12-2008

Counselors Working in Integrated Primary Behavioral Health and the Influence on Professional Identity: A Phenomenological Study

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COUNSELORS WORKING IN INTEGRATED PRIMARY BEHAVIORAL HEALTH AND THE INFLUENCE ON PROFESSIONAL IDENTITY: A PHENOMENOLOGICAL STUDY

by

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A Dissertation
Submitted to the
Faculty of The Graduate College
in partial fulfillment of the
requirements for the
Degree of Doctor of Philosophy
Department of Counselor Education and Counseling Psychology
Advisor: Suzanne Hedstrom, Ed.D.

Western Michigan University
Kalamazoo, Michigan
December 2008

COUNSELORS WORKING IN INTEGRATED PRIMARY BEHAVIORAL HEALTH AND THE INFLUENCE ON PROFESSIONAL IDENTITY: A PHENOMENOLOGICAL STUDY

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Over the past several years there has been a paradigm shift within the primary care delivery system from a traditional medical approach of providing behavioral health services to an integrated primary behavioral health model. This shift in patient care presents new opportunities for professional counselors to assume a role working in the health care arena. Currently there is a lack of research exploring the experiences of counselors working in this model. In addition, there is a deficit in the existing counseling literature specifically examining how working in this setting may potentially influence counselor identity. In an effort to inform counselors as well as contribute to the literature in the field of counseling this study examined the experiences of six counselors working in integrated primary behavioral health settings and explored how their experiences influenced their identities as counselors.

Participants identified rewards of working in an integrated primary behavioral setting such as collaborating with medical providers, learning from each other and satisfaction in working with patients in this model. The challenges described by participants included working within the culture of the medical model and the difference in approaches to patient care between medical providers and counselors. When describing

the impact on counseling skills of working in an integrated setting, participants shared the changes they made in their counseling skills as well as in their treatment approach in working with patients. Finally, counselors shared their unique experiences of how they perceived working in an integrated setting has influenced their professional identity by the way they conceptualized their role working with patients in this model as well as how they have changed how they identified their role, and experienced a sense of purpose in their role. Influences from the environment and interactions with others emerged as the two universal themes from participants' descriptions of their work experiences.

Implications are provided for counselors working in this setting as well as for counselor educators, supervisors, counselors in training, and for health care organizations considering implementation of such a model of patient care. Limitations of the study are described, and recommendations for further research are discussed.

ACKNOWLEDGEMENTS

The pursuit of this doctoral degree has been a life long dream I have had since I was a child. The journey has been both personally and professionally rewarding for me as I have grown as a person, and strengthened my skills as a professional counselor and a scholar. While working on this dissertation I have experienced some personal challenges and have made sacrifices along the way, however, I am of the belief that all things do truly happen for a reason. My hope is that I may continue to give back to the field of counseling and pursue new paths on the journey of my career as a counselor and a counselor educator. In honoring those who have influenced me, I will continue to work with people to facilitate change in their lives that has a positive impact on their health and well-being, as well as, helping to guide future counselors to do the same.

I would like to thank my Doctoral chair, Dr. Suzanne Hedstrom who has provided me with a constant level of guidance, support and encouragement throughout this endeavor. I value her knowledge and the time she provided me, as well as her flexibility in working around the hectic schedules of life. I also appreciate her patience as I tried to navigate through the many phases of the doctoral process.

I would like to thank Dr. Gary Bischof for his guidance and support and for sharing his professional expertise in medical family therapy. I would also like to thank Dr. Bischof for the opportunity to participate in research in the area of collaborative family health care. I would like to express thanks to Dr. Lynn Brice for her contagious

passion for qualitative research. Her unique way of conveying her knowledge to others made me eager to explore qualitative research. I appreciate her willingness to remain on my dissertation committee from a distance as she accepted a new position at the University of Minnesota.

I wish to thank Dr. John Geisler whom I have had the pleasure of being able to learn from during both my Masters and Doctoral programs. I feel very fortunate to have been part of his last Dissertation Seminar class before retirement. I appreciate the way that he challenged me to develop the foundation of what evolved into this dissertation study. His knowledge and guidance was invaluable to me during this process.

I would like to thank my cohort and other colleagues from Western Michigan University. The journey would not have been as rewarding or nearly as much fun without all of you. I am especially grateful to my colleagues and friends who were part of the "dissertation survival support group." I truly would not have been able to get through the home stretch without your support, encouragement, laughter and of course, holding me accountable to my weekly goals!

I would like to thank my colleagues at Grand Valley Health Plan. I appreciate the support you have given me by being flexible with my schedule during the time I have worked on my doctoral degree. I truly appreciate working as a counselor within a health care organization that values how integrative care can positively impact the quality of life of patients.

I would like to extend my deepest appreciation and thanks to the six counselors who were willing to share their time and their professional experiences about working in an integrated primary behavioral health setting with me. Each of these counselors' stories helped to develop to the rich and meaningful data which made this study possible. Their experiences will contribute to the counseling literature about counselors working in integrated primary behavioral health care settings.

I would like to express gratitude to my parents, Charles and Andrea Gersh who have always instilled the value of education, a strong work ethic, and made me feel as though I could always do anything I put my mind to. I appreciate your love and support of me through the years. I would like to thank my brother, Jeff who has influenced my life in many ways and through his challenges inspired me to work with others to help them with their own. I would also like to acknowledge my grandmother, Rosalyn Cunningham who was always proud of me no matter what I achieved. I always wanted her to see this day when she was alive, but I know that she has been with me all the way.

I want to thank my life partner of ten years, Colleen Cusick who has given me so much love, encouragement and support during my doctoral program. No words can ever express my appreciation for all you have been to me over the years. You have been my biggest cheerleader and for that I will always be grateful. I would like to acknowledge my beautiful daughter, Emily who was born at the beginning of this journey. Emily, Mommy is all done with her dissertation and I am looking forward to being able to spend more time exploring all of the wonders of the world through your eyes. You are truly a blessing

to me and I love you “all the way up to the sun, around the moon and stars and back, and even more.” I dedicate this dissertation to you.

Geniene Michelle Gersh

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CHAPTER I

INTRODUCTION

Overview of the Problem

Over the past 20 years, a significant amount of research has been conducted examining the benefits of integrating behavioral health practitioners within a primary care delivery system. The literature that supports this service delivery model consists of a plethora of empirical research demonstrating the strong interrelationship between a person's physical health and psychological well being (Blount & Bayona, 1994; Blount, 1998; Cummings, Cummings, & Johnson, 1997; Hafen, Karren, Frandsen, & Smith, 1996; Seaburn, Lorenz, Gunn, Gaawinski & Mauksch, 1996). Approximately 70% of patients who access primary care medical settings present with conditions that have biopsychosocial factors that are influencing their health condition (Fries, Koop, & Beedle, 1993; Pace, Chaney, Mullins & Olson, 1995).

The focus of primary care is in the prevention of illness and injury, the early detection and treatment of health problems, and ensuring coordinated and comprehensive care (Belar, 1995a; Newman & Rozensky, 1995). Higgins (1994) found that many of the unhealthy behaviors presented in primary care such as smoking, over-eating, substance abuse, violence, sedentary lifestyles, and unsafe sexual practices are significant contributors to physical illnesses. Furthermore, many medical disorders such as hypertension, headaches, and chronic pain have been shown to have a strong psychological component (Belar, 1995a, 1995b). Psychosocial stressors, behavior, and a

person's lifestyle habits have been found to be significant factors in five of the seven leading causes of death in the United States (Higgins, 1994; McGinnis & Foege, 1993). Given the nature of problems that the majority of the primary care population presents, counselors can play a significant role in collaborating with medical providers and patients in an effort to optimize the overall health of these patients (McDaniel, Belar, Schroeder, Hargrove, & Freeman, 2002).

The primary health care system has historically been based on the traditional biomedical model which focuses on physical symptomology, medical diagnosis of illness, disease and medication. The biomedical model views health in a dualistic manner grounded in the philosophy that the physical body is separate from the human mind (McDaniel, Campbell & Seaburn, 1995). George Engel, a physician and researcher at the University of Rochester, believed that the traditional bio-medical model is too limited and recommended the utilization of a new model, the biopsychosocial model (Engel, 1980, 1992, 1997). In the biopsychosocial model of care, a division of the organic and inorganic experience does not exist. This approach acknowledges the interconnection between health, behavior, and well-being, and holds the belief "that every psychosocial issue has some biological component and every biological event has psychosocial consequences" (McDaniel, et al., 1995, p. 286). There is an emphasis on a holistic perspective of health that focuses on the interrelationship among the biological, psychological, and social factors that influence health. The biopsychosocial model can provide a framework for both medical providers and behavioral health counselors to conceptualize a patient's health in an integrative manner.

The function of primary care is to provide health services for people across all chronic illnesses and conditions, including psychological disorders. Many health conditions and diseases are interrelated and driven by similar risk factors that present many clinical challenges for medical providers and mental health professionals working with primary health care patients. Counselors working in a primary care setting may encounter such challenges while working with patients who present with a vast array of conditions such as chronic pain, depression, anxiety, diabetes, and somatic complaints (Beck, 2001; Dea, 2000; Patterson, Peek, Heinrich, Bischoff, & Scherger, 2002). Approximately 75% of patients diagnosed with depression are treated solely by their primary care practitioner (Coyne, Thompson, Klinkman, & Nease, 2002). As a result, the majority of primary care patients may not access traditional behavioral health services for psychological conditions and a primary care provider may not have the time or the clinical expertise to adequately address these psychological and behavioral issues affecting a patient's health (Longlett & Kruse, 1992). Primary care providers have on the average between 12 to 15 minutes to assess, diagnose, and treat patients. It is not feasible that within this limited time period they are able to address all of the biopsychosocial concerns of their patients (Coyne et al.). Furthermore, patients presenting with emotional or psychological symptomology are often not diagnosed appropriately by their primary care providers and may not be referred for further treatment (Coyne et al.; Docherty, 1997; Higgins, 1994; Pruitt, Klapow, Epping-Jordan, & Dresselhaus, 1998; Von Korff & Simon, 1996).

In a study by Orlean, George, Houpt, and Brodie (1985) found that many patients refuse a referral to see a mental health practitioner. As a result of this study, Orlean and

colleagues discovered that 74% of physicians reported they believed that patient resistance to a mental health referral was a significant obstacle to effective treatment (Orlean et al.). The findings from similar studies show that approximately 50% of patients who were referred by their primary care physician to seek traditional mental health treatment failed to follow through with attending these mental health visits (Callahan et al., 1994, Frank, McDaniel, Bray, & Heldring, 2004; Gray, Brody, & Hart, 2000). Research suggests that the primary reasons behind the lack of follow through with mental health services have to do with the social stigma associated with pursuing mental health care as well the perceived inconvenience by patients to make a separate appointment to address their psychological issues (Arean & Miranda, 1996; Brody, Khaliq, & Thompson, 1997; Corrigan, 2004; Hayward & Bright, 1997). Furthermore, and probably one of the most significant barriers, is the perception by patients that their complaints are not being addressed by their primary care provider and thus conclude that the medical provider is dismissing their concerns as primarily psychological rather than medical in nature (Haley et al., 1998).

The integrated primary behavioral health model provides services to people who present with psychological, emotional, or behavioral health related factors that emerge as important in the care of primary care patients. Behavioral health counselors are frequently involved with patients who present with a broad spectrum of physical and psychological symptoms or conditions such as chronic health illnesses, headaches, vague physical complaints and psychiatric disorders that may negatively influence a patient's medical care and compliance to recommended treatment for their health conditions (Belar, 1995a, 1995b; Patterson et al., 2002).

In an integrated primary care setting behavioral health counselors share the same work space as medical providers where both behavioral and medical services are provided within an integrated service delivery system (Blount, 2003). The focus of this integrated model is to address both medical and behavioral needs of the primary care population (Strosahl, 1997).

Statement of the Problem

The literature suggests that the counseling profession needs to assume a more active role in the health care arena (Aitken & Curtis, 2004). Counselors are under represented as compared to their professional counterparts in health care. Other counseling-related and social science fields such as clinical psychology, counseling psychology, and marriage and family therapists have assumed an active professional role within health care and contributed to the mental health and primary care integration literature (Alcorn, 1991; Altmaier, 1991; Altmaier & Johnson, 1992; Carmin, Roth-Roemer, & Robinson-Kurpius, 1998; Corrigan, 1991; Mrdjenovich et al., 2004). Practitioners from these professional fields have developed educational training programs for students to pursue future employment in health care (McDaniel et al., 2003; Patterson, Bischoff, & McIntosh-Koontz, 1998). Counselors and the counseling profession have much to offer the health care sector by presenting themselves at the forefront of this critical role of counselors working in collaboration within a health care delivery system (Aitken et al, 2004; Sobel, 1995; McDaniel, 1995; McDaniel et al., 2002; Miller, Hall, & Hunley, 2004; Pace et al., 1995; Pruitt et al., 1998).

The field of counseling must have a willingness and commitment as a profession to demonstrate the ability to utilize the skills and abilities as counselors beyond the scope of traditional mental health and educational settings and assume a role within health care. Counselors can play an integral role as part of an integrated primary behavioral health team by working with patients who present with biopsychosocial drivers who may not have pursued traditional mental health services in an effort to have a positive impact on patients' overall health (Blount, 1998; Pace, et al., 1995).

Purpose of the Study

The paradigm shift from a traditional medical approach of behavioral health to an integrated primary behavioral health model represents a unique opportunity for research. This study examined how counselors trained in a traditional mental health model experience working in an integrated primary behavioral health model of service delivery.

A review of the current literature in the area of primary behavioral health integration demonstrates a clear deficit in the research that explores the experiences of counselors working utilizing a consultative approach in an integrated primary behavioral health setting. This lack of scholarly inquiry presents both a challenge and an opportunity to conduct research in this area. The challenge lies in the absence of existing research in the counseling field with which to conduct a comparative analysis. However, this lack of research presents an excellent opportunity for which one can examine the influences of the integrative model from the counselor’s perspective, while acknowledging the evidenced based research supporting the effectiveness of integration.

The purpose of this study was to better understand the lived experience of counselors trained in a traditional mental health model who are working in an integrated primary behavioral health model of patient care. Specifically, I examined how counselors view providing care in an integrated model and their perceptions of how these experiences may influence their professional identity.

In order to answer the statements of inquiry this researcher conducted a phenomenological study. Phenomenological inquiry was used in order to gain understanding into the intrinsic aspects of the phenomenon of the lived experiences of traditionally trained counselors who are working in an integrative primary behavioral health setting (Creswell, 1998; Patton, 1990). I was particularly interested in examining the key factors that might influence behavioral health practitioners' identities as counselors as a result of their experiences working within an integrated primary behavioral health model. Specifically, how does the phenomenon of their experiences affect counselor identity?

The Statement of Inquiry

The primary research question that guided this research study is: What is the experience of counselors working in an integrated primary behavioral health setting? The sub-questions that this researcher examined to support the statement of inquiry are as follows:

1. What are the rewards for counselors working in an integrated primary behavioral health setting?

2. What are the challenges for counselors working in an integrated primary behavioral health setting?
3. How does working in an integrated primary behavioral health setting impact the counseling skills of counselors?
4. How do the experiences of counselors working in an integrated primary behavioral health setting influence the way counselors perceive their professional identity?

Importance of the Study

This study explored an area of primary behavioral health integration that has not been thoroughly studied and reported. The findings from this study can potentially contribute to the field of counseling by encouraging further research in the area of the integration of counseling within a primary care setting. This would be important because the integrated primary behavioral health model offers a holistic approach that incorporates biological, psychological, social, and medical components of treatment in order to optimize a patient's overall health. This approach to care appears to be aligned well with the skills and abilities of counseling professionals.

This study will make a contribution in the field of counseling in an area in which there has been little if any exploration and description in the existing literature. Further research in the area of integrated counseling services may provide insight for counselors practicing in a traditional mental health setting into the key areas they would have to modify if they are to practice within a primary care delivery system.

This research may offer a better understanding into how counselors perceive themselves as professionals as they relinquish the familiar traditional medical model of therapy and explore the unchartered waters of the unique scope of practice in an integrated primary care setting. This is essential as counselors develop a sense of validity around their positions and duties in their role within the new framework of practice.

Definition of Terms

Integrated care describes an approach to health care that incorporates both physical and psychological symptoms that patients present. A behavioral treatment plan is developed with patients in collaboration with the behavioral health counselor and medical provider with the goal of optimizing a patient's overall health and functional status.

Integrated primary behavioral health model and *integrated mental health model* will be used interchangeably and are defined as an integral approach to health care which focuses on physical, psychological and social factors that potentially influence or affect a person's health or well-being. The foundation of this model of care is based upon the triadic collaboration between the patient, the behavioral health counselor, and the medical provider in order to coordinate a treatment plan to address a patient's comprehensive health care needs.

Primary care describes a health care delivery system where people receive health care services in a family practice clinic or health care organizational setting. *Behavioral Health* is a term that describes the emotional and behavioral influences that affect a

person's mental and physical health. This concept attempts to use a holistic view of health versus primarily focusing on mental disorders.

Counselor or behavioral health counselor will be used interchangeably to describe a mental health or counseling professional. This study specifically examined the experiences of counseling professionals and excluded counseling psychologists, clinical psychologists and social workers from the participant group.

Medical provider or *practitioner* is a medical clinician who provides health care services in a primary care delivery system. A medical provider includes such health care professionals as medical doctors, physician assistants and nurse practitioners.

Biopsychosocial is a term that describes the concept of the interrelationship of the biological, psychological and social factors that influence a person's overall health.

Consultation describes the dyadic collaboration between a medical provider and a behavioral health counselor to coordinate care for a patient. These consultative encounters are provided in a brief format and typically occur during or within a short time frame of a patient's visits.

Assumptions of the Study

The assumptions of this study include the following:

1. It is assumed that the 6 participant counselors have experiences working in an integrated primary behavioral health care setting and that they would be able to describe their experiences in a manner which conveyed understanding and meaning to the essence of these experiences.

2. Participants' responses were correctly portrayed in the descriptions of their experiences working as a counselor in an integrated primary behavioral health setting.

Limitations of the Study

The following are limitations of this study:

1. This study was designed to elicit information regarding individuals' experiences of a phenomenon. Therefore, the sample size of this study was limited to six counselors to allow for a thorough examination and rich description of the data of several individuals rather than using a larger sampling of subjects. A sample population of this size may have impacted the degree to which the findings from this study can be generalized to other similar populations.
2. This study is further limited due to the fact that participants were not excluded from the study based on differing racial, ethnic or cultural backgrounds; however, these factors may potentially have influenced the perception of the experiences of individuals.

Overview of the Study

Chapter II presents the review of the professional literature in the area of integrated primary behavioral health and provides the reader a context in which to conceptualize this study. This chapter provides a review of the literature focusing on prevalence of mental health conditions within primary care settings. Chapter II summarizes the professional literature focusing on the role of counselors working in

primary care settings and describes the model of integrated primary behavioral health care. This review of the literature will inform the reader of the lack of literature in the field of counseling specifically examining the experiences of counselors working in integrated primary behavioral health care settings. A summary of the distinction between the traditional mental health model and the integrated primary behavioral health model is delineated. Further differentiation is made distinguishing the characteristics between the collaborative health care model and the integrated primary behavioral health model. Chapter II concludes will outlining a conceptual framework of professional identity and exploring the potential influences of working in an integrated primary behavioral health model on professional counselor identity.

Chapter III outlines the qualitative methodology and the phenomenological approach to research that guided this study and informs the reader of the methodological process that was utilized to gather and analyze the research data. A review of qualitative methodology as well as the use of a phenomenological approach to research is described. Chapter III also includes a summary of the data collection process and includes the discussion of a pilot study that was conducted which helped to develop the interview questions that guided this study exploring the phenomena of the experiences of counselors working in an integrated primary behavioral health model and the influence on professional identity. The chapter continues with a description of the demographics of the participants selected in this study. Chapter III concludes with a detailed account of the inductive analysis process (Hatch, 2002) used to analyze the data and answer the research question. This section includes a description of how Transana (Version 2.12) was utilized to assist with the data analysis process.

Chapter IV includes a detailed report of the findings of this study to inform counselors working in an integrated primary behavioral health setting as well as those counselors who may be considering a counseling career in field of health care. Chapter V includes a discussion of the findings of this study including implications and limitations of these findings. Finally, Chapter V concludes with recommendations for future training and further research in the area of counselors working in integrated primary behavioral health care settings.

CHAPTER II

LITERATURE REVIEW

Organization of the Chapter

A qualitative phenomenological study was conducted to gain understanding of the lived experiences of traditionally trained counselors working within an integrated primary behavioral health care setting. This literature review will provide a rationale for this study. In this chapter, the research in the area of primary care and behavioral health integration will be delineated. A review of the research regarding the high prevalence rate of mental health disorders and behavioral conditions within primary care are presented. An examination of the lack of training and skills of primary care practitioners in the detection and treatment of mental health conditions in primary care follows this discussion. The body of literature exploring the effectiveness of behavioral health interventions with patients in primary care is introduced. In addition, the literature review contains a discussion about the future of the mental health services, specifically in the field of psychology, from the perspective of a pioneer in the development of the integrated primary behavioral health model.

The key concepts of the integration of behavioral health services within primary care are introduced and a description of the integrated primary behavioral health model of care will be presented. Following the introduction of the integrated primary behavioral health care model, a comprehensive overview outlining the distinctions between a traditional mental health model and an integrated primary behavioral health model is

presented. Further differentiation is made between the collaborative health care model and the integrated primary behavioral health model. Research findings regarding the application and effectiveness of the integrated primary behavioral health model are identified. The lack of existing research in the area of integrated care specifically with regard to the professional experiences of counselors is examined. An introduction of the theoretical foundation of the consultation approach will be discussed, and a comparison with this approach versus traditional therapy is offered.

The review of the literature identifies the areas where the existing research falls short of exploring the experiences of counseling professionals working within the integrated primary behavioral health model and how this may influence their sense of professional identity. Chapter II concludes with an overview of the conceptual framework of professional identity and the potential influence on the identity of counselors working in an integrated primary behavioral health model. A synthesis of the research presented in the aforementioned areas will serve as a prelude to this researcher's statements of inquiry. Finally, a call for further research in the area of counselors working in integrated primary behavioral health care settings will be emphasized and represents a framework for the phenomenological approach utilized in this study.

Prevalence of Mental Health Conditions in Primary Care

Research indicates that primary care medical providers deliver approximately 50% of all mental health services in the United States (Brody et al., 1997; Magill & Garrett, 1988; Narrow, Reiger, Rae, Manderscheid, & Locke, 1993; Strosahl, 1998). In a report conducted by the United States Department of Health and Human Services

(DHHS), *Mental Health: A Report of the Surgeon General, Executive Summary* (1999), it was found that annually only approximately 6% of the general population pursues mental health services (i.e., counseling) within a traditional mental health setting (i.e., private practice mental health setting or mental health agency). Nearly 50% of people with a diagnosed psychological disorder do not seek out mental health care either by a medical provider or by a behavioral health practitioner (Reiger et al., 1993).

A large body of research exists demonstrating the high prevalence rate of patients with psychological issues and disorders within a primary care setting (Fries et al., 1993; Narrow et al., 1993; Olfson, Marcus, & Druss, 2002; Pace et al., 1995; Reiger et al., 1993). Olfson and colleagues (2002) examined the number of patients with mental health issues in primary care between 1987 and 1997. They found that the number of patients being treated for depression tripled from 7.3 patients per thousand in 1987 to 23.3 per thousand in 1997. Within that decade the number of patients receiving treatment from their primary care provider increased from 61.1% to 87.3%. The Common mental health disorders found in primary care include depression, anxiety, substance abuse, eating disorders, and somatization disorders (Spitzer et al., 1995). Furthermore, researchers have found that often primary care practitioners do not adequately screen, diagnose, or provide treatment for psychological disorders (Brody & Saxena, 1996; Docherty, 1997; Higgins, 1994; Sobel, 1995; Von Korff, et al., 1996).

The health problems presented by primary care patients have significant psychological and behavioral co-morbidity (Kroenke, Spitzer, & Williams; 1994, Sherbourne, Jackson, Meredith, Camp, & Wells, 1996). Psychological disorders frequently co-occur with physical conditions. It is estimated this co-morbidity ranges

from approximately 20 to 80% within the primary care population (Olfson et al., 1997; Sherbourne et al., 1996). There are several studies exploring the effectiveness of behavioral health interventions in the treatment of mental health disorders and physical health conditions, somatic complaints and psychosocial problems within the primary care population (Anderson & Lovejoy, 2000; Cummings et al., 1997; Sobel, 1995).

In reviewing a study done in the area of the 10 most common presenting complaints in primary care (e.g., chest pain, fatigue, dizziness, headache, insomnia), Kreonke and Mangelsdorf (1989) found that 80% of these complaints had no diagnosable organic origin. The authors found only 16% of the patients who accessed care had clear organic physical causes of their condition and 10% had clear psychological conditions. The patients who reported significant psychological distress accounted for 80%. Other research demonstrates that approximately 60% of physical complaints in primary care have somatic origins and could be positively impacted if the patient's psychological problems were addressed (Cummings, 1997, 2004).

In summary, there is a disproportionate amount of people seeking treatment for psychological problems in primary care settings in contrast to those seeking care in traditional mental health settings (Reiger et al., 1993). Due to the high prevalence of lifestyle and behavioral issues present in the primary care population, the behavioral health counselor can play a key role in working with medical providers to enhance the health outcomes of this population (Blount, 1998). "Mental healthcare cannot be divorced from primary care and all attempts to do so are doomed to failure. Primary care cannot be practiced without addressing mental health concerns and all attempts to do so result in inferior care" (deGruy, 1996, p. 311).

The Financial Impact of Behavioral Health Disorders in Primary Care

The economic cost associated with behavioral health disorders is significant (McDaniel, Hepworth, & Doherty, 1992; National Institute of Mental Health [NIMH], 2007; Simon, VonKorff, & Barlow, 2003). The prevalence rates for psychiatric conditions in primary care are staggering with statistics for the adult population ranging between 18.5% and 25% (Narrow, Rae, Lee & Regier, 2002). According to deGruy (1996) approximately two thirds of the psychiatric conditions are not detected by primary care providers. Patients with psychological disorders such as depression and anxiety frequently utilize primary care services (Katon et al., 1990). Murray and Lopez (1996), in the Global Burden of Disease Study, found that psychiatric conditions, including suicide, accounted for approximately 15% of the burden of diseases in the United States which exceeds the total disease burden caused by cancer. According to the NIMH, untreated depression costs the Untied States over 40 billion dollars each year due to the missed days from the national workforce (NIMH, 2007). Mental health problems rank second to cardiovascular disease on the impact on disability in the United States (Murray & Lopez, 1996).

It is estimated that 10% of the primary care population are among the "high utilizers" of health care expenditures; these patients account for approximately 60% of the overall health care costs (McDaniel, et al., 1992). Seventy five percent of patients with depression present with physical complaints as the primary reason that they are seeking primary care services (Unützer, Schoenbaum, Drusss & Katon, 2006). Often the only treatment intervention that medical practitioners provide for patients is prescribing

antidepressant medications (Linden et al., 1999). Those people with depression utilize approximately twice the amount of health care resources as people without a depressive disorder (Simon, et al., 2003).

In summary, the professional literature on the costs related to untreated psychological and behavioral disorders in health care clearly supports the integration of behavioral health services within the primary care service delivery system. The findings of the aforementioned studies regarding the effectiveness of behavioral health interventions demonstrates the benefit of the counselor's role within primary care settings to influence patient care and effectively assist in the management and improvement of many conditions people present within primary care.

A Perspective on the Future of Mental Health Services

According to Cummings, O'Donohue, Hayes, and Follette (2001) the counseling of the future will be much different from that for which most psychologists and other mental health professionals have been traditionally trained. In an integrative model of care, Cummings and his colleagues assert that only 25% of practitioners' clinical time will be individual therapy that has been targeted and focused, and founded on evidenced based treatment techniques. They propose that another 25% of their time will be focused on group therapy that is time-limited and closed. In addition, 50% of behavioral health clinicians' time will be in population-based programs that will be focused on providing treatment using psychoeducational and therapeutic behavioral interventions. In order to provide effective care in an integrative primary behavioral health model, counselors need to make a significant change in their practice patterns.

The Emerging Role of Counselors Working in Health Care

Nicholas (1998) provides an overview of the emerging role of counselors working in health care. The author delineates the similarities between behavioral medicine and mental health counseling by identifying the following four key components: (1) A conceptual shift away from pathogenesis (development of disease or illness) towards salutogenesis (wellness or well-being); (2) the assumption of personal responsibility of health care; (3) an integrative, holistic view of health and the recipients of health care; and last, (4) prevention as one of the full range of health care services. Conceptually, mental health counseling and behavioral medicine match well (p. 73).

The inclusion of counseling professionals within the primary care setting is based upon clinical evidence about how emotional, behavioral, social and psychological factors influence health and well-being (Anderson et al., 2000; Blount, 1998; Sobel, 1995). "Health status, quality of life, and functional status are often better correlated with psychosocial factors than physical disease severity" (Sobel, p. 235). Several studies have illustrated the influence of behavioral and lifestyle practices and the actualization of physical illness such as cardiovascular disease, cancer, diabetes and hypertension as well as the impact these conditions have on a person's daily functioning, quality of life, morbidity and mortality (Frank et al., 2004, Gray et al., 2000). By integrating behavioral health practitioners into primary care settings, medical providers are able to utilize the expertise of counselors who employ such methods as screening, assessment, and psychoeducational consultation. The focus of these consultative encounters is to provide brief solution-oriented treatment interventions with patients in order develop behavioral

change plans that establish specific goals in an effort to optimize a patient's health. Quirk et al. (1995) contend that mental health care needs a model of care that recognizes the prevalence of mental health problems in health care and is integrated into the medical service delivery system.

Integrative behavioral health models have evolved in response to the inability of traditional specialty mental health models and health care to address the high volume of patients in primary care who present with a multitude of biopsychosocial factors that are negatively affecting their health. Integrated primary care services are better able to provide a broad spectrum of behavioral health interventions to meet the needs of the primary care population (Blount, 1998; Cummings et al., 1997; Dobmeyer, Rowan, Etherage, & Wilson, 2003; McDaniel et al., 1993; Strosahl, 1998).

Counseling professionals have the credentials and the clinical skills to pursue a role working in a health care setting (Alcorn, 1991; Blount, 1998; Strosahl, 1998). Among these roles are teaching interpersonal skills to medical providers, providing consultation with multidisciplinary teams, as well as working in consultation with patients in behavior change to reduce their health risk factors. Carmin and colleagues (1998) emphasize similar views of the role of counseling professionals in health care by asserting, "The health care arena needs counseling psychologists and other mental health professionals to become active members of treatment and research teams in order to meet the complex and multidimensional needs of patients" (p. 442). In a study conducted by Miller et al. (2004) examining the value perceptions concerning integrative health care, the findings suggest that both primary care providers and professional clinical counselors reported positive perceptions regarding integrative health care. Counselors and primary

care providers identified that they valued the collaboration process between the two disciplines and perceived that collaboration improved the quality of patient care.

The training of counselors is unique in that it assimilates both science and practice. Counselors are trained in the science of psychological methodology and utilize these methods in the practice of behavioral techniques and intervention strategies with patients. As a result of their training, counselors attempt to integrate theoretical approaches within the practice of behavioral intervention strategies (Pace et al., 1995). This science-practitioner model is an integral part of the foundation of the counseling profession and holds constructs similar to those in the integrated primary behavioral health model outlined in this study. The integration of these two skill sets well prepares a counselor's ability to make a significant contribution to work in an integrated primary care environment. In an integrated setting, a counselor assumes a multifaceted role providing behavioral treatment interventions, patient education, and consultation, as well as collaboration with other primary care providers in the effort to improve the emotional, behavioral and lifestyle habits of persons who access a primary care setting.

The Primary Behavioral Health Model

The term "primary behavioral or mental health" describes a new paradigm of behavioral health service delivery in the primary care medical setting that is dramatically different from traditional mental health services (Quirk et al., 1995; Strosahl, 1996a, 1996b, 1998; Strosahl et al., 1997). Most behavioral health practitioners have received their clinical training rooted in the traditional medical model of therapy that utilizes a standard 50 to 60 minute appointment. Traditional therapy is based upon the medical

model, which views the client as ill and dysfunctional and utilizes a clinical and therapeutic approach to treatment. In the primary behavioral health approach, treatment is derived from a psychoeducational and consultation model which promotes self-management skills and behavioral change.

Strosahl presented a model of primary care integration referred to as the Primary Mental Health Care Model. Working within a Primary Mental Health Care Model (Strosahl, 1997, 1998) presents both a professional and cultural shift for many counseling professionals. Successful transition to this new model requires the modification of many traditional mental health practices including the use of the 50 minute hour. Another cultural shift is to view counseling as a form of consultation that provides information or advice to both the patient and the medical provider (Blount, 1998; Quirk et al., 1995; Strosahl, 1998). The consultative approach to care is grounded in the theoretical concepts and principles of brief therapy utilizing a solution-oriented approach. In the solution-oriented approach, de Shazer (1982, 1988) describes a type of therapeutic approach that focuses on influencing behavioral patterns of clients. The focus is on working with the patient's strengths and ability to make behavioral changes. Treatment is solution-oriented and time-limited in that the patient and the counselor work together to define the problem and determine measurable goals and action steps designed to improve the presenting problem over a specified period.

Consultative encounters are conducted in a similar manner to how primary care practitioners provide care by seeing patients in 15 and 30 minute visits. Follow-up treatment planning may result in the behavioral health practitioner meeting with a patient on the average of two to three visits (Blount, 1998; Strosahl, 1998). Consultation services

are provided in the primary care practice area, so that patients view meeting with behavioral health practitioners as a routine primary care service (Strosahl, 1998, 2001). The goal of the primary behavioral health model is to manage patients within the structure of the primary care team with behavioral health providers functioning as a core team member. Specifically, there is an emphasis on early identification, treatment, long-term prevention, and "wellness" (Blount, 1998; Cummings et al., 2001; Strosahl, 1998, 2001).

Integrated primary behavioral health models of care have demonstrated success in many health care settings in the United States (Beck, 2001; Blount, 1998; Van Beek et al., 2008). Two of the country's leading health maintenance organizations, Group Health Cooperative of Puget Sound (currently HealthCare Partners) in Washington State and Kaiser Permanente in Northern California have actively promoted the integration of behavioral health services into primary care (Baird, 1998; Beck, 2001; Blount, 1998; Quirk et al., 1995; Strosahl, 1998). Kaiser Permanente developed an integrated primary care model that incorporated the collaboration of the primary care team including such key players as physicians, and mid-level providers such as nurse practitioners, physician assistants, nurses, and counselors (Dea, 2000).

Quirk and his colleagues (1995) describe the key components driving integrative behavioral health services: (1) recognition and response to the psychosocial needs of the primary care population to optimize health, and (2) an understanding of the clinical responsibility for treatment of the primary care patients lies with the primary care provider. This model allows primary behavioral health services to have a greater influence on patient care while still maintaining the central role of the primary care

practitioner. Finally, integrated behavioral health services have been found to have a positive impact both on medical provider satisfaction with services and as well as with the primary care population who report increased patient satisfaction, improved compliance with treatment, increased access to services, and effective clinical outcomes (Blount, 2003; Cummings, 1996; Friedman, Sobel, Myers, Candill, & Benson, 1995).

Distinguishing Characteristics of the Skills and Roles between the Integrated Primary Behavioral Health Model and the Traditional Behavioral Health Care Model

The role of a counselor working from an integrated behavioral health model is multifaceted. The primary role of a behavioral health counselor working in an integrated primary behavioral health model is that of a consultant for the medical provider. This model of care views the medical provider to be the "client" and it is the job of the consultant to work in collaboration with the provider to optimize the health of the patient. This view is in contrast to the role a counselor may have when working with a client individually using a traditional mental health model. In more traditional mental health practice, the client is the person with whom the counselor is working (Strosahl, 1997, 1998, 2001).

The transition for mental health clinicians to shift from a traditional practice model to an integrated practice model can often be initially difficult. The main reason for this difficulty in transition may be due to the vast differences of the culture and context of traditional mental health care and of primary care (Patterson et al., 2002). The authors differentiate between traditional behavioral health and integrated behavioral health models. In traditional mental health, the model is based upon behavioral health as a

specialty care service for referrals and consultations. In contrast to integrated behavioral health where the services are provided within the context of a medical setting, counselors are viewed as members of the medical team (Dobmeyer et al., 2003; Patterson et al., 2002; Strosahl, 1998). Another distinction lies in the clinical focus of each model. The clinical focus in a traditional behavioral health model is almost exclusively on the treatment of psychological disorders and mental health conditions, whereas, the clinical focus in an integrated model is on overall health, both physical and psychological. Counselors working within an integrated setting may be just as likely to have a visit with a patient with uncontrolled diabetes, as they would to see someone with major depression.

According to Patterson and colleagues (2002), the work culture in an integrated medical setting is vastly different from that experienced by many therapists working in a traditional behavioral health setting. Therapists working in a traditional behavioral health setting typically have a private office for meeting clients, whereas in a health care system or medical clinic most clinicians use an examination room along side of their medical provider colleagues. In a traditional behavioral health setting, a therapist would almost exclusively be working with other behavioral health specialists. However, in an integrated setting, the behavioral health counselor would be working primarily with other medical professionals and may not have daily contact with other behavioral health colleagues. Seaburn et al. (1996) assert that counselors working in health care may experience isolation. Working in this unfamiliar medical environment can create a "sense of homelessness" for counselors (p. 106). Counselors who practice in a medical setting may encounter a sense of professional isolation, as they may be the only counselor

working within the setting (Kates, Crustolo, Farrar, & Nikolaou, 2001; McDaniel et al., 1992).

Counselors working in a primary behavioral health care setting utilize briefer encounters with patients, and fewer follow-up appointments as compared to those professionals working within a traditional specialty mental health environment. Primary behavioral health appointments are shorter (e.g., 15 or 30 minutes consultations) as opposed to the standard 50-60 minute therapy session in a specialty mental health setting. Moreover, the intervals between return appointments are typically longer than in a specialty mental health care environment. The time between appointments in primary behavioral health setting may be one month in order to allow time for the patient to implement self-management skills. Most patients receiving care in a primary behavioral health location are seen approximately one to four times, (with an average of two encounters) compared to a higher return visit rate among patients in receiving care in a traditional specialty mental health care setting (Blount, 1998; Dobmeyer et al., 2003; Strosahl, 1998).

Counselors working in an integrated model require a core set of knowledge and behavioral intervention skills in the following areas: (1) a broad level of knowledge of primary care delivery systems; (2) a strong foundation of skills in general psychology; (3) a broad level of knowledge in health psychology or behavioral medicine; (4) the ability to work effectively within a multidisciplinary team; (5) appropriate screening, assessment, and behavioral intervention skills (McDaniel et al., 2002; Strosahl; 1998).

In a report by the American Psychological Association (American Psychological Association [APA], 1998) on the interprofessional health care services and training needs

in primary care provides a comprehensive outline of the general guiding principles of providing behavioral health care in a primary care setting. Included in these principles are a set of knowledge areas and a set of skills that are necessary to possess in order for a psychologist to work effectively in a primary care. Even though these guiding principles have been specifically designed for psychologists, these principles may be applied to other counseling professionals working in a primary care setting. Within the clinical role, it is essential that the counselor possess a high level of understanding of the biopsychosocial components that influence health and wellness as well as illness and disease. It is important to be knowledgeable regarding different health care delivery systems as well as the clinical services provided by other professions.

In addition, a strong level of understanding regarding behavioral health services in primary care and the application of a family systems approach to care is emphasized. Knowledge in the aforementioned areas require clinical skills in behavioral consultations or "curbside consults" in which behavioral health services are requested by the medical provider and delivered during the primary care visits and usually conducted in an examination room. Another skill is the ability to work in brief time frames using a solution-focused approach to care and apply the appropriate intervention to the problem (APA, 1998; Strosahl, 1996).

The APA guidelines also outline specific knowledge areas regarding assessment and diagnosis as well as the skills necessary to properly execute this knowledge in a primary care setting. A broad generalist skill base in assessment and diagnosis is needed including specific skills in problem identification, screening, treatment planning, concise documentation and good time management skills. Another area of required knowledge is

understanding the common biopsychosocial problems that are seen in primary care (e.g., depression, anxiety, substance abuse). The skills and abilities to work effectively in a multidisciplinary team and collaborate with medical providers to develop treatment plans are required. The ability to properly address and answer the consultation question requested by the medical provider as well as to use effective evidence-based behavioral interventions and psychoeducational skills to teach patients are all essential skills for counselors to possess who are working in primary care settings (APA, 1998).

In summary, the primary distinction with regard to the skill set of a clinician working in a traditional model as compared to an integrated model is having knowledge of effective brief counseling skills and interventions. A strong knowledge of physical, medical and somatic conditions is critical in order for a clinician to be effective in a primary care setting. Working in the fast paced and time-limited environment of primary care requires a counselor to have the ability to accurately screen, assess, diagnose and develop a treatment plan including specific goals and actions steps with a patient. In addition to a strong clinical knowledge base, the counselor must possess effective communication skills in order to engage in consultations with the medical practitioner and to convey necessary psychoeducational interventions with a client in a manner which promotes understanding and self-management skills.

As previously stated, this research investigator was interested in examining how the experiences of the aforementioned dynamics influence a counselor's professional identity. Very few publications address the concept of counselor identity as they relate to the counselor's experience of working within an integrated primary behavioral health model.

Distinguishing Characteristics of the Skills and Roles between the Integrated Primary Behavioral Health Model and the Collaborative Health Care Model

Blount and Bayona (1994) distinguish levels of collaborative health from "integrated primary care". The authors describe integrated primary care to be the highest level of collaboration between counselors and medical providers (p. 171). The primary behavioral health model employs a consultative approach to care that is grounded in the theoretical concepts and principles of brief therapy utilizing a solution-oriented approach. The solution-oriented approach as de Shazer (1982, 1988) describes is a type of therapeutic approach that focuses on influencing behavioral patterns of clients. The focus is on working with patients' strengths and abilities to make behavioral changes. Treatment is solution-oriented and time-limited in that patients and counselors work together to define problems and determine measurable goals and action steps designed to improve the presenting problem over a specified time period.

In a collaborative health care model, specialty mental health professionals may be co-located within a primary care facility, however, there is a physical separation of counselors and behavioral health services from the primary care delivery system. Counselors are accessible to medical providers for referrals and collaborative consult regarding patient care. In contrast to the collaborative role, the counselor working in an integrated practice model is considered a member of the primary care team. The counselor's role is to work along side of medical practitioners utilizing behavioral intervention skills while assisting patients who present with various physical and psychological conditions (Strosahl, 1998; McDaniel et al., 1992).

Seaburn and colleagues (1996) define collaboration between mental health professionals and health care providers stating, "To collaborate is to create conversations in which people are joined together, meanings are fashioned, purposes are defined, roles are clarified, goals are established and action taken" (p. 9). Bischof (2000) describes various contexts of collaborative health care. These collaborative care environments include primary care settings, specialty medical practices, managed care or health maintenance organizations, and hospital settings.

One form of a collaborative health care approach is the collaborative family health care model. This model involves mental health professionals collaborating with medical providers to assist in the care of patients in a medical health care setting (Bloch, 1992b). The collaborative health care model is based upon the integration of systemic family theory and practice approach and the biomedical model of health care. Professionals from these two disciplines collaborate to provide treatment that focuses on addressing how psychosocial stressors and interpersonal relationships can influence illness and health. (McDaniel, 1995; McDaniel et al., 1992; McDaniel et al., 1996).

McDaniel, et al. (1992) provide an operational definition of the role of a medical family therapist as follows:

> . . . it is distinguished by conscious attention to medical illness and its role in the personal life of the patient and the interpersonal life of the family. It combines biopsychosocial and family systems perspectives and uses them to work simultaneously with patients, families, health care professionals and community groups and agencies (p.4).

Katon and his colleagues demonstrated that a collaborative care model can improve mental health outcomes for patients with depression. In the collaborative care

model, mental health professionals see the patient with the primary care provider. The counselors assume various roles and are involved in monitoring medication compliance, presenting medical practitioners with patient assessments and treatment plans, and providing educational information to patients (Katon et al., 1995; 1996). Doherty (1995) provides a comprehensive overview of different levels of collaborative care. The author describes five levels of collaborative health care as follows: (1) minimal collaboration; (2) basic collaboration at a distance; (3) basic collaboration on site; (4) close collaboration in a partly integrated system, and last; (5) close collaboration in a fully integrated system. The majority of research literature on collaborative health care focuses on systems that primarily use level three collaboration which entails basic collaboration on site or level four collaborative care where there exists close collaboration in a partly integrated system of care.

It is important to note that while the skill set that is required for counselors working in a collaborative health care model is similar to those working in an integrated model with regard to a strong knowledge base of medical and psychological conditions and ability to execute solution focused behavioral interventions. There is a distinctive difference in the role that a counselor plays working in a collaborative health care model as compared to working within an integrated model of care. The role of a counselor in a collaborative model differs from that of a counselor in an integrated system from the point of initial contact. In a collaborative model most of the patient-counselor contact is done through the process of a written referral and a patient may not be seen that same day. The great majority of patients receiving care in an integrated primary behavioral health model are seen during or after their appointment with their medical provider.

Treatment by the counselor is viewed as part of their primary care treatment. This is in contrast to the collaborative model where the patient may view treatment as separate from primary care since these services are segregated from the primary care setting (Strosahl, 1998).

Conceptual Framework of Professional Counselor Identity

There is an extensive amount of literature within the field of counseling examining the construct of professional counselor identity (Feit & Lloyd, 1990; Gale & Austin, 2003; Hanna & Bemak, 1997; Ivey & Ivey, 1998; Ivey & Ivey, 1999; Kleist & White, 1997; Watts, 2004). Many of the scholars who have explored the concept of professional counselor identity have promoted the idea that counselors must possess a professional identity that is distinct from that of other social science professions such as psychology and social work (Gale et al., 2003; Ivey et al., 1998, 1999; Kleist et al., 1997; Ritchie, 1990). Pistole and Roberts (2002) proclaim that among the important components of professional identity are the values, beliefs, knowledge, and the ability to distinguish one's profession from other related professions.

In 1981, in an attempt to distinguish itself from psychology, the field of counseling established an accreditation body specifically for counselors and counselor educators and formed the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (Gale et al., 2003; Hanna et al., 1997). CACREP standards have historically focused on the development of professional identity (Fong, 1990). Identity development of counselors is a central theme for counselors and counselor educators as well as for the faculty members who train them (CACREP, 2001).

The 2001 CACREP standards have defined a qualified faculty member as an individual having "a doctoral degree, preferably from an accredited counselor education program" and further states that the "faculty member is clearly committed to preparing professional counselors and promoting the development of the student's professional identity" (CACREP, 2001, p. 66). It is important to note that since the time period in which this study was conducted the CACREP standards have been revised. The 2009 CACREP standards place an even stronger emphasis on both the professional identity of counselors as well as the professional identity of qualified faculty members.

The development of a professional identity as a counselor is a developmental process that begins during counselor training and continues throughout one's professional career (Brott & Myers, 1999). This professional identity serves as a frame of reference for counselors to understand their roles and decisions (Brott et al., 1999). Pistole and Roberts (2002) concur with the view that professional identity provides a frame of reference for counselors, "A professional identity provides a stable frame of reference which enables persons to make sense of their work and their lives, as it contributes to both a sense of belongingness and uniqueness" (p. 1).

In a study examining the training of counselors, Skovholt and Ronnestad (1992) offer that the identities of counselors differ from other professions given that in addition to forming attitudes about their professional selves, counselors develop a "therapeutic self that consists of a unique personal blend of the developed professional and personal selves" (Skovholt & Ronnestad, p. 507). Counselors' personal selves include "values and theoretical stance" (p. 507). The authors examine professional identity development focusing on both the external and internal influences on professional identity stating "the

process occurs through the individual's interaction with multiple sources of influence over a long period of time (p. 514).

In their article in the *Journal of Counseling and Development* (*JCD*) Weinrach, Thomas, Lustig and Chan (1998) examined the professional identity of authors who published articles in the *JCD* from 1978 through 1993. In a subsequent article written in 2001 Weinarch and colleagues addressed the importance of the professional identity of the scholars who were contributors to the *JCD*. Weinrach, et al (2001) defined the construct of professional identity stating the following: "Professional identity is the possession of a core set of values, beliefs and assumptions about the unique characteristics of one's profession that differentiates it from other professions" (p. 168).

The roots of the counseling profession are based upon a foundation of human growth and development (Hanna et al., 1997; Myers, 1992). In addition, the counseling profession promotes heath, wellness, prevention, and education as well as empowering behavior change (Gale et al., 2003; Kleist et al., 1997; Remley & Herlihy, 2005; Van Hesteren & Ivey, 1990; Watts, 2004) rather than focusing on psychopathology (Hansen, 2003). These core values and beliefs of the counseling profession are aligned with the purpose and goals of primary care which focus on prevention and wellness promotion, thus making counselors uniquely suited for working within in an integrated primary behavioral health setting.

Potential Influences on Professional Identity

Patterson et al. (2002) provide an excellent description of the differences between traditional and integrated behavioral health. The authors examine the mental health

provider's role in the new integrated setting and how their identity may be influenced and expanded in an integrated behavioral health model. Counselors working in the traditional model may perceive their identity as that of a counselor who is a member of a mental health team. This is in contrast to a counselor working in an integrated model who may view themselves as a health care provider who is a member of a multidisciplinary team.

Counselors practicing in a traditional mental health setting may perceive themselves as mental health specialists who practice within the context of various psychological theories and treatment approaches. Whereas, counselors working within an integrated model may perceive themselves as a generalist working within an eclectic theoretical framework in an effort to address various medical and behavioral disorders. Last, in a traditional model of care counselors may typically assume full responsibility for a patient's care. In contrast, the role of counselors working within an integrated system is typically that of a facilitator of care in collaboration as part of a multidisciplinary team.

Hudson-Allez (2000) articulates similar sentiments while addressing several distinguishing factors between counselors working in a primary care setting in comparison to those working in other mental health environments. Among these differences is the work environment and fast pace nature of primary care service delivery as well as the primary focus on time-limited treatment interventions. Hudson-Allez goes on to explain the transition as she discusses the adaptation process a counselor will likely experience when working within a primary care setting: "It requires an adaptation of methods used in private practice or other settings in terms of time-limited approaches, confidentiality ethics, note taking, techniques of interventions, and dealing with referrals and attrition" (p. 211).

In reviewing the research literature regarding psychologists and marriage and family therapists working in health care settings a limited body of research was found (e.g., Altmaier, 1991; Altmaier et al., 1998; Bernard, 1992; Good, 1992; Mrdjenovich et al., 2004; Newman et al., 1996; Seaburn et al., 1996). Within this limited body of research there are only a few articles addressing issues of professional identity of mental health professionals working in health care (Altmaier et al.; Bernard; Good; Mrdjenovich et al.; Seaburn et al.). Altmaier and colleagues assert that it is possible to be a counseling psychologist and work in a non-traditional setting such as health care (Altmaier; Altmaier et al.).

In referencing the field of counseling psychology, Newman and Reed (1996) address the need for field of psychology to be actively involved in the health care arena. They acknowledge the need for the profession of psychology to not continue to limit its identity as solely a mental health care profession, but rather to see the potential benefits of having a role in the health care profession. Moreover, the authors discuss the issue of the profession of psychology addressing their "internal struggles and anxiety related to this professional role transition" (p. 24). Good (1992) mirrors these same views as he speaks to the hierarchical culture of a medical setting and how this may present difficulty for professionals entering the health care field, "who by nature feel unsure of themselves and of their professional identity" (p. 69). Seaburn et al. (1996) state the collaborative process involves mental health professionals "venturing out from traditional definitions and carving out narrow paths into foreign lands. One may sometimes feel disloyal to one's own professional identity" (p. 106).

In another article related to the field of counseling psychology, Mrdjenovich and Moore (2004) define "professional identity as a sense of connection to the values and emphases of counseling psychology" (p. 72). The premise of this definition of identity could be applicable to the field of counseling as well, as it is essential to our identity as counselors to have a strong sense of connection to the values and emphases of the counseling profession which is comprised of such tenets as human growth and development, wellness and prevention (Hanna et al., 1997; Myers, 1992; Remley & Herlihy, 2005). Mrdjenovich and Moore present a comprehensive review of the limited body of research literature in the field of counseling psychology and health care. While this article focuses specifically on the field of counseling psychology, it presents an excellent position for the two key components of this researcher's study: (1) the paucity of evidenced based research examining counselors in the field of integrated mental health care, and (2) a call for research that examines the potential influences on counselors' sense of identity from their experiences in working in health care.

Mrdjenovich and Moore (2004) call for further research in the area of integrated health care with specificity on professional identity, "considering the limitations of existing literature, it seems necessary to expand research concerning counseling psychologists in health care settings. It would be particularly important to address the issue of professional identity in future research" (p. 74). Research specific to the field of counseling may potentially hold value in assisting counselors as they make the transition to working in the health care arena.

In summary, due to the significant amount of research that reflects a high percentage of psychological disorders found in primary care, this calls for counselors to

recognize the value of their role within the health care arena. The literature supports that counselors can make a significant contribution in the care of patients within a primary care setting (Aitken et al., 2004; Beck, 2001; Coyne et al., 2002; McDaniel et al., 1992). By bringing this issue to the forefront of research inquiry and clinical discussion, counselors may begin to recognize the importance of the role they are able to assume within health care. In examining the issue of professional identity of counseling psychologists in health care, Altmaier et al. (1998) state, "It is our strong belief that counseling psychologists can maintain their identity as such while practicing and conducting research in health care settings" (p. 22). Furthermore, Altmaier et al. argue, "developing a new professional specialty and a new professional identity does not imply relinquishing the old ones" (p. 23). The same may be said with regard to counselors and their ability to maintain their professional identity and remain connected to the core values of the counseling professional such as human development, prevention and wellness which seem to fit well with integrated primary behavioral health care.

Chapter Summary

Despite the growing body of literature regarding the potential benefits of integrating mental health professionals as a part of the health care services in primary care, there is a lack of research specifically examining the lived experiences of counselors working in an integrated primary behavioral health setting. The literature in the field of counseling focusing on the interdisciplinary integration of counselors and primary care providers is quite scarce. In addition, there is an absence in the existing literature in the counseling field that specifically focuses on the experiences of counselors working in an

integrated primary behavioral health setting and how these experiences may influence their professional counselor identity. Furthermore, the body of research that does exist in the area of integrated primary behavioral health care is primarily written by scholars in clinical psychology, counseling psychology, or the medical field.

The intent of this study was to examine the lived experiences of counselors working in the area of integrated primary behavioral health care. The findings of this study may inform counselors working in the field of integrated primary behavioral health care as well as encourage future counselors to consider pursuing a career working in an integrated primary behavioral health care setting.

CHAPTER III

METHODOLOGY

Overview of the Methodology

This chapter provides a detailed explanation and rationale for the methodology utilized in this study. A description of qualitative research is provided, followed by a description of the phenomenological methodology employed in this study. Following the details of the study, there is an overview of the methods and procedures for data collection. This chapter includes a summary of the pilot study that was conducted in 2005. A description of how the findings from the pilot research assisted in the development of the interview guide used in this study will be discussed. Chapter III concludes with a detailed review of the nine steps and procedures of inductive analysis outlined by Hatch (2002) that were utilized to analyze the data in this study.

Qualitative Research

Qualitative methods are useful for the exploration, understanding and description of an unknown phenomenon (Strauss & Corbin, 1998). "Qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods" (Strauss & Corbin, p. 11). The purpose of this study was to examine and explore the subjective experiences of counselors working within an integrated primary behavioral health model of care. The researcher implemented qualitative research

methods based on the constructivist paradigm as described by Hatch (2002). Constructivist qualitative research assumes that "multiple realities exist that are inherently unique because they are constructed by individuals who experience the world from their own vantage point" (Hatch, p. 15). Constructivist research utilizes naturalistic inquiry methods to create rich narrative data and provides sufficient contextual detail so that the reader can "place themselves in the shoes of the participants at some level" (Hatch, p. 16).

This investigator conducted a qualitative inquiry using phenomenological methodology (Creswell, 1998; Patton, 1990). Phenomenological methods are selected in order to assist in conceptualizing the phenomenon or essence of how the participant counselors experience working within an integrated behavioral health setting and how these experiences influence their professional identity as counselors. According to Creswell (1998), phenomenological studies describe "the meaning of lived experiences for several individuals about a concept or the phenomenon" (p. 51). Patton (2002) states, "phenomenological research seeks to grasp and elucidate the meaning, structure, and essence of the lived experience of a phenomenon for a person or group of people" (p. 482).

Often qualitative data is collected through interviews and then reviewed repeatedly to discover patterns, themes, and sub themes among the individuals' experiences (Patton, 1990). These themes emerge to provide descriptions of the lived experience, which provide meaningful insight to the reader about the phenomenon. Phenomenological methodology appeared to be most applicable for a study of this nature, as there does not exist much research about the phenomenon of the lived experiences of

counselors in the existing body of research in integrated primary behavioral health care. Phenomenological methods are useful for studying a phenomenon that has not been fully explored and provides in-depth and rich inquiry into an individual's experience (Creswell, 1998).

Research Procedure

Phenomenological Research

Phenomenological methodology was adopted to answer the aforementioned statements of inquiry. This methodology was used to gain understanding of the intrinsic aspects of how counseling professionals experience working in an integrated primary care model. Specifically, the researcher was interested in examining what are the key factors that influence the counselor's professional experience and professional identity by working in an integrated mental health care setting. Phenomenological research requires participants to describe their everyday lived experiences of the phenomenon being studied (Creswell, 1998). Therefore, it was crucial that participants of this study were "carefully chosen to be individuals who have experienced the phenomenon" (p. 55).

The phenomenological approach is associated with the German philosopher Edmund Husserl (1859-1938) who believed in the idea that "we can only know what we experience by attending to perceptions and meaning that awaken our conscious awareness" (Patton, 2002, p. 105-106). This approach is focused on examining how individuals make sense of an experience and develop meaning. The process of creating meaning of one's experiences occurs through "capturing and describing how people

experience some phenomenon, how they perceive it, describe it, feel about it, judge it, remember it, make sense of it and talk about it with others" (Patton, p. 104).

Research Questions

The primary research question that guided this research study is: What is the experience of counselors working in an integrated primary behavioral health setting? The sub-questions that this researcher examined to support the research question are as follows:

1. What are the rewards for counselors working in an integrated primary behavioral health setting?
2. What are the challenges for counselors working in an integrated primary behavioral health setting?
3. How does working in an integrated primary behavioral health setting impact the counseling skills of counselors?
4. How do the experiences of counselors working in an integrated primary behavioral health setting influence the way counselors perceive their professional identity?

Participant Selection

Inclusion Criteria

This study utilized a criterion-based sampling method to select participants who have experienced the phenomenon being studied (Creswell, 1998; Heppner & Heppner,

2004). Participants chosen for this study were specifically counselors who held a masters degree in counseling or a counseling related program. Additional criteria for inclusion required participants in this study to have been working in the counseling profession for a minimum of three years and who have worked in an integrated health care setting for a minimum of one year. Volunteers were asked a series of screening questions (Appendix C) to determine if they met the inclusion criteria for the study. Those volunteers who met all of the necessary inclusion criteria were invited to participate in the study.

Volunteers for participation were sought by sending an announcement of the study (Appendix A) to the professional listserv of the Collaborative Family Healthcare Association (CFHA), a national organization that promotes the practice of collaborative and integrated care and provides education and training for professionals working in collaborative and integrated primary care settings. This announcement was posted on a national membership listserv until six counselors agreed to participate in this study. This researcher contacted the chairperson of the CFHA in the spring of 2007 to obtain permission to post the announcement of this study. The announcement included a description of the study and criteria for participation and an invitation for participation of counselors who met the criteria for this study. The announcement also included contact information for this researcher in an effort to arrange a date and time to participate in a telephone interview between October 2007 and April 2008.

Participant Consent

Prior to participating in the study all 6 potential participants were asked to read and sign a consent form (Appendix B) after a description of the study was given to them.

The participant's voluntary signature of the consent form served as a written confirmation of their consent. After the completion of the consent form, participants were be asked to verbally consent to being audiotaped during the interview process prior to this researcher turning the tape recorder on. There was no more than minimal risk to individuals who participated in this research study.

Demographics of Participants

Phenomenological research requires participants to describe their everyday lived experiences of the phenomenon being studied (Creswell, 1998). Therefore, it was crucial that participants of this study were "carefully chosen to be individuals who have experienced the phenomenon" (p. 55). This study examined the professional experiences of six counselors working in an integrated primary behavioral health setting and explored how their experiences influenced their identity as a counselor. A summary of the demographic profile of the participants is outlined in Table 1. The six counselors who participated in the study all held a master's degree and possessed counseling credentials. Two of the participants possessed credentials as a Licensed Professional Counselor (LPC). In addition, one of the participants held credentials both as a Licensed Professional Counselor and a Nationally Certified Counselor (NCC). One of the participants held credentials both as a Licensed Clinical Professional Counselor and a NCC. Two of the counselors possessed credentials as a Licensed Mental Health Counselor (LMHC). The number of years working as a counselor ranged from 3 to 27 years with the average years worked as a counselor of 13.7 years. The range in the number of years participants had been working in an integrated primary behavioral health

Table 1: Participant Demographic Information

Participant Pseudonym	Years working in Counseling	Years working in Integrated Model	Credentials Licensure	Organizational Membership	Primary Professional Identification
Barb	11	2.5	LPC	None	Counselor
Carol	20	4	LMHC	MHCA	Counselor
Diane	27	8	LPC/NCC	ACA/NBCC	Behavioral Health Counselor
Mary	15	1	LCPC/NCC	ACA	Behavioral Health Counselor
Anne	6	5	LMHC	MHCA	Mental Health Counselor
Judy	3	2	LPC	None	Counselor

setting ranged from 1 year to 8 years with the average years worked in an integrated behavioral health setting of 3.9 years.

Description of Participants

Barb is a licensed professional counselor who has been working in the field of counseling for the past eleven years. She has been working for two and a half years as counselor in a family practice clinic in the Southwest. Carol is a licensed mental health counselor who has been working in the counseling field for twenty years in a variety of settings. For the past four years Carol has been working as a counselor in three different family medicine clinics in the Pacific Northwest. In addition to her degree in counseling, Carol is certified in medical family therapy. Diane is a licensed professional counselor who has worked in the field of counseling for the past twenty seven years including working in private practice. Diane has been working as a behavioral health counselor in a multidisciplinary integrated health care setting for the past eight years in the Midwest.

Mary is a licensed clinical professional counselor who has been working in the counseling field for fifteen years. Mary has been working for the past year as a behavioral health counselor in an integrated health care setting in the Midwest. Mary has worked in a variety of mental health settings in the past including working in a hospital. Anne is a mental health counselor who has been working in the counseling field for six years. She has been working as a mental health counselor in an integrated health center for the past five years in the Northeast. Judy is a licensed professional counselor who has been working as a counselor for the past three years. Judy has worked as a behavioral health counselor in an integrated primary care setting for the past two years in the Midwest. In

addition to working as a counselor in primary care, Judy also completed her internship in an integrated primary care setting.

Data Collection

This investigator conducted a phenomenological analysis in order to examine the intrinsic aspects and unique dynamics of how counselors experience working in an integrative model and how this may influence their identity as a counselor. Specifically, this investigator was interested in examining how counselors perceive working in an integrated primary behavioral health setting and the influences on their identity as counselors. The study employed the use of two sources of data collection: (1) a demographic survey (Appendix D) comprised of a series of twelve demographic questions for participants to complete, and (2) one in-depth interview (Appendix E) with each of the participants utilizing an interview guide of eight questions examining how participants experience working in an integrated behavioral health setting. Two of the six interviews were face-to-face and took place in a private office setting. The remaining four interviews were conducted by telephone. The length of the average interview was 46 minutes. The interviews ranged in length from 32 minutes to 64 minutes.

Demographic Survey

A demographic survey was given to participants to complete prior to the interview. The survey (Appendix D) included such items as field of degree, credentials, years of experience as a counselor and years worked in integrated primary behavioral health, and other questions exploring participants' experiences working in an integrated

primary behavioral health setting. This survey allowed this investigator to develop a sense of the participant's experiences and work setting prior to the interview process. Once participants met the criteria for inclusion in the study and agreed to participate, participants were mailed a copy of the demographic survey along with the consent form to complete and return to this investigator. Table 1 summarizes the demographic information of each participant.

In-depth Interviews

In-depth interviews are often used in conducting qualitative research. Qualitative data was collected through the use of semi-structured interviews. Seidman (1998) states,

> Interviewing provides access to the context of people's behavior and thereby provides a way for researchers to understand the meaning of that behavior. A basic assumption in in-depth interviewing is that meaning people make of their experience affects the way they carry out that experience. . . . Interviewing allows us to put behavior in context and provides access to understanding their action (p. 4).

The study involved asking participants to respond to a series of eight semi-structured and open-ended interview questions (Appendix E) specifically probing how counselors perceived their professional experiences working in an integrated primary care setting and the influence of these experiences on their professional identity as counselors. Follow-up questions were asked by this research investigator to clarify answers or to get more in-depth information regarding a participant's response. These questions were used to assist the interviewee in exploring the topic of study and provide a framework to

answer the research questions. “The aim of phenomenology is to transform lived experience into a textual expression of its essence” (Van Manen, 1990, p. 36).

The interview guide in this study included four different types of questions including background, descriptive, structural, and essential questions (Hatch, 2002). The researcher began the interviews with a background question designed to set the interviewee at ease and invited the participants to share demographic information. For example, “How did you get into the field of integrated primary behavioral health care?” Descriptive questions were used to elicit details about the research participant or context. For example, “What is your experience of being a counselor working predominately among medical practitioners?” Structural questions were used to invite the interviewees to demonstrate how they organize their knowledge of the cultural context and allow the researcher to examine “how individuals make sense of the social phenomena under investigation” (p. 104). An example of a structural question used in this study is, “How has your work in integrated primary behavioral health impacted your counseling skills?” The last type of questions used in this study is essential questions. Essential questions are those questions that “generate the central data of the study” (p. 103). An example of the essential questions utilized in this study were the following: “In what ways does your work in an integrated primary behavioral health model influence your professional identity as a counselor?” and “How have you found your work in your current position to be aligned with how you perceive yourself as a counselor?” In addition, the researcher occasionally used probes and asked for clarification in order to gain understanding of what the interviewee was conveying.

This investigator conducted each of these interviews using audiotapes that were later transcribed for data analysis. Following each interview, this investigator taped her reflections through the use of a "reflexive journal" (Patton, 1990, p. 109) to document any biases to the interview that were observed. Miles and Huberman (1994) suggest a contact summary form following each interview to focus and summarize information gained from the interviews and the interviewer's insight regarding the participants. A contact summary was completed after each interview to summarize the interview, and to document the main themes and important information. In additions, these summaries were used to record my initial impressions of each interview (Appendix F).

Confidentiality

Confidentiality of the research data was maintained through the use of pseudonyms for all participants interviewed and the organizational settings. All information and identifiers that were potentially disclosing were also masked. Audiotapes and transcriptions of the interviewees were numbered and only this investigator maintained a list of the names of the participants with the corresponding numbers. The list of transcripts was kept in a locked filing cabinet in the investigator's office.

Pilot Study

A pilot study was conducted using three semi-structured open-ended questions with three (3) counselors in March of 2005 before recruiting participants for this study. Creswell (1994) noted that pilot studies enable the researcher to improve the format and questions of the interview guide. The pilot sample provided an opportunity to determine

the effectiveness of the interview questions protocol and its ability to gather useful data collection for this study. As a result of the findings from this pilot study, revisions were made to the interview questions in order to better probe interviewees regarding their experiences and understanding of the phenomenon of the study.

In the pilot study participants were asked to speak about the transition process of working in a traditional mental health setting to working in an integrated primary behavioral health care setting. Modifications were made to the interview format to specifically focus on such areas as the perceptions of participants about the necessary skills for a counselor to have working in an integrated primary behavioral health setting. Other revisions included questions focusing on the perceived rewards and challenges of working within an integrated primary behavioral health setting. These revisions allowed this investigator to specifically focus on the experiences of counselors working in an integrated primary behavioral health setting rather than on the transition process from working in a traditional mental health environment to an integrated primary behavioral health setting. As a result of these modifications, this investigator was better able to develop questions in this study in order to answer the statements of inquiry.

Researcher Objectivity

As with any research, the investigator must examine the potential biases he or she may bring to the study. It is important to examine the investigator's background and experience and how this may influence the research process. "Particularly in qualitative research, the role of the researcher as the primary data collection instrument necessitates

the identification of personal values, assumptions and biases at the outset of the study" (Creswell, 2003, p. 200).

I have a Masters of Arts in Counseling Psychology and am completing a doctoral degree in Counselor Education. I have worked in the counseling field for over 15 years. Ten of these years have been spent working as a behavioral health counselor within a primary care setting. I have long had a research interest in the area of counselors working in primary care settings. Since 2004, my employer, Grand Valley Health Plan (GVHP) has undergone a restructuring of the delivery of primary care and behavioral health services to develop an integrated primary care setting. This restructuring process has involved professional training and mentoring in the integrated primary behavioral health model and observing the training of fellow behavioral health colleagues. As the investigator, I acknowledge that my personal bias stems from these experiences.

As a result of these professional experiences and opportunities of working within an integrated primary behavioral health setting, I attempted to be aware of these potential biases throughout the research process and "bracket" (Creswell, 1998), or set them aside, in order to "suspend all judgments about what is real until they are founded on a more certain basis" (p. 52).

The Role of the Researcher

In qualitative research, "the researcher is the instrument" (Patton, 2001, p. 14). I first became interested in integrated primary behavioral health about 10 years ago when I read several articles written in the journal *Behavioral Healthcare Tomorrow*. As a counselor working in a primary care setting I found the concepts discussed in these

articles to be quite intriguing. I was working as a counselor within a primary care setting; however, my office as well as those of my colleagues was far removed from primary care service delivery area and primary care practitioners. Instead counselors were nestled within a far corner of the primary care health centers. GVHP had counselors providing services in this manner for over twenty years and I never critically questioned how disconnected behavioral health services were from the other services within the family practice centers.

As I read more in the literature on integrated primary behavioral health care, I began to reflect on my master's training as a counseling psychologist and tried to conceptualize how this model differed from the traditional mental health model in which I was trained. I developed an interest in learning more about the integrated primary behavioral health model. I have always had an interest in the interconnection between one's physical and emotional health. At one point in my undergraduate career I considered pursuing medicine, but decided to pursue a path in another area of passion in counseling. For me working as a counselor within a primary care setting was an ideal "marriage" of these two areas of interest.

In 2002 I began working on a doctoral degree in counselor education with a concentration on counseling and leadership which allowed me to pursue advanced training in program development and evaluation. In addition to training in Counseling and counselor education, I received advanced training in holistic health education as well as program development and evaluation.

When the integrated primary behavioral health model was initially presented to the behavioral health team, counselors appeared to be receptive to the ideas and goals of

the model. It made sense that counselors working within a primary care setting would be integrated in the service delivery model versus being isolated in a private office working independently of the primary care team. However, when the transition began to move from a more traditional 50-minute mental health model to a consultative model working with patients within 15-minute to 30-minute visits, a few counselors began to voice their concerns regarding how they perceived this change and appeared to be challenged with how to provide these behavioral health services within the context of an integrated model of care.

As an observer to these challenges encountered by my colleagues, it appeared as though some of the counselors who held this belief would say that the integrated primary behavioral health model went against the traditional mental health model in which they were trained. I was both an observer and a participant of this paradigm shift within the organization and among my colleagues with whom I worked. I wanted to know what were the experiences of counselors working in this integrated model of care. As a result of my experiences, I decided to conduct a qualitative research study examining the experiences of counselors working within an integrated primary behavioral health setting as the basis of this dissertation study. It is the hope of this investigator that this study contributes to the counseling literature by lending a voice to the experiences of counselors working in an integrated primary behavioral health setting. Furthermore, it is the desire of this investigator that the findings from this study will spark other scholars to pursue further research of this phenomenon.

Data Analysis

According to Hatch "Data analysis is a systematic search for meaning" (2002, p. 148). In order to answer the statements of inquiry, this researcher employed data analysis techniques that I anticipated would support the research findings and conclusions. The information gathered from the analysis of data provided this research investigator with a rich and detailed description of data from which to answer the statement of inquiry. Upon completion of the interviews, each recorded interview was transcribed verbatim from the interview, logged, and categorized in a computerized database. After the transcription was completed, this investigator read through each transcript several times until the data was thoroughly understood and examined from "all possible meanings and divergent perspectives" (Creswell, 1995, p. 150). Each participant was assigned a pseudonym to identify the individual cases in a confidential manner.

This investigator attempted to accurately portray the experiences of the participants by the use of member checking (Hatch, 2002; Lincoln et al., 1985). A cover letter (Appendix J) along with a summary of each interview was completed and given to each of the participants in order to verify the accuracy of the transcription of their experiences before data analysis was initiated. This process also included the use of follow-up e-mails to each participant to confirm the accuracy of the data collected. All 6 participants responded that the summaries did accurately portray their experiences and none of the participants requested any modifications be made to the content of the interview summaries.

Phenomenological methodology is used to understand the essence and meaning of the phenomenon through the use of inductive analysis, which identifies common themes and provides rich meaningful descriptive accounts of the research findings (Merriam, 2002). Inductive analysis was utilized in this phenomenological study to identify the common themes in the described lived experiences of counselors working in an integrated primary behavioral health model.

Inductive Data Analysis

This investigator employed the nine steps of inductive analysis summarized by Hatch (2002): (1) The data was read and frames of analysis or units of meaning were identified, (2) Domains were created based on the semantic relationships discovered within frames of analysis, (3) Salient domains were identified and codes were assigned, (4) Data was re-read, salient domains were refined and records were kept that demonstrated where relationships were found within the data, (5) Decisions were made to determine whether the domains that emerged were supported by the data and then data was searched for examples that that did not fit or ran counter to the relationships found in each domain, (6) Analysis within domains was completed, (7) Analysis of themes across domains were identified, (8) A master outline was developed that expressed the relationships within and across domains, and finally, and (9) Data excerpts were selected to support components of the master outline.

The Use of Computer Software for Data Analysis

This investigator chose to use the data analysis software program, Transana to assist in the qualitative data analysis process. The use of Transana served as a means to insert and store the rich interview transcription data. Transana refers to units of meaning as clips and salient domains as keywords. The Transana software refers to the keywords associated within each of the themes as keyword groups. Transana created a method to organize the data and identify themes and sub themes by assigning keywords to specific audio clips from each of the six interviews (Woods, 2006). After the interview summaries were verified by each of the participants through the member checking process, this investigator entered each of the 6 transcripts into the Transana software program. The Transana software assisted in the inductive analysis process outlined by Hatch (2002).

Identifying Frames of Analysis

The first step of inductive analysis outline by Hatch (2002) is to identify frames of analysis or unit of meanings by thoroughly reading and re-reading the interview data. Using Transana this investigator identified that initial frames of analysis or units of meaning within specific clips of the transcripts using the clip identification function in Transana. Each of the individual transcripts was read and specific clips were identified that contained a unit of meaning used by the participants to describe each of the counselor's experience working in an integrated primary behavioral health model. These units of meaning or clips were stored in the Transana database and this collection of clips comprised the frames of analysis used to answer the research questions for this study. For

example, how does working in an integrated primary behavioral health model impact a counselor's counseling skills? And how do counselors perceive working in an integrated primary behavioral health care model to influence their professional identity as a counselor? The Transana database was comprised of the frames of analysis or units of meaning reported by the 6 participants.

Identifying Domains Based on Semantic Relationships

The second step in the inductive analysis process is to create domains based on the semantic relationships identified within each of the units of meaning or clips. Transana was used to identify the semantic relationships and assign keywords to each of the clips or units of meaning found within each individual clip. The clips identified from each of the participants' transcripts were organized and stored in a database according to the keywords that were assigned to each of the clips. As a result of this identification process, domains or keywords were identified within each of the clips. According to Hatch (2002) this process "gives researchers a systematic way to develop domains by exploring relationships among particulars within frames of analysis" (p. 164). Upon completion of this step, the domains were identified and organized and entered into the Transana database which was comprised clips from all 6 of the participants. For example, as part of the domain identification process this investigator identified 19 different domains (e.g., collaborating with medical providers, increased medical knowledge, learning from each other, and mutual respect and understanding) which later would develop into the theme identifying the perceived rewards shared by counselors

working in an integrated primary behavioral health setting. These series of clips formed the rewards of working in an integrated primary behavioral health setting theme.

Identifying Salient Domains and Assigning Codes

The third step of the inductive analysis described by Hatch (2002) is the process of identifying salient domains and assigning corresponding codes. All of the clips were reread thoroughly by the investigator and the clips were then organized and stored in each of the 64 domains or keywords to identify whether these initial domains accurately represented the lived experiences conveyed by each of the counselor participants. Hatch asserts "Your goal is to narrow the focus of your analysis by studying the categories that emerged from your domain analysis and deciding which domains will be salient to the project underway" (2002, p.168).

In order to complete this step of the data analysis process, the investigator further delineated the experiences shared by counselors during their interview. Transana was used to assist in reducing the number of clips or units of meaning that were assigned to each domain and focus on those units of meaning that specifically described participants' experiences with regards to their perceived rewards and challenges of working in an integrated primary behavioral health setting. This step also examined those units of meaning that described how counselors perceived the impact of working in such a setting on their counseling skills as well as the influence on their professional identity as a counselor. Using the Boolean search function in Transana, the investigator was able to reduce the number of units of meaning and identify salient domains. Once the salient

domains were identified, the investigator assigned codes to each domain in order to organize and keep track of the data.

Refining Domains

After the salient domains were identified, the transcripts were reread and the salient domains or keywords were refined according to the fourth step described by Hatch (2002). Transana was used to review the refined list of salient domains or keywords that were supported by the units of meaning or clips describing the experiences of counselors working in an integrated primary behavioral health model. After the list of domains was thoroughly reviewed, the domains or keywords were further refined by combining similar domains and keywords. Transana was used to analyze the list of salient domains or keywords previously identified that were supported by the units of meaning or clips described by the participants. In describing this step of the data analysis process, Hatch stated, "The idea is to be confident that the data support the existence of the domain and that all of the important included terms within a domain have been identified" (2002, p. 169). After the revision process the final list was reduced to 38 salient domains or keywords from the initial 64 domains or keywords previously identified. For example, the investigator regrouped the domains or keywords describing participants' perceived challenges of working in an integrated primary behavioral setting (e.g., dumping ground, fast pace, feeling isolated, and the medical culture) under one domain or keyword environment. Once this new domain or keyword was formed, this investigator assigned those clips or units of meaning associated with these four identified domains or keywords

that emerged from the data. A detailed description of these salient domains is presented in the findings in Chapter IV.

Examining the Data to Determine Domains Are Supported by the Data and Searching Data for Examples that Ran Counter to the Relationships Identified Within Domains

During the fifth step of inductive analysis process outlined by Hatch (2002) the data was thoroughly examined to determine if there was sufficient data to support the identified domains. After completing this step, the investigator further reviewed the data for examples that did not fit with or appeared to run counter to the relationships found within each of the domains. According to Hatch, "this step involves examining the quality of the data that have included in constructing your domains" (p. 170).

This step of the analysis process allowed the investigator to examine all of the domains that were considered to be significant to the findings of this study. As a part of this process, the investigator examined certain demographic variables which were applied to the data to determine if this information influenced the description of the shared experiences of counselors working in an integrated primary behavioral health model. Specific demographic data were examined within each of the domains or keywords. The two demographic variables selected included: (1) number of years of experience working as a counselor with a range from 3 years to 27 years; and (2) number of years of experience working in an integrated primary behavioral health setting with a range from 1 year to 8 years. A complete illustration of the demographic variables of the study is summarized in Table 1. The two demographic factors identified were thought to possibly account for differences in the described experiences from one participant to another.

The Transana program was utilized to assist in the process if assigning the demographic variable to each participant's transcript. As a part of this process, each transcript was programmed to identify the two selected demographic variables from the clips within each transcript related to the number of years of experience working as a counselor and the number of years working in an integrated primary behavioral health setting. The investigator explored the clips that ran counter to the semantic relationships identified within each keyword by examining the demographic variables of the clips to determine whether or not they accounted for differences in the experiences reported by each of the 6 participants. This differentiation process is described in detail in Chapter IV.

Complete an Analysis within Domains

The sixth step of inductive analysis described by Hatch (2002) entailed "looking within the domains for complexity, richness, and depth" (p. 171). In this step the investigator printed out a summary of all of the clips within each of the keywords from the Transana database and examined how they were organized. The investigator reread all of the clips that were assigned to each keyword and examined whether or not the clip fit within the domain. Upon completion of reading the transcripts and examining each of the clips no other units of meaning or domains were identified and it was determined that the analysis process of assigning clips to each of the keywords or domains from each of the participants of the participants was completed.

Search for Themes Across Domains

Hatch (2002) states that the seventh step of analysis is characterized by examining across the data for broad connections that attempts to bring the data all together. During this process the investigator studied the domains and explored for connections among them. "We are looking for relationships among the relationships we outlined in our domain analysis" (p. 173). Patterns were identified in the data using the salient domains or keywords identified in the Transana database. The investigator grouped the keywords into themes that emerged across the salient domains from each of the 6 particpants' descriptions of the phenomena of their experience.

The investigator organized these keywords into a total of four main themes that emerged across each of the salient domains identified in the participants' descriptions of their experiences. The following four themes were identified: (1) rewards of working with medical providers, (2) challenges working in an integrated primary behavioral health setting, (3) impact on counseling skills, and (4) influences on professional identity as a counselor. A summary of these four themes as well as the units of meaning or clips and the salient domains or keywords within each of these 4 themes are illustrated in Table 2.

Within the theme of the rewards of working with medical providers there were five domains that emerged from that data. These domains included the following: (1) collaborating with medical providers, (2) learning from each other, (3) mutual respect and understanding, (4) satisfaction in working with patients, and (5) rewards of working in an integrated primary behavioral health environment. The second theme was identified from the 6 participants' descriptions of their experiences of the challenges of working in

an integrated primary behavioral health setting. Further analysis of the data within this theme revealed two domains. The following two domains were identified: (1) challenges working within the culture of the medical model, and (2) different approaches to patient care.

The third theme identified by participants' descriptions of their experiences focused on the impact on counseling skills in working in an integrated primary behavioral health setting. From the participants' descriptions of their experiences two domains were revealed. The two domains included: (1) changes in counseling skills, and (2) changes in treatment approach to working with patients. Last, the fourth theme that emerged from the data collection of participants' experiences in working in an integrated primary behavioral health setting focused on the descriptions of the perceived influences of the participants on their professional identity as counselors. The three following salient domains were identified within this theme: (1) influence of role working with patients, (2) change in role identification, and (3) sense of purpose in role.

During the process of searching for themes across domains the investigator identified two themes that emerged from the data from participants' descriptions of their experiences: (1) influences from the environment, and (2) interactions with others. For example, when examining the participants' descriptions regarding the challenges of working in an integrated primary behavioral health setting, it was observed that the participants' descriptions or units of meaning could be categorized into two themes (1) influences from the environment, and (2) interactions with others. These themes could be identified across all of the salient domains that were identified within each of the other themes. Table 2 summarizes all of these themes and domains.

Table 2: Summary of Themes and Domains Within and Across Units of Meaning

Within Themes and Domains

Themes (Keyword Groups)	Salient Domains (Keywords)
Rewards of Working with Medical Providers	Collaborating with Medical Providers Learning from Each Other Mutual Respect and Understanding Satisfaction in Working with Patients Rewards of Working in an Integrated Primary Behavioral Health Environment
Challenges of Working in an Integrated Primary Behavioral Health Setting	Challenges Working Within the Culture of the Medical Model Different Approaches to Patient Care
Impact on Counseling Skills	Changes in Counseling Skills Changes in Treatment Approach Working with Patients
Influence on Professional Identity	Influence of Role Working with Patients Change in Role Identification Sense of Purpose in Role

Across Themes and Domains

Themes (Keyword Groups)	Salient Domains (Keywords)
Influences from the Environment	Influences from the Primary Care Setting Influences from the Medical Culture
Interactions with Others	Interactions with Medical Providers Interactions with Patients

Create a Master Outline and Select Data Excerpts

The eighth step recommended by Hatch (2002) involved creating a master outline that illustrated the relationships within and among domains. This outline was created in the Transana database. The purpose of the master outline is to "create a comprehensive representation of how the overall analysis fits together" (p. 176). During this process Hatch recommends that data excerpts are selected to support the clips that were organized in the Transana database. A thorough report of these clips is included in the findings of this study described in Chapter IV.

Trustworthiness of the Study

Lincoln and Guba (1985) suggest that the characteristics of qualitative research require the use of techniques for determining confirmability that differ from conventional quantitative methods. Four criteria for assessing the trustworthiness of a study are credibility, transferability, dependability, and confirmability.

Credibility

The primary purpose of qualitative research is to gain an understanding of how people make meaning out of their lives (Merriam & Simpson, 2000). Credibility is the first of the four quality standards used to judge trustworthiness in qualitative research. Credibility is related to the congruence of the findings of the study with the contextual perspectives of the participants (Lincoln et al., 1985). While the credibility in quantitative

research depends on instrument construction, in qualitative research, “the researcher is the instrument" (Patton, 2001, p. 14).

This study attempted to establish credibility by the use of member checking with having each of the participants review and verify the accuracy of their interview summary (Lincoln & Guba, 1985). Lincoln and Guba assert that member checking is the most essential technique for establishing the credibility of a study. Member checking in this study was conducted by the researcher asking for clarification and feedback throughout the duration of each of the interviews to ensure the information gathered was accurate. In addition, all participants were sent a summary of their interview and given the opportunity to make corrections of modifications to their comments. None of the 6 participants requested any revisions be made to their interview summary. All 6 of the participants provided a written response confirming the accuracy of their reported experiences.

Transferability

Transferability is the second quality standard used to judge trustworthiness of qualitative research. Transferability is related to the applicability of the research findings with other participants in other contexts (Lincoln & Guba, 1985). Transferability is similar to the concept of generalizability in quantative inquiry (Morrow, 2005).

Generalizability refers to how the findings of a study may be applied to the general population. The phenomenological approach design in qualitative research is not expected to obtain generalizable data, therefore the findings of this study may

not be generalizable to all counselors. Through the inductive analysis process, this investigator made an effort to present a rich description of the research findings in order to give the reader a meaningful account of the phenomenon. "The validity of the generalization hinges on the extent to which the attributes compared are relevant, which…rests upon rich, dense, thick description of the case" (Kvale, 1996, p. 233).

Dependability

Dependability is the third quality standard used to judge trustworthiness of qualitative research. Dependability is related to the extent to which the research finding would be the same if the study were to be conducted with the same or similar participants in the same or similar contexts (Lincoln & Guba, 1985). Dependability is similar to the concept of reliability in qualitative research (Morrow, 1995). Reliability examines if a study were to be conducted again would it produce similar findings. Patton (2002) states there is no standardized method to accurately replicate the qualitative process, and suggested that researchers should "do your very best with your full intellect to fairly represent that data and communicate what the data reveal given the purpose of the study" (p. 432).

In an effort to assure dependability in this study, this investigator conducted a pilot study in order to refine the interview guide. In addition, this investigator has provided a rich and detailed description of the data collection and analysis of the lived experiences provided by the counselor participants in this study.

Confirmability

Confirmability is the fourth quality standard used to judge the trustworthiness in qualitative research. Confirmability is related to the extent which the research findings are determined by the participants voices rather than on the biases and perspectives of the researcher (Lincoln et al., 1985). Hatch (2002) recommends that the researcher maintain field notes during the data collection process. The researcher completed contact summaries and a journal during the research process. These summaries included impressions, reactions, and initial interpretations during the interview process.

Chapter Summary

In summary, this study was conducted utilizing a qualitative research design and phenomenological methodology approach to data collection and analysis. Participants in the study were comprised of six counselors who have worked in an integrated primary behavioral health setting. The purpose of the study was to gain an understanding about counselors' experiences working in an integrated care setting and the potential influence of these experiences on counselor identity. Participants were recruited through the CFHA listserv, and were offered an incentive for their participation which was a $25.00 gift card to Amazon. Participants completed a demographic survey prior to the actual interview. Two of the interviews were face-to-face and the other four interviews were conducted by telephone. All six of the interviews were audiotaped. Experiences of counselors were prompted by using a series of eight open-ended questions presented in a semi-structured interview format. Following the interviews, this investigator used a professional

transcriptionist to transcribe each interview verbatim. Following the transcription of each interview, the investigator listened to the recordings again as all transcripts were checked for accuracy. A phenomenological methods approach utilizing an inductive data analysis process was used to identify themes and salient domains. The inductive process used to analyze the data was thoroughly delineated.

In addition, the four quality standards for establishing trustworthiness of the study are illustrated. The study used member checking to ensure the trustworthiness of this study. The findings of this study are presented in the following chapter.

CHAPTER IV

FINDINGS

The goal of this study was to increase the understanding of the lived experiences of six counselors working in an integrated primary behavioral health setting. Counselors were asked questions across a variety of areas examining their perceptions of working in integrated primary behavioral health settings. The findings of this study suggest that although counselors described their experiences working within an integrated primary behavioral health setting as positive with regard to the rewards of both collaborating with medical providers and working with patients in an integrative approach to care, they also identified several challenges in their role. These challenges include adapting to working within the culture of the medical model and the differing treatment approaches to patient care among medical providers and counselors. Moreover, participants identified how working in an integrated setting has made an impact on their counseling skills as participants reported the need to make modifications in their counseling skills as well as changes in their treatment approach with patients. The perceptions of the participants' experiences regarding the influence of working in an integrated primary behavioral health setting on their professional identity as a counselor were unique; some participants shared similar experiences, although they used different language to express these influences.

While many of the experiences identified by participants are consistent with the literature in the area of integrated primary behavioral health, there is a clear deficit in the counseling literature regarding the experiences of counselors working within this model of health care delivery. The findings of this study add to the literature in that these

findings specifically capture the voice of six counselors working in an integrated primary behavioral health setting and their descriptions of these lived experiences.

Chapter Overview

The findings in this chapter describe the phenomenon of the lived experiences of six counselors working in integrated primary behavioral health settings. This chapter is organized into six sections which provide the responses to the research questions outlined in this study. The first section of the chapter describes the perceived rewards for counselors working in an integrated primary behavioral health setting. The second section describes the perceived challenges for counselors working in an integrated primary behavioral health setting. The third section describes the lived experiences of counselors working in an integrated primary behavioral health setting and the impact on their counseling skills. The fourth section of the chapter describes the perceived influences of working in an integrated primary behavioral health care has on participants' professional identity as a counselor. A thorough description of the four themes that emerged from the data is described. Rich description is used to demonstrate how the four themes were constructed across the units of meaning and salient domains for each of the emergent themes. Excerpts from the data are used to illustrate the salient domains, and themes are reported in each section of the research findings.

The fifth section of this chapter provides the reader with a summary of the themes and domains across all frames of analysis. Two universal themes were identified across all of the themes and domains described by the participants in this study (Hatch, 2002). These themes included: (1) influences from the environment, and (2) interactions with

others. A thorough illustration of these universal themes and the domains identified within the themes are found in this section. The sixth and final section of this chapter includes a summary of the analysis of themes and domains within and across units of meaning. In addition, a description of differences in demographic variables (i.e., number of years working as a counselor and number of years working in an integrated primary behavioral health setting) are examined. Limitations of this study and implications of these research findings for counselor educators and new counselors are explored in Chapter V of this study.

Report of Counselors' Experiences

Four themes emerged from the research data as descriptions of the phenomenon of counselors' experiences working in an integrated primary behavioral health setting. The following four themes were identified: (1) rewards of working with medical providers, (2) challenges of working in an integrated primary behavioral health setting, (3) impact on counseling skills, and (4) influences on professional identity as a counselor. Thorough descriptions of each of the salient domains found within each of the four themes are reported describing the experiences of the six counselors who participated in this study. These four themes and the salient domains identified within each theme are summarized in Table 2.

Rewards of Working with Medical Providers

As participants described their experience working in an integrated primary behavioral health setting, an emergent theme identified from the data was the rewards of

working with medical providers. Within this theme of the rewards of working with medical providers, there were five domains that emerged from the data. These domains included the following: (1) collaborating with medical providers, (2) learning from each other, (3) mutual respect and understanding, (4) satisfaction in working with patients, and (5) rewards of working in an integrated primary behavioral health environment. A list of each of these domains is reported in Table 2.

Collaborating with Medical Providers

The first domain in this theme included clips or units of meaning from the data collection describing how counselors viewed collaborating with medical providers in an integrated primary behavioral health setting. Further analysis of these clips or units of meaning revealed semantic relationships and patterns within this domain. Many of the participants reported favorable interactions while collaborating with medical providers. Anne shared her experiences by describing how the medical director and other medical providers utilize her role and "believe in mental health very strongly." Anne reported the following:

> I think they're just really good about it. I mean, they kind of don't touch the mental health stuff; so they just come and get me. I really like it. We had a new medical director, and so she believes in mental health very strongly; so that was great. So she calls me in whenever she's worried about somebody, even if its one of her clients that I wouldn't normally be around for, . . . she'll have them come in on the days that I'm at the health center just so they can talk to me. I work with a nurse practitioner. She and I we see all teenagers; but I have ended up seeing more than just teenagers. . . but we run the teen clinic together. But there are doctors on the other side who see the adults; and they always call me over too. So it's just kind of, you know, whatever they need.

Anne went on to describe how she recognizes how helpful it is to be able to work in an integrated setting and "affiliate" herself with medical staff when working with patients. Anne shared the following:

> So it's nice, and it's really helpful; and it's good to be able to affiliate myself with the medical staff when I'm dealing with those people because it can be kind of scary if I was just in like a mental health practice with no medical staff around me. I don't know how I would manage some of those patients.

Anne described her experiences of working with other people within the medical team as part of an integrated approach to patient care. Anne commented, "There are more people kind of following some of the higher risk clients. Like you've got nurses to see them and you've got technicians, so you kind of get to talk to everybody and see how people are doing which is really nice."

Barb shared similar experiences in working with medical providers in describing how her input is valued and how this provides a more "holistic" approach to care. Barb reported, "Now I can just go and talk to them. I'm there when they're changing their meds; I understand clearly why. They even ask my input sometimes, and its just such a wonderful way to have holistic care. That to me is just the coolest part about this whole thing."

Diane described the "intercollaborative" relationship working with individual medical providers as well as her experiences working as a part of an integrated team. Diane shared the following:

> Providers have come to realize that that's the level of care that they can enjoy with me. It's been very favorable. I get a lot of doctors,

> pediatricians, who send me children who have physical symptoms that they're fairly certain are somatic in nature. It seems to be an age where children have a lot of GI distress that most often is related to an inability to manage the stress those young people are dealing with. There's a lot of intercollaboration; and it's been very, very positive. Again, it's by name recognition. The other thing that I get to do is I actually sit on an integrated team where there's a doctor, a nurse, and myself; and we are clinically seeing patients. And that's extremely exhilarating because you don't have to say "they gotta make an appointment with me". . . you know all of us are at the table collaborating with patients; and that is probably by far my most satisfying setting. Three days of my clinical practice are taken up in that setting, and we see the patients in our program once a month.

Judy commented that she believes that her work collaborating with medical providers is a positive experience and how she perceives the patients benefit by having two providers in the room "working together." Judy discussed the following:

> Well, just that overall I think it's been a positive experience in that I think that it's most positive for the patient because they're going to get the best benefit of having two providers a behavioral health counselor and a medical practitioner both working together . . . with the problem that the patient has and that its not going to just be a one sided view point, its going to be more well-rounded and therefore, I think, more effective.

Mary described that she feels "very accepted" working with medical providers and appreciates how the doctor she works with is a "team player." Mary shared the following about her experiences:

> I felt very accepted in a world where I didn't think I would be as respected as I was. So, I found that to be unusual and continue to do so because the doctor I work with is very much of a team player and doesn't have that position of, you know, 'I'm better than God' or whatever. So he really takes my whole team's perspective from our particular domain to heart.

Carol described how she enjoys the medical culture and talking with the doctors about the patients with whom she works. Carol offered the following experiences:

> I like the medical culture. On one hand, when I got into this field, I, you know, quite honestly working in family practice, I worked basically with anxiety and depression. It's not so much illness-related, per se, other than anxiety and depression. You know, I'd get some chronic pain people; but I love just kind of talking with the doctors.

Learning from Each Other

The second domain that emerged from the data regarding collaborating with medical providers focused on the participants' descriptions of ways they perceived that counselors and medical providers learned from each other. The following excerpts illustrate each counselor's descriptions of this domain.

Barb shared her experiences working with medical providers and learning from each other. Barb said, "You get to work side by side with the doctor, so I get to hear what they're saying; and they get to hear what I'm saying, and we learn from each other as well as learn about our patient." Similarly, Mary talked about her learning experiences working with medical providers by sharing the following:

> I think, you know, the physician I work with is very good at sharing knowledge; and I really find that very valuable. He's not, I guess, bothered if I ask him questions because it just helps me learn; and, you know, there are certain reports that I have to do that, when I first starting doing them, I was thinking "I don't know why they have a therapist doing this" because it's all medically-based; but I've learned so much from it, so I can think differently. So, that's been great. So, when I can't answer it myself, I'll go to him; and he's just happy to sit there with me and, you know, teach. So it's great.

Diane described how "exciting" it is to work with patients "with other professionals in the room." She shared her experiences teaching providers to take the "patient into account." Diane said the following:

> Probably the other thing is with them in the room to be able to really look at some times symptoms that are, what I would call psycho emotional in nature; but the cause of them is may be medication, a particular medication or an interaction with a medication, or a misunderstanding of taking it correctly. It's very exciting to me as a clinician to be able to do that rule out with professionals in the room. . . and sometimes get the medical team to explain it, be more clear in their explanation. . . you know with the patient in the room with us, also teaching them to take the patient into account as they are talking about the problem they're figuring out.

With regard to counselors' experiences learning from medical providers, Judy shared how what she has learned from the medical providers has helped her understand the "physical side of it." She said, "I've learned these things through the help of the medical practitioners. They help me to understand the physical side of it, the medical team, as far as the symptoms and how that coincides with the stress that a patient may have."

Mutual Respect and Understanding

The third domain that emerged from the data collection focused on the area of perceived respect and understanding on the part of counselors between medical providers and themselves. In describing their experiences collaborating with medical providers, three participants (i.e., Carol, Judy, and Mary) expressed feeling appreciated, respected, and valued by medical providers. Carol reported, ". . . among the doctors, I'm very well-

respected for being the expert, and very much appreciated that I'm willing to take these patients that they don't really quite know what to do with."

Similarly, Judy shared some of the most rewarding aspects of her work in an integrated primary behavioral health setting. She discussed how, by working together with medical providers, they were able to "understand and respect each other" in an effort to help patients. Judy said the following:

> The most rewarding part was after. . . and over time. . . when I worked with the medical practitioners. . . is when we finally understand each other and understand and respect the viewpoints of each other so that we can help a patient. . . have a common goal for a patient. . . even though we are focused on different aspects of a problem. That's been the most rewarding part that we've been able to come together.

Mary spoke about how she was pleasantly "surprised" at how much medical practitioners valued her opinion. Mary shared the following:

> Well, I was kind of surprised actually first coming into it, how much value they put on my opinion. I didn't expect that. I expected, you know, how you operate in a hospital setting from a medical model, especially in the emergency department . . . it's such a team oriented group that I was really caught off guard. I mean, I just expected, you know, they would decide what medicine needed to be prescribed; and, you know, I'd just kind of give them my impression, diagnosis, and whatever. But I was really relied on much more and was considered somewhat of an equal, which I was, you know, pleasantly surprised.

Mary went on to further describe how she felt as though she was an equal among her peers within an integrated team and how this contributed to the holistic approach they were able to provide to patients. Mary said, "So, I feel very much an equal. I do, you know, we have a physician, psychologist, nurse; and then we have like a support staff.

So, it's just the four of us who integrate and implement more of, I guess, solution focused health care that's more holistic."

Satisfaction in Working with Patients

The fourth domain identified within the theme of the rewards of working with medical providers was comprised of the shared experiences of the counselors' descriptions of working with medical providers to deliver care to patients in an integrated primary behavioral health setting. One counselor, Diane, described a sense of satisfaction with teaching patients about behavioral strategies. She shared how she feels that she and the medical providers are working toward "a common goal" in working with patients. Diane said the following:

> Clinically, helping the patient see that what I call that body-mind connection between illness and health and their habits and getting them to realize that you might be dealing with a lifelong period of depression and how important it is to move, physically. And teaching them to make that change. For example, exercise might impact their mood. And, by having those discussions and getting those health habits to be part of their regular life.

Furthermore, Diane described how she feels a sense of gratification seeing the change that patients make in their lives. She shared how she recognizes that it could not be done without working in an integrated team. Diane commented:

> On a very individual person-by-person level, to see that change, to see them sustain that change and be in charge of their life, even if that life involves a disability like post polio or MS but to be able to congruently work through things and feel in charge of themselves, it's gratifying to know we helped them. . . and that, by myself, could not be done, not without an integrated team.

Likewise, Barb shares the satisfaction she gets from her role training residents about substance abuse treatment in addition to her role as a counselor feeling as though she can "really make a difference" working with patients in an integrated primary behavioral health setting. Barb said the following:

> I have the honor of actually being part of their training curriculum, where I have designed a whole curriculum; and I get to train the resident docs on substance abuse. And that, to me, is good. I love doing that. But the other piece that I find really rewarding with the patients, with the clients, is that, when you can really make a profound difference in somebody's life.

Diane described how she experiences a sense of reward from seeing how patients experience "immediate satisfaction because there are providers in the room that are devoted to their care." Diane shared the following about her experiences:

> Seeing people get some immediate satisfaction because there are providers in the room that are devoted in their care. . . in a classically rewarding way. And, for me, the second thing is, when I'm that close in the room with the medical people, I'm able to really teach the patient what questions they have to ask to be able to facilitate an appropriate follow-through in care.

Similarly, Mary shared the satisfaction she gets from seeing the "long-term effects" of her work with patients. Mary said the following:

> I love my job. I get so much satisfaction out of it. I get to see the long-term effects of it; and most of the people we're working with at some time or another, not that we're looking for that, but it's certainly nice to hear how appreciative they are. . . they have years and years of working certain ways and trying to make some behavioral changes and just being able to work with them that way to continue to motivate them and not make them feel less in control.

Rewards of Working in an Integrated Primary Behavioral Health Environment

The final domain identified within this theme of working with medical providers focused on the rewards participants identified specifically regarding working in an integrated primary behavioral health environment. The clip collection for this domain included participants' descriptions of learning about health care, and increased knowledge about health care and medicine. Anne identified the following rewards of working within an integrated primary behavioral health environment:

> I have definitely learned a lot about health care and access or lack there of to health care and just how important it is to have a primary care provider that believes in mental health kind of pushing for their patients to get the right mental health treatment. I just really like it.

Similarly, Anne shared that she has become "more medically savvy." Anne said, "I'm definitely more medically savvy, I think; and I think that it's important to find out how all the medical issues can affect certain people's mental health." Judy also commented that she too has learned more about medical conditions and the interconnection between physical health and mental health. Judy reported the following:

> I learned a lot about medical conditions and how they affect patients' mental health and how a patient's mental health affects the medical condition. And that their mind and body are connected, and they affect each other sometimes positively and sometimes otherwise.

In addition to learning more about health care, Anne also identified that she believes a reward of working within an integrated environment is there is not as much

"stigma" associated with seeing a counselor as compared to when she provided counseling in a more traditional counseling center. Anne shared the following:

> There's not as much stigma with me at the health center as there was with me at the counseling center; like clients don't mind coming to see me because I'm just one of the people that works at the health center. Back when I was over at the counseling center, they were like, forget it.

Two participants, Carol and Anne, identified rewards with the fast pace of the primary care setting. The following excerpts represent the experiences expressed by counselors regarding this domain. Carol reported, "I just really kind of enjoy the whole excitement of being in a medical setting. It's faster paced." Likewise, Anne commented, "I kind of like the commotion of the medical area. Yeah, and I definitely do well with that."

In summary, five domains emerged from the theme of the rewards of working with medical providers. The data provided by the six counselor participants of this study included descriptions of the following domains: (1) collaborating with medical providers, (2) learning from each other, (3) mutual respect and understanding, (4) satisfaction in working with patients, and (5) rewards of working in an integrated primary behavioral health environment. An examination of the demographic factors of each participant showed no apparent differences were identified from the data collection with regard to the theme of rewards of working with medical providers.

Challenges of Working in an Integrated Primary Behavioral Health Setting

The theme of the challenges of working in an integrated primary behavioral health setting was identified from the 6 participants' descriptions of their experiences. Further analysis of the data within this theme revealed two domains. Two domains identified were: (1) challenges working within the culture of the medical model, and (2) different approaches to patient care. A summary of this theme as well as a report of the four salient domains identified within this theme is summarized in Table 2.

Challenges Working Within the Culture of the Medical Model

The participants identified challenges they experienced working within the culture of the medical model. These challenges included such experiences as communication issues with medical providers, lack of time by medical providers to address mental health issues, lack of respect for counselors within the medical culture, and feelings of isolation.

Judy expressed some of her frustrating experiences when trying to communicate with medical providers by sharing the following:

> . . . it was difficult and very frustrating at times when trying to communicate with the practitioners about the patient's conditions as far as their mental health and their physical health and the link between the two. There's just a connection that I learned about, but then it was all frustrating when trying to communicate how I could work together with the medical practitioner to help the patients.

Anne reported one of the challenges she faced working within the culture of the medical model with regard to feeling a lack of respect for counselors by medical staff. Anne shared the following:

> . . . you know, people make comments that aren't always, kind of like "oh well she's the counselor" you know, those kind of things. I'd say the same staff that doesn't really have respect for the nurses doesn't really respect the counseling staff either. I mean, we collaborate with the counseling center across the street. And that's where I used to work, so we still we kind of still felt the same type of attitude there too.

Barb reflected on her initial challenges working in primary care and how she felt that medical providers were not interested in "true integration," but rather wanted to "dump their difficult patients" on her. Barb shared the following:

> When I got here, and my first experience of it was almost like some kind of dumping ground, especially because I was the very first person they had ever hired at this medical clinic that specialized in substance abuse. So, you know, it felt like they all just wanted to dump their difficult patients on to me and weren't interested in true integration.

Barb went on to describe how she soon came to recognize how the fast paced environment of primary care was a barrier that prevented medical providers' ability to adequately address mental health issues. Barb shared how this challenge was equally frustrating to both her as the counselor and to the medical providers with whom she works. Barb shared the following examples of these challenges of working within the culture of the medical model:

> I would have to say the culture of the medical model. . . and I think that some of the docs feel trapped by this as well; but it's just way too fast and it's not conducive to holistic care, it's way too fast-paced, it's, you know, double-booking people at 20-minute sessions.

Barb described her experience of a recent conversation she had with a physician

who expressed frustration with the time constraints of the primary care environment. Barb shared the following:

> I just had a conversation with this doc today, and we're talking about how important assessment is; and you should be assessing mental health and substance abuse stuff at every visit, every visit. And he's like "I agree! And, let me just tell ya, when I have 15 minutes; and they're coming in with a list of complaints and I can't even get through their list, it's not gonna happen!" And he even wants to, he doesn't take any convincing; and so, its frustrating to me that and he even sits there and admits, he's like "even if I know that their mental health problem is at the root of everything else that they're coming and bringing to me, I don't have time to address it."

Carol identified being most challenged by her feelings of isolation within the medical culture of primary care. Among the 6 participants, Carol was the only one who reported having to travel between multiple clinics in her position. Carol attributed her feelings of isolation to both not working with other counselors and being at multiple locations. She shared the following:

> I'm a bit isolated. I have one other colleague that does mental health counseling; but we don't see each other very much, she works in different clinics. We talk on the phone, we e-mail; but we don't have that much contact, per se. So, most of my contact is with either the doctors or other people in the office. My job is, I travel to three different clinics. And, so, in two of the clinics, I have a regular office. In one of the clinics, I meet with people in treatment rooms. So, again, the isolation piece.

Carol further explained how being isolated from other counselors interferes with her ability to consult with other counselor colleagues about patients. She shared the following experiences:

> The isolation. You know, I don't have colleagues. Like, if I see somebody that kind of blows me away, you know I can't kind of go stumble into another room and say "Oh my God, do you have a minute to talk about this." The doctors don't want to know that much. I mean, they want to talk to me about it, they're being blown away; but they don't want to hear it from me, they want me to be, you know, okay with this kind of stuff. So, it's the isolation I would say.

The final challenge identified focused on working with patients with significant psychiatric issues specifically issues related to trauma. Mary described her experiences with this challenge by sharing the following:

> Some of the people we work with. I was surprised that every single person that we've had come into our program has significant psychiatric issues. All of them have trauma issues, every single one of them, whether it's sexual abuse, emotional abuse, physical abuse, they've had some sort of trauma like that; and it just becomes a systemic problem if they are approaching adulthood and continues on.

Different Approaches to Patient Care

The second domain found in the participants' descriptions of the challenges of working in an integrated primary behavioral health setting focused on the different approaches to patient care between medical providers and counselors. Two participants, Judy and Diane, both shared similar challenges with regard to their experiences with how their approach to patient care differed from that of medical providers. Judy described how despite their differences in treatment approach they were able "to come together" to care for patients. Judy shared the following:

> In the beginning, it was apparent that the way that the medical practitioners how they focused on a particular problem a patient would have was very different from how I focused on the problem. We came

> about it at two different ways; and that, in the beginning, was really hard to communicate that throughout time; and, over time, we were able to come together and see how each the medical team and the behavioral health team came together.

Similarly, Diane reported the challenge in helping providers look beyond medication treatment to care for the patient's problem. Diane said, "One of the more challenging things is helping the medical staff see that some problems aren't solved by taking a pill or doing this treatment and that they require time and sometimes a relationship." Judy echoed this same experience in her work with medical providers by stating the following:

> The most challenging part is when a medical practitioner wants to treat the symptoms of the problem versus maybe the cause, the origin, and the reasons why the problem is happening. That has been the most challenging part for me, is when a patient is depressed or say a medical practitioner may want to immediately give them medication. Whereas my focus might be on the cause of the depression and helping the patient work through the tensions of their feelings that may be causing the depression or anxiety.

In summary, the domains identified within the theme of the challenges working in an integrated primary behavioral health model included (1) challenges working within the culture of the medical model, and (2) different approaches to patient care. The challenges described by participants included communication issues with medical providers, lack of time by medical providers to address mental health issues, lack of respect for counselors within the medical culture, and feelings of isolation by counselors. In addition, counselors reported different treatment approaches to patient care between counselors and medical providers. Differences in treatment included the difference in approaching the treatment of symptoms with the use of medication rather than initially focusing on

behavioral strategies when appropriate. An examination of demographic factors was made to determine if demographic factors such as years worked in an integrated primary behavioral health setting accounted for any differences in the experiences described by participants. No significant differences were found with regard to demographic information within this theme or the salient domains identified within the theme.

The Impact on Counseling Skills

The third theme identified by participants' descriptions of their experiences focused on the impact on counseling skills in working in an integrated primary behavioral health setting. From the participants' descriptions of their experiences, two domains emerged from the data. The two domains included: (1) changes in counseling skills, and (2) changes in treatment approach working with patients.

Changes in Counseling Skills

The first domain identified within the theme of the impact on counseling skills, participants described how they have experienced changes in their counseling skills. The changes described included learning to assess at a quicker pace, asking patients more questions, and learning evidenced-based treatment interventions in order to better assist patients. The following excerpts represent the counselors' experiences described within this domain.

Four participants, Barb, Judy, Diane, and Anne, described how they believe their counseling skills have improved by working in an integrated primary behavioral health setting. Barb's response was unique in that she not only identified how her counseling

skills have changed, but also discussed how she has been doing more research and enjoys the challenge of learning new evidence-based treatment approaches to working with patients with a broad spectrum of presenting issues. Barb said the following:

> So I've definitely improved my counseling skills because I'm just reading more literature, doing more research, trying different things because I'm working with so many different types of people too. Like I saw a complete paranoid schizophrenic over here to just a guy who's a little depressed but coping quite well in his life. So, definitely broad spectrum of clientele forces you to be able to do lots of different things. Yeah, so I just feel like it's completely broadened my whole spectrum. I've needed to really keep up with the coming research. The doctors, at least the doctors I'm working with, they're all about evidence-based you know, what does the most recent research show is the best practice here and so remaining stagnant and just doing the same old Carl Rogers bit isn't gonna fly, you know. We need to be up on the latest CBT techniques; and I love that, I love being challenged by that and having sort of a higher level of integrity needed because these doctors are genuinely interested in what I'm doing; and, if I can't describe it, then that's not gonna work for them.

Judy shared similar experiences by sharing how she feels working in an integrated primary behavioral health setting has positively impacted her counseling skills and is able to utilize different tools to assist different patient populations based on their specific needs. Judy shared the following experience:

> Well, it's positively impacted my counseling skills, in that it has helped me to understand how I can use different tools to help a patient's stress; and those tools may be helping them to use guided imagery or visualization or deep breathing, physically relax their body so that they can relax and lessen the tension, emotional tension, and mental tension and anxiety. So, I've learned new skills, those being more physical tools, to help people reduce their mental and emotional stress. So I think that it has added to my counseling skills.

Diane echoed the experiences of both Barb and Judy as she, too, described how

she believes that her counseling skills have improved since working in an integrated primary behavioral health setting. Diane spoke about how she has changed how she works with people about learning how to make behavioral and lifestyle changes by sharing the following:

> I have learned to be more specific in change process questions in a clinical setting, and I've learned to break it down psychologically to people far better than I was originally trained to do. When a person is fighting depression, we encourage some psychotherapy to talk about stuff; but we really don't teach people what they need to do in the routine of their lives at home to better effectively get a handle on their depression. Like, we don't instruct them to focus on their sleep, we don't instruct them to be careful about drinking alcohol, we don't talk to them about where they might have things that have caffeine in it all things that will disrupt the sleep pattern that will make the depression worse and talking about self hygiene around depression.

Diane went on to describe how she helps patients learn behavioral self management strategies to manage their depression differently since working in an integrated primary behavioral health setting. She said that she recognized that she needs to "clinically break it down" for patients and "ask more questions" than before. Diane shared the following about her experiences:

> If I want them to do movement because I believe movement triggers the brain to start helping themselves, and I know they can't manage that, then maybe we'd figure out specific exercises they do in bed and that's what I mean by really clinically breaking it down. Before, I would say "you know you need to do some exercises, think about what you need to manage your sleep what's that sleep like;" now I ask a lot more questions than before.

Judy identified that, as a result of working in an integrated primary behavioral

health setting, she is better able to understand the interrelationship between mental health and physical health. Judy described her experiences by sharing the following, “I guess the way that it has influenced me is that I'm able to identify the cause and effect relationships between mental stress and physical stress and the medical conditions that can result from that.” Anne discussed how her counseling skills have changed by assessing patients at a quicker pace since working in an integrated primary behavioral health setting. Anne said, “I assess a lot quicker because I don't have much time sometimes. Like, they'll call me in as more of an emergency-type thing. And so I have to be a lot faster.”

Changes in Treatment Approach Working with Patients

The second domain that emerged from the theme of the impact on counseling skills was participants’ description of the change in their approach to treatment working with patients. Some of the changes described by participants included using short-term treatment approaches to care, being flexible in working with patients, and working “in the here and now.”

Barb described how the manner in which she had practiced counseling in the past was challenged by working in an integrated primary behavioral health setting. As a result she recognized that the research indicates that traditional treatment approaches are not as effective working with a primary care population. Barb stated the following about her experiences in changing her treatment approach with patients:

> It’s just been interesting! So, I came from a real traditional counseling background, you know the 50-minute hour business. In learning about my job and learning about integrated care, I really got my own system of what good treatment is completely challenged. I'm a pretty open-minded person.

> So, I looked at the research; and I looked at what was happening, and I said you know, this 50-minute hour thing is kind of archaic to begin with.

Mary expressed how she is able to "tap into" or utilize other areas of interest and her life experiences working with patients in an integrated primary behavioral health setting. Mary shared the following:

> Because we integrate all these other facets of quality of life, I'm able to tap into some of my other areas of interest. So I'm just very lucky to have a position that takes a lot of my lifetime experiences and uses them.

Barb described similar experiences as she commented on how she enjoys the flexibility in her role in order to meet the needs of working within a primary care population. Barb reported the following experiences:

> So, I kind of, you know, I fluctuate; and I happen to like it this way, but I fluctuate between seeing someone for a scheduled visit and running up to the clinic to see somebody who is in with their doc. So, yeah, it's really nice.

Barb went on to state that she described her role is that of a "helper" in the work that she does with patients. She shared the following:

> You know, I guess I see myself, not to sound cliché, but I see myself as a helper. That's what I'm good at, listening, and having people feel heard and all of that good stuff; and I see that that's all I do "all day long" in this job. And whether or not I'm doing case management, helping somebody fill out a Medicaid application or talking to an addict who just relapsed or talking to a completely unmedicated paranoid schizophrenic who is delusional or training a recently graduated medical student in their residency, those skills are what I utilize in every step of the way.

Moreover, Barb expressed how she enjoys how she functions as a counselor working in an integrated primary behavioral health setting. She described how she perceives value in her ability to be flexible in her treatment approach in order to best meet the needs of the patient with whom she is working. Barb reported the following about her experiences:

> So I've sort of opened my mind as well to this whole medical model, and I really like the way I function now because, if somebody needs an hour, I can give it to them. But, if all they need is 20 minutes, that's ok too.

Carol reflected on how she used to practice treatment with patients in the past and described her experiences in changing her approach to focusing on 'the here and now' when working with patients in a primary care.

> I think back in the old days you know I did more of a psychodynamic kind of approach and, now, I don't feel that. . . I mean, I think family is important and they're influential; but I find myself kind of wanting to more deal with the here and now than changing the past. You know, there's a reflection of the past, etc, etc; but, you know, its kind of something to acknowledge and then move on. I'm much more interested in kind of working with the here and now, the feelings that they're having now, the anxiety; okay let's see how you can move through that anxiety and move through you know, how you can experience these without getting so overwhelmed. So, it's kind of that ACT stuff.

In summary, the experiences described by participants concerning the theme focusing on the impact on counseling skills included the following salient domains: (1) changes in counseling skills, and (2) changes in treatment approach working with patients. Differences in the demographic factors among the six counselors were explored

within this theme. No significant differences across the demographic variables were noted.

Influences on Professional Counselor Identity

The fourth theme that emerged from the data collection of participants' experiences in working in an integrated primary behavioral health setting focused on the descriptions of the perceived influences of this work on their professional identity as counselors. Three salient domains were identified within this theme: (1) influence of role working with patients, (2) change in role identification, and (3) sense of purpose in role.

Influence of Role Working with Patients

The first domain that emerged from the descriptions of how counselors perceived their professional identity was the influence of their role when working with patients. Counselors described how they made changes in their treatment approach and how this influenced their sense of how they perceived themselves as a counselor. These modifications included how participants conceptualized the changes they made in their role when working with patients, thought about treatment differently, utilized their strengths, and how they perceived that these changes increased their effectiveness as a counselor.

Barb described how her experiences working in an integrated primary behavioral health setting has "altered" her identity as a counselor by changing her thinking about how she approaches treatment. Barb said, "I think it's completely altered it in a great way.

I think I was a little, without even knowing it, a little stuck in the long-term therapy 50-minute hour kind of way of thinking."

Barb commented further on how she perceived herself as a "more effective" counselor since working in an integrated primary behavioral health setting. Additionally, Barb said that she did not recognize "how stuck" she was in the ways that she viewed doing treatment with patients until working in an integrated setting. Barb shared the following:

> It feels like I'm way more effective with my clients when I have the ability to bend around whatever the circumstances need of me rather than thinking, you know, you've got to go through these steps; and therapy has to look this way. I didn't even realize I was kind of so stuck until I got in this setting and had that really challenged and then wow.

Anne shared that she recognizes that she is more "assertive" in her treatment approach since working in an integrated primary behavioral health model. Anne shared the following about how she is more confident in her role:

> It probably makes me a little bit more assertive and makes me stand up for myself a lit bit more as a counselor because I have to because I'm not a doctor, you know, I don't have the MD after my name; and I have to kind of be like, "no, no, I'm knowledgeable about this; and I know about this and I am just as knowledgeable as you are" so, that helps me in that way.

Similarly, Mary shared how she perceives the influence on her identity as a counselor and in how she approaches treatment has been a "metamorphosis" and that she has "grown as a professional." Mary expressed the following:

> Well, I think it's a normal metamorphosis, especially for me, because I have just never been, like I said, comfortable just doing one thing and

> getting pigeon-holed. So, I think, as I'm able to do things, master them or at least get better at doing them, it helps me feel like I'm growing as a professional.

Judy identified that understanding the connection between emotional and physical health has helped her with patients and that she would not have been able to do this if she did not work within integrated primary behavioral health setting. Judy shared the following:

> . . . . because I know the link of both the emotional and physical, it helps me to help my clients in a way that I wouldn't have been able to help them had I not been in an integrated model.

Change in Role Identification

The second domain identified within the theme of the influences on professional counselor identity was how counselors described changes in how they identified their role with patients as well as the ways in which they changed how they conceptualized their role working within an integrated primary behavioral health setting. The participants' experiences are represented in the following excerpts from the collection of clips found within this theme.

Barb shared how her identity as a counselor has "broadened," noting that she used to identify her role by the type of area she specialized in. However, since working in an integrated primary behavioral health setting, she recognizes her role is more "generalized" and she is able to "work with many different things and many different people and many different issues." Barb described the following experiences:

> I guess my identity as a counselor has broadened and become much more generalized. I used to see myself as somebody who likes this or didn't like that and specialized in this but not so much that you know worked great with adolescents, not so great with kids, good with substance abuse, not so good with trauma victims, and now, I see that the skills that I have stretch in all areas; and I can work with many different things and many different people and many different issues. I see myself as someone who is much more generalized and capable of crossing all kinds of lines. And see, my strengths that I always knew were there for some areas, also applied, wouldn't ya know, to these other areas, you know?

Mary used the analogy of a "conductor" to identify her role working in an integrated primary behavioral health model as both a counselor and a supervisor. Mary said, "I feel like I've become more of a conductor; I guess I don't know how else to put it. Yeah, I kind of coordinate care. In my position, I micromanage the counselors and the providers." Additionally, Mary described how she has "moved away" from her previous role and views the changes she has experienced as a "good evolution" and how she is able to be involved in different things and "they've all kind of come together" in her current position. Mary shared the following:

> I do the psychiatric assessments and I meet with these people and that's therapeutic, but I feel like I've really kind of moved away from that role; and I think that the timing was good because, like I said, I was in private practice by myself. I guess I kind of expected, at some point, to kind of move forward, not always be doing counseling in the same way. And I've been teaching, too; so there's just been a good evolution of, like I said, all these different things that I've been involved with, that they've all kind of come together in this position I have now.

Diane shared how she perceives that her role has "raised my status" among her peers. Diane commented, "Actually, it has significantly raised my status, in that, among my professional peers now, in the medical as well as the counseling world." Carol shared

how she perceives her role as “unique.” Carol said the following about her experiences of her role:

> It is, it's a unique role. So, you know, some people I tell what I do; and they'll think "oh, wow, that wouldn't interest me at all,” you know, other colleagues; but others think "wow, that's very cool.” I may have an inflated opinion of how cool it really is.

Similarly, Barb explained how she has changed how she identifies her role to colleagues. Barb shared the following experiences:

> And, so, I started like when people ask me, you know, "what do you do?" I notice myself saying things like "well, I'm a counselor" or, you know, "I help people with their mental health issues" instead of saying you know "I work with people who have addictions" instead of being that specific about it.

Judy shared how she believes that as a result of working in an integrative approach she has become a “more integrated counselor.” Judy stated the following about the influences on her identity by working in an integrated primary behavioral health setting:

> My identity in the beginning was different because I saw myself more just on behavioral health side. Over time, and as I've worked in the model; and, as I've said before, I recognize that the behavioral health piece and the medical piece are very connected. So now, as a counselor, I have a different perspective, in that I don't feel that the two are separate. I feel like I am a more integrated counselor as a result of working in an integrated model.

Sense of Purpose in Role

The final domain that emerged from the theme of the influences on professional

identity as a counselor was the participants' descriptions of their sense of purpose in their role working in an integrated primary behavioral health setting. The units of meaning described by the participants were unique as they spoke about such concepts as feeling good about their work, feeling as though they were making a contribution in their role, and feeling that they were meant to be working in an integrated primary behavioral health setting. Salience was found in this domain not by the similarities of the participants' responses, but rather in the unique manner in which each counselor spoke about the shared construct of purpose in their role.

Mary shared how she feels good about the change she has made working as a counselor in an integrated primary behavioral health setting. Mary said, "I feel good about what I'm doing; so it really is kind of a feedback loop, so I mean it's just been an interesting change. So, it's been a good move."

Diane described how she, too, experiences a sense of purpose in her role as she shared how she feels she is making a contribution through her work. Diane said, "I find it exciting. You know, I feel in my little world, with the teams and people that we're working with, we are contributing significantly to the change in health care that needs to happen."

Carol described how she feels a sense of "pride" in her identity as a counselor and feels as though she is part of being "on the cutting edge of a new field." Carol said the following about her experiences:

> My identity as a counselor. I have a lot of pride about it; you know I feel that I've obtained my goal. I also feel. . . let me think. . . ,well you know, we're kind of a rare commodity; so its kind of fun to be on the cutting edge

> of a new field that I think is forming. So that's, you know, I feel kind of cool about that.

Carol identified feeling appreciated and viewed as an expert in her role. Carol expressed her sense of purpose in her role by stating, “I’ve always felt like I was meant to do something like this.” Carol reported the following:

> I find I'm very much appreciated, I'm an expert and that feels good. I feel very fortunate. But I also feel like it was meant to happen. So, I'm very blessed. I feel very fortunate. I can make a living doing this and enjoy myself; but I've always felt like I was meant to do something like this, and it just kind of unfolded.

Two participants, Carol and Barb, shared similar experiences about feeling as though there was a “spiritual component” to their sense of purpose in their work. Carol said, “I mean, quite honestly, when I say ‘I've always been meant to do this’; when I was younger, in, you know, third grade, I wanted to be a nun. So I always kind of had this kind of spiritual component.”

Similarly, Barb commented on her perceptions of how working in an integrated primary behavioral health setting has influenced both her identity as a counselor and her sense of purpose in her role by allowing her to “use the gifts that God gave me.” Barb shared the following about her experiences:

> It feels to me like it brings out the strengths that got me into this whole field to begin with. Whereas, in the past I have felt somewhat limited, like where I've worked for substance abuse agencies; and they don't even want you to diagnose mental health issues in that setting. I felt limited in the past. I worked in a mental hospital where it was just so intensely structured; and, here, I really feel like I have the freedom to just go ahead and use the gifts that God gave me in everything that I do, and that's what's working.

Mary also expressed how she feels “very lucky” in her position and have the ability to utilize other areas of interest and her “lifetime experiences” in her work in an integrated primary behavioral health setting. Mary said, “Because we integrate all these other facets of quality of life, I'm able to tap into some of my other areas of interest. So I'm just very lucky to have a position that takes a lot of my lifetime experiences and uses them.” Moreover, Mary expressed how she enjoys the ability to explore new areas and how working in an integrated setting is “a constant learning environment.” Mary shared the following about her experiences:

> For me, I never liked to be pigeon-holed in any one area. So, this offers me to continue to be exploring lots of new areas. There's not really a whole lot of limitations on me with what I can read, what I can do, what I can be involved with. So, for me, that's great. It's a constant learning environment.

In summary, the three salient domains that emerged from the data of participants’ experiences regarding the perceived influences on their professional identity as counselors were as follows: (1) influence of role working with patients, (2) change in role identification, and (3) sense of purpose in role. When examining participants’ descriptions of their experiences within the theme of the influence on professional identity, it was observed that all of these descriptions were positive. Some counselors expressed feeling good in their role and having a sense of pride in their professional identity, and others spoke of being appreciated and fortunate working in their role in an integrated primary behavioral health setting.

Further analysis revealed that when participants spoke about their sense of purpose in their role, two participants, Carol and Barb, shared similar experiences about

feeling as though there was a "spiritual component" to their sense of purpose in their work. Overall, each of the participants' descriptions within this theme were unique in that counselors described similar experiences regarding the influence on their professional identity as a counselor, although they used different language to express these units of meaning.

Summary of Themes and Domains Within Units of Meaning

The themes that emerged from the rich descriptions of experiences provided by the 6 participants of this study included the following four themes: (1) rewards of working with medical providers, (2) challenges working in an integrated primary behavioral health setting (3) impact on counseling skills, and (4) influences on professional identity as a counselor. Five domains emerged from the theme of the rewards of working with medical providers identified by counselor participants of this study included descriptions of the following areas: (1) collaborating with medical providers, (2) learning from each other, (3) mutual respect and understanding, (4) satisfaction working with patients, and (5) rewards of working in an integrated primary behavioral health environment. Challenges of working in an integrated primary behavioral health setting were identified by participants in the following two areas: (1) challenges working within the culture of the medical model, and (2) different approaches to patient care. When participants described their perceptions regarding the impact working in an integrated primary behavioral health setting had on their counseling skills they identified the following two areas: (1) changes in counseling skills, and (2) changes in treatment approach working with patients.

Last, counselor participants described how they believed their professional identity as a counselor was influenced by working in an integrated primary behavioral health setting in the following areas: (1) influence of role working with patients (2) change in role identification, and (3) sense of purpose in role. The influences on professional identity expressed by counselors included feeling good in their role, having a sense of pride in their professional identity, and having a sense of being appreciated. In addition, some participants identified feeling fortunate working in their role in an integrated primary behavioral health setting. Further analysis revealed that when participants spoke about their sense of purpose in their role, two participants, Carol and Barb, shared similar experiences about feeling as though there was a "spiritual component" to their sense of purpose in their work. These collective experiences were unique in that they exemplify a sense of purpose both professionally and personally.

Themes Identified Across All Frames of Analysis

As a part of the data analysis process, the investigator examined themes that emerged across the participants' descriptions of their experiences working in an integrated primary behavioral health setting. During this stage of the analysis process two universal themes emerged across each of the salient domains that were identified within each of the themes or keyword groups: (1) influences from the environment, and (2) interactions with others. For example, when examining the participants' descriptions regarding the challenges of working in an integrated primary behavioral health setting, it was observed that the participants' descriptions or units of meaning could be categorized into two themes: (1) influences from the environment, and (2) interactions with others.

Further analysis revealed these two themes could be applied across all of the salient domains that were previously identified within each of the four themes. The first theme that emerged across the domains was the influences from the environment. Particpants' descriptions of their experiences revealed two types of influences: (1) influences from the primary care setting, and (2) influences from the medical culture. These two types of influences reported by participants formed the salient domains in this theme. The second theme identified across the domains of participants' experiences included their interactions with others. The investigator observed two domains from the data collection concerning the theme of the interactions with others: (1) interactions with medical providers, and (2) interactions with patients. These two themes and the salient domains within these themes are discussed in the following sections of this study. In an effort to illustrate the universal themes among and across all themes and domains, some excerpts used to describe the main themes and domains are used to support these findings.

Influences from the Environment

As participants described their experiences working in an integrated primary behavioral health setting, the investigator noted that participants described two types of external influences from the primary care environment: (1) influences from the primary care setting, and (2) influences from the medical culture. These two types of external influences created the salient domains that were described by participants of this study. Although the duration of time worked in an integrated primary behavioral health setting

as well as the years worked as a counselor varied among the participants, each of the participants described being influenced by these two types of interactions.

Influences from the Primary Care Setting

A salient domain that emerged from counselors' descriptions of their experiences focused on the influences they encountered from working in a primary care setting. These influences shared by participants included the adjustment to working within a medical model, adapting counseling skills to meet needs of patients in primary care, and being the only counselor within the primary care setting.

This domain was supported by participants (i.e., Diane and Judy) as they described their experiences of working in a primary care setting. Diane shared her experiences adjusting to working within the medical model and how medical providers and counselors have differing approaches to working with people about behavioral "health changes." Diane reported the following:

> One of the more challenging things is helping the medical staff see that some problems aren't solved by taking a pill or doing this treatment and that they require time and sometimes a relationship. When you get people to come from what I call a critical care training, they're making life decisions immediately, they haven't got time to sit around and think about the implications of this action. . . and to sit at a table with patients because you're looking at life-changing events; and you're trying to teach health changes and having to be able to say that clinician "this is gonna take a little more time. We are probably gonna have to repeat this process a couple of times." Sometimes, dealing with their frustrations and understanding that it is just, you know. . . "why can't you just tell them what to do and have them do it?"

Similarly, Judy described how she, too, has faced some challenges working

within the medical model of care which often focuses on medication treatment rather than behavioral interventions. Judy shared the following example which illustrates this domain:

> The most challenging part is when a medical practitioner wants to treat the symptoms of the problem versus maybe the cause, the origin, and the reasons why the problem is happening. That has been the most challenging part for me. . . is when a patient is depressed. . . or say a medical practitioner may want to immediately give them medication whereas my focus might be on the cause of the depression and helping the patient work through the tensions of their feelings that may be causing the depression or anxiety.

Furthermore, Judy discussed how medical providers and counselors differ in measuring success working with patients by sharing the following:

> Measuring the outcome. Measuring the success of a patient. That is very challenging. Whereas, in the medical side, there is more quantitative measures; and, sometimes, those quantitative measures aren't able to measure the quality of life changes of a patient in a way that the medical side wants to see it.

Five participants (i.e., Mary, Diane, Carol, Judy, and Anne) discussed how they have made modifications to their practice of patient care by changing their counseling skills to meet the needs of patients within a primary care delivery system. Mary shared how she has "adapted" her counseling skills as a result of the influence of working in a primary care setting. The following example demonstrates how Mary perceives how she has adapted to working in a primary care environment:

> Some of my skills adapted; but I think it also, again, tapped into things I thrive in or areas I thrive in. I look at things as more challenging and not fearful to try. . . so you know we have lots of new situations; every person

> we're working with has a different life story and has different issues. . . each one has its own challenge. So, I think if we want sameness all the time, this wouldn't be the job. But, since I don't, it's good for me.

Diane commented on how working in a primary care setting has influenced her to make changes in her treatment approach with patients. The following example illustrates this domain: "I have learned to be more specific in change process questions in a clinical setting, and I've learned to break it down psychologically to people far better than I was originally trained to do. . . . "

Carol also shared her experiences with how working in primary care has influenced her counseling skills by focusing on "the here and now." Carol stated the following about making this change:

> . . . . and so I'm much more interested in kind of working with the here and now, the feelings that they're having now, the anxiety, okay let's see how you can move through that anxiety and move through. . . you know, how can you experience these without getting so overwhelmed. So, it's kind of that ACT stuff.

This domain is further illustrated by the description of Judy's experiences regarding the influences of working in a primary care setting. Judy described how she believes working in a primary care setting has helped her "understand how I can use different tools" in her work with patients by stating the following:

> Well, its positively impacted my counseling skills, in that it has helped me to understand how I can use different tools to help a patient's stress; and those tools may be helping them to use guided imagery or visualization or deep breathing, physically relax their body so that they can relax and lessen the tension, emotional tension, and mental tension and anxiety. So, I've learned new skills, those being more physical tools, to help people

> reduce their mental and emotional stress. So I think that it has added to my counseling skills.

Anne described the influences she has experienced as a result of working within the environment of primary care and important it is to know how medical issues influence one's mental heath. Anne stated, "I'm definitely more medically savvy, I think; and I think that it's important to find out how all the medical issues can affect certain people's mental health."

The final illustration of the domain focusing on the influences from the primary care setting is found in the experiences shared by Carol as she describes the isolation of being the only counselor within the primary care setting:

> The isolation. You know, I don't have colleagues. Like, if I see somebody that kind of blows me away, you know I can't kind of go stumble into another room and say "Oh my God, do you have a minute to talk about this." The doctors don't want to know that much. I mean, they want to talk to me about it, they're being blown away; but they don't want to hear it from me, they want me to be, you know, okay with this kind of stuff. So, it's the isolation I would say.

Influences from the Culture of the Medical Model

In addition to describing the influences of working in a primary care setting, participants shared their experiences with adapting to the culture of the medical model. The influences from the culture of the medical model described by participants included adapting to the pace of patient care (i.e., quicker assessment and treatment interventions), duration of time spent with patients (15 minute appointments aligned with the medical

model delivery system), and the practice of evidenced-based behavioral interventions with patients.

Some participants (i.e., Carol, Diane, Barb, and Mary) had many years of experience as counselors and came from more traditional behavioral health backgrounds to work in an integrated primary behavioral health setting. Another group of participants (i.e., Judy and Anne) had worked as counselors for a shorter period of time prior to working in an integrated primary behavioral health setting. Two participants, Anne and Carol, identified positive aspects of the fast paced culture of the primary care setting. The following excerpts represent the experiences expressed by counselors regarding this domain or keyword. Carol reported, "I just really kind of enjoy the whole excitement of being in a medical setting. It's faster paced." Likewise, Anne commented, "I kind of like the commotion of the medical area. Yeah, and I definitely do that well with that."

Unlike Anne and Carol, Barb expressed how she feels frustrated with some of her observations of how "the whole culture of the medical world" influences medical providers." Barb shared the following experience: "To me, that is so frustrating because the mental health stuff gets shoved by the wayside because of the whole culture around the medical world, just how fast it is and how they just don't have time."

Another domain voiced by participants (i.e., Anne and Barb) focused on adjustments they had to make with treatment due to the limited duration of time while working with patients in a primary care setting. Working within an integrated primary behavioral health model requires counselors to adapt their treatment intervention to be aligned with the 15 minute appointment service delivery system of primary care. The following statement by Anne illustrates this domain: "I assess a lot quicker because I

don't have much time sometimes. Like, they'll call me in as more of an emergency-type thing. And so I have to be a lot faster."

Likewise, Barb commented on she has adapted her approach to meet the needs of the patients in the "whole medical model." Barb shared the following experience: "So I've sort of opened my mind as well to this whole medical model, and I really like the way I function now because, if somebody needs an hour, I can give it to them. But, if all they need is 20 minutes, that's ok too." Barb went on to describe how her encounters with patients "fluctuate" throughout the day to be aligned with the medical model delivery system of primary care. Barb shared the following statements as she described her experiences:

> So, I kind of, you know, I fluctuate; and I happen to like it this way, but I fluctuate between seeing someone for a scheduled visit and running up to the clinic to see somebody who is in with their doc. So, yeah, it's really nice.

The last illustration within this domain is shared by Carol as she describes how working in the culture of the medical model has influenced her to pursue further research on behavioral treatment approaches and the recognition of evidenced-based treatment within in a primary care setting.

> . . . . Yeah, so I just feel like it's completely broadened my whole spectrum. I've needed to really keep up with the coming research. The doctors, at least the doctors I'm working with, they're all about evidence-based you know, what does the most recent research show is the best practice here and so remaining stagnant and just doing the same old Carl Rogers bit isn't gonna fly, you know. We need to be up on the latest CBT techniques. . . .

Interactions with Others

A second theme identified across the themes of participants' descriptions of their experiences working in an integrated primary behavioral health setting included their interactions with others. It was noted by the investigator that there were two types of interactions experienced by participants: (1) interactions with medical providers, and (2) interactions with patients. These two types of interactions created the salient domains for this theme. In analyzing the data further, the investigator noted a pattern in the data that when some counselors described their interactions with others their descriptions included examples of working together with the medical providers and the patients. This triadic relationship appeared several places across the descriptions of counselors' experiences.

Interactions with Medical Providers

Several participants (i.e., Judy, Barb, Anne, Diane, and Mary) described various types of interactions with medical providers they experienced working within an integrated primary behavioral health setting. These interactions included working together with patients during integrative patient care encounters, and collaborative consultations between medical providers and counselor to discuss patient care. The following statements represent this domain of interactions with others.

Judy commented about her belief that working in an integrative model has been "a positive experience" and the perceived benefits of "working together" with the patient. Judy stated the following thoughts:

> Well, just that overall I think it's been a positive experience in that I think that it's most positive for the patient because they're going to get the best benefit of having two providers, a behavioral health counselor and a medical practitioner both working together. . . with the problem that the patient has and that it's not going to just be a one sided view point, it's going to be more well-rounded and therefore, I think, more effective.

Similarly, Barb expressed how she, too, viewed the interactions she has with medical providers to be a "learning opportunity." Barb's experiences illustrate the domain of interacting with medical providers, " . . . . it can be such a learning opportunity; and it is, at times, where we both learn from each other and we come out of there going 'man, that was great.'"

Anne's description of her experiences interacting with medical providers further illustrates this domain:

> So it's nice, and it's really helpful; and it's good to be able to affiliate myself with the medical staff when I'm dealing with those people because it can be kind of scary if I was just in like a mental health practice with no medical staff around me. . . I don't know how I would manage some of those patients.

Diane also shared her interactions working in an integrated primary behavioral health setting with medical providers. She provided the following example of her experiences:

> . . . . it's very exciting to me as a clinician to be able to do that rule out with professionals in the room. . . and sometimes get the medical team to explain it, be more clear in their explanation. . . you know with the patient in the room with us, also teaching them to take the patient into account as they are talking about the problem they're figuring out.

Mary explained her interactions working with medical providers and "sharing knowledge." Mary shared the following experiences which are representative of this domain:

> I think, you know, the physician I work with is very good at sharing knowledge; and I really find that very valuable. He's not, I guess, bothered if I ask him questions because it just helps me learn; and, you know, there are certain reports that I have to do that, when I first starting doing them, I was thinking I don't know why they have a therapist doing this' because it's all medically-based; but I've learned so much from it, so I can think differently. So, that's been great. So, when I can't answer it myself, I'll go to him; and he's just happy to sit there with me and, you know, teach. So it's great.

Interactions with Patients

All six of the participants shared about their interactions working with patients in an integrated primary behavioral health setting. The following descriptions of participants' experiences represent this domain of the interactions with others.

Mary shared her experience with feeling a sense of satisfaction in her interactions working with patients. Mary described the following experiences:

> I get so much satisfaction out of it. I get to see the long-term effects of it; and most of the people we're working with at some time or another, not that we're looking for that, but it's certainly nice to hear how appreciative they are. . . .

Similarly, Diane spoke about her experiences interacting with patients in her role of teaching patients to make changes in their lives. Diane shared the following:

> Clinically, helping the patient see that what I call that body-mind connection between illness and health and their habits and getting them to

> realize that you might be dealing with a lifelong period of depression and how important it is to move, physically. And teaching them to make that change. For example, exercise might impact their mood. And, by having those discussions and getting those health habits to be part of their regular life.

Carol shared how medical providers utilize her role when seeing patients. She shared an example of how the doctor introduced her to a patient and allowed the interaction with patient to "evolve." Carol's description of her experience is illustrative of the domain focusing on the interactions with patients in an integrated primary behavioral health setting. " . . . . It's like my intake today, you know, I met her yesterday. The doctor came in and said 'can you just, you know, show your face, introduce yourself. . . because I want her to come see you.' And so I did, and you know it evolved from there."

Judy shared about typical daily interactions she may have with patients to teach them behavioral strategies to manage stress and anxiety. She shared the following experience:

> . . . . I can use different tools to help a patient's stress; and those tools may be helping them to use guided imagery or visualization or deep breathing, physically relax their body so that they can relax and lessen the tension, emotional tension, and mental tension and anxiety. So, I've learned new skills, those being more physical tools, to help people reduce their mental and emotional stress.

Anne described how her interactions with patients have changed since working in an integrated primary behavioral health model has "not as much stigma" associated with it versus accessing counseling services through a mental health agency or counseling center. Anne comments demonstrate the domain of participants' interactions with patients:

> . . . . there's not as much stigma with me at the health center as there was with me at the counseling center; like clients don't mind coming to see me because I'm just one of the people that works at the health center. Back when I was over at the counseling center, they were like 'forget it.'

The final illustration of the interactions participants experienced working in an integrated primary behavioral health setting examined the statements expressed by Barb regarding her experiences working "side by side with the doctor." This example is a unique illustration of her day-to-day interactions working with both medical providers and patients. She shared the following example of these experiences:

> But the other piece that I find really rewarding with the patients, with the clients, is that, when you. . . you can really make a profound difference in somebody's life. When they are in the doctor's office, it is their choice, they want to be there. . . . even if, you know, whatever brought them there they're not happy with. They're seeking help for it, and they have a tremendous amount of trust and respect for this physician; and then you step in the room as a mental health provider, and you automatically get that same level of trust and respect. You get to work side by side with the doctor, so I get to hear what they're saying; and they get to hear what I'm saying, and we learn from each other as well as learn about our patient.

The description provided by Barb offers the reader a glimpse into the lived experiences of a counselor working in an integrated primary behavioral health setting. Barb provides a thick and rich illustration that weaves together several of the themes identified across domains. It describes the integrative interactions between the patient, the medical provider, and the counselor. Moreover, she speaks to the element of trust and respect by the patient when counselors are working within an integrated primary behavioral health environment. This description demonstrates the triadic relationship between patient, medical provider, and the counselor that can be achieved within an

integrated service delivery system. Last, this example shows how the triadic relationship allows medical providers, counselors, and patients to learn from each other.

Summary of Themes and Domains Across All Frames of Analysis

Two universal themes emerged across each of the salient domains that were identified within each of the themes or keyword groups described by the 6 participants of this study. The two universal themes included the following: (1) influences from the environment, and (2) interactions with others. The first theme that emerged across the domains was the influences from the environment. Particpants' descriptions of their experiences revealed two types of influences: (1) influences from the primary care setting, and (2) influences from the medical culture. The second theme identified across the domains of participants' experiences included the interactions with others. Two domains emerged from the data collection concerning the theme of the interactions with others: (1) interactions with medical providers, and (2) interactions with patients. When examining demographic factors with the participants' statements with regard to this theme, it was noted that participants with more years of experience (greater than 3 years) were similar to those experiences reported by participants who had been working in the area of integrated primary behavioral health for less than 3 years.

Chapter Summary

The findings reported in this study documented the lived experiencing of six counselors working in an integrated primary behavioral health setting. This study attempted to answer the following research questions: (1) What are the rewards for

counselors working in an integrated primary behavioral health setting? (2) What are the challenges for counselors working in an integrated primary behavioral health setting? (3) How does working in an integrated primary behavioral health setting impact the counseling skills of counselors? and (4) How do the experiences of counselors working in an integrated primary behavioral health setting influence the way counselors perceive their professional identity? This phenomenological study examined the experiences of counselors working in an integrated primary behavioral health setting. Four themes were identified within the statements shared by participants. Furthermore, two themes emerged across all frames of analysis herein.

Participants identified rewards of working with medical providers (e.g., collaborating with medical providers). When describing the challenges counselors encountered working in an integrated primary behavioral health setting, participants reported challenges (e.g., challenges working within the culture of the medical model). Participants identified two areas when describing their perceptions regarding the impact working in an integrated primary behavioral health setting has had on their counseling skills. Changes in counseling skills and changes in treatment approach working with patients. The last theme described by participants focused on the influence that working in an integrated primary behavioral setting has had on their professional identity as a counselor. Three focal areas emerged from the theme regarding the influence on professional identity which included the following: influence of role working with patients, change in role identification, and sense of purpose in role.

The two universal themes identified by participants across all frames of analysis were: influences from the environment and interactions with others. The influences from

the environment identified by participants included influences from the primary care setting and influences from the medical culture. When describing counselors' interactions with others, two types of interactions were identified: interactions with the medical providers, and interactions with patients.

A discussion of these findings including implications for further research and the limitations of the study are included in Chapter V. In addition, recommendations for future research in the area of counselors working in integrated primary behavioral health are discussed in Chapter V.

CHAPTER V

DISCUSSION

This study used a qualitative approach with phenomenological methodology to examine the professional experiences of six counselors working in an integrated primary behavioral health setting and explored how their experiences influenced their professional identity as a counselor. This chapter includes a summary of the significant findings of this study, followed by a discussion of the findings in relation to the existing body of research related to counselors working in an integrated primary behavioral health setting. Implications of the findings yielded from this study are described in this chapter as they relate to (1) the instruction and training of new counselors and counselor supervisors pursuing work in an integrated primary behavioral health setting, as well as (2) current counselors and counselor educators who may consider pursuing a career working in an integrated primary behavioral health setting. In addition, potential implications are presented for health care organizations (1) considering developing an integrated primary behavioral health model of care into their organization, and (2) during the transition process of implementation.

The chapter also includes a discussion of the findings as they relate to how the training in counselor education and counseling related programs could better assist in preparing counselors to work in an integrated primary behavioral health setting. The final section of this chapter includes a review of the limitations of this study followed by recommendations for future research related to counselors working in an integrated primary behavioral health setting.

Overview of Significant Findings

The purpose of this study was to examine the experiences of six counselors working in an integrated primary behavioral health setting in order to better understanding of the meaning of the lived experiences working within this integrated care setting. The findings that emerged from the data collection in this study give voice to the counselors' experiences working in an integrated primary behavioral health setting. In addition, the findings from this study will provide direction to future counselors seeking a career in an integrated primary behavioral health setting. Furthermore, this research will provide valuable insight for counselor education and counseling programs to provide counselors with the training and guidance necessary to prepare counselors pursuing a career working in an integrated primary behavioral health setting.

The six counselors practicing in an integrated primary behavioral health setting described several perceived rewards of working in this setting which included collaborating with medical providers, learning from each other, mutual respect and understanding, satisfaction working with patients, and rewards of working in an integrated primary behavioral health environment. Challenges identified by counselors working within this type of environment included challenges working within the culture of the medical model, and different approaches to patient care. The challenges faced by counselors regarding the culture of the medical model included such experiences as communication issues with medical providers, lack of time by medical providers to address mental health issues, lack of respect for counselors within the medical culture, and feelings of isolation by counselors. In addition, counselors described the challenges

they experienced due to differing approaches to patient care between medical providers and counselors. An example of the difference in approach to patient care has to do with how medical providers often approach the treatment of depressive symptoms with the use of antidepressant medications compared to counselors who might initially focus on behavioral strategies to treat the patient when appropriate.

Participants further identified ways in which their counseling skills were impacted as a result of working in an integrated primary behavioral health setting. Participants identified having experienced changes in counseling skills, and changes in treatment approaches working with patients. The changes in counseling skills described by participants included learning to assess at a quicker pace, asking patients more questions, and learning evidenced-based treatment interventions to better assist patients. Furthermore, participants' description of the changes in their approach to treatment working with patients included the use of short-term treatment approaches to care, the ability to be flexible in working with patients, and working "in the here and now."

Finally, the six counselors reported how they perceived their experiences working in this type of setting have influenced their professional identity as a counselor. Descriptions of the perceived influences of the participants regarding their professional identity as counselors included (1) influence of role working with patients (2) change in role identification, and (3) possessing a sense of purpose in their role. Counselors described how they made changes in their treatment approach and how this influenced their sense of how they perceived themselves as a counselor. These modifications included how participants conceptualized the changes they made in their role when

working with patients, thought about treatment differently, utilized their strengths, and how they perceived that these changes increased their effectiveness as a counselor.

Last, participants shared their perceptions about the influences on their professional identity as a counselor by describing their sense of purpose in their role as a counselor working in an integrated primary behavioral health setting. Each of the participants' experiences were unique as they spoke about such concepts as feeling good about their work, a sense as though they were making a contribution in their role, and feeling that they were meant to be working in an integrated setting.

In describing their lived experiences and perceptions of working in an integrated primary behavioral health model, counselors' descriptions could be categorized into two main areas: influences from the environment and interactions with others. The influences from the environment shared by participants included adjustment to working within a medical model, adapting counseling skills to meet needs of patients in primary care, and being the only counselor within the primary care setting. The two types of interactions identified by participants included interactions with medical providers, and interactions with patients. Interactions with medical providers included working together with patients during integrative patient care encounters, and collaborative consultations between medical providers and counselors to discuss patient care. When participants described their interactions with patients they focused on such issues as working with patients to make behavioral changes, working "side by side with the doctor," as well as some counselors' perceptions that there is "not as much stigma" perceived by patients in accessing counseling services in an integrated primary behavioral health setting versus a traditional behavioral health setting. Some counselors believed an integrated primary

behavioral health approach lessened the barrier for people accessing behavioral health treatment within a primary care setting.

Discussion of Findings

Although the literature in the area of integrated behavioral health services has been reported to have a positive impact on medical provider satisfaction with behavioral health services, increased patient satisfaction, improved compliance with treatment, increased access to services, and effective clinical outcomes (e.g., Blount, 2003; Cummings, 1996; Friedman et al., 1995; Van Beek et al., 2008), to date there is a significant void in the literature regarding the lived experiences of counselors working within an integrated primary behavioral health setting. The findings of this study examining the experiences of counselors working in an integrated primary behavioral health setting are discussed in this section. This discussion explores how the experiences reported by the participants in this study compare with the research literature in the area of integrated primary behavioral health described in the literature reviewed in Chapter II.

Rewards of working with medical providers included collaborating with medical providers, learning from each other, mutual respect and understanding, satisfaction working with patients, and rewards of working in an integrated primary behavioral health environment. The reported rewards of working with medical providers from participants are consistent with the exiting literature regarding the collaboration process between counselors and medical practitioners working with patients across an array of behavioral and physical conditions (e.g., Katon et al., 1995, 1996; Miller et al., 2004; Seaburn et al., 1996). Similar to the findings of this study, when examining the value perceptions of

integrated health care, Miller and colleagues (2004) found that both primary care physicians and professional clinical counselors perceived the collaborative process between the two disciplines in a favorable manner. Another example of the benefits of collaboration is documented in the research conducted by Katon and his colleagues which demonstrated how medical providers and counselors working together in a collaborative care model can improve mental health outcomes for patients with depression.

Participants' descriptions of their experiences of the rewards of working within a primary care environment such as the perception that integrated care minimizes the stigma of receiving behavioral health services is demonstrated in the literature examining how integrated care can minimize the stigma associated with accessing behavioral health services (e.g., Arean et al., 1996; Brody et al., 1997; Corrigan, 2004; Hayward et al., 1997). Another reward was that participants reported they developed a greater understanding of the biopsychosocial influences on health from working in an integrated primary behavioral health setting. This finding is also in the literature regarding the interconnection between physical health and emotional well-being (e.g., Blount et al., 1994; Blount, 1998; Cummings et al., 1997; Hafen et al., 1996; Seaburn et al., 1996).

The challenges experienced by some participants working in an integrated primary behavioral health setting included working within the culture of the medical model, and differing approaches to patient care. The challenges faced by counselors regarding the culture of the medical model included such experiences as communication issues with medical providers, lack of time by medical providers to address mental health issues, lack of respect for counselors within medical culture, and feelings of isolation by counselors. It was noted that many of the experiences described by counselors regarding

the challenges of the culture of the medical model of primary care is represented in the counseling literature regarding this topic (e.g., Hudson-Allez, 2000).

Many of the challenges described by some counselors working in an integrated primary behavioral health model are consistent with the literature regarding the inability of primary care medical providers to adequately address the mental health needs of their patients (e.g., Coyne et al., 2002; Higgins, 1994; Pruitt et al., 1998; Von Korff et al., 1996). For example, the research literature supports participants' descriptions regarding the lack of time by medical providers to address psychological issues (e.g., Coyne et al., 2002; Longlett et al., 1992). The findings from this study are further illustrated by the research conducted by Coyne and colleagues that examined how the time constraints of the primary care delivery system do not allow medical providers to effectively address the medical and psychological concerns of their patients.

The challenges experienced by participants regarding the lack of time for medical providers to address psychological problems are also demonstrated by the literature regarding how counselors integrated into the primary care system, are able to assist medical providers in providing a broad spectrum of behavioral health interventions to meet the needs of the primary care population with whom they serve (e.g., Blount, 1998; Cummings et al., 1997; Dobmeyer et al., 2003; McDaniel et al., 1993; Strosahl, 1998). The challenge experienced by some counselors regarding the feeling of isolation working in the culture of the medical model is illustrated in the literature regarding the challenges that counselors who practice in a medical setting may encounter (e.g., Kates et al., 2001).

A comparison of the findings of this study and the literature in this area suggests a potential source of professional isolation may be the result of the experience of some

counselors of being the only counselor within an integrated primary care setting working predominately among medical providers and other primary care staff. Participants described the challenges they experience due to differing approaches between medical providers and counselors to patient care. For example, some participants described the differences in how medical providers approach the treatment of depressive symptoms with the use of antidepressant medication as the first line of treatment rather than initially focusing on behavioral strategies when working with patients.

Counselors identified ways in which their counseling skills were impacted as a result of working in an integrated primary behavioral health setting. Participants described making changes in their counseling skills, as well as changes in the treatment approaches they utilized in working with patients. The changes in counseling skills discussed by participants included learning to assess at a quicker pace, asking patients more questions, and learning evidenced-based treatment interventions to better assist patients. These changes described by participants regarding counselors having to adapt their counseling skills in order to effectively work in primary care is further supported by the literature in the area of integrated care (e.g., APA, 1998; Blount, 1998; Hudson-Allez, 2000; Quirk et al., 1995; Strosahl, 1998). For example, the experiences identified by some participants regarding the fast pace nature of primary care is demonstrated in the counseling literature (e.g., Hudson-Allez, 2000) which distinguishes the differences counselors experience working in a primary care setting in comparison to those working in other traditional mental health environments. Similar to the findings of this study, Hudson-Allez (2000) identified the need for counselors to adapt to the fast pace of patient care, as well as the need to make modifications in their counseling techniques and

interventions. Last, the experiences reported by counselors about changes in their counseling skills is supported in the literature regarding the use of effective evidence-based behavioral interventions and psychoeducational strategies as essential skills for counselors to possess working in primary care settings (e.g., APA, 1998).

Participants' descriptions of the changes in their approach to treatment when working with patients included using short-term treatment approaches to care, being flexible in working with patients, and working "in the here and now." The need for counselors working in an integrated primary behavioral health setting to possess the ability to work in brief time frames using solution-focused approaches to care and apply these interventions when working with patients is illustrated in the literature (e.g., APA, 1998; Strosahl, 1996). Moreover, the experiences described by participants concerning the impact on counseling skills is consistent with the counseling literature describing how the future of counseling services will differ from that for which counselors have been traditionally trained (e.g., Cummings et al., 2001). Among the changes in counseling skills identified by Cummings and colleagues include an emphasis on time limited and goal focused treatment, as well as the use of evidenced-based treatment, and psychoeducational and behavioral strategies similar to those experienced by participants in this study.

Last, each of the 6 participants in this study reported their perceptions of how their experiences working in an integrated primary behavioral health setting have influenced their professional identity as a counselor. These descriptions included the influence of their role working with patients, changes in role identification, and possessing a sense of purpose in their role. The influences of their role working with

patients included changes in how counselors thought about treatment, the ability to utilize their strengths, and increased effectiveness working with patients. Counselors further described changes in how they identified their role with patients, as well as, the ways in which they changed how they conceptualized their role working within an integrated primary behavioral health setting. Finally, participants shared their perceptions about the influences on their professional identity as a counselor by describing their sense of purpose in their role as a counselor working in an integrated primary behavioral health setting. Each participant's experience was unique as they spoke about these internal influences as it relates to their identity as a counselor working in this model of care.

Counselors' descriptions regarding their sense of purpose in their role included such internal influences as feeling good about their work, feeling as though they were making a contribution in their role, and feeling that they were meant to be working in an integrated setting. The findings from this study in the area of the influences on counselor identity is supported in the counseling literature by a study conducted by Skovholt and Ronnestad (1992) which examined the training of counselors and professional identity development focusing on the external and internal influences on professional identity. The findings of this study suggest that the descriptions of counselors' experiences such as of feeling a sense of pride in their identity as a counselor, feeling as though they are making a significant professional contribution in their role, and possessing the belief that they were meant to work in an integrated primary behavioral health setting are some examples of the internal influences on professional identity experienced by counselors working in this model of care.

A review of the literature examining counselors working in health care demonstrated a minimal amount of literature in the field of counseling (e.g., Aitken et al., 2004; Hudson-Allez, 2000; Miller et al., 2004) that specifically addresses the experience of counselors. However, an exploration of the literature specific to the report of the lived experiences of counselors working in an integrated primary behavioral health setting revealed a void in research exploring this phenomenon. Although there is a deficit in research in the field of counseling examining the influence of working in this setting on the professional identity of counselors, there is a limited amount of literature regarding psychologists working in health care settings (e.g., Altmaier et al., 1998; Bernard, 1992; Good, 1992; Mrdjenovich et al., 2004; Newman et al., 1996). Within this limited body of research there are only a few articles addressing issues of professional identity of counseling psychologists working in health care (e.g., Altmaier et al.; Bernard; Good; Mrdjenovich et al.).

Interestingly, even though the literature in this area is almost exclusively from the field of counseling psychology, findings from the descriptions of the experiences of the six counselors in this study reflect similar experiences with regard to influences on professional identity. Mrdjenovich and Moore (2004) question whether or not those counseling psychologists who pursue a career working in the health care arena continue to identify as a counseling psychologist. In examining this issue as it relates to the field of counseling, the findings of this study suggest that the six counselors who participated in this study perceived value in their work within an integrated primary behavioral health setting which appeared to influence their perceptions of their professional identity. For example, counselors described feeling a sense of pride in their identity as a counselor,

feeling as though they are making a significant professional contribution in their role, and believing they were meant to work in an integrated primary behavioral health setting. These experiences reported by participants in this study are consistent with the assertions of Altmaier et al. (1998) that it is possible for counseling psychologists to work in a non-traditional setting such as health care. The experiences reported by the participants indicate that not only do counselors work in non-traditional settings such as integrated primary behavioral health care, but that counselors find a sense of purpose in their role and value in their work with both medical providers and patients in this setting.

Summary of Findings

The findings from this study indicate that, overall, counselors perceive their experiences working in an integrated primary care setting as positive. The rewards described by counselors focused primarily on their interactions with others (i.e., medical providers and patients). These rewards included collaborating with medical providers, counselors and medical providers learning from each other, a sense of mutual respect, an understanding between counselors and medical providers, satisfaction working with patients, and rewards identified of working within a primary care environment. Although participants identified several rewards of working in an integrated primary behavioral health setting, participants were also met with various challenges in their work. The challenges described by participants centered on the areas of communications issues with medical providers, lack of time by medical providers to address mental health issues, lack of respect for counselors within the medical culture and feelings of isolation by counselors.

The impact on counseling skills described by the counselor participants indicate that counselors are able to utilize their existing clinical skills working in primary care; however, there was a clear emphasis by participants regarding the need to broaden their skill base to include changes in both their treatment approach and behavioral interventions to be aligned with the delivery system and population served within a primary care setting. These changes in counseling skills included the ability to assess and diagnose within a shorter time frame, and the ability to learn and apply evidenced-based treatment interventions when working with patients. The changes in treatment approaches identified by counselors included utilizing short-term treatment approaches with patients, and being flexible in working with patients with varying needs, and focusing on "the here and now."

Participants' experiences in working in an integrated primary behavioral health setting included influences on their professional identity as counselors. The influences identified by participants included the influence of their role working with patients, change in role identification, and having a sense of purpose in their role. Five out of the six participants described changes in how they practice within an integrated primary behavioral health setting. These changes included how participants thought about treatment differently, utilized their strengths, and how they perceived working in an integrated model has increased their effectiveness working with patients.

The 6 participants described their sense of purpose in their role working in an integrated primary behavioral health setting. The descriptions of participants were uniquely personal as many spoke about their internal experiences of having a sense of pride in their professional identity; others spoke of feeling appreciated and fortunate, and

feeling good about their work. Some participants described how they felt they were making a contribution in their role. Two of the six participants made reference to a spiritual component regarding how they believed they were meant to be working in an integrated primary behavioral health setting.

In a thorough examination of the findings from this research study, the researcher observed that the types of experiences described by participants fell into two primary categories: influences from the environment and interactions with others. Within these two categories the experiences identified by the participant counselors of this study can be further grouped into either external or internal influences. External influences included such activities as collaborating with medical providers, working with patients to make behavioral changes, and working within the biomedical culture of a primary care environment. Internal influences included the influence of working in an integrated primary behavioral health setting on counselors' professional identity, how participants conceptualized their role working with patients, and the sense of purpose participants expressed from working in an integrated primary behavioral health setting.

Several implications have been inferred from the findings of this study regarding the instruction and training needs of counselors who wish to pursue a career working within in an integrated primary behavioral health setting. A discussion of the implications of this study is presented in the following section of this chapter.

Implications

Several implications have been drawn from the findings of this study to support the need for counselor educators and counseling programs to provide training to

counselors in the treatment approaches and the counseling skills necessary to be successful working within a primary care work environment. Further implications from the findings of this study indicate a need for counselor educators and supervisors to be able to provide support to new counselors who are pursuing careers in an integrated primary behavioral health environment. Counselor educators, supervisors, and counseling programs will need to provide instruction and guidance to new counselors about the biomedical culture of primary care and other factors related to health care to help new counselors effectively transition into this type of work setting. Implications for health care organizations regarding the training of behavioral health administrators and counselors working in an integrated primary behavioral health setting are discussed.

Implications for Counselor Educators, Supervisors, and Counselors in Training

Training in counselor education and counseling related programs could provide preparation in the basic skills and competency areas for counseling services in a primary care setting. Aitken et al. (2004) explore several ways in which educators can assist in the training of counselors who wish to pursue working in integrated behavioral health practices. As a part of a comprehensive training program for counselors seeking positions within integrated health care settings, areas of instruction might include training in the primary behavioral health model, evidenced-based treatment approaches, as well as brief solution-focused and goal-oriented behavioral interventions. Counselor education and counseling programs may better assist their students to adapt to the changes in the field of counseling by recognizing and providing training in the changes within the new or non-traditional models of counseling and related behavioral health practices.

One aspect of the findings of this study was the identification of ways that participants' counseling skills were impacted by working in an integrated primary behavioral health setting. These changes included learning to adapt to working within the fast pace of this setting, including assessing patients more quickly, and utilizing briefer time frames in working with patients. Counselor education training should consider including these areas of instruction to effectively prepare future counselors working in the health care field.

Counselor education programs may want to consider including discussion and training regarding the integrated primary behavioral health model as part of a community counseling course. Another consideration for counselor training programs might be offering an elective course specifically focused on counselors working in health care settings. Due to the need for trained counseling professionals to work in health care organizations, counselor education programs may want to consider including a multi-coursework specialization program in working in health care organizations as a component of community counseling. This presents an opportunity to advance the field of counselor education and counseling into another area of social service by increasing the presence of counselors in health care. Furthermore, specialized training in the area of health care has the potential for enhancing opportunities for those counselors who have an interest in the area of integrated primary behavioral health care and will prepare future counselors to assume a role as a counseling professional in the health care arena.

Implications for Counselor Supervisors in Training

When examining the training for counselor supervisors in integrated primary behavioral health, counselor educators might consider providing supervision training to include instruction regarding counselors working in health care. This training might occur as part of the instruction provided in a supervision class in order to expose supervisors in training to the types of skills they need to possess in order to provide proper guidance and support of those counselors with whom they may provide supervision.

Training and instruction for supervisors might include a basic understanding of the integrated primary behavioral health model and the role a counselor assumes in this model of patient care. Additional instruction might include learning the clinical approaches to treatment and counseling skills required to work in this type of setting as well as training regarding the cultural differences that a counselor supervisee may encounter when working in an integrated primary behavioral health setting. Such training in supervision could impact the quality of supervision received by counselors who work within this type of setting.

Implications for Health Care Organizations

The findings of this study have potential implications for health care organizations for the purpose of informing behavioral health administrators within these organizations about the importance of providing mentoring and support to those counselors transitioning into an integrated primary behavioral health model. The findings from this research may assist in identifying the knowledge base and clinical skills

necessary for administrators to possess in order to ensure the successful implementation of such a model while recognizing that this is a fundamental shift in practice and service delivery from the way that most counselors have been trained.

Based upon the findings of this research, health care organizations may want to consider training behavioral health administrators in the integrated primary behavioral health model in order to equip them to provide effective mentoring and support to counselors transitioning into this model of care. In addition, health care organizations may consider investing in the training of both new and experienced counselors in the integrated primary behavioral health model and provide varying aspects of training across the continuum of implementation of an integrated primary behavioral health model.

Summary of Implications

The findings of this study have implications for counselor educators, counselor education training programs, supervisors, and counselors who wish to pursue a career working in an integrated primary behavioral health setting. The implications related to counselor supervisors and counselor education training programs include the need to provide counselors with instruction and guidance specifically focused on developing the clinical skill set required for working in an integrated primary behavioral health setting.

The implications drawn from the findings this study for counselor educators, supervisors, and counselor education training programs include developing training in the integrated primary behavioral health model, evidenced-based treatment approaches, brief solution-focused and goal-oriented behavioral interventions, and training focused on the cultural difference between traditional mental health models and the biomedical model.

Furthermore, the findings of this study have implications for health care organizations considering implementing an integrated primary behavioral health model. These implications include the following: (1) develop and offer on the job training in the integrated primary behavioral health model, and (2) counseling administrators to provide mentoring and support in order to ensure successful transition for counselors during the implementation stage.

Limitations of the Study

This study utilized a phenomenological approach to examine the lived work experiences and perceptions of six counselors working in an integrated primary behavioral health setting. During this investigation specific strategies were used to ensure the accuracy of the data collection and minimize researcher bias. These strategies included the use of member checking with participants to confirm the accuracy of the data, as well as an attempt by this investigator to bracket or suspend judgment that would influence the findings of this study. By using these measures to reduce researcher bias, it is the belief of this researcher that the findings of this study accurately represent the essence of the experiences of the six counselors who participated in this study.

The following areas have been identified as additional possible limitations of this study: (1) sampling bias, (2) demographics of the participants, (3) use of a transcriptionist, and, (4) the use of data analysis software. All of the limitations identified in this study are inherent in studies utilizing similar qualitative methodology.

Sampling of Participants

A limitation that may have had an impact on this study involved sampling bias. Participants for this study were sought through the use of a national listserv of the CFHA. Thus, those members who chose to respond to the invitation to participate in this study were members of this organization and may not reflect a broader sample of the general population of counselors working in an integrated primary behavioral health setting. In addition, selecting people who are associated with CFHA might be biased by virtue of that fact that the counselors who are affiliated with this organization may identify with the mission and goals of the organization with regard to collaborative and integrated care. An additional limitation with regard to the sampling of participants was the small sample size used for this study. Six participants were selected for inclusion in the study; however, the goal of this study was to gather in-depth data from a smaller group of participants in order to develop a greater understanding of the essence of their experiences rather than focus on attempting to make generalizations from a larger sample population.

Demographics of the Participants

Another potential limitation of this study had to do with the gender of the participants. Participants were selected for this study using set criteria. All of the 6 participants in this study who responded to the invitation for participation and met the inclusion criteria for this study were female. A study that explored a broader

demographic base with regard to gender or other demographic variables may have potentially yielded different experiences and ultimately different findings of this study.

Use of a Transcriptionist

The use of a transcriptionist to assist in transcribing interviews is viewed by some as a limitation as it may prevent researchers' abilities to begin to immediately immerse themselves in the data. Although this investigator used a transcriptionist to document the interviews, the investigator was still able to stay close to the data by listening repeatedly to the recorded interviews, examining the interview summary forms completed after each interview, reviewing each completed transcript upon completion, and comparing the transcription data to the recorded verbatim interviews for accuracy prior to data analysis.

Use of Data Analysis Software

Transana software was used by the researcher to identify, categorize and organize data in order to assist with the data analysis process. Transana aided the researcher in storing the large volume of the interview data and coding transcriptions from the data collection. Hatch (2002) cautions researchers that data analysis software is not a substitute for "careful reading and complex thinking necessary for making sense of the qualitative data" (p. 207). The investigator attempted to stay immersed in the data throughout the analytical process by reading the transcripts several times during this analysis process, using a reflexive journal, and reviewing the interview summaries completed by the researcher upon completion of each interview.

Recommendations for Future Research

Further research in the area of integrated primary behavioral health should be considered. Specifically, studies are needed examining how counselors experience working within an integrated approach to care (Aitken et al., 2004). If the primary behavioral health model is a paradigm shift in how behavioral health services are delivered in the future, then the field of counseling must examine how it will train future counselors in this treatment model. This shift in service delivery has potentially significant implications in the counseling field as it moves toward such models mentioned herein. Those already in the counseling field will unquestionably need to make changes if they are to pursue roles within integrative care. Moreover, those counselors who are presently in training must be trained in both the traditional mental health model as well as the integrated primary behavioral health model in order to be effective in their field and to understand the importance of their roles in both models of practice.

Training and Instruction Needs of Counselors

Future research inquiry might consider addressing the training and instruction needs of counselors who wish to pursue a career working in a health care organization. Research questions might include: "What are the training and instruction needs of new counselors seeking a career in an integrated primary behavioral health setting?" Additional research questions for scholars to consider include: "What is the best format for training counselors in the integrated primary behavioral health model?" Another

possible question to examine is the differences in training needs among counselors. "What are the differences in training needs among new counseling professionals as compared to experienced counselors?"

Health Care Organizations in Transition

With regard to health care organizations, a consideration for future research might include examining organizations transitioning to this model of patient care and the potential challenges counselors who are accustomed to providing services within a traditional mental health model may encounter during this transition. Research may also provide further insight into how health care organizations can support their counseling staff while making this transition. A possible statement of inquiry might be: "What are the areas of mentorship and support needed by counselors during the implementation stage of transitioning to working within an integrated primary behavioral health model of care?"

The Experiences of Patients Receiving Integrated Treatment

Although this study did not specifically examine the experiences of patients receiving integrated primary behavioral health services, as indicated by the findings of this study, counselors reported how their experiences working with patients influenced them in their work within this model of patient care. As a result of these findings, future research should consider further exploration into the experiences of patients receiving services in integrated primary behavioral health settings. A question examining the patient's experience in receiving integrated primary behavioral health services may

include: “What are the benefits to the patient in having counselors integrated within the primary care treatment team?”

Conclusions

Phenomenological methodology was utilized to answer the statements of inquiry presented in this study examining the lived experiences of six counselors working in an integrated primary behavioral health setting. The investigator used naturalistic inquiry methods to answer the four guiding research questions. Rich narrative data were collected through semi-structured interviews. An inductive analysis process identified patterns, relationships, and themes both within and across the data. The findings of this study indicate that counselors experience several rewards as well as challenges in their position working in an integrated primary behavioral health setting. In addition to these experiences, counselors identified multiple ways in which their counseling skills have been impacted by their work within this model. Perhaps the most personal and unique of their descriptions was how each counselor expressed how they perceived their professional identity was influenced by working in an integrated primary behavioral health setting. The findings from this study indicate that counselors were able to identify both internal and external influences from their work in an integrated primary behavioral health setting on their professional identity as a counselor. Furthermore, the findings of this study suggest that counselors found both a sense of value and purpose in their role working in this model of integrated primary behavioral health care.

Although many of the findings of this study are supported by the research literature in the area of integrated primary behavioral health care, the majority of this

research has been done by scholars in other social science fields such as psychology. To date there has been minimal attention, if any, given specifically to the lived experiences of the counselors who work within an integrated primary behavioral health setting. The rich descriptive meaning shared by each of the participants in study will help to inform and better prepare counselors in training to work in an integrated primary behavioral health environment. Further examination of the phenomenon of counselors working in an integrated primary behavioral health setting may provide direction for counselor educators, supervisors and counselor education training programs to gain a better understanding of the therapeutic approaches, behavioral interventions, and other clinical skills necessary in order to provide instruction and training to future counselors wishing to pursue a career working in integrated primary behavioral health care. By doing so, counselors may be better equipped to deal with the potential challenges of practicing within this work setting.

It is the desire of this researcher that the findings of this study not only make a contribution to the existing literature on the topic of integrated primary behavioral health, but that it also may encourage future scholars in the field of counseling and counselor education to pursue further research exploring the lived experiences of counselors working in an integrated primary behavioral health setting. In addition to providing direction for instruction and training, further research may provide counselor educators, supervisors, and administrators of health care organizations a better understanding of ways to support counselors in making a successful transition into working in an integrated primary care behavioral health setting and the health care arena.

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Appendix A

Request for Research Participation Listserv Announcement

Request for Research Participation Listserv Announcement

Title of Research Study: *Counselors Working in Integrated Primary Behavioral Health: Examining the Influence on Professional Identity*

Researcher: Geniene Gersh, MA, LLP, a doctoral student in Counselor Education from the Department of Counselor Education and Counseling Psychology of Western Michigan University. This study will be the basis for Geniene Gersh's dissertation, which is being completed as part of the requirements for a Doctorate in Philosophy Degree (Ph.D.) in Counselor Education.

Purpose of the Study: The purpose of this study is to better understand the perceptions and experiences of counselors who practice in an integrative behavioral health model of service delivery and how these experiences potentially influence their professional identity. The findings in the analysis may benefit professional counselors who are providing this type of integrative care by furthering their understanding of this change in practice and how it influences a counselor's professional identity.

Participation in the Study: Participation in this study will involve an interview with the researcher in which participants will discuss their perceptions and experiences as a counselor who practices in an integrative primary behavioral health model and how providing these experiences may have influenced their counselor identity. I am invited to participate in a one interview with the student investigator, Geniene Gersh. The interview will take approximately 60 to 90 minutes and will be audiotaped and transcribed for later analysis.

Confidentiality: Participation in this study is voluntary and all of responses will be treated with strict confidentiality. The interview will take place in a private room so that confidentiality is maintained. All participants will be assigned a pseudonym and other identifying information will be masked. The student investigator will securely store all data and documentation. Following the end of this study, data collected from all transcriptions and audiotapes for the purposes of this research project will be destroyed. Participating in this study is not likely to have any negative effects

If I have questions or concerns about the study and /or my participation, I am to notify the student investigator, Geniene Gersh, MA, LLP at (616) 2348-0345 or (616) 706-2468 or the Chair of my doctoral committee, Suzanne Hedstrom, Ed.D. at (616) 742-5069 who are prepared to provide assistance with any questions or concerns. I may also contact the Chair, Human Subjects Institutional Review Board (269) 387-8293 or the Vice President

for Research (269) 387-8289. All participants retain the right to withdraw their participation from this study at any time without negative social or economic consequences.

Participant Incentive: As an appreciation for participation in this study, each participant will receive a gift card to Amazon.com in the amount of $25.00.

Contact Information: If you wish to participant in this study please contact Geniene Gersh at
(616) 248-0345 or (616) 706-2468 or email at gmgersh@aol.com .

Thank you in advance for your willingness to participate in this study.

Respectfully,

Geniene M. Gersh, MA, LLP
Limited Licensed Psychologist
Doctoral Student

Appendix B

Participant Consent Letter

Participant Consent Letter

I have been invited to participate in a research study entitled, *Counselors Working in Integrated Primary Behavioral Health: Examining the Influence on Professional Identity*, by Geniene Gersh, MA, LLP, a doctoral student in Counselor Education from Department of Counselor Education and Counseling Psychology of Western Michigan University. This study will be the basis for Geniene Gersh's dissertation, which is being completed as part of the requirements for a Doctorate in Philosophy Degree (Ph.D.) in Counselor Education.

The purpose of the study is to better understand the perceptions and experiences of counselors who practice in an integrative behavioral health model of service delivery and how these experiences potentially influence their professional identity. The findings in the analysis may benefit professional counselors who are providing this type of integrative care by furthering their understanding of this change in practice and how it influences a counselor's professional identity. My participation in this study will involve an interview with the student investigator in which I discuss my perceptions and experiences as a counselor who practices in an integrative primary behavioral health model and how providing these experience may have influences my identity as a counselor. My participation in this study is voluntary and all of my responses will be treated with strict confidentiality.

I am invited to participate in a one interview with the student investigator, Geniene Gersh. The interview will take approximately 60 to 90 minutes and will be audio taped and transcribed for later analysis. As above, my confidentiality will be protected and respected. The interview will take place in a private room so that confidentiality is maintained. I will be assigned a pseudonym and other identifying information will be masked. The student investigator will securely store all data and documentation. Following the end of this study, data collected from all transcriptions and audio tapes for the purposes of this research project will be destroyed.

I may benefit from participating in this study by becoming more aware of my experiences in working in an integrated primary behavioral health setting and how these experiences may have influenced my counselor identity. In addition, as an appreciation for your participation in this study, I will receive a gift card to Amazon.com in the amount of $25.00.

Participating in this study is not likely to have any negative effects. As in all research, however, there may be unforeseen risks to participants. If I have questions or concerns about the study and /or my participation, I am to notify the student investigator, Geniene Gersh, MA, LLP at (616) 706-2468 or the Chair of my doctoral committee, Suzanne Hedstrom, Ed.D. at (616) 742-5069 who are prepared to provide assistance with any questions or concerns. I may also contact the Chair, Human Subjects Institutional Review Board (269) 387-8293 or the Vice President for Research (269) 387-8289 if

questions or problems arise during this study. I retain the right to withdraw my participation from this study at any time without negative social or economic consequences. By my signature, I indicate that I agree to participate in this research study and the requirements for participated as explained to me.

_____ _____

Signature Date

Appendix C

Participant Inclusion Screening Questions

Participant Inclusion Screening Questions

1. What field is your master's or doctoral degree in?
2. What counseling licensing credentials do you currently hold?
3. What is your primary professional identification?
4. How long have you been working in the counseling field?
5. How long have you been working in an integrated primary behavioral health setting?
6. Do you work in a consultation model of service delivery providing same day appointments or "curbside consultations" in a 15 to 30 minute service delivery model?

Appendix D

Participant Demographic Questionnaire

Participant Demographic Questionnaire

1. What field is your master's or doctoral degree in?
2. What counseling licensing credentials do you currently hold?
3. What is your primary professional identification?
4. How long have you been working in the counseling field?
5. Do you work in an integrated primary behavioral health care setting?
6. How long have you been working as a counselor in an integrated primary care model?
7. What is your current work setting and the position that you hold?
8. Do you work in a consultation model of service delivery providing same day appointments or "curbside consultations" in a 15 to 30 minute service delivery model?
9. Are you a member of any national professional counseling organization and if so, which ones do you hold membership?
10. Based on your experience, what do you believe are some of the skills necessary for a counselor working in an integrated primary behavioral health care setting?
11. What part of your training as a counselor do you believe prepared you for working in an integrated behavioral health model?
12. Did you receive professional training in addition to your counseling program that you believe prepared you to work in an integrated primary behavioral health model?

Appendix E

Interview Protocol Questions

Interview Protocol Questions

Study: *Counselors Working in Integrated Primary Behavioral Health: Examining the Influence on Professional Identity.*

Participants will be asked a series of eight open-ended questions about their experiences of working within an integrated primary behavioral health setting and their perception of the influence of these experiences on their professional counselor identity.

Interview Questions:

1. How did you get into the field of integrated primary behavioral health care?

2. What is your experience of being a counselor working predominately among medical practitioners?

3. Based on your experience, what has been the most rewarding part of working in an integrated primary behavioral health setting?

4. Based on your experience, what has been the most challenging part of working in an integrated primary behavioral health setting?

5. In what ways does your work in an integrated primary behavioral health model influence your professional identity as a counselor?

6. How have you found your work in your current position to be aligned with how you perceive yourself as a counselor?

7. How has your work in integrated primary behavioral health impacted your skills as a counselor?

8. Is there anything else you would like to add that I did not ask you about?

Appendix F

Permission to Post Participant Recruitment Listserv Announcement

Permission to Post Participant Recruitment Listserv Announcement

Hi Geniene,

I am happy to work with you en route to sending an announcement to our CFHA membership about your research project and request(s) for participation.

Please send me the title and brief description of your study (e.g., specific aims, background/significance, proposed methods, assurances of confidentiality and consent processes, etc.), and frame it as an "announcement" that our members will read.

Also send me a brief description of who you are, what University and Program you are affiliated with, contact information, and confirmation of IRB approval to proceed.

From there, we can put on the final-touches to a broad listserv announcement and send it out.

Talk to you soon,
Tai

- - - -

Tai J. Mendenhall, Ph.D., LMFT, CTR
University of Minnesota Medical School
Dept of Family Medicine and Community Health
925 Delaware St., Suite 220 Dinnaken
Minneapolis, MN 55414

Office: 612-624-3138
Fax: 612-624-3037
Email: mend0009@umn.edu

- - - -

On 21 Apr 2007, Hodgson, Jennifer L. wrote:
> Tai...please communicate with Geniene about her research idea.
> =20
> jennifer

>
> _____
>
> From: Blount, Alexander [mailto:BlountA@ummhc.org]
> Sent: Sat 4/21/2007 9:28 AM
> To: Hodgson, Jennifer L.; 'GMGersh@aol.com '
> Cc: Blount, Alexander
> Subject: RE: CFHA Conference - Question
>
> > Jennifer, I am away from my usual email and it's addresses. Can you
> forward this to Tai?
>
> This is exactly the kind of message we welcome from members to members. =
> Tai Mendenhall puts out the contacts messages. Sometimes he has one he =
> sends out right away and sometimes he holds them until he has enough to make =
> more of a newsletter. I am not sure what he will want to do, but if you =
> prepare something to go out that has all the information, it probably will not =
> be too long before he gets it out.
> Sandy Blount
>
> -----Original Message-----
> From: Hodgson, Jennifer L.
> To: GMGersh@aol.com
> Cc: blounta@ummhc.org
> Sent: 4/20/07 9:16 PM
> Subject: RE: CFHA Conference - Question
>
> Geniene,
>
> I welcome this type of research and of course your attendance at the
> conference. I am going to cc Dr. Sandy Blount regarding your request.
> Dr. Blount is the Chair of the CFHA Board. He will know more how to
> assist you in your request for research participants. There is a
> protocol that the Board uses in approving e-mails that go out to CFHA
> members.
>
> Goood Luck!
>
> Jennifer Hodgson, PhD
> Chair 2007 CFHA Conference
> Hello, Dr. Hodgson.
>
> My name is Geniene and I am looking forward to attending the CFHA
> conference this year. I am a counselor who has been working in an
> integrated primary care setting for the past several years. I am also a

> doctoral student in Counselor Education and am currently working on
> research for my dissertation which focuses on the experiences of
> counselors working in integrated primary care settings.=20
>
> As the CFHA conference chair, the question I have for you has to do with
> gaining potential access to people (counselors) who would be willing to
> participate in my study by being involved in a brief interview about
> their experiences working in integrated settings. It is not often when
> someone can have an opportunity to be with so many people who are
> involved in a specialized area as integrated care. Is it possible that
> I could be able to obtain permission to send an email on the bulletin
> board or by some other method to members of CFHA who may be attending
> the conference and would be interested in participating in my study?=20
>
> If I should be contacting someone else regarding this matter, please
> direct me to whom I should be contacting. I appreciate your time with
> this matter.
>
> Sincerely,
>
> Geniene Gersh
>
>
>

Appendix G

Letter of Introduction

Letter of Introduction

Date

Dear [Name of Participant]

My name is Geniene Gersh and I am a doctoral student in the Counselor Education program at Western Michigan University. The chair of my dissertation is Dr. Suzanne Hedstrom. In partial fulfillment of the requirement of the doctoral program, I am conducting a research study examining the experiences of counselors working in an integrated primary behavioral health setting and the influence of these experiences on professional counselor identity.

Thank you for your willingness to participate in my research study and appreciate your time and assistance. The study will include signing the written consent form and completing a demographic survey questionnaire and participating in a 90 minute interview. Please complete and return both the consent form and the demographic survey prior to arranging your interview time. Your participation, and sharing of professional experiences, may bring insight and understanding about experiences of counselors working in an integrated primary care setting and the influence on professional counselor identity.

Enclosed please find a participant consent form which details the procedures and expectations if you decide to become involved in my research. If you have questions at any time about this study, please feel free to contact me or the chair of my dissertation at the telephone numbers or email addresses listed below.

Thank you in advance for giving consideration to this matter

Suzanne Hedstrom, Ed.D.

Geniene M. Gersh, MA, LLP
Student Investigator
(616) 248-0345
(616) 706-2468
Email-gmgersh@aol.com

Appendix H

Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

As a transcriber, it is my responsibility not to violate any confidence of the participants of this study through indiscriminate discussion pertaining to the information shared by the participants. I understand and agree that all information shared by participants on the audio recordings is strictly confidential and I will not make any disclosures of these recordings.

_____ _____

Signature Date

Appendix I

Contact Summary Form

Contact Summary Form

Contact: Date:

Main Issues and Themes in this Contact:

Salient, Interesting, Illuminating Information:

Target Questions to Consider for Next Contact:

Impressions/Reflections of Participants/Interview:

(Adapted from Miles & Huberman, 1994).

Appendix J

Cover Letter to Participants for Member Checking

Cover Letter to Participants for Member Checking

Dear _____,

Attached please find a summary of the interview that you participated in for my dissertation study. As I mentioned at the time of interview, I would like your feedback on whether or not this summary accurately reflects your responses to the questions regarding your experiences or not. Please remember these are summaries of the actual interview and include the parts of the interview that specifically answer each of the research questions. I have omitted anything that compromises your confidentiality and anonymity including names and names of organizations. In addition, certain examples given with regard to working with clients and other details from the entire interview may not have been included in the summary.

If you agree that the summary is an accurate portrayal of your interview then please provide me with an email confirming this. Otherwise, if you feel that anything has been misrepresented feel free to make corrections if necessary. Please be specific, and include the page number, if needed.

Please email your feedback back to me at gmgersh@aol.com. If you could please get your feedback to me within the next week to 10 days, that would be greatly appreciated.

Thank you again for your participation in this study. I greatly appreciate your time.

Respectfully,

Geniene Gersh
Doctoral Candidate

Appendix K

Human Subject Institutional Review Board
Letter of Approval

Human Subject Institutional Review Board Letter of Approval