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Professional Counselors' Experiences on Interprofessional Teams in Hospital Settings

Kaprea F. Johnson, Jennifer Blake, and Hannah E. Ramsey

This qualitative study explored the experiences of 11 professional counselors who work on interprofessional teams in hospital settings. We conducted semistructured interviews and identified four themes using interpretative phenomenological analysis: (a) support patient care and positive team interactions, (b) interprofessional supervision, (c) scope of practice, and (d) ethical considerations. Implications for interprofessional supervision and professional counselors' contribution to interprofessional engagement in hospital settings are discussed.

Keywords: interprofessional teams, ethics, supervision, career human agency theory (CHAT), interpretative phenomenological analysis

Professional counselors (PCs) are prepared to work in settings that demand interprofessional engagement, teamwork, and collaboration (Johnson & Freeman, 2014). In fact, many counselors work outside of professional silos in a variety of work environments (Johnson & Mahan, 2019). An emerging work setting for PCs that requires interprofessionalism is the hospital setting. According to the Bureau of Labor Statistics (2019), 10% of mental health, substance abuse, and behavioral disorder counselors work in hospital settings. Although there are far more psychologists and social workers who work in hospital settings, the number of PCs in the setting is growing (Bureau of Labor Statistics, 2019). Related research on the experiences of mental health professionals in hospital settings highlights the benefits and barriers related to training, ethics, and supervision, but PCs are rarely included (Britton et al., 2015; Jones & Phillips, 2016; Supper et al., 2015). To fill this gap, the current study explored the experiences of PCs engaging on interprofessional teams (IPTs) in hospital settings.

IPTs

An IPT is defined as two or more health care professionals collaborating to enhance patient care through shared case conceptualization and treatment (World Health Organization, 2010). An IPT is considered a best practice approach to solve complex health care challenges, improve the quality of care, and lower the cost of health care (Agency for Healthcare Research and Quality, 2010). Additionally, there is an acknowledgment in medical health care that one of the main drivers of health and wellness is mental health care (Happell et al., 2019). This acknowledgment has increased the demand for mental health care providers on IPTs in a variety of settings, but especially in hospitals (Corigliano et al., 2017; Fox et al., 2018; Ghassemi, 2017). Because of this increased need, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (2008) and the Patient Protection and Affordable Care Act (2010) combined to present many opportunities for PCs in the United States to engage on IPTs in hospitals (Fox et al., 2018). As the practice of including PCs on IPTs grows in hospital settings, additional research is needed on training, ethics, and supervision needs and experiences, similar to the research on IPTs in other behavioral health care professions (Britton et al., 2015; Jones & Phillips, 2016; Supper et al., 2015). These factors (i.e., training, ethics, and supervision) can interfere with client/patient care, affect the functionality of the team, and disrupt job satisfaction; therefore, understanding the perspective of PCs working on IPTs in hospital settings is important (Espinoza et al., 2018; Fowler & Hoquee, 2016; Fox et al., 2018; Supper et al., 2015).

Training

Specific training to prepare PCs for IPTs in hospital settings is rare but has included interprofessional counseling classes with health care students or professionals for course credit

Kaprea F. Johnson https://orcid.org/0000-0001-7127-3370, Jennifer Blake https://orcid.org/0000-0002-4026-7776, and **Hannah E. Ramsey** https://orcid.org/0000-0002-2792-0355, Department of Counseling and Special Education, Virginia Commonwealth University. Kaprea F. Johnson is now at College of Education and Human Ecology, The Ohio State University. We would like to thank Dr. Dana Brookover for her assistance in editing. Correspondence concerning this article should be addressed to Kaprea F. Johnson, College of Education and Human Ecology, 172 Arps Hall, 1945 N. High Street, Columbus, OH 43210 (email: KapreaJohnson@gmail.com).

(Johnson et al., 2015; Johnson & Rehfuss, 2021), simulation-based exercises (Fowler & Hoquee, 2016), workshops (Quealy-Berge & Caldwell, 2004), and joint field experiences (Crumb et al., 2018; Vereen et al., 2018). In addition, the Substance Abuse and Mental Health Services Administration–Health Resources and Services Administration grant mechanism for interprofessional behavioral health workforce training, of which several counselor education programs were recipients, enabled additional advanced training opportunities for counselor trainees interested in counseling in hospital settings (Health Resources and Services Administration, 2014). Last, PCs are uniquely positioned to excel on IPTs for several reasons: (a) humanistic tenets inherent in training, professional identity, and basic counseling skills (Hansen, 2012; Mellin et al., 2011); (b) principles that guide ethical counseling practice, including collaboration, communication, and teamwork (American Counseling Association [ACA], 2014); and (c) core curriculum in counseling graduate training programs that provide a solid foundation for IPT engagement (Council for Accreditation of Counseling and Related Educational Programs, 2016; Johnson & Freeman, 2014). The literature available about PCs training to engage on IPTs is not robust, but it is growing. With its growth, researchers have noted the importance of engaging in related areas of inquiry, such as ethics and supervision experiences (Boland et al., 2016; Johnson, 2016).

Ethical and Practice Factors

Ethical practice is paramount in all health and human services professions. Engaging on IPTs in hospital settings brings to light unique ethical challenges, such as scope of practice, navigation of several different ethical value systems and codes, conflict resolution among team members, and settings-based turf challenges that can be further complicated by reimbursement (Kossaify et al., 2017; Madigosky et al., 2019; Manspeaker et al., 2017). Although health care ethical codes do have similar core values, researchers have suggested that navigating different professional ethical codes in interprofessional collaboration is a major challenge (Hodgson et al., 2013). An ethical challenge for PCs in hospital settings is role confusion—both their own and other team members' understanding of PCs' role and contributions on IPTs (Arthur & Russell-Mayhew, 2010; Crumb et al., 2018; Johnson, 2016). Although a dearth of empirical research exists in counseling regarding ethics of IPTs, the *ACA Code of Ethics* provides guidance for PCs (see ACA, 2014, Section D: Relationships With Other Professionals). In addition, practice factors provide a guide for PC ethical practice and obligatory duties in all clinical settings.

In a clinical setting such as a hospital, the *common factors approach* is a valuable method of conceptualization for PCs because of the benefit for the client and the IPT. The common factors approach notes that, indiscriminate of specific theoretical orientation or evidence-based treatment, all therapies share common therapeutic factors that make counseling effective (Wampold, 2001, 2015). These common factors also overlap with moral or ethical expectations of PCs (e.g., acceptance, empathy, genuineness) and best practice in maintaining a functioning IPT (e.g., trust, collaboration, understanding). Relevant common factors for the current investigation are therapeutic relationship/alliance, empathy, and cultural adaptation. Therapeutic relationship/alliance has been established through large meta-analytic studies as an important contributor to the effectiveness of psychotherapeutic outcomes (Flückiger et al., 2018; Orlinsky et al., 2004; Wampold, 2001). For example, Horvath et al. (2011) reviewed over 200 research reports and found a correlation between alliance and outcome with a medium-size effect (Cohen's *d* of 0.57). Similarly, empathy is an important common factor, with findings of large effect sizes in meta-analytic studies correlating empathy and affiliated constructs, such as positive regard, with therapy outcomes (Elliott et al., 2011; Farber & Doolin, 2011). Last, Wampold (2015) noted, in the contextual model of common factors, the importance of cultural adaptation for effective therapy outcomes. Cultural adaptation for evidence-based approaches to therapy is viewed as best practice and effective (Benish et al., 2011; Chu & Leino, 2017). To date, the researchers who are engaged in projects to understand training and IPT ethical and practice factors have noted supervision as an opportunity for growth (Tomizawa et al., 2017; Wright & Brajtman, 2011).

Supervision Considerations

In general, *supervision* is defined as an intervention and relationship that a senior member of a profession engages in with a junior member (Carpenter et al., 2015). In interprofessional environments, such as in hospital settings, supervision can either be provided by a member of the same profession or be provided interprofessionally (Bogo et al., 2011). Although there is a robust amount of research on interprofessional supervision with health science professions in hospital settings, there is a scant amount of literature related to behavioral health professionals (Bostock, 2015). In a qualitative exploration of PCs' experiences on IPTs, Johnson and Mahan (2019) found there was limited access to clinical supervision and an overemphasis on administrative supervision. Quality supervision in interprofessional settings is integral to the success of the individual provider, the team, and the client (Okech & Geroski, 2015). Additional research is needed to understand the unique experiences of PCs in these settings to inform interprofessional supervision practice.

PCs in interprofessional settings are uniquely positioned to thrive on IPTs because of their counseling training; however, challenges related to ethics and supervision may arise. Understanding the experiences of PCs who make the decision to work in these settings can improve necessary

training. The *career human agency theory* (CHAT; Chen & Hong, 2020) presents a useful model for considering factors at different levels that may influence a PC's experience on an IPT in hospital settings. The CHAT (Chen & Hong, 2020) combines the concepts of human agency and constructivism to view professionals as active agents in their own career. Professionals are viewed as being constantly and consistently affected by factors on personal, proxy, and collective levels. The personal level relates to the individual's development of self (e.g., skills, regulation, confidence); the proxy level relates to the individual being affected by those around them (e.g., IPT); and the collective level relates to the individual being affected by larger entities (e.g., the organization, the hierarchy of the medical field; Chen & Hong, 2020). Hence, the research question for this study is, "What are the personal, training, ethics, and supervision experiences of PCs on IPTs in hospital settings?"

Method

To explore the shared experiences of PCs working on IPTs in hospital settings, we conducted a qualitative interpretative phenomenological analysis (IPA; Smith & Osborn, 2008). We used an iterative approach to data collection and analysis following the requirements and process of IPA (Smith & Osborn, 2008). The aim of the analysis was to get a deeper understanding of PCs' experiences and meaning attributed to them. IPA was the best approach for this study because it acknowledges the active role of the researcher during the research process and interprets the study's findings in relation to theories, previous research, and the researchers' lived experiences.

Recruitment Procedure and Participants

After institutional review board approval, we used purposeful and snowball sampling to recruit PCs in hospital settings (Patton, 2015; Smith & Osborn, 2008). Potential participants were screened for eligibility and provided informed consent. The consistency in participants' experiences is imperative to the design and use of IPA; therefore, the inclusion criteria were strictly followed (Smith & Osborn, 2008). Eleven participants met the following inclusion criteria: (a) licensed professional counselors (LPC)/LPC resident/closely related credential, (b) at least 1 year on an IPT in a hospital setting, (c) graduate degree in counseling, (d) PC identity, and (e) 18 years of age or older. Recruitment continued until redundant data and saturation were noted by the research team (Larkin & Thompson, 2012). No remuneration for participation was provided. The participants represented PCs in the southern and North Atlantic regions of the United States with IPT experience ranging from 1 to 15 years (see Table 1 for all demographics).

Research Team Reflexivity

The research team consisted of three women. The first author is a counselor educator who has experience working on IPTs in clinic settings and teaching interprofessional education to counselors and health science students. Her experiences in clinic settings informed her career and passion for training health care students and practitioners how to work together better to meet the needs of clients. The second author is a 2nd-year counselor education doctoral student who is a registered nurse specializing in hospice nursing. She has a unique view because of her dual identities and background as a nurse in a hospital setting and as a counselor. The third author is a 2nd-year counselor education doctoral student who currently works as a certified rehabilitation counselor. As a certified rehabilitation counselor, she has worked on IPT settings and described both positive and negative experiences while in those positions.

We engaged in bracketing and used journaling throughout data collection to reinforce reflexivity (Creswell, 2007). Because of the power imbalance between the first author (a professor) and the second and third authors (doctoral students), we made intentional steps to increase the doctoral students' comfort with challenging potential biases of the first author and among themselves. We discussed our ethical obligation to be true to the process and the need to support each other in making sure biases were not seeping into the process at any stage. Reflexivity positions included the following: (a) past frustrating experiences on IPTs in hospital and other settings; (b) experience-driven thoughts on supervision on IPTs (i.e., should be interprofessional); (c) conceptualization of some experiences as simply being a part of the medical model and not a challenge (i.e., hierarchy in the medical field); and (d) concern that the narratives would be negative, causing readers to foreclose on a career in hospital settings.

Data Sources and Collection

Semistructured interview protocols (i.e., two separate protocols) were codeveloped by the research team, informed by the CHAT (Chen & Hong, 2020), and piloted with three practicum mental health counseling students who were at integrated care sites. Sample questions include (a) How did your training prepare you for being on an IPT as a PC in hospital settings? and (b) What personal and professional competencies/characteristics do you possess that prepared you for being on an IPT as a PC in hospital settings? We asked participants a standard set of questions, using clarifying questions as needed to better understand the response (Smith & Osborn, 2008). The interviews were conducted online by the first author using video conferencing software. The mean length of the first interview was 92 minutes (range = 73–121 minutes). The first interview incorporated elements identified in the literature review, with space for new areas and personal experiences to be explored.

The second interview occurred between 32 and 48 days after the first interview, and the mean length was 58 minutes (range = 40–69 minutes). In the second interview, we

TABLE 1

Participant Demographics

Pseudonym	Age (in Years)	Race	Gender	Licensure/ Credentials	IPT Experience (in Years)	Counseling Experience (in Years)
Tarif	45	White	Male	LPC-R, CSAC, PhD-S	1.0	4.0
Bonni	47	White	Female	LPC, PhD	4.0	22.0
Kaylin	35	Black	Female	LPC	5.0	10.0
Dion	41	Black	Male	LPC	1.0	14.0
Erin	32	White	Female	LPC, NCC	10.0	10.0
Fanta	58	White	Female	LPC-R, PhD-S, RN	3.0	10.0
Gary	31	White	Male	LPC-R, PhD-S	1.5	5.0
Holly	43	White	Female	LPC, PhD	3.0	18.0
Iyani	53	Black	Female	LPC-R, CSAC, PhD	15.0	31.0
Jacia	34	Black	Female	LPC, PhD	4.0	10.0
Chloe	29	Latinx	Female	LMFT-R, PhD	1.0	4.0

Note. IPT = interprofessional team; LPC-R = licensed professional counselor–resident; CSAC = certified substance abuse counselor; PhD-S = doctorate in counselor education student; LPC = licensed professional counselor; PhD = doctorate in counselor education; NCC = national certified counselor; RN = registered nurse; LMFT-R = licensed marriage and family therapist resident.

prompted for further reflection of the experiences previously described in the first interview. There were three questions for all participants and specific questions probing individual participants on topics in their transcript. The three questions for all participants were as follows: (a) Ethical considerations appeared to be extremely important on IPT in hospital settings; how did this shape your practice (clinical, thoughts, and behaviors) in this setting? (b) Some participants noted limited access to clinical supervision by qualified PCs in hospital settings; if you relate to this experience, can you share your experience and your personal beliefs on why this might occur? and (c) Specifically for you, how would you describe the personal and professional impact of being on an IPT in a hospital? The goal of these questions was to elicit broad descriptions of the participants' experiences and in-depth interpretations of their experiences. Field notes were made following the completion of each individual interview to supplement the data file and to include in the audit trail.

Data Analysis

The transcripts were transcribed verbatim by Rev.com, which we checked for accuracy. We conducted an iterative approach to data analysis following Fade (2004), Larkin and Thompson (2012), and Smith (2009). The entire research team conducted the analysis. In preparation for the first meeting, we each analyzed four transcripts individually, engaging in line-by-line coding and identifying meaning units within a word, phrase, or entire sentence. After the first four transcripts were coded, we met to review the initial codes identified by each individual team member. We then developed a list of all the initial patterns and codes (i.e., approximately 280 codes identified), including short phrases from the transcripts that were relevant to understanding the meaning participants attached to their experiences. Additionally, we developed a preliminary codebook, and we started a preliminary list of initial themes across all transcripts with specific focus on making meaning of the participants' experiences as opposed to a description (Larkin & Thompson, 2012).

We analyzed four additional interviews using the codebook, met to discuss the four additional interviews as a group, bracketed any additional assumptions, and added six additional codes to the codebook. The codebook was updated, and the remaining three interviews were analyzed. Last, we applied the final codebook to all 11 participants' transcripts. The process of data organization included (a) mapping the connection between initial themes and clustering the themes together to formulate the structure of relationships; (b) organizing and naming the clusters to represent subthemes and arranging these subthemes to superordinate themes; and (c) using this organization to develop the final hierarchical structure that represented the experiences of the participants, as well as the meaning they attached to the content (Larkin & Thompson, 2012). The final hierarchical structure in relation to the research questions, the existing theories, and the existing research on the topic resulted in the consensus of four themes.

Trustworthiness

Trustworthiness is defined as the degree of confidence in the data and analysis of the study (Polit & Beck, 2014). We engaged in several complementary strategies to increase trustworthiness in this study. Researcher transparency, in line with IPA (Dickens et al., 2016), consisted of the first author sharing the rationale for the research study with participants. In addition, we used investigator triangulation, which allows multiple investigators to provide their viewpoints, assessments, and interpretations of participants' lived experiences (Carter et al., 2014). The research team served as peer reviewers for each other, and that provided investigator triangulation of findings (Creswell, 2013). An audit trail was

maintained throughout the study, which included notes from the interviews as well as reflective statements and thoughts. The audit trail also served to document the iterative process to theme development. We each kept an audit trail, and at the conclusion of the study, we engaged an outside auditor to review the audit trail, codes, and themes. Last, member checks were completed within 2 weeks of the interviews (Creswell, 2013). Participants were sent an email with their transcript, audio/video recording, and additional questions for clarity when needed. Each participant was asked to review the transcript of their interview and to indicate, within 10 days, either no points of clarity were needed or the specific points of clarity noted on their transcript (Creswell, 2013). Two participants responded with points of clarity for (a) removal of reference to their place of employment and (b) clarification of a statement that was made during the interview, whereby they indicated that instead of "could not," it was really that they "refused or would not." The remaining nine participants did not have any points of clarity.

Findings

This study sought to understand the unique experiences of PCs on IPTs in hospital settings. Four themes emerged: (a) support patient care and positive team interactions, (b) interprofessional supervision, (c) scope of practice, and (d) ethical considerations. Below, the themes are defined and substantiated by thick descriptions from participants. Pseudonyms were used to maintain confidentiality; where necessary, any identifying information about the PCs' place of employment was also blinded.

Support Patient Care and Positive Team Interactions

The first theme represented PCs' reflection on their experience and role on IPTs in hospital settings. The theme encompassed PCs' reflection of utilizing foundational principles (e.g., wellness, development, prevention) and common factors of counseling (e.g., unconditional positive regard, reflective listening, empathy) to support patient care and the functionality of the IPT. Jacia reflected on the dual benefits of using common factors:

> Being able to be a giver, and a good listener on top of the other attributes, it just helps to create a teamwork environment. In the hospital setting, it can be easy to get caught up in "Oh, that's not my job" or "That's not my role." And so those attributes help to create a more cohesive team to get things done. In the interdisciplinary—in that particular setting—being a good listener is important because everyone comes in with a crisis. And so, it can be easy to get caught up in the urgency of care, and not really care about the [other]-care that's needed. It's helpful in slowing things down and reaching goals.

Similarly, Dion noted his approach to working on an IPT:

> I think I try to [use] unconditional positive regard with everyone I meet. I try to be friendly, I try to be warm. I try to be, I think in every interaction, there's a chance to be caring and so I try to do that as well. To be a model of healthy boundaries.

Along similar lines, Chloe noted how her view of counseling benefits the team, echoing the use of common factors, "I'm also very person centered, so the warm empathy, unconditional positive regard, all of that goes in. So I'm very relational and insight oriented." The core values of the counseling profession, including a focus on wellness and development, were also reflected in the participants' stories. As Erin stated,

> Attending to someone's development, attending to their psychosocial bio history, instead of being very focused on symptomatology and illness, that type of thing . . . I think . . . really what has become the most important is really looking at things, first of all developmentally. I really enjoy the developmental piece of it, but then really looking at people through that developmental lens, and then also looking at them very holistically.

Fanta explained her professional focus based on the ethos of counseling: "Knowing that we are based on a wellness/developmental model, and really taking everything through the lens of development when working with people." In discussing how personal experiences can be beneficial on IPTs, participants reflected on the use of counseling skills. Tarif, in describing how his experiences as a father affected his approach to IPT, highlighted his use of counseling skills in these interactions:

> Being a father of a large family, a lot of moving parts, a lot of stuff going on. Having to see things in the big picture, having to have everyone feel heard. I see that playing out in the integrated care setting in terms of, there are a lot of moving parts, there are a lot of different voices that want to be heard and want to feel like they are being heard. . . . I can't tell you how often being a therapist, those people skills pay off in other fields. I've watched other doctors, other practitioners think I'm working magic by just listening, basic listening skills. They're like, "How did you do that?" I definitely use them on a daily basis just interacting with other professionals in the clinic.

The core techniques that are taught in counselor education guide the PCs' interactions on their IPT in the hospital setting. Related to their role on IPTs, many PCs also discussed the supervisor's role in their experiences in hospital settings; this is reflected in the second theme.

Interprofessional Supervision

The second theme focused on the PCs' reflections on their supervision experiences while engaging on IPTs in hospital settings. This theme contained two subthemes: (a) barriers to quality supervision and (b) growth opportunities.

Barriers to quality supervision. The PCs were often among the first group of staff to be incorporated into their hospital's attempt at a new model of collaboration. Hospital systems seemed to value PCs but often fell short in providing appropriate or quality supervision. Bonni's hospital hired a supervisor from outside of the hospital system who was not invested in her development on the IPT:

> We did not get supervision. So, all of us in the ER, all the counselors in the ER, we're licensed, but our supervisor was pretty much absent. She had a private practice, and that's where she stayed, and so maybe once every 3 to 4 months, she would come through briefly, in the ER, and then she would be gone again. And so the system was not set up well for internal supports, professionally.

Some hospitals hired full-time supervisors who lacked IPT experience in hospital settings. Many of the PCs found these supervisors to be problematic or subpar. Kaylin felt strongly that if a person is supervising PCs engaged on IPTs, prior IPT experience is necessary:

> The worst supervisors I've ever had in health care integration are supervisors that have never worked in health care integration whatsoever. There's no way you can come into working in health care integration as a supervisor and only have community mental health, private practice experience. It's just not going to work. It's not going to translate well and it's going to . . . [contribute] to the high turnover of staff.

Other PCs, such as Erin, required better supervision and self-advocated for their needs but were met with resistance:

> I was really pushing to do some changes and have more of a psych team be available for proper supervision, triage supervision, group supervision, one-to-one supervision, and there was a lot of pushback from that. One of the nurses was getting extremely offended that I was saying that they need proper training for supervision because in the state of Colorado you don't need to. . . . And then the psychologist on the ward . . . would just make all these excuses and I didn't quite understand. The psychiatrist was like, "I really don't have time to do that kind of supervision you're talking about. I've never even heard of that type of supervision."

Growth opportunities. For some PCs, the ability to receive interprofessional supervision was a positive experience and growth opportunity. Gary noted, "Through supervision, through learning more about the medical field, learning more about other fields. I think the information helped a lot. Understanding how their training has impacted their point of view has helped me a lot." Along similar lines, Iyani noted the benefits of interprofessional supervision during her experience as an addictions counselor in a hospital setting: "I do feel like it has strengthened me. I think, like I said earlier, to me it enhances what I do by knowing the dynamics of other disciples too." The ability to provide interprofessional supervision to a team of providers was also a growth and leadership opportunity. Chloe described her experience as a supervisor:

> I'm very relational and systems orientated, so in my role as a supervisor at the [blinded hospital site], I'm constantly thinking about how I can help the supervisee adjust their expectations of what clinical work looks like with this population because a lot of their lower or basic needs are not met. They're going to present different challenges in counseling and then how does that kind of then translate into their physical well-being and how we can collaborate with the medical care staff, kind of addressing both sides.

Scope of Practice

The third theme included the PCs' thoughts, experiences, and perspectives of navigating relationships with clients when knowledge and interest in health care topics went beyond the scope of counseling practice. Holly discussed the potential of confusing clients:

> So, let's say . . . let's go back to nutrition, and what we're learning about physiologically with depression. So if I'm . . . if I've read up on all that, and I can talk about things like hormone levels, and maybe neurotransmitters, and fermented foods and how it impacts gut microbiome, and I'm saying all these things to a client, 'cause I happen to read some books and journal articles. Clients can then say, "Wow. You know, my mental health counselor really knows a lot about the body, and kind of seems like a doctor, or seems like a nutritionist," and then they can get very confusing to a client. . . . If we're interested in or going into an area that's not in our scope, we have to make sure that we're just educating, and we're not coming across like another medical professional that we aren't, or that we make sure we don't come across like we're prescribing something, or trying to push something.

Having a clear understanding of their roles in integrated care settings allows PCs to have boundaries and be able to articulate their scope of practice. Dion summarized this as "understanding limitations and our scope and when to collaborate or when to refer out." Bonni shared her own experience of the dangers of not having a clear grasp of her role:

> So I think being very aware of scope of practice, and where we fit into the whole system. Sometimes that got blurry, too. Where they would think we had different roles than what we truly did, and so having to articulate what my role was in the system . . . when I worked in the integrated setting, I really did not have a clear grasp, and I was just developing a clear understanding of what it meant to be a counselor. And so really, I think, in that integrative setting, I really took on more of probably a psychology, psychologist type of role. We did a lot of assessment, primarily assessment.

Ethical Considerations

The fourth theme related to the PCs' perspectives on their ethical obligations on the IPT. Gary discussed how he conceptualized his role on the team and his goal to do no harm:

> I would say we should always keep in mind that the patient is the focus, at the end, and we need to do no harm, as they would probably say in medicine. And understanding how our actions or inaction may actually do harm. Whether it be cutting a doctor off in mid-speech while they are talking to a client, or patient, I mean, or just not saying anything to a doctor who clearly is not able to articulate, you know, in an effective manner to a client. Like maybe how to take their diabetes medication. They just say, "Read the sheet." You know? I think it would be . . . is within our ethical standards to help the doctors do as little harm as possible.

In a setting with multiple professions in which each has their own code of ethics and frame of reference for acting in an ethical manner, conflicts and difficulties may arise that require PCs to advocate. Dion noted diversity-related concerns as a potential ethical issue that PCs may need to negotiate on IPTs in hospital settings:

> You should be aware that the other practitioners in the room have not had the diversity training, and that you will quite often hear people say things that are inappropriate, politically incorrect, and that you oftentimes have to be the voice of diversity or awareness in the room and it's honest to speak up.

In reflecting on their experiences in interprofessional hospital settings, all PCs highlighted the importance of being familiar with counseling's ethics codes and understanding the ethics resources that are available in case they are needed. Kaylin noted,

> Be well versed in your ethics and always know what numbers are available for you to contact your ethics rep. Because there are going to be situations where you do want to check into what are your boundaries and what are your ethics. Not because anybody purposely asked me to do anything wrong. You just need to be on top of that stuff.

Another related ethical concern was managing self-care in high-stress, interprofessional hospital settings. Bonni noted,

> I mean, I think it does come to ethics where, especially working in the high-stress situations, you get a little jaded, and so just being very aware of, "Where am I at personally? Where am I at self-care-wise?" And "Am I still functioning at my fullest capacity when working with this particular person?" Not having biases that you see other people in the setting have.

Balancing multiple disciplines' ethics codes and perspectives seems to be a definitive challenge within IPT. The transcripts point to the usefulness of being well versed in the counseling ethics codes as well as the need for flexibility and awareness of the different ethical perspectives. Iyani stated, "I definitely think we should start being more aware of other professions' ethical codes and how they're supposed to provide treatment so that we can be able to better adopt that into our lens and collaborate with those professions."

Discussion

This IPA focused on understanding the experiences of PCs working on IPTs in hospital settings. Four themes assisted us in understanding PCs' experiences with supervision, ethics, and use of basic counseling skills to support team cohesion and client/patient care.

The first theme, support patient care and positive team interactions, furthers the research literature on PCs' roles on IPTs. The skills that many of the PCs noted as particularly useful for IPTs are grounded in the foundational principles and common factors of counseling; these are also the same competencies assessed in counseling program practicum and internship experiences (Miville et al., 2006). PCs in the current study connected their role and value on the IPT to their ability to use basic counseling skills to create positive IPT dynamics as well as to triage and treat clients. This finding is unique because it expands the current literature on the role of PCs by focusing on their clinical role (i.e., behavioral health specialist) on an IPT (Glueck, 2015; Johnson & Mahan, 2019). It also expands the literature on PCs' perceptions of IPT fit, place, and value in counseling practice (Gergerich et al., 2019; Johnson, 2016; Johnson et al., 2017). These empirical findings add to the current conceptual understanding of the potential dual benefit of PCs on IPTs (Johnson et al., 2014) because of the connectedness between counselor education competencies and the Core Competencies for Interprofessional Collaborative Practice (CCICP; Interprofessional Education Collaborative, 2011). Many of the CCICP, such as communication and respect, are inherent in the foundation of counselor education training.

The second theme, interprofessional supervision, was highlighted in all the transcripts, with PCs sharing their experiences of supervision while working in hospital settings. Supervision in interprofessional environments was a challenge for PCs who were expecting traditional supervision provided by a senior member of the same profession (Arthur & Russell-Meyhew, 2010; Bogo et al., 2011). Contrary to the current body of literature, this theme speaks to the benefits of interprofessional supervision (i.e., improved interprofessional communication and improved understanding of the function and point of view of other professionals; Okech & Geroski, 2015). Many participants were disappointed with the quality or lack of supervision received. In a research study focused on European countries seeking to integrate mental health services into primary health care and informatic platforms (Patel et al., 2013), a challenge that was noted included support and supervision for mental health care professionals. Patel et al. (2013) did not discuss PCs specifically in their article, but the challenges they noted were similar to the concerns voiced by PCs in the current study.

With regard to the third theme, scope of practice, the PCs in this study were engaged in mental health counseling on IPTs in hospital settings, but they all noted additional competencies that were gained outside of their graduate counseling program. For example, they noted having expertise in biofeedback, neuropsychology, nutrition/health coaching, integrative nutrition, public health, meditation, reiki, and tai chi, as well as other techniques/competencies that may be viewed as outside the scope of counseling practice. PCs in any setting are continually faced with ethical dilemmas, including scope of practice. This concern is increased on IPTs in hospital settings (Crumb et al., 2018; Johnson, 2016). In the current study, PCs noted scope of practice specifically and made statements related to not always understanding how they fit into the "system" of care, which created scenarios in which they might have occasionally worked outside their scope of practice. Recognizing one's own limitations is a core component of counseling as written in the *ACA Code of Ethics* (ACA, 2014, Section C: Professional Responsibility). This is also echoed by the CCICP (Interprofessional Education Collaborative, 2011), which specify professionals' roles and responsibilities in recognizing their own limitations. Scope of practice is a major concern in medical health literature; however, for PCs, there is very little research related to their concerns, experiences, or challenges (Johnson & Mahan, 2019; Kossaify et al., 2017). The current study's findings support the need to further investigate scope of practice challenges for PCs on IPTs in hospital settings.

The fourth theme, ethical considerations, was reflected in many of the participants' statements related to their values, principles, and roles as PCs on an IPT. Regarding IPTs, PCs voiced their appreciation for the support provided by the *ACA Code of Ethics* (ACA, 2014) and noted the importance of having a firm grasp on counseling ethics, boundaries, and scope of practice. The ethical concerns of PCs are substantiated in other research studies that focused on health care professionals on IPTs aligning multiple codes of ethics, communication, and ethical boundaries (Green & Johnson, 2015; Hodgson et al., 2013; Löffler et al., 2017). The participants in our study supported this idea and expanded on some potentially effective interventions for mitigating these disagreements: focusing on common ethical themes, having a strong base in one's own ethics codes and resources, and understanding the ethics codes of other disciplines. The utilization of these interventions could potentially, as was claimed by the study participants, be effective in bridging some of the ethical gaps and lead to a more comprehensive, collaborative decision-making model within the IPT that improves client/patient outcomes.

One interesting area of focus that seemed to diverge from the literature was the counselor-specific nuances of ethical considerations within this context. The *ACA Code of Ethics* (ACA, 2014) details expectations for PC clinical practice with regard to not doing harm to clients, expectations for advocacy related to cultural competence, and counselor self-care. The additional training specific to these areas that PCs receive in their graduate programs was reflected in participants' thoughts on the importance of self-reflection and cultural competency. The holistic lens through which PCs are taught to view their clients and themselves provided a unique point of view on the IPT in hospital settings.

Limitations and Future Research

Limitations of the study must be discussed in light of the findings. With the use of IPA, it is quite possible that themes within the participants' stories might have been overlooked, and in seeking to identify the shared experiences across the group, we might have lost some nuanced differences among participants. In terms of data collection, five of the participants were colleagues, and the standing relationship could have affected their responses. Although bracketing and an auditor were used, there is still a possibility of bias seeping into the analysis process and interpretation of the results because of the relative closeness of the authors to the topic of IPT work. The sample size of the current study (11 PCs) is within the recommended guidelines for IPA; however, it is small, and care must be taken not to assume that results are transferable to the population at large (Smith, 2009). Nevertheless, the results are relevant and may be

useful for similar groups in a comparable context (Smith & Osborn, 2008).

In short, more research is needed to thoroughly explore PCs' experience on IPTs in hospital settings related to their contributions, roles, responsibilities, ethical considerations, and supervision needs. Future research could investigate supervision models that work well for PCs on IPTs in hospital settings or focus on the development of an interprofessional supervision framework for PCs in similar interprofessional settings. The theme of ethics was reflected in all transcripts, and further investigation into the challenges related to PCs' ethical roles and responsibilities on IPTs is needed. In addition, the development of ethical competencies for IPTs in hospital settings would add an additional layer of support for PCs in these roles.

Implications for Practice

Overall, the results of the study showed that PCs are reflective of their role and value on IPTs in hospital settings and are cognizant of the challenges. Many PCs reflected on the common factors (Wampold, 2001) across all counseling approaches that were beneficial to the team and the client/patient. For PCs considering this work environment, it may be beneficial for them to revisit common factors theory because of the potential benefit to the team and client/patient. Additional considerations noted by participants included scope of practice and the lack of qualified supervisors. The results would imply that PCs on IPTs in hospital settings should have a strong professional identity because of the potential lack of guidance and supervision when working in the environment. A practical recommendation is to seek outside supervision when working in hospital settings, specifically from someone with IPT experience. PCs in the current study also noted the potential for working outside the scope of counseling practice. They provided recommendations that are both practical and useful: (a) be transparent with clients/patients and be clear about when your advice is based on outside knowledge versus when it is based within the scope of your professional duties as a PC; (b) utilize the ethics hotline that is provided through ACA when you have a question or a concern related to practices in the hospital; and (c) advocate for yourself and what you need (e.g., supervisor onsite with IPT experience). The recommendations are useful and can be a potential area for further discussion and investigation.

Conclusion

A strong professional identity and utilization of counseling skills support IPTs in hospital settings. In addition, PCs acknowledge that there are some challenges related to supervision and ethics on IPTs in hospital settings. Guidance on interprofessional supervision practices is emerging, and the voices of PCs are reflected in the current study. As the counseling field increases the presence of PCs on IPTs, voices from those currently practicing may help define the value of counselors on such teams, as well as provide guidance for future directions.

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