, *8*, 19. http://dx.doi.org/10.1186/1748-5908-8-19

Bernard, J. M., & Goodyear, R. K. (2012). Fundamentals of Clinical Supervision (Upper Saddle River, New Jersey: Pearson Education Inc., 2009). *Reflective Practice: Formation and Supervision in Ministry*, *31*. Retrieved from http://journals.sfu.ca/rpfs/index.php/rpfs/article/view/124/123

Beronio, K., Po, R., Skopec, L., & Glied, S. (2013). Affordable Care Act expands mental health and substance use disorder benefits and federal parity protections for 62 million Americans. *Washington, DC: US Department of Health and Human Services*.

Berwick, D. M., Nolan, T. W., & Whittington, J. (2008). The triple aim: care, health, and cost. *Health Affairs*, *27*(3), 759–769.

Betz, N. E. (2004). Contributions of Self-Efficacy Theory to Career Counseling: A Personal Perspective. *The Career Development Quarterly*, *52*(4), 340–353.

Betz, N. E. (2013). Assessment of self-efficacy. Retrieved from http://psycnet.apa.org/books/14048/022.html

Bishop, C. S. (2012). Advanced practitioners are not mid-level providers. *Journal of the Advanced Practitioner in Oncology*, *3*(5), 287.

Blount, A. (2003). Integrated Primary Care: Organizing the Evidence. *Families, Systems, & Health*, *21*(2), 121.

Blount, A., & Bayona, J. (1994). Toward a system of integrated primary care. *Family Systems Medicine*, *12*(2), 171.

Blount, F. A., & Miller, B. F. (2009). Addressing the workforce crisis in integrated primary care. *Journal of Clinical Psychology in Medical Settings*, *16*(1), 113–119.

Bluestein, D., & Cubic, B. A. (2009). Psychologists and primary care physicians: A training model for creating collaborative relationships. *Journal of Clinical Psychology in Medical Settings*, *16*(1), 101–112.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252.

Bordin, E. S. (1983). Supervision in counseling: II. Contemporary models of supervision: A working alliance based model of supervision. *The Counseling Psychologist*. Retrieved from http://psycnet.apa.org/psycinfo/1984-02314-001

Boswell, D. L., White, J. K., Sims, W. D., Harrist, R. S., & Romans, J. S. (2013). Reliability and Validity of the Outcome Questionnaire-45.2. *Psychological Reports*, *112*(3), 689–693.

Bower, P., Gilbody, S., Richards, D., Fletcher, J., & Sutton, A. (2006). Collaborative care for depression in primary care. *The British Journal of Psychiatry*, *189*(6), 484–493.

Bridges, A. J., Gregus, S. J., Rodriguez, J. H., Andrews III, A. R., Villalobos, B. T., Pastrana, F. A., & Cavell, T. A. (2015). Diagnoses, intervention strategies, and rates of functional improvement in integrated behavioral health care patients.

Journal of Consulting and Clinical Psychology, *83*(3), 590.

Bridges, D. R., Davidson, R. A., Odegard, P. S., Maki, I. V., & Tomkowiak, J. (2011). Interprofessional collaboration: three best practice models of interprofessional education. *Medical Education Online*, *16*. Retrieved from http://med-ed-online.net/index.php/meo/article/viewArticle/6035

Brody, A. A., Ciemins, E., Newman, J., & Harrington, C. (2010). The effects of an inpatient palliative care team on discharge disposition. *Journal of Palliative Medicine*, *13*(5), 541–548.

Brough, P., & Kelling, A. (2002). Women, work & well-being: the influence of work-family and family-work conflict. *New Zealand Journal of Psychology*, *31*(1), 29.

Brown, G. S., & Jones, E. R. (2005). Implementation of a feedback system in a managed care environment: What are patients teaching us? *Journal of Clinical Psychology*, *61*(2), 187–198.

Bryan, C. J., Corso, K. A., Neal-Walden, T. A., & Rudd, M. D. (2009). Managing suicide risk in primary care: Practice recommendations for behavioral health consultants. *Professional Psychology: Research and Practice*, *40*(2), 148.

Bryan, C. J., Corso, M. L., Corso, K. A., Morrow, C. E., Kanzler, K. E., & Ray-Sannerud, B. (2012). Severity of mental health impairment and trajectories of improvement in an integrated primary care clinic. *Journal of Consulting and Clinical Psychology*, *80*(3), 396.

Bryan, C. J., Morrow, C., & Appolonio, K. K. (2009). Impact of behavioral health consultant interventions on patient symptoms and functioning in an integrated family medicine clinic. *Journal of Clinical Psychology*, *65*(3), 281–293.

Budden, J. S., Zhong, E. H., Moulton, P., & Cimiotti, J. P. (2013). Highlights of the national workforce survey of registered nurses. *Journal of Nursing Regulation*, *4*(2), 5–14.

Bureau of Labor Statistics, U.S. Departement of Labor. (2016). *Occupational Outlook Handbook*. Retrieved from http://www.bls.gov/ooh/community-and-social-service/mental-health-counselors-and-marriage-and-family-therapists.htm

Burke, B. T., Miller, B. F., Proser, M., Petterson, S. M., Bazemore, A. W., Goplerud, E.,

& Phillips, R. L. (2013). A needs-based method for estimating the behavioral health staff needs of community health centers. *BMC Health Services Research*, *13*(1), 1.

CACREP 2016 standards. (2016). *Council for Accreditation of Counseling and Related Educational Programs*.

Caprara, G. V., Barbaranelli, C., Steca, P., & Malone, P. S. (2006). Teachers' self-efficacy beliefs as determinants of job satisfaction and students' academic achievement: A study at the school level. *Journal of School Psychology*, *44*(6), 473–490.

Caron, J., Latimer, É., & Tousignant, M. (2007). Predictors of psychological distress in low-income populations of Montreal. *Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique*, S35–S44.

Carpenter, W. R., Godley, P. A., Clark, J. A., Talcott, J. A., Finnegan, T., Mishel, M., … Fontham, E. T. (2009). Racial differences in trust and regular source of patient care and the implications for prostate cancer screening use. *Cancer*, *115*(21), 5048–5059.

Cashwell, T. H., & Dooley, K. (2001). The impact of supervision on counselor self-efficacy. *The Clinical Supervisor*, *20*(1), 39–47.

Casimiro, L., MacDonald, C. J., Thompson, T. L., & Stodel, E. J. (2009). Grounding theories of W (e) Learn: A framework for online interprofessional education. *Journal of Interprofessional Care*, *23*(4), 390–400.

Chan, A. W., Pristach, E. A., & Welte, J. W. (1994). Detection by the CAGE of alcoholism or heavy drinking in primary care outpatients and the general population. *Journal of Substance Abuse*, *6*(2), 123–135.

Chemers, M. M., Hu, L., & Garcia, B. F. (2001). Academic self-efficacy and first year college student performance and adjustment. *Journal of Educational Psychology*, *93*(1), 55.

Chen, H., Coakley, E. H., Cheal, K., Maxwell, J., Costantino, G., Krahn, D. D., … others. (2006). Satisfaction with mental health services in older primary care patients. *The American Journal of Geriatric Psychiatry*, *14*(4), 371–379.

Chiaburu, D. S., & Harrison, D. A. (2008). Do peers make the place? Conceptual synthesis and meta-analysis of coworker effects on perceptions, attitudes, OCBs, and performance. *Journal of Applied Psychology*, *93*(5), 1082.

Christian, E., & Curtis, R. (2012). Introduction to integrated care. *Integrated Care: Applying Theory to Practice*, 3–19.

Cigrang, J. A., Dobmeyer, A. C., Becknell, M. E., Roa-Navarrete, R. A., & Yerian, S. R. (2006). Evaluation of a collaborative mental health program in primary care: Effects on patient distress and health care utilization. *Primary Care and Community Psychiatry*, *11*(3), 121.

Cohen, D. J., Balasubramanian, B. A., Davis, M., Hall, J., Gunn, R., Stange, K. C., … England, M. J. (2015). Understanding care integration from the ground up: five organizing constructs that shape integrated practices. *The Journal of the American Board of Family Medicine*, *28*(Supplement 1), S7–S20.

Cohen, D. J., Davis, M., Balasubramanian, B. A., Gunn, R., Hall, J., Peek, C. J., … Levy, S. (2015). Integrating behavioral health and primary care: consulting, coordinating and collaborating among professionals. *The Journal of the American Board of Family Medicine*, *28*(Supplement 1), S21–S31.

Coleman, J. V., & Patrick, D. L. (1976). Integrating mental health services into primary medical care. *Medical Care*, *14*(8), 654–661.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614.

Corso, K., Bryan, C., Morrow, C., Appolonio, K., Dodendorf, D., & Baker, M. (2009). Managing posttraumatic stress disorder symptoms in active-duty military personnel in primary care settings. *Journal of Mental Health Counseling*, *31*(2), 119–136.

Cox, J., Adams, E., & Loughran, M. J. (2014). Behavioral health training is good medicine for counseling trainees: Two curricular experiences in interprofessional collaboration. *Journal of Mental Health Counseling*, *36*(2), 115.

Cramer, K. M. (1999). Psychological antecedents to help-seeking behavior: A reanalysis using path modeling structures. *Journal of Counseling Psychology*, *46*(3), 381.

Craske, M. G., Rose, R. D., Lang, A., Welch, S. S., Campbell-Sills, L., Sullivan, G., … Roy-Byrne, P. P. (2009). Computer-assisted delivery of cognitive behavioral therapy for anxiety disorders in primary-care settings. *Depression and Anxiety*, *26*(3), 235–242.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, *24*(4), 349.

Cummings, N. A., & O'Donohue, W. T. (2011). Where we are, how we got there, and where we need to go: The promise of integrated care. *Understanding the Behavioral Healthcare Crisis: The Promise of Integrated Care and Diagnostic Reform*, 1–18.

Cummings, N. A., O'Donohue, W. T., & Cummings, J. L. (2009). The financial dimension of integrated behavioral/primary care. *Journal of Clinical Psychology in Medical Settings*, *16*(1), 31–39.

Dale, H., & Lee, A. (2016). Behavioural health consultants in integrated primary care teams: a model for future care. *BMC Family Practice*, *17*. doi: http://dx.doi.org/10.1186/s12875-016-0485-0

Daniels, J. A., & Larson, L. M. (2001). The Impact of Performance Feedback on Counseling Self-Efficacy and Counselor Anxiety. *Counselor Education and Supervision*, *41*(2), 120–130.

Davis, M. M., Balasubramanian, B. A., Cifuentes, M., Hall, J., Gunn, R., Fernald, D., … Cohen, D. J. (2015). Clinician Staffing, Scheduling, and Engagement Strategies Among Primary Care Practices Delivering Integrated Care. *The Journal of the American Board of Family Medicine*, *28*(Supplement 1), S32–S40.

de Vries, S. R., & Valadez, A. A. (2006). Counseling Students' Mental Health Status and Attitudes toward Counseling. *Journal of Professional Counseling: Practice, Theory & Research*, *34*. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&profile=ehost&scope=site&authtype=crawler&jrnl=15566382&AN=24557550&h=zakmdaxop22AcpZOK3c4Wg8Aaw7USwyfHDlf3cnLiZtsvQruEz2qAchY%2Frry1WiP4oHdAMyiB3QyX4pP0QemlQ%3D%3D&crl=c

deGruy, F. V. (1997). Mental healthcare in the primary care setting: A paradigm problem. *Families, Systems & Health*, *15*(1), 3–26.

Derogatis, L. R. (1979). Symptom Checklist-90-Revised (SCL-90-R). *Lyndhurst, NJ: NCS Pearson*.

DeVoe, J. E., Tillotson, C. J., & Wallace, L. S. (2009). Usual source of care as a health insurance substitute for US adults with diabetes? *Diabetes Care*, *32*(6), 983–989.

Dickinson, W. P. (2015). Strategies to Support the Integration of Behavioral Health and Primary Care: What Have We Learned Thus Far? *The Journal of the American Board of Family Medicine*, *28*(Supplement 1), S102–S106.

Dickinson, W. P., & Miller, B. F. (2010). Comprehensiveness and continuity of care and the inseparability of mental and behavioral health from the patient-centered medical home. *Families, Systems, & Health*, *28*(4), 348.

Doherty, W., McDaniel, S., & Baird, M. (1996). MD. FIVE LEVELS OF PRIMARY CARE/BEHAVIORAL HEALTHCARE COLLABORATION. Retrieved from http://in.bgu.ac.il/en/fohs/communityhealth/Family/Documents/ShlavB/physician%20involvment%20with%20families.pdf

Durden, E. D., Hill, T. D., & Angel, R. J. (2007). Social demands, social supports, and psychological distress among low-income women. *Journal of Social and Personal Relationships*, *24*(3), 343–361.

Easton, C., Martin, W. E., & Wilson, S. (2008). Emotional Intelligence and Implications for Counseling Self-Efficacy: Phase II. *Counselor Education and Supervision*, *47*(4), 218–232.

Edwards, T. M., & Patterson, J. E. (2006). Supervising Family Therapy Trainees in Primary Care Medical Settings: Context Matters. *Journal of Marital and Family Therapy*, *32*(1), 33–43.

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, *37*(3), 322.

El-Ghoroury, N. H., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology*, *6*(2), 122.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine.

Science, *196*(4286), 129–136.

Engel, G. L. (1989). The need for a new medical model: a challenge for biomedicine. *Holistic Medicine*, *4*(1), 37–53.

Engel, G. L. (1996). From biomedical to biopsychosocial: I. Being scientific in the human domain. *Families, Systems, & Health*, *14*(4), 425.

Enochs, W. K., Young, M., & Choate, R. O. (2006). Counselors and Physicians Providing Mental Health Services: An Integrated Approach. *Adultspan Journal*, *5*(2), 101–113.

Felker, B. L., Barnes, R. F., Greenberg, D. M., Chaney, E. F., Shores, M. M., Gillespie-Gateley, L., … Morton, C. E. (2004). Preliminary outcomes from an integrated mental health primary care team. *Psychiatric Services*. Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.55.4.442

Ferris, G. R., & Kacmar, K. M. (1992). Perceptions of organizational politics. *Journal of Management*, *18*(1), 93–116.

Figley, C. R. (1995). Compassion Fatigue as Secondary Traumatic Stress Disorder an overview. In *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized.* (pp. 1–20). New York: Brunner/Mazel.

Figley, Charles R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology*, *58*(11), 1433–1441.

Fisher, L., & Ransom, D. C. (1997). Developing a strategy for managing behavioral health care within the context of primary care. *Archives of Family Medicine*, *6*(4), 324.

Fitts, W. H., & Roid, G. H. (1964). *Tennessee self concept scale*. Counselor Recordings and Tests Nashville, TN.

Fortney, L., Luchterhand, C., Zakletskaia, L., Zgierska, A., & Rakel, D. (2013). Abbreviated mindfulness intervention for job satisfaction, quality of life, and compassion in primary care clinicians: a pilot study. *The Annals of Family Medicine*, *11*(5), 412–420.

Frame, M. W., & Stevens-Smith, P. (1995). Out of harm's way: Enhancing monitoring and dismissal processes in counselor education programs. *Counselor Education and Supervision*, *35*(2), 118–129. https://doi.org/10.1002/j.1556-6978.1995.tb00216.x

Frick, M. H., & Glosoff, H. L. (2014). Becoming a Supervisor: Qualitative Findings on Self-Efficacy Beliefs of Doctoral Student Supervisors-in-Training. *The Professional Counselor*, 35.

Friedlander, M. L., Keller, K. E., Peca-Baker, T. A., & Olk, M. E. (1986). Effects of role conflict on counselor trainees' self-statements, anxiety level, and performance. *Journal of Counseling Psychology*, *33*(1), 73.

Friedlander, M. L., & Ward, L. G. (1984). Development and validation of the Supervisory Styles Inventory. *Journal of Counseling Psychology*, *31*(4), 541.

Funderburk, J. S., Sugarman, D. E., Maisto, S. A., Ouimette, P., Schohn, M., Lantinga, L., … Coolhart, D. (2010). The description and evaluation of the implementation of an integrated healthcare model. *Families, Systems, & Health*, *28*(2), 146.

Galassi, J. P., & Akos, P. (2004). Developmental Advocacy: Twenty-First Century School Counseling. *Journal of Counseling & Development*, *82*(2), 146–157.

Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling & Development*, *81*(1), 3–10.

Gallo, J. J., Zubritsky, C., Maxwell, J., Nazar, M., Bogner, H. R., Quijano, L. M., … Sanchez, H. (2004). Primary care clinicians evaluate integrated and referral models of behavioral health care for older adults: results from a multisite effectiveness trial (PRISM-e). *The Annals of Family Medicine*, *2*(4), 305–309.

Garcia-Shelton, L., & Vogel, M. E. (2002). Primary care health psychology training: A collaborative model with family practice. *Professional Psychology: Research and Practice*, *33*(6), 546.

Gary, R. A., Dunbar, S. B., Higgins, M. K., Musselman, D. L., & Smith, A. L. (2010). Combined exercise and cognitive behavioral therapy improves outcomes in patients with heart failure. *Journal of Psychosomatic Research*, *69*(2), 119–131.

Gatchel, R. J., & Oordt, M. S. (2003). *Clinical health psychology and primary care: Practical advice and clinical guidance for successful collaboration.* American Psychological Association. Retrieved from http://psycnet.apa.org/psycinfo/2003-02043-000

Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. *Archives of Internal Medicine*, *166*(21), 2314–2321.

Gloria, A. M., Castellanos, J., Lopez, A. G., & Rosales, R. (2005). An examination of academic nonpersistence decisions of Latino undergraduates. *Hispanic Journal of Behavioral Sciences*, *27*(2), 202–223.

Glueck, B. P. (2015). Roles, attitudes, and training needs of behavioral health clinicians in integrated primary care. *Journal of Mental Health Counseling*, *37*(2), 175.

Glueck, B. P., & Foreman, B. H. (2014). Lessons learned from designing and leading multidisciplinary diabetes educational groups. *Journal of Mental Health Counseling*, *36*(2), 160.

Goldenson, R. M., & Glanze, W. D. (1984). *Longman dictionary of psychology and psychiatry*. Longman New York. Retrieved from http://www.getcited.org/pub/102292726

Graff, C. A., Springer, P., Bitar, G. W., Gee, R., & Arredondo, R. (2010). A purveyor team's experience: Lessons learned from implementing a behavioral health care program in primary care settings. *Families, Systems, & Health*, *28*(4), 356.

Gray, G. V., Brody, D. S., & Hart, M. T. (2000). Primary care and the de facto mental health care system: improving care where it counts. *Managed Care Interface*, *13*(3), 62–65.

Greason, P. B., & Cashwell, C. S. (2009). Mindfulness and counseling self-efficacy: The mediating role of attention and empathy. *Counselor Education and Supervision*, *49*(1), 2–19.

Guck, T. P., Guck, A. J., Brack, A. B., & Frey, D. R. (2007). No-show rates in partially intergrated models of behavioral health care in a primary care setting. *Families, Systems & Health*, *25*, 137–146. https://doi.org/10.1037/1091-7527.25.2.137

Haines, V. A., Hurlbert, J. S., & Zimmer, C. (1991). Occupational stress, social support, and the buffer hypothesis. *Work and Occupations*, *18*(2), 212–235.

Hale, C. J., Hannum, J. W., & Espelage, D. L. (2005). Social support and physical health: The importance of belonging. *Journal of American College Health*, *53*(6), 276–284.

Haley, W. E., McDaniel, S. H., Bray, J. H., Frank, R. G., Heldring, M., Johnson, S. B., … Wiggins, J. G. (1998). Psychological practice in primary care settings: Practical tips for clinicians. *Professional Psychology: Research and Practice*, *29*(3), 237.

Hall, J., Cohen, D. J., Davis, M., Gunn, R., Blount, A., Pollack, D. A., … Miller, B. F. (2015). Preparing the workforce for behavioral health and primary care integration. *The Journal of the American Board of Family Medicine*, *28*(Supplement 1), S41–S51.

Health, U. D. of, Services, H., Health, U. D. of, & Services, H. (2013). The US nursing workforce: Trends in supply and education. *Health Resources and Services Administration, Washington, DC, USA*.

Heath, B., Wise Romero, P., & Reynolds, K. A. (2013). *A review and proposed standard framework for levels of integrated healthcare*. Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions.

Hefner, J., & Eisenberg, D. (2009). Social support and mental health among college students. *American Journal of Orthopsychiatry*, *79*(4), 491.

Hegel, M. T., Imming, J., Cyr-Provost, M., Noel, P. H., Arean, P. A., & Unutzer, J. (2002). Role of behavioral health professionals in a collaborative stepped care treatment model for depression in primary care: Project IMPACT. *Families, Systems, & Health*, *20*(3), 265.

Hemmings, A. (2000). A systematic review of the effectiveness of brief psychological therapies in primary health care. *Families, Systems, & Health*, *18*(3), 279.

Henderson, D. A., & Montplaisir, B. F. (2013). From Good to Great: Examining Exemplary Counselor Development. *Journal of Counseling & Development*, *91*(3), 336–342.

Heppner, P. P., & Petersen, C. H. (1982). The development and implications of a

personal problem-solving inventory. *Journal of Counseling Psychology*, *29*(1), 66.

Hill, T. D., Ross, C. E., & Angel, R. J. (2005). Neighborhood disorder, psychophysiological distress, and health. *Journal of Health and Social Behavior*, *46*(2), 170–186.

Hoge, M. A., Morris, J. A., Laraia, M., Pomerantz, A., & Farley, T. (2014). Core competencies for integrated behavioral health and primary care. *Washington, DC: SAMHSA-HRSA Center for Integrated Health Solutions*.

Hoge, Michael A., Jacobs, S., Belitsky, R., & Migdole, S. (2002). Graduate education and training for contemporary behavioral health practice. *Administration and Policy in Mental Health and Mental Health Services Research*, *29*(4–5), 335–357.

Hollis, J. W. (2013). *Counselor preparation 1999-2001: Programs, faculty, trends*. New York, NY: Taylor & Francis.

Homrich, A. M. (2009). Gatekeeping for personal and professional competence in graduate counseling programs. *Counseling and Human Development*, *41*(7), 1–23.

Hooker, R. S., Brock, D. M., & Cook, M. L. (2016). Characteristics of nurse practitioners and physician assistants in the United States. *Journal of the American Association of Nurse Practitioners*, *28*(1), 39–46.

Hooper, L. M. (2014). Mental health services in primary care: Implications for clinical mental health counselors and other mental health providers. *Journal of Mental Health Counseling*, *36*(2), 95.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, *56*(6), 885.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology*, *36*(2), 223.

House, J. S., Umberson, D., & Landis, K. R. (1988). Structures and processes of social support. *Annual Review of Sociology*, 293–318.

Hudson-Allez, G. (2000). What makes counsellors working in primary care distinct from

counsellors working in other settings? *British Journal of Guidance and Counselling*, *28*(2), 203–213.

Hunter, C. L., & Goodie, J. L. (2010). Operational and clinical components for integrated-collaborative behavioral healthcare in the patient-centered medical home. *Families, Systems, & Health*, *28*(4), 308.

Hyun, J. K., Quinn, B. C., Madon, T., & Lustig, S. (2006). Graduate student mental health: Needs assessment and utilization of counseling services. *Journal of College Student Development*, *47*(3), 247–266.

Iarussi, M. H., Tyler, J. M., Littlebear, S., & Hinkle, M. S. (2013). Integrating Motivational Interviewing into a Basic Counseling Skills Course to Enhance Counseling Self-Efficacy. *Professional Counselor*, *3*(3), 161–174.

Ibrahim, H. I. (2014). The Relationship between Job Stress, Co-Worker Support and Organization-Based Self-Esteem: A Survey across Different Occupations. *Researchers World*, *5*(2), 69.

Institute of Medicine. (1994). *Part 3: The new definition and an explanation of terms.* (Defining primary Care: An interim report). Washington, DC: The National Academies Press.

Jacobs, S. R., & Dodd, D. (2003). Student burnout as a function of personality, social support, and workload. *Journal of College Student Development*, *44*(3), 291–303.

Jakupcak, M., Wagner, A., Paulson, A., Varra, A., & McFall, M. (2010). Behavioral activation as a primary care-based treatment for PTSD and depression among returning veterans. *Journal of Traumatic Stress*, *23*(4), 491–495.

James, L. C. (2006). Integrating clinical psychology into primary care settings. *Journal of Clinical Psychology*, *62*(10), 1207–1212.

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validational study. *Journal of Traumatic Stress*, *15*(5), 423–432.

Johnson, K. F., & Freeman, K. L. (2014). Integrating Interprofessional Education and Collaboration Competencies (IPEC) into Mental Health Counselor Education. *Journal of Mental Health Counseling*, *36*(4), 328–344.

Joiner, T. A. (2007). Total quality management and performance: The role of organization support and co-worker support. *The International Journal of Quality & Reliability Management*, *24*(6), 617–627. doi:http://dx.doi.org/10.1108/02656710710757808

Jones, A. L., Cochran, S. D., Leibowitz, A., Wells, K. B., Kominski, G., & Mays, V. M. (2015). Usual primary care provider characteristics of a patient-centered medical home and mental health service use. *Journal of General Internal Medicine*, *30*(12), 1828–1836.

Karademas, E. C. (2006). Self-efficacy, social support and well-being: The mediating role of optimism. *Personality and Individual Differences*, *40*(6), 1281–1290.

Kaslow, N. J., Dunn, S. E., & Smith, C. O. (2008). Competencies for psychologists in academic health centers (AHCs). *Journal of Clinical Psychology in Medical Settings*, *15*(1), 18–27.

Kates, N., Crustolo, A., Farrar, S., & Nikolaou, L. (2002). Counsellors in primary care: Benefits and lessons learned. *Canadian Journal of Psychiatry*, *47*(9), 857–862.

Kates, N., Crustolo, A.-M., Farrar, S., & Nikolaou, L. (2001). Integrating mental health services into primary care: Lessons learnt. *Families, Systems, & Health*, *19*(1), 5.

Katon, W., Russo, J., Von Korff, M., Lin, E., Simon, G., Bush, T., … Walker, E. (2002). Long-term Effects of a Collaborative Care Intervention in Persistently Depressed Primary Care Patients. *Journal of General Internal Medicine*, *17*(10), 741–748.

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health*, *78*(3), 458–467.

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, *6*(1), 21–37.

Kessler, R. (2010). Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention. *Families, Systems & Health*, *28*(4), 389–391.

Kozina, K., Grabovari, N., Stefano, J. D., & Drapeau, M. (2010). Measuring changes in counselor self-efficacy: Further validation and implications for training and supervision. *The Clinical Supervisor*, *29*(2), 117–127.

Kroenke, K., Bair, M. J., Damush, T. M., Wu, J., Hoke, S., Sutherland, J., & Tu, W.

(2009). Optimized antidepressant therapy and pain self-management in primary care patients with depression and musculoskeletal pain: a randomized controlled trial. *Jama*, *301*(20), 2099–2110.

Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: a new depression diagnostic and severity measure. *Psychiatric Annals*, *32*(9), 509–515.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The Phq-9. *Journal of General Internal Medicine*, *16*(9), 606–613.

Labor Force Statistics from the Current Population Survey. (2018). United States Department of Labor. Retrieved from https://www.bls.gov/cps/cpsaat11.htm

Ladany, N., Ellis, M. V., & Friedlander, M. L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development*, *77*(4), 447–455.

Laliotis, D. A., & Grayson, J. H. (1985). Psychologist heal thyself: What is available for the impaired psychologist? *American Psychologist*, *40*(1), 84.

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology & Psychotherapy*, *3*(4), 249–258.

Lambert, M. J., & Finch, A. E. (1999). The Outcome Questionnaire. Retrieved from http://psycnet.apa.org/psycinfo/1999-02767-026

Lambert, M. J., Hansen, N. B., & Finch, A. E. (2001). Patient-focused research: Using patient outcome data to enhance treatment effects. *Journal of Consulting and Clinical Psychology*, *69*(2), 159.

Lambie, G. W., Smith, H. L., & Ieva, K. P. (2009). Graduate counseling students' levels of ego development, wellness, and psychological disturbance: An exploratory investigation. *Adultspan Journal*, *8*(2), 114–127.

Larson, L. M., Clark, M. P., Wesely, L. H., Koraleski, S. F., Daniels, J. A., & Smith, P. L. (1999). Videos Versus Role Plays to Increase Counseling Self-Efficacy in Prepractica Trainees. *Counselor Education and Supervision*, *38*(4), 237–248.

Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature.

The Counseling Psychologist, *26*(2), 179–218.

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology*, *39*(1), 105-120.

Laschober, T. C., de Tormes Eby, L. T., & Kinkade, K. (2013). Mentoring support from clinical supervisors: Mentor motives and associations with counselor work-to-nonwork conflict. *Journal of Substance Abuse Treatment*, *44*(2), 186–192.

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-Efficacy and Counselor Development: Testing the Integrated Developmental Model. *Counselor Education and Supervision*, *37*(2), 115–124.

Leiter, M. P., & Maslach, C. (1988). The impact of interpersonal environment on burnout and organizational commitment: Summary. *Journal of Organizational Behavior (1986-1998)*, *9*(4), 297.

Leiter, M. P., & Maslach, C. (2001). Burnout and quality in a sped-up world. *The Journal for Quality and Participation*, *24*(2), 48.

Lent, R. W., Hill, C. E., & Hoffman, M. A. (2003). Development and validation of the Counselor Activity Self-Efficacy Scales. *Journal of Counseling Psychology*, *50*(1), 97.

Lent, R. W., Hoffman, M. A., Hill, C. E., Treistman, D., Mount, M., & Singley, D. (2006). Client-specific counselor self-efficacy in novice counselors: Relation to perceptions of session quality. *Journal of Counseling Psychology*, *53*(4), 453.

Leung, K.-K., Chen, C.-Y., Lue, B.-H., & Hsu, S.-T. (2007). Social support and family functioning on psychological symptoms in elderly Chinese. *Archives of Gerontology and Geriatrics*, *44*(2), 203–213.

Levant, R. F., & Heldring, M. (2007). Commentary: Health care for the whole person. *Professional Psychology: Research and Practice*, *38*(3), 276.

Levey, S. M. B., & Miller, B. F. (2012). Behavioral health integration: an essential element of population-based healthcare redesign. *Translational Behavioral Medicine*, *2*(3), 364–371.

Levine, D. (2005). A healthcare revolution: Quebec's new model of healthcare.

Healthcare Quarterly (Toronto, Ont.), *8*(4), 38–46.

Liu, H., Robbins, M., Mehrotra, A., Auerbach, D., Robinson, B. E., Cromwell, L. F., & Roblin, D. W. (2017). The impact of using mid-level providers in face-to-face primary care on health care utilization. *Medical Care*, *55*(1), 12–18.

Lo, R. (2002). A longitudinal study of perceived level of stress, coping and self-esteem of undergraduate nursing students: an Australian case study. *Journal of Advanced Nursing*, *39*(2), 119–126.

Luszczynska, A., Gutiérrez-Doña, B., & Schwarzer, R. (2005). General self-efficacy in various domains of human functioning: Evidence from five countries. *International Journal of Psychology*, *40*(2), 80–89.

Luszczynska, A., & Schwarzer, R. (2005). Social cognitive theory. *Predicting Health Behaviour*, *2*, 127–169.

Macgeorge, E. L., Samter, W., & Gillihan, S. J. (2005). Academic Stress, Supportive Communication, and Health A version of this paper was presented at the 2005 International Communication Association convention in New York City. *Communication Education*, *54*(4), 365–372.

Mallinckrodt, B., & Leong, F. T. (1992). Social support in academic programs and family environments: Sex differences and role conflicts for graduate students. *Journal of Counseling & Development*, *70*(6), 716–723.

Mallinckrodt, B., & Wei, M. (2005). Attachment, Social Competencies, Social Support, and Psychological Distress. *Journal of Counseling Psychology*, *52*(3), 358.

Marmarosh, C. L., Nikityn, M., Moehringer, J., Ferraioli, L., Kahn, S., Cerkevich, A., … Reisch, E. (2013). Adult attachment, attachment to the supervisor, and the supervisory alliance: How they relate to novice therapists' perceived counseling self-efficacy. *Psychotherapy*, *50*(2), 178.

Martin Jr, W. E., Easton, C., Wilson, S., Takemoto, M., & Sullivan, S. (2004). Salience of emotional intelligence as a core characteristic of being a counselor. *Counselor Education and Supervision*, *44*(1), 17–30.

Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology*, *52*(1), 397–422.

Mauch, D., Kautz, C., & Smith, S. (2008, February). Reimbursement of Mental Health Services in Primary Care - Google Search. Retrieved February 20, 2018, from https://www.google.com/search?q=Reimbursement+of+Mental+Health+Services+in+Primary+Care&oq=Reimbursement+of+Mental+Health+Services+in+Primary+Care&aqs=chrome..69i57j0j69i60l2.1348j0j1&sourceid=chrome&ie=UTF-8

McClelland, M., & Kleinke, D. (2013). Improving lives using multidisciplinary education: Partnering to benefit community, innovation, health, and technology. *Journal of Nursing Education*, *52*(7), 406–409.

McDaniel, S. H., Campbell, T. L., & Seaburn, D. B. (1995). Principles for collaboration between health and mental health providers in primary care. *Family Systems Medicine*, *13*(3–4), 283.

McDaniel, S. H., Hepworth, J., & Doherty, W. J. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems*. New York, NY: Basic Books.

McFeature, B., & Pierce, T. W. (2012). Primary care behavioral health consultation reduces depression levels among mood-disordered patients. *Journal of Health Disparities Research and Practice*, *5*(2), 4.

McGough, P. M., Bauer, A. M., Collins, L., & Dugdale, D. C. (2015). Integrating Behavioral Health into Primary Care. *Population Health Management*. Retrieved from http://online.liebertpub.com/doi/abs/10.1089/pop.2015.0039

McLean, S., Wade, T. D., & Encel, J. S. (2003). The contribution of therapist beliefs to psychological distress in therapists: An investigation of vicarious traumatization, burnout and symptoms of avoidance and intrusion. *Behavioural and Cognitive Psychotherapy*, *31*(04), 417–428.

Meany-Walen, K. K., Carnes-Holt, K., Barrio Minton, C. A., Purswell, K., & Pronchenko-Jain, Y. (2013). An exploration of counselors' professional leadership development. *Journal of Counseling & Development*, *91*(2), 206–215.

Melchert, T. P., Hays, V. L., Wiljanen, L. M., & Kolocek, A. K. (1996). Testing Models of Counselor Development With a Measure of Counseling Self-Efficacy. *Journal of Counseling & Development*, *74*(6), 640–644.

Miller, B., Glichrist, E., Ross, K., Wong, S., Blount, A., & Peek, C. J. (2016). *Core Competencies for Behavioral Health Providers Working in Primary Care*.

Prepared from the Colorado Consensus Conference, Denver, CO.

Miller, H. L., Hall, S. E., & Hunley, S. A. (2004). Value perceptions of integrative health care: a study of primary care physicians and professional clinical counselors. *Journal of Contemporary Psychotherapy*, *34*(2), 117–124.

Molenaar, P. J., Boom, Y., Peen, J., Schoevers, R. A., Van, R., & Dekker, J. J. (2011). Is there a dose–effect relationship between the number of psychotherapy sessions and improvement of social functioning? *British Journal of Clinical Psychology*, *50*(3), 268–282.

Monson, S. P., Sheldon, J. C., Ivey, L. C., Kinman, C. R., & Beacham, A. O. (2012). Working toward financial sustainability of integrated behavioral health services in a public health care system. *Families, Systems, & Health*, *30*(2), 181.

Mueller, R. M., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the Outcome Questionnaire: A confirmatory factor analysis. *Journal of Personality Assessment*, *70*(2), 248–262.

Myers, I. B., McCaulley, M. H., & Most, R. (1985). *Manual: A guide to the development and use of the Myers-Briggs Type Indicator* (Vol. 1985). Consulting Psychologists Press Palo Alto, CA.

Nash, J. M., McKay, K. M., Vogel, M. E., & Masters, K. S. (2012). Functional roles and foundational characteristics of psychologists in integrated primary care. *Journal of Clinical Psychology in Medical Settings*, *19*(1), 93–104.

Nelson, K. M., Helfrich, C., Sun, H., Hebert, P. L., Liu, C.-F., Dolan, E., … Hernandez, S. E. (2014). Implementation of the patient-centered medical home in the Veterans Health Administration: associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. *JAMA Internal Medicine*, *174*(8), 1350–1358.

Ng, T. W., & Sorensen, K. L. (2008). Toward a further understanding of the relationships between perceptions of support and work attitudes: A meta-analysis. *Group & Organization Management*. Retrieved from http://gom.sagepub.com/content/early/2008/02/01/1059601107313307.short

Nicholas, D. R. (1988). Behavioral Medicine and Mental Health Counseling: An Overview. *Journal of Mental Health Counseling*, *10*(2), 69–78.

Norcross, J. C., & Prochaska, J. O. (1986). Psychotherapist heal thyself: I. The psychological distress and self-change of psychologists, counselors, and laypersons. *Psychotherapy: Theory, Research, Practice, Training*, *23*(1), 102.

O'Donnell, A. N., Williams, M., & Kilbourne, A. M. (2013). Overcoming roadblocks: current and emerging reimbursement strategies for integrated mental health services in primary care. *Journal of General Internal Medicine*, *28*(12), 1667–1672.

O'Donohue, W. T., Byrd, M. R., Cummings, N. A., & Henderson, D. A. (2005). *Behavioral integrative care: Treatments that work in the primary care setting*. Routledge. Retrieved from https://books.google.com/books?hl=en&lr=&id=RNCSAgAAQBAJ&oi=fnd&pg=PP1&dq=dialectical+behavioral+therapy+primary+care&ots=f7m-XqVSUp&sig=UH3aVogH-DcTJJbthV_h_hRQcaU

O'Driscoll, M. P. (2000). Work and Family Transactions. *Transactions in the Mid-Life Family*, 92–112.

O'Driscoll, M. P., Brough, P., & Kalliath, T. J. (2004). Work/family conflict, psychological well-being, satisfaction and social support: A longitudinal study in New Zealand. *Equal Opportunities International*, *23*(1/2), 36–56.

Ohaeri, J. U. (2003). The burden of caregiving in families with a mental illness: a review of 2002. *Current Opinion in Psychiatry*, *16*(4), 457–465.

O'Leary, A. (1992). Self-efficacy and health: Behavioral and stress-physiological mediation. *Cognitive Therapy and Research*, *16*(2), 229–245.

Ozer, E. M., & Bandura, A. (1990). Mechanisms governing empowerment effects: a self-efficacy analysis. *Journal of Personality and Social Psychology*, *58*(3), 472.

Pace, T. M., Chaney, J. M., Mullins, L. L., & Olson, R. A. (1995). Psychological consultation with primary care physicians: obstacles and opportunities in the medical setting. *Professional Psychology: Research and Practice*, *26*(2), 123.

Patterson, J., Peek, C. J., Heinrich, R. L., Bischoff, R. J., & Scherger, J. (2002). *Mental health professionals in medical settings: A primer.* WW Norton & Co. Retrieved from http://psycnet.apa.org/psycinfo/2002-17363-000

Peek, C. J. (2013). Lexicon for behavioral health and primary care integration: concepts and definitions developed by expert consensus. *Agency for Healthcare Research and Quality, Rockville, MD*.

Peek, C. J., Cohen, D. J., & deGruy III, F. V. (2014). Research and evaluation in the transformation of primary care. *American Psychologist*, *69*(4), 430.

Peeters, M. C., Buunk, B. P., & Schaufeli, W. B. (1995). Social interactions and feelings of inferiority. *Journal of Applied Social Psychology*, *25*(12), 1073–1089.

Pepinsky, H. B., & Patton, M. J. (1971). The psychological experiment: A practical accomplishment. Retrieved from http://psycnet.apa.org/psycinfo/1973-03491-000

Philipsen, N., Carruthers, W., Chi, G., Ensey, D., Shmorhun, A., & Valdez, R. (2014). A mixed-methods assessment of time spent documenting by nurses using an electronic medical records system. In *Systems and Information Engineering Design Symposium (SIEDS), 2014* (pp. 118–123). New York, NY: IEEE.

Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings*, *16*(1), 40–46.

Pomerantz, A. S., Kearney, L. K., Wray, L. O., Post, E. P., & McCarthy, J. F. (2014). Mental health services in the medical home in the Department of Veterans Affairs: Factors for successful integration. Retrieved from http://psycnet.apa.org/psycinfo/2014-20174-001/

Pratt, K. J., & Lamson, A. L. (2012). Supervision in Behavioral Health: Implications for Students, Interns, and New Professionals. *The Journal of Behavioral Health Services & Research*, *39*(3), 285–294. http://dx.doi.org/10.1007/s11414-011-9267-6

Price, J. H., & Murnan, J. (2004). *Research limitations and the necessity of reporting them*. Taylor & Francis Group.

Pruitt, S. D., Klapow, J. C., Epping-Jordan, J. E., & Dresselhaus, T. R. (1998). Moving behavioral medicine to the front line: A model for the integration of behavioral and medical sciences in primary care. *Professional Psychology: Research and Practice*, *29*(3), 230.

Raabe, B., & Beehr, T. A. (2003). Formal mentoring versus supervisor and coworker relationships: Differences in perceptions and impact. *Journal of Organizational Behavior (1986-1998)*, *24*, 271–293.

Rak, S., & Coffin, J. (2013). Affordable care act. *The Journal of Medical Practice Management: MPM*, *28*(5), 317.

Rathi, N., & Barath, M. (2013a). Work-family conflict and job and family satisfaction: Moderating effect of social support among police personnel. *Equality, Diversity and Inclusion: An International Journal*, *32*(4), 438–454.

Rathi, N., & Barath, M. (2013b). Work-family conflict and job and family satisfaction: Moderating effect of social support among police personnel. *Equality, Diversity and Inclusion: An International Journal*, *32*(4), 438–454.

Ray-Sannerud, B. N., Dolan, D. C., Morrow, C. E., Corso, K. A., Kanzler, K. E., Corso, M. L., & Bryan, C. J. (2012). Longitudinal outcomes after brief behavioral health intervention in an integrated primary care clinic. *Families, Systems, & Health*, *30*(1), 60.

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, *3*(3), 157.

Robben, S., Perry, M., van Nieuwenhuijzen, L., van Achterberg, T., Rikkert, M. O., Schers, H., … Melis, R. (2012). Impact of interprofessional education on collaboration attitudes, skills, and behavior among primary care professionals. *Journal of Continuing Education in the Health Professions*, *32*(3), 196–204.

Roberts, S. A., Kiselica, M. S., & Fredrickson, S. A. (2002). Quality of life of persons with medical illnesses: Counseling's holistic contribution. *Journal of Counseling & Development*, *80*(4), 422–432.

Robinson, P., & Reiter, J. (2016). *Behavioral consultation and primary care: A guide to integrating services*. Springer Science & Business Media. Retrieved from https://books.google.com/books?hl=en&lr=&id=H-kDh54RwpYC&oi=fnd&pg=PR4&dq=Behavioral+Consultation+and+Primary+Care:+A+Guide+to+Integrating&ots=vt65ckTTbg&sig=xL7wN3YorF4FIN2240eo

H6ZO27Q

Rollnick, S., Miller, W. R., Butler, C. C., & Aloia, M. S. (2009). *Motivational interviewing in health care: helping patients change behavior*. Taylor & Francis. Retrieved from http://www.tandfonline.com/doi/full/10.1080/15412550802093108

Ross, R. R., Altmaier, E. M., & Russell, D. W. (1989). Job stress, social support, and burnout among counseling center staff. *Journal of Counseling Psychology*, *36*(4), 464.

Rout, A., Ashby, S., Maslin-Prothero, S., Masterson, A., Priest, H., Beach, M., … Sturdy, D. (2011). A literature review of interprofessional working and intermediate care in the UK. *Journal of Clinical Nursing*, *20*(5–6), 775–783.

Roy-Byrne, P., Craske, M. G., Sullivan, G., Rose, R. D., Edlund, M. J., Lang, A. J., … Golinelli, D. (2010). Delivery of evidence-based treatment for multiple anxiety disorders in primary care: a randomized controlled trial. *Jama*, *303*(19), 1921–1928.

Roy-Byrne, P. P., Katon, W., Cowley, D. S., & Russo, J. (2001). A randomized effectiveness trial of collaborative care for patients with panic disorder in primary care. *Archives of General Psychiatry*, *58*(9), 869–876.

Rush, A. J., Trivedi, M., Carmody, T. J., Biggs, M. M., Shores-Wilson, K., Ibrahim, H., & Crismon, M. L. (2004). One-year clinical outcomes of depressed public sector outpatients: a benchmark for subsequent studies. *Biological Psychiatry*, *56*(1), 46–53.

Sabin-Farrell, R., & Turpin, G. (2003). Vicarious traumatization: implications for the mental health of health workers? *Clinical Psychology Review*, *23*(3), 449–480.

Serrano, N., & Monden, K. (2011). The effect of behavioral health consultation on the care of depression by primary care clinicians. *WMJ: Official Publication of the State Medical Society of Wisconsin*, *110*(3), 113–118.

Shukla, A., & Srivastava, R. (2016). Development of short questionnaire to measure an extended set of role expectation conflict, coworker support and work-life balance: The new job stress scale. *Cogent Business & Management*, *3*(1), 1.

Skillman, S. M., Snyder, C. R., Frogner, B. K., & Patterson, D. G. (2016). The Behavioral Health Workforce Needed for Integration with Primary Care. Retrieved from http://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/04/Integrated_behavioral_health_workforce_FR_2016_Apr_Skillman.pdf

Skovholt, T. M. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. Routledge. Retrieved from http://books.google.com/books?hl=en&lr=&id=leKPAgAAQBAJ&oi=fnd&pg=PP1&dq=skovholt&ots=4FSl4hmdJ2&sig=m-cXAeqJ7-lzOqbEL_UW-a5LIEY

Smith, H. L., Robinson, E. H., & Young, M. E. (2007). The Relationship Among Wellness, Psychological Distress, and Social Desirability of Entering Master's-Level Counselor Trainees. *Counselor Education and Supervision*, *47*(2), 96–109.

Solberg, L. I., Crain, A. L., Jaeckels, N., Ohnsorg, K. A., Margolis, K. L., Beck, A., … Van de Ven, A. H. (2013). The DIAMOND initiative: implementing collaborative care for depression in 75 primary care clinics. *Implementation Science*, *8*(1), 135.

Solberg, V. S., & Viliarreal, P. (1997). Examination of self-efficacy, social support, and stress as predictors of psychological and physical distress among Hispanic college students. *Hispanic Journal of Behavioral Sciences*, *19*(2), 182–201.

Soman, M. D., & Larson, E. B. (2009). Patient-Centered Medical Home Demonstration: A Prospective, Quasi-Experimental, Before and After Evaluation. *American Journal of Managed Care*, *15*(9), e71–e87.

Spielberger, C. D., Gorsuch, R. L., Lushene, R. E., Vagg, P. R., & Jacobs, G. A. (1970). *State-trait anxiety inventory. Palo Alto*. ca: consulting psychologists press.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097.

Stajkovic, A. D., & Luthans, F. (1998). Self-efficacy and work-related performance: A meta-analysis. *Psychological Bulletin*, *124*(2), 240.

Sternberg, R. J., & Williams, W. M. (1997). Does the Graduate Record Examination predict meaningful success in the graduate training of psychology? A case study.

American Psychologist, *52*(6), 630.

Stetz, T. A., Stetz, M. C., & Bliese, P. D. (2006). The importance of self-efficacy in the moderating effects of social support on stressor–strain relationships. *Work & Stress*, *20*(1), 49–59.

Steward, R. J. (1998). Connecting counselor self-efficacy and supervisor self-efficacy: The continued search for counseling competence. Retrieved from http://psycnet.apa.org/psycinfo/1998-00446-004

Strauser, D. R., & Berven, N. L. (2006). Construction and field testing of the Job Seeking Self-efficacy Scale. *Rehabilitation Counseling Bulletin*, *49*(4), 207–218.

Stravynski, A., & Boyer, R. (2001). Loneliness in Relation to Suicide Ideation and Parasuicide: A Population-Wide Study. *Suicide and Life-Threatening Behavior*, *31*(1), 32–40.

Strosahl, K. (1998). Integrating behavioral health and primary care services: The primary mental health care model. Retrieved from http://psycnet.apa.org/psycinfo/1998-07432-006

Strosahl, K., Robinson, P., & Gustavsson, T. (2012). *Brief interventions for radical change: Principles and practice of focused acceptance and commitment therapy*. New Harbinger Publications. Retrieved from https://books.google.com/books?hl=en&lr=&id=38f7xrBJx0MC&oi=fnd&pg=PT7&dq=Brief+therapy+interventions+for+radical+change&ots=OJ1G98sPMd&sig=JuL2-7LlCt40_fAWVKwcHADHSxU

Tang, M., Addison, K. D., LaSure-Bryant, D., Norman, R., O'Connell, W., & Stewart-Sicking, J. A. (2004). Factors That Influence Self-Efficacy of Counseling Students: An Exploratory Study. *Counselor Education and Supervision*, *44*(1), 70–80.

Taylor, J. A. (1953). A personality scale of manifest anxiety. *The Journal of Abnormal and Social Psychology*, *48*(2), 285.

Teti, D. M., & Gelfand, D. M. (1991). Behavioral competence among mothers of infants in the first year: the mediational role of maternal self-efficacy. *Child Development*, *62*(5), 918–929.

Tew, J., Klaus, J., & Oslin, D. W. (2010). The Behavioral Health Laboratory: building a stronger foundation for the patient-centered medical home. *Families, Systems, & Health*, *28*(2), 130.

Thompson, C. A., & Prottas, D. J. (2006). Relationships among organizational family support, job autonomy, perceived control, and employee well-being. *Journal of Occupational Health Psychology*, (11), 100–118.

Torrence, N. D., Mueller, A. E., Ilem, A. A., Renn, B. N., DeSantis, B., & Segal, D. L. (2014). Medical provider attitudes about behavioral health consultants in integrated primary care: A preliminary study. *Families, Systems, & Health*, *32*(4), 426.

Umphress, V. J., Lambert, M. J., Smart, D. W., Barlow, S. H., & Clouse, G. (1997). Concurrent and construct validity of the Outcome Questionnaire. *Journal of Psychoeducational Assessment*, *15*(1), 40–55.

Unützer, J., Katon, W., Callahan, C. M., Williams Jr, J. W., Hunkeler, E., Harpole, L., … Lin, E. H. (2002). Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *Jama*, *288*(22), 2836–2845.

Vargas-Tonsing, T. M., & Bartholomew, J. B. (2006). An Exploratory Study of the Effects of Pregame Speeches on Team Efficacy Beliefs. *Journal of Applied Social Psychology*, *36*(4), 918–933.

Vera, M., Perez-Pedrogo, C., Sarah Enid Huertas, Maria Leticia Reyes-Rabanillo, Juarbe, D., Huertas, A., … Chaplin, W. (2010). Collaborative care for depressed patients with chronic medical conditions: a randomized trial in Puerto Rico. *Psychiatric Services*. Retrieved from http://ps.psychiatryonline.org/doi/abs/10.1176/ps.2010.61.2.144

Vernon, S. W., & Roberts, R. E. (1981). Measuring nonspecific psychological distress and other dimensions of psychopathology: Further observations on the problem. *Archives of General Psychiatry*, *38*(11), 1239–1247.

Vogel, D. L., & Wei, M. (2005). Adult Attachment and Help-Seeking Intent: The Mediating Roles of Psychological Distress and Perceived Social Support. *Journal of Counseling Psychology*, *52*(3), 347.

Vogel, M. E., Malcore, S. A., Illes, R. A. C., & Kirkpatrick, H. A. (2014). Integrated

primary care: Why you should care and how to get started. *Journal of Mental Health Counseling*, *36*(2), 130.

Vogt, W. P., & Johnson, R. B. (2015). *The SAGE dictionary of statistics & methodology: A nontechnical guide for the social sciences*. New York, NY: Sage publications.

Wales, P. (1997). Solution-focused brief therapy in primary care. *Nursing Times*, *94*(15), 48–49.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 629–640.

Watkins, C. E. (2014). The supervisory alliance: A half century of theory, practice, and research in critical perspective. *American Journal of Psychotherapy*, *68*(1), 19–55.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, *33*(9), 1111–1115.

Westheimer, J. M., Steinley-Bumgarner, M., & Brownson, C. (2008). Primary Care Providers' Perceptions of and Experiences With an Integrated Healthcare Model. *Journal of American College Health*, *57*(1), 101–108.

Wetherell, J. L., Afari, N., Rutledge, T., Sorrell, J. T., Stoddard, J. A., Petkus, A. J., … others. (2011). A randomized, controlled trial of acceptance and commitment therapy and cognitive-behavioral therapy for chronic pain. *Pain*, *152*(9), 2098–2107.

Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the US Preventive Services Task Force. *Annals of Internal Medicine*, *140*(7), 557–568.

Wiedenfeld, S. A., O'leary, A., Bandura, A., Brown, S., Levine, S., & Raska, K. (1990). Impact of perceived self-efficacy in coping with stressors on components of the immune system. *Journal of Personality and Social Psychology*, *59*(5), 1082.

Wilks, S. E. (2008). Resilience amid academic stress: The moderating impact of social support among social work students. *Advances in Social Work*, *9*(2), 106–125.

Woltmann, E., Grogan-Kaylor, A., Perron, B., Georges, H., Kilbourne, A. M., & Bauer, M. S. (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Perspectives*, *169*(8). Retrieved from http://ajp.psychiatryonline.org/doi/10.1176/appi.ajp.2012.11111616

Zajacova, A., Lynch, S. M., & Espenshade, T. J. (2005). Self-efficacy, stress, and academic success in college. *Research in Higher Education*, *46*(6), 677–706.

Zaleski, E. H., Levey-Thors, C., & Schiaffino, K. M. (1998). Coping mechanisms, stress, social support, and health problems in college students. *Applied Developmental Science*, *2*(3), 127–137.

Zhou, J., & George, J. M. (2001). When job dissatisfaction leads to creativity: Encouraging the expression of voice. *Academy of Management Journal*, *44*(4), 682–696.

Zung, W. W. (1976). SAS, self-rating anxiety scale. *ECDEU Assessment Manual for Psychopharmacology, Revised Edition. Rockville, Maryland*, 337–340.

APPENDICES

Appendix A

Demographic Items

Demographic Inventory

1. Age: What is your age in years? (please enter a number)
    - _____
2. Gender: What is your gender?
    - Male
    - Female
    - Other
3. What is your race/ethnicity? (Please select all that apply.)
    - African American or Black
    - Asian or Asian American
    - Caucasian or White
    - Hispanic or Latino
    - Native American or Alaskan Native
    - Native Hawaiian or Other Pacific Islander
4. What was the focus of your masters program?
    - Mental health counseling (LPC)
    - Marriage and Family Therapy (LMFT)
    - Social Work (LCSW)
    - Psychology
    - Other
5. In what state are you pursuing your license?
    - _____
6. How many post-masters years of experience do you have working in the mental health field?
    - _____ Years (enter a number)
    - _____ Months (enter a number)
7. How many years of experience do you have working in a primary care setting?
    - _____ Years (enter a number)
    - _____ Months (enter a number)

8. How many hours of licensure supervision have you completed? (Your best guess is fine.)

    - _____

9. Where do you meet with your supervisor?

    - On-site, face to face
    - Off-site, face to face
    - Online (Skype or similar)
    - Phone
    - Other

10. What training have you received for working in a primary care setting? (Please select all that apply).

    - Masters program coursework
    - Post-masters training (i.e., continuing education, etc.)
    - On-the-job training
    - Other (please specify)

Appendix B

Assessments

Counseling Self-Estimate Inventory

Instructions: Read each statement, and then indicate the extent to which you agree or disagree with that statement, using the following alternatives:

Likert Scale: 1 = Strongly Disagree, 2 = Moderately Disagree, 3 = Slightly Disagree, 4 = Slightly Agree, 5 = Moderately Agree, 6 = Strongly Agree

Measure Items:

1. When using responses like reflection of feeling, active listening, clarification, probing, I am confident I will be concise and to the point.
2. When I initiate the end of a session, I am positive it will be in a manner that is not abrupt or brusque and that I will end the session on time.
3. I am confident that I will respond appropriately to the client in view of what the client will express (e.g., my questions will be meaningful and not concerned with trivia and minutia).
4. I am certain that my interpretation and confrontation responses will be concise and to the point.
5. I feel I will respond to the client in an appropriate length of time (neither interrupting the client nor waiting too long to respond).
6. I am sure that the content of my responses, i.e., reflection of feeling, clarification, and probing, will be consistent with and not discrepant from what the client is saying.
7. I feel confident that I will appear competent and earn the respect of my client.
8. I am confident what my interpretation and confrontation responses will be effective in that they will be validated by the client's immediate response.
9. I feel that the content of my interpretation and confrontation responses will be consistent with and not discrepant from what the client is saying.
10. I am confident that the wording of my interpretation and confrontation responses will be clear and easy to understand.
11. I am confident that I will be able to conceptualize my client's problems.
12. I am confident that I can assess my client's readiness and commitment to change.
13. I am worried that the wording of my responses lack reflection of feeling, clarification, and probing, and may be confusing and hard to understand.
14. I am worried that the type of response I use at a particular time, reflection of feeling, interpretation, etc., may not be the appropriate response.
15. I may not be able to maintain the intensity and energy level needed to produce client confidence and active participation.
16. I am not sure that in a counseling relationship I will express myself in a way that is natural, without deliberating over every response or action.
17. I am afraid that I may not understand and properly determine probable meanings of the client's nonverbal behaviors.

18. My assessments of client problems may not be as accurate as I would like them to be.
19. I am uncertain as to whether I will be able to appropriately confront and challenge my client in counseling.
20. When giving responses, i.e., reflection of feeling, active listening, clarification, probing, I'm afraid that they may not be effective in that they won't be validated by the client's immediate response.
21. I am worried that my interpretation and confrontation responses may not, over time, assist the client to be more specific in defining and clarifying his/her problem.
22. I am unsure as to how I will lead my client towards the development and selection of concrete goals to work towards.
23. I feel that I have enough fundamental knowledge to do effective counseling.
24. I am confident that I will know when to use open or closed-ended probes and that these probes will reflect the concerns of the client and not be trivial.
25. I do not feel that I possess a large enough repertoire of techniques to deal with the different problems my clients may present.
26. I feel competent regarding my abilities to deal with crisis situations that may arise during the counseling sessions (e.g., suicide, alcoholism, abuse).
27. I am uncomfortable about dealing with clients who appear unmotivated to work towards mutually determined goals.
28. I may have difficulty dealing with clients who do not verbalize their thoughts during the counseling session.
29. I am unsure as to how to deal with clients who appear noncommittal and indecisive.

Reference:

Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., Toulouse, A. L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology*, *39*(1), 105-120.

Outcome Questionnaire 45.2 (OQ 45.2)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation.

Likert Scale: 0-4 (never, rarely, sometimes, frequently, almost always)

Measure Items:

1. I tire quickly.
2. I feel no interest in things.
3. I blame myself for things.
4. I feel irritated.
5. I have thoughts of ending my life.
6. I feel weak.
7. I feel fearful.
8. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")
9. I am a happy person.
10. I feel worthless.
11. I have difficulty concentrating.
12. I feel hopeless about the future.
13. I like myself.
14. Disturbing thoughts into my mind that I cannot get rid of.
15. I have an upset stomach.
16. My heart pounds too much.
17. I am satisfied with my life.
18. I feel that something bad is going to happen.
19. I have sore muscles.
20. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
21. I feel nervous.
22. I feel something is wrong with my mind.
23. I have trouble falling asleep or staying asleep.
24. I feel blue.
25. I have headaches.
26. I feel stressed at work/school.
27. I find my work/school satisfying.
28. I work/study too much.
29. I enjoy my spare time.
30. I am not working/studying as well as I used to.
31. I have trouble at work/school because of drinking or drug use. (If not applicable, mark "never")
32. I feel that I am not doing well at work/school.
33. I have too many disagreements at work/school.
34. I feel angry enough at work/school to do something I might regret.

Reference:

Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology & Psychotherapy*, *3*(4), 249–258.

Supervisory Working Alliance Inventory – Trainee (SWAI-T)

Instructions: Please indicate the frequency with which the behavior described in each of the following items seems characteristic of your work with your supervisee.

Likert Scale: 1-7 (almost never - almost always)

Measure Items:

1. I feel comfortable working with my supervisor.
2. My supervisor welcomes my explanations about the client's behavior.
3. My supervisor makes the effort to understand me.
4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.
5. My supervisor is tactful when commenting about my performance.
6. My supervisor encourages me to formulate my own interventions with the client.
7. My supervisor helps me talk freely in our sessions.
8. My supervisor stays in tune with me during supervision.
9. I understand client behavior and treatment techniques similar to the way my supervisor does.
10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.
11. My supervisor treats me like a colleague in our supervisory sessions.
12. In supervision, I am more curious than anxious when discussing my difficulties with clients.
13. In supervision, my supervisor places a high priority on our understanding the client's perspective.
14. My supervisor encourages me to take time to understand what the client is saying and doing.
15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.
16. When correcting my errors with a client, my supervisor offers alternative ways to intervening with that clients.
17. My supervisor helps me work within a specific treatment plan with my clients.
18. My supervisor helps me stay on track during our meetings.
19. I work with my supervisor on specific goals in the supervisory sessions.

Reference:

Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, *37*(3), 322.

Social Support Scale

Instructions: Please answer the following questions based on different groups of co-workers in the medical settings.

Likert Scale: 1-5 (strongly disagree, disagree, neither, agree, strongly agree)

Measure Items:
Please answer the following questions related to support from co-workers who are doctors (i.e., MDs, DOs, etc.)

1. The doctors I work with provide helpful information or advice about my work.
2. The doctors I work with provide sympathetic understanding and advice.
3. The doctors I work with provide clear and helpful feedback about my work.
4. The doctors I work with provide me practical assistance at work.

Please answer the following questions related to support from co-workers who **are** mid-level providers (i.e., nurse practitioners, physician's assistants, etc.)

1. The mid-level providers I work with provide helpful information or advice about my work.
2. The mid-level providers I work with provide sympathetic understanding and advice.
3. The mid-level providers I work with provide clear and helpful feedback about my work.
4. The mid-level providers I work with provide me practical assistance at work.

Please answer the following questions related to support from co-workers who are nurses (i.e., registered nurse, licensed practical nurse, etc.)

1. The nurses I work with provide helpful information or advice about my work.
2. The nurses I work with provide sympathetic understanding and advice.
3. The nurses I work with clear and helpful feedback about my work.
4. The nurses I work with provide me practical assistance at work.

Please answer the following questions related to support from co-workers who are support staff (i.e., front desk, administrative assistants, etc.)

1. The support staff I work with provide helpful information or advice about my work.
2. The support staff I work with provide sympathetic understanding and advice.
3. The support staff I work with provide clear and helpful feedback about my work.
4. The support staff I work with provide me practical assistance at work.

References:

O'Driscoll, M. P. (2000). Work and Family Transactions. *Transactions in the Mid-Life Family*, 92–112.

O'Driscoll, M. P., Brough, P., & Kalliath, T. J. (2004). Work/family conflict, psychological well-being, satisfaction and social support: A longitudinal study in New Zealand. *Equal Opportunities International*, *23*(1/2), 36–56.

Appendix C

Informed Consent

INFORMED CONSENT

Project Title:
Understanding the Experiences of Mental Health Professionals Working in Medical Settings

Investigator:
Andy Melton
Trevecca Nazarene University
Graduate Counseling Department
Phone: 615-457-7791

You are being asked to participate in a project conducted through Trevecca Nazarene University.

Please read the following purpose of the project, the procedures to be used, and the potential benefits and possible risks of participation. Please print a copy of this consent for your records.

Background and Purpose of this Project: This consent form is a request and agreement for your participation in a doctoral research study completed by Andrew Melton, doctoral candidate at Trevecca Nazarene University. This research is being conducted under the supervision of Susan Lahey, Ph.D. The study is an investigation of the training and experiences of mental health professionals working in primary care settings. To participate, you must be a mental health professional currently pursing your state license and working in a primary care setting. If you choose to participate, the information you provide may help in the understanding of the training and development needs of clinicians working in primary care settings.

Explanation of Procedures: You will be asked to complete a background survey (such as demographics and some training-related information) and four surveys addressing areas such as co-worker support, supervisor support, life, stress, and confidence. The entire online survey will take approximately 15-20 minutes to complete. Upon completion of the survey, you will be directed to a new screen offering you the opportunity to be entered into a random drawing for one of three $25 Visa gift cards. These cards can be used anywhere Visa cards are accepted. To enter the drawing, you will be asked to provide your email address on a separate screen following the survey completion.

Discomfort and Risks: There are no obvious risks incurred through participation in this survey. However, you may experience discomfort related to answering questions about lived experiences in your behavioral health role. You will have the option of skipping questions. Participation in the study is voluntary and you are free to refuse to participate or withdraw from the study at any time. This study is not in any way connected with any participant's place of employment.

Benefits: There are no anticipated benefits from participating in this research. However, you may experience new awareness or insights related to your experiences working in a primary care setting. You may experience positive emotions related to the understanding that you are contributing to counseling research.

Confidentiality: The website you have accessed, Survey Monkey, is a secure website that uses the latest data encryption technology to securely collect and store data. Neither your email address nor your computer IP address will be attached to survey responses. This allows survey data to remain anonymous. You are able to take the survey anonymously, providing your email address only if you are interested in being entered into a drawing for incentives. The researcher cannot guarantee absolute confidentiality of data due to the limited protections of online access. Collected survey data will be stored on the investigators laptop and password protected at all times. Data will be maintained for two years following the completion of the study, at which point they will be erased. Data collected for this study will remain confidential unless revelation is required by law.

Refusal/Withdrawal: Refusal to participate in this study will have no effect on any future services you may be entitled to from the University or your place of employment. Anyone who agrees to participate in this study is free to withdraw from the study at any time with no penalty.

Use of Research Data: The information from this research will be used only for scientific and education purposes. It may be presented as scientific meetings and/or published in professional journals or books, or used for any other purpose, which Trevecca Nazarene University's Department of Graduate Counseling considers proper in the interest of education, knowledge, or research. Current plan include incorporating the responses into a doctoral dissertation.

Liability/Limitations: Trevecca Nazarene University, its agents, trustees, administrators, faculty and staff, are release from all claims, damages, or suit, not limited to those based upon or related to any adverse effect upon which may arise during or develop in the future as a result of participation in this research. Please understand that this release of liability is binding upon you, your heirs, executors, administrators, personal representatives, and anyone else who might make a claim through or under you.

Consent to Participate: By clicking "yes" below and completing the survey, I am authorizing my consent to participation in this study. I also hereby acknowledge that:

1. I have read and understand the above description of the study.
2. I understand that if I participate I may withdraw at any time without penalty.
3. I understand that should I have any questions about this research study, I may contact:

Andrew Melton, Doctoral Candidate at melton.andy@gmail.com

(consent form continued)

You understand also that it is not possible to identify all potential risks in an experimental procedure, and you believe that reasonable safeguards have been taken to minimize both the known and potential but unknown risks.

_____ _____

Signature of Participant Date

_____ _____

Witness Date

THE DATED APPROVAL ON THIS CONSENT FORM INDICATES THAT THIS PROJECT HAS BEEN REVIEWED AND APPROVED BY THE TREVECCA NAZARENE UNIVERSITY HUMAN SUBJECTS REVIEW BOARD

Appendix D

Screener and Non-consent Information

Screener Questions

1. Are you currently providing mental health services (full-time or part-time) within a medical setting?

- o Yes
- o No

2. Are you currently in process of obtaining your state license in the mental health profession (i.e., LPC, LMFT, LCSW, LCP, or similar)?

- o Yes, I am pursuing a temporary license
- o Yes, I have a temporary license and seeking a permanent license
- o No, I already have a license in professional counseling (LPC) or similar
- o No, I already have a license in marriage and family therapy (LMFT) or similar
- o No, I already have a license as a clinical social worker (LCSW) or similar
- o No, I already have a license as a clinical psychologist (LCP) or similar

3. How long have you been meeting with your current licensure supervisor?

- o Less than 3 months
- o 3 months or more

Screener Exit Page

"Your responses indicate that you do not meet eligibility requirements for survey completion. Thank you for your desire to participate in this research project. Click "Next" or exit your browser to leave this survey."

Non-consent Information Page

Participants who did not agree to participate were directed to a "Non-consent" page and were given the following:

At this time, you have indicated that you do not wish to consent to participate. If you change your mind, please click on the link that brought you here and start the survey again. Click "Next" or exit your browser to leave this survey.

Thank you!