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Abstract

The authors explored 18 mental health counselor trainees' (MHCT) experiences regarding the focus of supervision they received in integrated behavioral health settings. Utilizing Q methodology, they obtained clinical skill development as a counselor and interdisciplinary team membership as the main areas of trainees' supervision focus. More specifically, counselor trainees identified developing clinical skills related to client care, case conceptualization, and the delivery of clinical services, as well as strengthening their professional identity while integrating into an interdisciplinary team, as critical areas of their supervision. They discuss the findings along with practical and research implications, as well as limitations of the study.

Significance to the Public

This study reveals counselor trainees in integrated behavioral health settings (IBH) benefit most from supervision that focuses on developing clinical skills and integrating trainees into interdisciplinary teams. Findings highlight the importance of tailored supervision to enhance trainees' ability in client care and team collaboration, ensuring they are well-prepared to provide effective and comprehensive care in IBH settings.

Keywords: Integrated Behavioral Health (IBH), counseling supervision, supervision focus, Q methodology, mental health counselor trainee

Individuals with mental health issues (e.g., depression, anxiety) frequently experience co-occurring physical health diagnoses (e.g., diabetes, cardiovascular disease), creating a complex challenge for effective healthcare delivery (Kordon et al., 2024; Ramanuj et al., 2019). Despite significant advances in recognizing the role of behavioral health in primary care over the past 35 years, the continued separation of behavioral health and primary care practices continues to hinder the needs of individuals with comorbid, chronic medical, and behavioral health conditions (Held et al., 2019; Kallenberg & Sieber, 2024). Many clients remain underdiagnosed and inadequately cared for due to limited provider training, time constraints during visits, and the underdetection of symptoms (Kordon et al., 2024). An increasing number of concerns related to the identification and management of mental health concerns in primary care settings called for attention and effective solutions (e.g., Utter et al., 2023). Thus, these unmet needs prompted providers to integrate behavioral health into medical settings as an effective solution to these needs (Ma et al., 2022). By integrating behavioral health into primary care, healthcare providers can better address comorbidities, improve patient outcomes, and reduce healthcare costs (Walker & Renn, 2024).

Integrated Care and Integrated Behavioral Health

Integrated care (IC) is a "systematic coordination of behavioral health care with primary medical care"

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(American Mental Health Counselors Association [AMHCA], 2021, p. 1). As an umbrella term, IC focuses on all aspects of the organization and delivery of work with a unified care plan including many professionals (e.g., physicians, nurses, psychologists, psychiatrists, marriage and family therapists, social workers, substance use counselors). In integrated behavior health (IBH) delivery systems, primary care providers (PCPs; e.g., physicians, nurses), and behavioral health clinicians (BHCs; i.e., counselors, social workers) work together with patients and families using a systematic and cost-effective approach (Giresunlu et al., 2024). Previous studies have consistently demonstrated the effectiveness of IBH, not only in improving physical, behavioral, and overall health outcomes, but also overall utilization of mental health services and reducing costs for hospital stays (Reist et al., 2022). In the literature, IBH delivery services are described in various ways including primary care behavioral health (PCBH), the collaborative care model (CoCM), coordinated care, co-located care, and fully integrated care (Giresunlu et al., 2024; Johnson et al., 2023; Kallenberg & Sieber, 2024; Reist et al., 2022; Speice & McDaniel, 2016). PCBH, a widely adopted model, integrates BHCs into primary care to address behavioral health factors in mental and physical health conditions offering services like tress and pain management, adherence support, and brief interventions (Possemato et al., 2018; Walker & Renn, 2024). Another widely used delivery model, CoCM, follows chronic care management principles incorporating a psychiatric consultant alongside primary care and BHCs to treat chronic health conditions, depression, and anxiety (Carlo et al., 2020; Kordon et al., 2024). Both models improve client outcomes, including increased engagement in treatment and improved mental health related symptoms (Carlo et al., 2020; Possemato et al., 2018). IBH services also vary by integration level: coordinated care involves separate service locations with minimal collaboration; co-located care includes services in the same location with increased communication and collaboration, and fully integrated care involves the highest level of collaboration with a shared treatment plan and clear understanding of provider roles (Curtis & Christian, 2012).

Counselors in IBH Settings

Mental health counselors (MHCs) have been integrated into the behavioral health workforce through IBH (Micallef Marmara' & Kemer, 2024). As a member of the IBH team, MHCs work with medical professionals in a variety of settings (e.g., hospitals, ambulatory care clinics, primary care clinics, community behavioral health settings). MHCs address social and emotional needs of individuals who experience mental health and/or substance use conditions (e.g., depression, anxiety, relationship issues); provide support and resources to patients and their families; offer consultation to PCPs and clients; and deliver psychoeducation related to behavioral aspects of chronic medical conditions (e.g., diabetes) and co-occurring conditions (Hall et al., 2015). Additionally, MHCs work with issues linked to stress, such as social determinants of health and physiological conditions (Tambling et al., 2020). Similar to other BHCs in these settings, MHCs also need to possess specialized knowledge on chronic illnesses, including but not limited to asthma, diabetes, and co-occurring mental health problems, as well as the symptoms and appropriate treatments for such ailments (AMHCA, 2021). Reporting on the client-level data from the mental health counseling field, Fields and colleagues (2023) highlighted the improvement of holistic client functioning, a decrease in crisis events, and a decrease in risky drinking behaviors as benefits of IBH. Micallef Marmara' and Kemer (2023) highlighted MHCs' interconnected role in medical settings serving in a variety of roles and needing to have specialized knowledge about medical terminology along with attending to the social and emotional well-being of the client, providing support while adhering ethical considerations. Yet, MHCs may not be receiving this information and/or training in a systemized manner (Fields et al., 2023). Glueck (2015) reported that BHCs frequently feel underprepared and rely on on-the-job training or shadowing to develop skills necessary to adapt to the fast-paced and team-

based environment, suggesting MHCs may face similar challenges. As more MHCs are practicing in IBH settings, opportunities arise to describe their roles and practices. However, despite an increased understanding of clinical supervision in mental health counseling, knowledge of counseling supervision in IBH settings remains limited (Bernard & Goodyear, 2019; Borders, 2014; Fields et al., 2023).

Supervision and Counselor Trainee Development in IBH Settings

Clinical supervision in IBH settings focuses on administrative and clinical considerations across professions, while fostering profession-specific clinical skill development (Arzuyan et al., 2023; Ogbeide & Bayles, 2024; Tugendrajch et al., 2021). Literature on IBH supervision explores delivery model specific practices (e.g., PCBH), models specific to integration levels (e.g., patient, ask, recommend, see, and evaluate [PARSE]), and general supervision models (e.g., integrative developmental model of supervision [IDM]; Ogbeide et al., 2023; Ogbeide & Bayles, 2024). Ogbeide and Bayles (2024) identified key supervisor competencies in PCBH: primary care knowledge (e.g., medical terminology, social determinants of health, health equity, biopsychosocial model, behavioral change); clinical supervision skills (e.g., time management, onboarding, evaluation, supporting supervisee's needs); and clinical supervisor development (knowledge of supervision models, Socratic questioning, reflective practices). The PARSE model, primarily used in psychology, integrates medical precepting by offering "on-demand" (p. 338) supervision by a designated psychologist. IDM, a widely used supervision model, focuses on supervisee development across three levels, with supervisors adjusting their approach based on the supervisee's stage of growth (McNeill & Stoltenberg, 2016).

In addition to the models, scholars from psychology, family therapy, school counseling, and clinical mental health counseling explored their trainees' experiences in supervision in IBH settings (i.e., Hall et al., 2015; Johnson et al., 2023; Speice & McDaniel, 2016). Findings across different professions indicate that there are several competencies that are critical for trainee development, including a clear understanding of skills, attitudes, and knowledge about each other's professional roles and their own professional positioning in the IBH team; effective communication skills for improved interprofessional collaboration among the care team members; and continuing discussions and conversations on medical terminology and practices (Giresunlu et al., 2024).

There are, however, unique practices or emphases when it comes to supervision in IBH settings for different professions. The administrative focus of the supervision in IBH settings depends on the educational standards of the profession and the program (Dorsey et al., 2017). For example, within medical education, the precepting model is most commonly used to provide clinical supervision and clinical teaching. The precepting model includes clinical rotations, usually for 8 weeks in different specialties, and exposes the trainees to cross-disciplinary supervision to help them learn different practices in IBH settings (Ma et al., 2022). With this model, trainees learn about different specialty areas. In the field of psychology, on the other hand, Hall and colleagues (2015) discussed the supervision process for psychology interns working in interdisciplinary settings. In their model, supervisees consult with supervisors during and after patient visits. Psychology trainees acknowledged the effectiveness of unscheduled curbside consultations to accommodate the complexity of the IBH setting. In the field of family therapy, Speice and McDaniel (2016) discussed supervision roles for medical family therapist (MedFT) trainees in integrated care. They identified focus areas such as biopsychosocial assessments, clinical competency development, and interventions useful in IBH settings (e.g., motivational interviewing). On the other hand, attending therapist issues with themselves, addressing feelings trainees have about the power and hierarchy in the IBH settings, as well as providing a safe and validating relationship, were additional foci of supervision.

MedFT trainees reported shadowing their supervisor to learn the skills needed to practice in IBH settings as a positive supervision experience (Speice & McDaniel, 2016).

The research on supervision in IBH settings is scarce in the counseling field (Fields et al., 2023; Johnson et al., 2021). In one of these studies, Johnson and colleagues (2023) explored the experiences of school counseling trainees in a primary care IBH care practicum and identified five areas of focus for trainee development: contributing school system knowledge, expansion of professional identity through practical application, collaborative interventions and techniques, interprofessional supervision (cross-disciplinary supervision), and program and setting challenges. School counseling trainees reported positive experiences with interprofessional supervision, citing value in understanding and hearing different perspectives during supervision. In another exploration of supervisors' perspectives on the supervision of mental health counselor trainees (MHCTs) in IBH settings, Giresunlu and colleagues (2024) reported that supervisors focused on clinical skill development of supervisees as well as administrative and interdisciplinary mentorship. Clinical skill development focused on tailoring support to the supervisee's developmental needs while addressing the complex nature of the IBH setting, including multicultural considerations and navigating healthcare regulations. Interdisciplinary mentorship emphasizes fostering professional relationships, helping trainees understand their place withing the interdisciplinary teams, and supporting the development of their professional identity.

The Current Study

Despite our increased understanding of clinical supervision of counselor trainees (Bernard & Goodyear, 2019), supervision provided in IBH settings is understudied in general (Ogbeide & Bayles, 2024; Tugendrajch et al., 2021) and has not yet received enough attention from counseling researchers (Borders, 2014; Giresunlu et al., 2024; Jonhson et al., 2023). Johnson and colleagues' (2021) study highlights that counselors working in interprofessional teams in hospitals often face challenges such as a lack of qualified supervisors and guidance, which may hinder their professional identity. Similarly, Ogbeide and colleagues (2023) emphasized a lack of supervisee and supervisor competence to effectively practice in IBH settings. Considering the similarities and differences between trainee development and supervision in IBH settings across professions, it becomes critical to understand how these themes translate into counselor training and supervision. As we continue tracking the evolving processes of mental health counseling and its supervision, there is a demand for further research informing guidelines of supervision of counselor trainees in the field of IBH (Giresunlu et al., 2024; Johnson et al., 2021). Existing supervision literature focused on supervisors' perspectives (Rocha & Kemer, 2022); giving attention to supervisees' perspectives is critical for the development of supervision competencies in IBH settings for counselors. An exploration of MHCTs' experiences with the focus of their supervision in IBH settings could support our efforts on supervisees' learning and growth regarding how to work effectively on collaborative care teams and navigate through healthcare setting protocols. Improved collaboration can contribute not only to the development of counselor training programs and stronger integration of counseling professionals in IBH settings, but also enhanced healthcare services for clients and their families (Fields et al., 2023; Johnson et al., 2021). Thus, our research question of concern was: *What do mental health counselor trainees report as the focus of supervision they received in IBH settings?*

Method

We utilized a mixed-methods research design, Q methodology, involving both qualitative and quantitative procedures to facilitate the measurement of personal viewpoints and subjectivity (Brown, 1980). Q Methodology is ideal to explore and identify patterns of diversity and similarities in viewpoints and relationships between

the categories of a specific phenomenon (McKeown & Thomas, 2013), such as counseling supervision in IBH settings. We followed the research design steps suggested for Q methodology (Watts & Stenner, 2012). Next, we describe the steps and procedures of Q methodology that we employed.

Supervision Structure

Participants in this study were receiving supervision as part of their fieldwork experience (e.g., number of semesters completed in the program). Both master's- and doctoral-level supervisees participated in weekly 1-hour individual or triadic meetings with their site supervisors at their IBH setting as well as a weekly 90-minute group supervision with a counselor education faculty supervisor. We only focused on supervision completed at the IBH sites.

P Set (Participant Sample)

Our inclusion criteria for the participants were (a) being currently enrolled in an internship as a master's or doctoral student, and (b) having completed at least one semester of practicum/internship in an IBH setting within the last year or having completed at least two semesters of practicum/internship in an IBH setting within the last year. This includes master's and doctoral students who are considered prelicensure trainees (Ogbeide & Bayles, 2024), who have graduated from their program within the last 3 months. After receiving approval from the institutional review board at our institution, we contacted graduate program directors (GPDs) and/or clinical coordinators in programs across the United States that are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP), to request that an announcement of our study be posted on their student listservs. In addition, we also contacted the directors of local IBH sites hosting practicum/internship students. We had two P sets in the current study. We applied the same inclusion and recruitment criteria for both. The first P set (n = 7) included the participants for concourse development to create statements for the Q set development, while the second P set (n = 18) completed the Q sort. Some participants participated both in generation of the concourse and the Q sort, due to targeting a specific group of students.

For the Q sort, a total of 18 participants were involved in the study, 17 female (94.44 %) and 1 male (5.55 %); 5 Black or African American (27.77 %), 9 Caucasian (50%), 2 Hispanic or Latinx (11.11 %), and 2 Asian or Pacific Islander (11.11%). Five doctoral students (27.77%) and 13 master's students collectively had been supervised for more than one semester in IBH settings (100%). All participants worked with each of the following providers in their practice at their IBH settings: physicians, physician assistants, nurses, social workers, dental hygienist students, physical therapy students, medical students, nurse practitioner students, psychiatrists, and psychologists.

Supervisors

Supervisors of the participants in this study were all mental health counselors with a minimum of a master's degree from a CACREP-accredited program, didactic and experiential supervision training in their educational background, and at least 2 years of experience with providing clinical supervision to mental health counseling trainees in IBH settings.

Procedures

The Concourse and Q Set

The concourse represents the total number of viewpoints regarding a specific topic (Watts & Stenner, 2012). We observed that there is lack of information in the counseling field on supervision experiences of counselor trainees in IBH settings; therefore, we focused on obtaining information that directly correlated to our research question. More specifically, we asked participants to reflect on their supervision experience and create statements regarding what specific areas of practice they have been bringing to their supervision sessions to discuss with their supervisors (e.g., in general,

unique to this setting). We also asked them to reflect and create statements regarding their experience, focusing on suggestions they had received from their supervisors that they had not thought of before in relation to their practice (e.g., in general, unique to this setting). We used Qualtrics to collect the data, where we first screened the participants to confirm they met our criteria based on their completion of a demographic information questionnaire.

We obtained 98 statements from seven MHCTs to establish the concourse composing the Q set for the next step. Of the 98 statements, the first and second authors reviewed the responses for language clarity and redundancy, consulting with an auditor, the third author of the study, for this editing and synthesis work. The auditor, whose primary research interest was supervision, had published peer-reviewed articles in counselor education and supervision journals and had extensive experience with quantitative and mixed methods research designs. The final Q set included a total of 69 statements, satisfying the recommended number of statements for Q methodology (Watts & Stenner, 2012).

Q Sort and Post-Q Sort Questionnaire

For the administration of the Q sort, 18 participants were instructed to rank each of the 69 statements according to their perspectives of *most significant* to *least significant* in the focus of their IBH supervision as a counselor trainee. We determined the steepness of the statement sort (e.g., a shallower distribution) intentionally (i.e., *most significant* [+6] to *least significant* [-6]), complementing the expertise of the participants as well as the Q set (Watts & Stenner, 2012). Additionally, we consulted a second auditor who held specialty in Q methodology to ensure our decisions were appropriate prior to the Q sort. Following the Q sort, the participants also answered a series of open-ended questions to express their interpretation of the items they sorted, any additional items they wanted to add, and comments on the statements they found confusing (post–Q sort questionnaire). We used these responses to further understand each participant's sorting process and to assist with the interpretation of the data (Watts & Stenner, 2012). We completed this procedure in the year 2020.

Data Analysis

We entered 18 completed Q sorts into Ken-Q software intended for Q methodology analysis (Banasick, 2019). We first reviewed the correlation matrix of the Q sorts to determine the initial similarities. We then used principal component analysis (PCA) with varimax rotation of the 18 Q sorts, where we decided to extract a 2-factor solution (eigenvalues > 1) that 11 of 18 Q sorts loaded upon. We considered a few criteria to extract a 2-factor solution (McKeown & Thomas, 2013; Watts & Stenner, 2012). First, the Kaiser-Guttman criterion suggests an eigenvalue of 1.00 or above as a cut-off point for an extracted factor (Watts & Stenner, 2012). Second, we choose $p = .01$ to ensure significant statistical significance. Thus, according to Brown (1980), only factors equal to or exceeding .30 were considered significant. Third, we reviewed the variance of each factor presented on the output, and ensured that the total variance explained was more than 35–40% (Watts & Stenner, 2012). Lastly, Webler et al. (2009) suggest that retaining fewer factors makes viewpoints easier to understand. We decided to use Varimax rotation because in most of the literature published in Q methodology, Varimax rotation complements PCA the most (Ramlo, 2016). Due to their significant loadings to both factors ($p = .01 > .30$), the remaining seven participants were excluded from the factor arrays and did not contribute to the interpretations discussed in the next section. Our goal for excluding these sorts was to have a clearer presentation of the viewpoints and to reduce the correlation between the factors (Webler et al., 2009). Lastly, we utilized identifying items that were ranked at each pole (e.g., +6, -6), distinguishing and consensus items, as well as the demographic questionnaire and the post sorting question responses for the factor interpretation and factor naming processes.

Results

The data analysis revealed two factors explaining 45% of the total variance and meeting the acceptable criteria of factor solution for Q methodology (Watts & Stenner, 2012). We identified two factors that represented patterns of the statements of trainees' viewpoints of clinical supervision in IBH settings: *clinical skill development as a counselor* and *interdisciplinary team membership*. Each factor resolution offered three types of statement loadings: (a) distinguishing statements, (b) higher ranked statements, and (c) neutral statements. To analyze each factor, we adapted the crib sheet method developed by Watts and Stenner. This approach uses guiding statements (e.g., top two, higher/lower than other factors, bottom two) to interpret factor distinctions. Using a 2-factor solution, we created crib sheets for each factor based on KenQ output (see Tables 1 and 2). Distinguishing statements represented statements exclusively loading in the current factor (ranked from 0 to +6), while higher ranked statements were the ones ranked higher in the respective factor (ranked +6, +5, or +4) when compared to the other factor. On the other hand, neutral statements represented the ones ranked in the middle (ranked 0 and +1). Additionally, the two-factor solution also yielded consensus statements that highlighted similarities in perspectives in both factors. Factor names represent the focus of supervision that MHCTs perceived in supervision.

Factor 1: Clinical Skill Development as a Counselor

Seven participants were associated with Factor 1, clinical skill development as a counselor, accounting for 26% of the variance. All participants in this factor identified their sex as female (100%) while three (43%) identified as Black or African American, three (43%) as Caucasian, and one (14%) as Asian/ Pacific Islander. Of the seven, six of the participants were master's-level and one was a doctoral student. Four master's-level counselor trainees had been supervised for at least two semesters in IBH settings, and two graduated from their program within the last year. The doctoral student had also graduated from their program. Six of the participants reported working in an outpatient community ambulatory care clinic serving underprivileged clients and one of the participants reported working in an in-patient community services board.

The viewpoint of Factor 1 focused on trainees' clinical skill development and client care in IBH settings. Table 1 includes the Factor 1 crib sheet, with the highest rated items. Items ranked higher in Factor 1 than Factor 2 and the items loaded in the middle of the Q sort for Factor 1 suggested neutrality — where trainees were aware of the need for these statements, but they were not as important to them as the distinguishing statements.

Factor 2: Interdisciplinary Team Membership

Four participants were associated with Factor 2, explaining 19% of the variance. Three participants identified their sex as female and one as male. Two (50%) participants identified as Caucasian, one (25%) as Asian/Pacific Islander, and one (25%) as Hispanic or Latinx. Of the four participants, two were master's-level counselor trainees; one has been supervised more than three semesters and one has been supervised for one semester in IBH settings. Two other participants were doctoral-level counselor trainees; both had been supervised over three semesters. Two of the participants indicated they are working in an outpatient hospital setting, while one reported working in an in-patient crisis stabilization unit/detox, and one reported working in an in-patient community services board.

Overall, the viewpoint of Factor 2 focused on trainees' experiences with providing services in interdisciplinary settings, specifically, challenges related to professional identity development and being an interprofessional team member. See Table 2 for the Factor 2 crib sheet.

Table 1

Crib Sheet for Factor 1

Item	Statement	Ranking
Highest ranked items		
16	Case conceptualization and case review (e.g., exploring various factors that might affect clients' progress in counseling)	+5
56	Discussing specific approaches/interventions and theories to use with my clients	+5
40	Discussing clients' challenges with lack of resources (e.g., financial, social)	+4
Items ranked higher in Factor 1 than in Factor 2		
28	Converging medical needs and mental health needs (e.g., integrating information from past medical concerns in explaining current functioning)	+3
29	Using Maslow's hierarchy of needs when working with clients	+4
35	My client's needs for other services at my site (e.g., medication management)	+3
52	Treatment planning for my clients	+3
57	Discussing resources to use and offer working with my clients (e.g., evidence-based approaches, medication interactions)	+2
58	Discussing referrals for my clients	+3
62	Validating and normalizing my personal feelings and self-care practices while working in the IBH setting	+3
Neutral items		
66	Ways to advocate for my profession in an IBH setting to enhance the role of a mental health counselor to be more prominent, understood, and recognized	0
11	Maintaining my professional identity while working in an interdisciplinary environment	0
2	Crisis assessment and intervention	+1
30	Discussing ways for seeking referrals for new clients from physicians	+1

Consensus Statements

In addition to distinguishing and neutral statements, consensus statements were important for both groups (factors) of participants in their supervision. These statements included the importance of clinical judgement (1 [statement number], +6 [loading in Factor 1 array], +4 [Factor 2 loading]), clinical work such as crisis assessment and intervention (2, +4, +3), multicultural considerations in work with clients (17, +4, +3), multicultural competence in their work with clients (18, +3, +4), communicating with other health professionals at their site (3, +5, +5), writing progress notes within the IBH setting (5, +4, +4), establishing boundaries with clients (7, +2, +3), maintaining boundaries with clients (8, +2, +2), and establishing rapport with clients (24, +2, +4). On the other hand, being supervised by professionals from different fields (69, -6, -5) and assessment and diagnostic considerations and competencies unique to their site (54, -3, -3) were the items categorized as less important topics for supervision in IBH settings by both groups.

Discussion

The purpose of the current study was to understand the focus of clinical supervision in IBH settings from the perspective of MHCTs.

Table 2

Crib Sheet for Factor 2

Item	Statement	Ranking
Highest rank items		
12	My competency concerns about respect/competence in an interprofessional team	5
14	Medical model vs. wellness model (e.g., counseling is holistic and able to be incorporated within different practices in health care)	6
6	Interprofessional collaboration (e.g., social workers, care managers, physicians, charge nurses, bed nurses, chaplains) to address client needs and/or progress	5
Items ranked higher in Factor 2 than Factor 1		
9	Establishing boundaries with other health professionals	4
11	Maintaining my professional identity while working in an interdisciplinary environment	4
34	Collaborating with medical professionals on clients' concerns (e.g., duration, frequency, type, note writing for substance abuse)	3
36	Understanding and acknowledging the complexities of services provided by mental health counselors at my site (e.g., acute setting, nontraditional counseling, addressing trauma via short-term treatment)	2
39	Responding to challenges involving staff's engagement with clients (e.g., staff not engaging therapeutically with clients)	2
44	Administrative components of IBH setting (e.g., navigating healthcare, Medicaid regulations)	-4
47	Developing a professional relationship not only with mental health professionals but also with staff in other roles	2
Neutral items		
46	Developing an understanding of each professional's perspective on mental health and the specific client concern (e.g., substance use)	0
63	Understanding medical terminology to add credibility to my counseling work within my setting	0
43	Dynamics among healthcare professionals (e.g., working with staff, consulting with dismissive medical staff, comments that the medical staff make)	0
60	Addressing the health professional's order needs (e.g., perform a mental status examination, PHQ-9) and client's emerging needs, respectively	0
13	Clients' view of the leadership in our interprofessional team	0

Q methodology procedures revealed two complementary factors as focus areas: clinical skill development as a counselor and interprofessional team membership.

The primary viewpoints of the *clinical skill development as a counselor* factor were clinical skill development and case conceptualization with an awareness of the critical dynamics of interprofessional practice within the IBH system. A major component of the clinical skill development as a counselor factor findings represented specific focus areas of the supervisory process, such as case conceptualization and treatment planning. While we are aware that community mental health supervision focuses on these components (Dorsey et al., 2017), it is also important to notice that these focus areas are considered common to all counseling supervision regardless of the setting requirements

(Bernard & Goodyear, 2019; Borders, 2014; Ogbeide et al., 2023; Ogbeide & Bayles, 2024). As part of supervision discussions regarding treatment planning and resource identification for clients, MHCTs in Factor 1 emphasized the importance of the client's experience with compounding issues such as socioeconomic status and Maslow's hierarchy of needs. Reflecting on IBH settings' unique needs, thus, a significant amount of supervision time is used for care and management related to compounding issues and risk factors of clients from underserved communities (Fields et al., 2023; Tugendrajch et al., 2021). MHCT supervision consistently uses systemic components as part of case conceptualization, regardless of the setting (Borders, 2014). While advocacy for clients is considered a natural extension of systemic considerations, MHCTs identified areas such as advocacy for clients as important yet received less attention in MHCTs' supervision in IBH settings. These findings can be interpreted by IBH settings' unique components of learning administrative regulations of healthcare systems (i.e., understanding the insurance regulations, and electronic health records) and interprofessional roles and responsibilities. Thus, addressing such challenges may need more attention in supervision.

Clinical skill development as a counselor also included a specific focus on trainees' personal functioning considerations in relation to their work with clients and relevant skill development, validating and normalizing personal feelings and endorsing self-care practices, further emphasizing that professional and personal functioning and development are intertwined processes (Kemer, 2024). Supporting the literature from medical family trainees' supervision (Speice & McDaniel, 2016), MHCTs also explained the process of becoming a part of the context and relevant self of the therapist aspects as an important focus of their supervision in IBH settings. These findings suggest MHCTs are still integrating their counseling focus into the medical settings or vice versa. Thus, the MHCTs' developmental levels may also contribute to this process (Giresunlu et al., 2024). Looking at the demographic data, the majority of the trainees associated with this factor were master's-level, working in outpatient ambulatory care clinics, and being supervised for an average of two semesters. Even though they may recognize that they are in an interdisciplinary setting requiring special attention to interprofessional collaborations (Giresunlu et al., 2024), their primary focus appears to be acquiring clinical skills.

If we consider Factor 1 and Factor 2 on a continuum, Factor 2's focus was on the other end of the spectrum, with supervisory focus aimed at working in an interdisciplinary environment. Highlighting collaboration with other healthcare professionals more than Factor 1, Factor 2, interprofessional team membership, particularly involved trainees' understanding of their professional identity development as they navigated their way through the IBH setting. Our findings, such as experiences with being part of the interprofessional team, maintaining MHC identity in the interdisciplinary setting, and drawing professional boundaries with other professionals, reflected similar focus areas for social work and MedFT trainees, including feeling valued as a social worker, and feeling challenged by power differentials among other disciplines (Berrett-Abebe et al., 2023; Speice & McDaniel, 2016).

Supervisees identified discussions around nontraditional mental health counseling and short-term treatment, navigating administrative considerations with healthcare (e.g., Medicaid regulations), and addressing challenges involving staff engagement with clients as challenging. These findings indicate supervisees' lack of knowledge of the practices at the IBH setting and can be reflective of the lack of collaboration between mental health counseling and other disciplines. Similarly, exploring supervisors' perspectives, comparable results were reported, highlighting the challenges in interdisciplinary collaboration (Giresunlu et al., 2024). Consistent with our findings, Micallef Marmara' and Kemer (2024) reported that other health professionals identified several specific roles and responsibilities for MHCs in hospital settings. These included mediating communication between healthcare professionals, patients, and families; collaborating with other multidisciplinary team

members on patients' care; and training other members on general wellness and mental health. This study involved a different set of participants. Thus, MHCTs may still be trying to find their place in IBH settings in relation to their professional competency and identity development. Along with the evident lack of interprofessional education and practice in counselor training (IPE; Johnson et al., 2021), these findings further highlight the importance of clinical supervision and respective focus as counselor trainees practice in IBH settings.

Healthcare professionals from Micallef Marmara' and Kemer's (2024) study considered psychological assessment of patients' emotional reactions to referrals and interventions as a responsibility of MHCs. Different from their findings, counselor trainees in the current study considered testing and assessment as less of the focus of their supervision, and perhaps their practices. Thus, these findings also emphasized and presented supervision in IBH settings with a special focus on understanding counselor trainees' roles in the healthcare treatment system, similarly experienced by trainees who practice in IBH settings (i.e., Curtis & Christian, 2012). Compared to Factor 1, Factor 2 participants included doctoral-level students with additional semesters of practice under supervision in IBH settings. Factor 2 participants' experiences with a supervisory focus on interprofessional team membership and relevant consideration areas may also be related to their developmental level, which may have allowed them to be focused more on competency and identity development as well as on systems and stakeholders rather than solely on solidifying their clinical skills.

Finally, our results revealed certain supervisory focus areas relevant and critical to all participants. Trainees emphasized competencies such as clinical judgment, making and maintaining boundaries, crisis assessment and intervention, multicultural counseling considerations and competence, communication with other health professionals, and administrative work. These findings align with established best practices in counseling supervision, such as skill acquisition, client care, documentation, diversity and advocacy considerations, and ethical practice (Borders et al., 2014). Moreover, trainees highlighted specific skills competencies in IBH settings including providing comprehensive care (AMHCA, 2021). Additionally, trainees identified communication among healthcare professionals as a crucial component, as well as how to communicate with other professionals in an effective manner, as a supervisory focus of their training. These findings align with supervision components for supervisors practicing in PCBH settings developed by Ogbeide and Bayles (2024), including differentiating roles among providers, engaging in team-based practice, and understanding point of care resources within the electronic medical record concerns.

On the other hand, there were areas neither factor's participant groups believed to be an important aspect of their supervision focus. A unique one was being supervised by other professionals (i.e., being supervised by professionals from different fields), where counselor trainees appeared to solely have experience with being supervised by mental health counseling supervisors. Considering the support for cross-disciplinary supervision in IBH settings (Ma et al., 2022), this difference may be reflective of the supervision structure in these settings and the developmental level of MHCTs. An interpretation of this finding may be related to program requirements, lack of exposure to cross-disciplinary supervision at the site, and, once again, trainees' developmental level requiring supervision from a professional of the same profession. In other words, counselors of more advanced developmental levels may have considered focusing on supervision by a professional from a different field highly relevant to their professional practice.

Limitations

As in all research, our study had several limitations. First, we strived to include a diverse sample, yet white female participants being supervised in a southeast region of the United States comprised the majority of the sample. A larger group of trainees with broader representation from the U.S. population may have increased the comprehensiveness of the results. Secondly,

methodological limitations of the current study included limiting the range and quality of the statements as well as sorting them using a predetermined grid. This approach may restrict the range of expressed viewpoints by imposing discriminations participants may not otherwise be inclined to make (Kampen & Tamás, 2014). In addition, differences across the IBH settings, such as integration level, client profiles of the settings served, and trainee developmental levels (e.g., master's-level versus doctoral trainee), may have created variations across their supervision focus. To address some of these limitations in this study, we attempted to make the concourse as broad as possible and consulted with an auditor about the type of factor analysis, extraction, and rotation methods used (Watts & Stenner, 2012).

Implications for Supervisors, Counselor Education, and Future Research

Findings of the current study offer unique considerations of IBH supervision for MHCTs, providing specific directions to clinical supervisors and counselor training programs. Utilizing Factor 1's focus on clinical skill development, to help supervisees plan for treatment, clinical supervisors in IBH settings may consider attending to supervisees' needs for reviewing cases; discussing case conceptualization and treatment planning; taking specific client information into account (e.g., SES); and using specific approaches, interventions, and theories. IBH settings are complex clinical environments that may stir the personal challenges of supervisees in relation to their work. In addition, our findings highlighted a mismatch between perceived importance of advocacy and how MHCTs ranked it in their supervision experiences, underscoring the need for supervisors to address advocacy concerns and enhance advocacy efforts to better support clients during supervision sessions. Supervisors may consider educating supervisees about professional and cultural differences in IBH settings (Berrett-Abebe et al., 2023). In doing so, supervisors can have a positive impact on client outcomes, as supervision can foster culturally competent care by increasing trainees' confidence and improving their ability to address complex client needs (Ogbeide & Bayles, 2024; Tugendrajch et al., 2021). Counseling supervisors may consider establishing collaborative relationships with other healthcare professionals, such as informing them about the counseling profession (Berrett-Abebe et al., 2023) and learning more about other medical professionals' perspectives, to model such interprofessional practice to their supervisees. Efforts may include shadowing experiences of medical and other professionals (Speice & McDaniel, 2016).

Our findings provided implications for counselor education programs aligning with CACREP standards (CACREP, 2023). The 2024 standards require interprofessional education and collaboration into training programs (Section 3, Standard A.3). However, a lack of interprofessional literature in counseling journals (Fields et al., 2023) creates challenges for advocacy and inclusion in IBH settings. Counselor education programs may consider addressing the need for IPE (Johnson et al., 2021) in their training procedures. Particularly, the findings from Factor 2, interprofessional team membership, may offer guidelines to counselor training programs to deepen their curriculum and further feed into counselor trainees' professional identity development as they are educated about professional challenges as well as interprofessional strategies to solidify a counselor's place and be successful in IBH settings.

The findings of the study also have several research implications. Researchers may consider replicating this study with a larger sample of counselor trainees (e.g., residency counselors in IBH settings) to explore the similarities and differences between their experiences with supervision focus areas. Similarly, researchers may consider exploring focus of supervision that is specific to the types of IBH settings (e.g., hospitals, primary care settings) to understand unique supervision practices of each of the settings. In another study, researchers may specifically study the two factors, clinical skill development as a counselor and interprofessional team membership, to further understand the content and

processes of these factors. Finally, researchers may consider exploring if there are developmental differences in terms of supervisees' needs with specific supervision focus in IBH settings.

Conclusion

Our study highlighted the two distinguished focus areas of clinical supervision for MHCTs in IBH settings: clinical skill development as a counselor and interprofessional team membership. These focus areas emphasized the needs of MHCTs, such as clinical competencies, case conceptualization, treatment planning and interventions, and navigating professional identity as part of an interdisciplinary team. Our findings reinforced the importance of tailoring supervision to address the unique challenges of IBH settings, such as addressing systemic client issues, fostering interprofessional communication, and enhancing counselor trainees' professional and personal development. Our findings called for enhanced curriculum development in counselor education to promote interdisciplinary collaboration, which is crucial for advancing counselor training and improving client outcomes in IBH settings.

References

American Mental Health Counseling Association. (2021). *Behavioral health counseling in health care integration practices and health care systems* [White Paper].

Arzuyan, A., Lara, R., & Fu, M. (2023). Introduction to the special section: Supervision in publicly funded settings: Best practices. *Psychological Services*, *20*(2), 203–205. https://doi.org/10.1037/ser0000750

Banasick, S. (2019). Ken-Q Analysis (Version 1.0.6) [Computer Software]. Free Software Foundation. https://shawnbanasick.github.io/ken-q-analysis

Bernard, J. M., & Goodyear, R. K. (2019). *Fundamentals of clinical supervision* (6th ed.). Pearson.

Berrett-Abebe, J., Padykula, N., Clark, M., Zenevitch, R., Bjorklund, D., Gentile, M., Ward, K., & Haven, T. J. (2023). Social work student reflections on training in integrated care: Opportunities for social work educators. *Social Work Education*, *42*(4), 531–547. https://doi.org/10.1080/02615479.2021.1976137

Borders, L. D. (2014). Best practices in clinical supervision: Another step in delineating effective supervision practice. *American Journal of Psychotherapy*, *68*(2), 151–162. https://doi.org/10.1176/appi.psychotherapy.2014.68.2.151

Brown, S. R. (1980). *Political subjectivity: Applications of Q methodology in political science*. Yale University Press.

Carlo, A. D., Drake, L., Ratzliff, A. D., Chang, D., & Unützer, J. (2020). Sustaining the collaborative care model (CoCM): Billing newly available CoCM CPT codes in an academic primary care system. *Psychiatric Services*, *71*(9), 972–974. https://doi.org/10.1176/appi.ps.201900581

Council for the Accreditation of Counseling and Related Educational Programs. (2023). *2024 CACREP standards*. https://www.cacrep.org/for-programs/2024-cacrep-standards/

Curtis, R., & Christian, E. (2012). *Integrated care: Applying theory to practice*. Taylor & Francis.

Dorsey, S., Pullmann, M. D., Kerns, S. E., Jungbluth, N., Meza, R., Thompson, K., & Berliner, L. (2017). The juggling act of supervision in community mental health: Implications for supporting evidence-based treatment. *Administration and Policy in Mental Health and Mental Health Services Research*, *44*, 838–852. https://doi.org/10.1007/s10488-017-0796-z

Fields, A. M., Thompson, C. M., Schneider, K. M., Perez, L. M., Reaves, K., Linich, K., & Limberg, D. (2023). The state of integrated primary and behavioral health care research in counselor education: A review of counseling journals. *Professional Counselor*, *13*(3), 206–221. https://doi.org/10.15241/amf.13.3.206

Giresunlu, Y., Kemer, G., & Akpinar-Elci, M. (2024). Supervision of counselor trainees in integrated behavioral health settings. *Counselor Education and Supervision*, *63*(2), 117–130. https://doi.org/10.1002/ceas.12296

Glueck, B. (2015). Roles, attitudes, and training needs of behavioral health clinicians in integrated primary care. *Journal of Mental Health Counseling*, *37*(2), 175–188. https://doi.org/10.17744/mehc.37.2.p84818638n07447r

Hall, J., Cohen, D. J., Davis, M., Gunn, R., Blount, A., Pollack, D. A., Miller, W. L., Smith, C., Valentine, N., & Miller, B. F. (2015). Preparing the workforce for behavioral health and primary care integration. *The Journal of the American Board of Family Medicine*, *28*(1), S41–S51. https://doi.org/10.3122/jabfm.2015.S1.150054

Held, M. L., Black, D. R., Chaffin, K. M., Mallory, K. C., Milam Diehl, A., & Cummings, S. (2019). Training the future workforce: Social workers in integrated health care settings. *Journal of Social Work Education*, *55*(1), 50–63. https://doi.org/10.1080/10437797.2018.1526728

Johnson, K. F., Blake, J., & Ramsey, H. E. (2021). Professional counselors' experiences on interprofessional teams in hospital settings. *Journal of Counseling & Development*, *99*(4), 406–417. https://doi.org/10.1002/jcad.12393

Johnson, K., Clemons, K., Robins, L., Gantt-Howrey, A., Shaikh, A., & Jones, H. A. (2023). Experiences of school counseling trainees in a primary care integrated behavioral health care practicum. *Teaching and Supervision in Counseling*, *5*(2), Article 2. https://doi.org/10.7290/tsc05LqLx

Kallenberg, G. A., & Sieber, W. J. (2024). "Integrated behavioral health plus": The best of the worlds of collaborative care management, primary care behavioral health, *and* primary care. *Families, Systems, & Health*, *42*(3), 454–463. https://doi.org/10.1037/fsh0000885

Kampen, J. K., & Tamás, P. (2014). Overly ambitious: Contributions and current status of Q methodology. *Quality & Quantity*, *48*, 3109–3126. https://doi.org/10.1007/s11135-013-9944-z

Kemer, G. (2024). Cohesive model of supervision: An empirically based approach. *Counselor Education and Supervision*, *64*(1), 136–157. https://doi.org/10.1002/ceas.12320

Kordon, A., Carroll, A. J., Fu, E., Rosenthal, L. J., Rado, J. T., Jordan, N., Hendricks Brown, C., & Smith, J. D. (2024). Multilevel perspectives on the implementation of the collaborative care model for depression and anxiety in primary care. *BMC Psychiatry*, *24*(1), Article 519. https://doi.org/10.1186/s12888-024-05930-w

Ma, K.P.K., Breedlove, D., LePoire, E., Prado, M. G., Ratzliff, A., & Stephens, K. A. (2022). Integrated primary care psychology training programs: Challenges and strategies. *Families, Systems, & Health*, *40*(4), 491–507. https://doi.org/10.1037/fsh0000770

McKeown, B., & Thomas, D. B. (2013). *Q methodology* (Vol. 66). Sage.

McNeill, B. W., & Stoltenberg, C. D. (2016). *Supervision essentials for the integrative developmental model*. American Psychological Association. https://doi.org/10.1037/14858-000

Micallef Marmara', S., & Kemer, G. (2024). An investigation of healthcare professionals' perspectives on the tasks of mental health counselors in hospital settings. *Journal of Counseling & Development*, *102*(1), 82–95. https://doi.org/10.1002/jcad.12499

Ogbeide, S. A., Bauman, D., & Beachy, B. (2023). Clinical supervision within the primary care behavioral health model: What we know and where we need to go. *Psychological Services*, *20*(2), 335–342. https://doi.org/10.1037/ser0000684

Ogbeide, S. A., & Bayles, B. (2024). Using a Delphi technique to define primary care behavioral health clinical supervision competencies. *Journal of Clinical Psychology in Medical Settings*, 31, 108–121. https://doi.org/10.1007/s10880-023-09964-2

Possemato, K., Johnson, E. M., Beehler, G. P., Shepardson, R. L., King, P., Vair, C. L., Funderburk, J. S., Maisto, S. A., & Wray, L. O. (2018). Patient outcomes associated with primary care behavioral health services: A systematic review. *General Hospital Psychiatry*, *53*, 1–11. https://doi.org/10.1016/j.genhosppsych.2018.04.002

Ramanuj, P., Ferenchik, E., Docherty, M., Spaeth-Rublee, B., & Pincus, H. A. (2019). Evolving models of integrated behavioral health and primary care. *Current Psychiatry Reports*, *21*, 1–12. https://doi.org/10.1007/s11920-019-0985-4

Ramlo, S. (2016). Centroid and theoretical rotation: Justification for their use in q methodology research. *Mid-Western Educational Researcher*, *28*(1), 73–92.

Reist, C., Petiwala, I., Latimer, J., Raffaelli, S. B., Chiang, M., Eisenberg, D., & Campbell, S. (2022). Collaborative mental health care: A narrative review. *Medicine*, *101*(52), e32554. http://dx.doi.org/10.1097/MD.0000000000032554

Rocha, J., & Kemer, G. (2022). What must supervisees do to promote supervision? An exploratory sequential mixed methods approach. *The Clinical Supervisor*, *41*(1), 70–87. https://doi.org/10.1080/07325223.2022.2045526

Speice, J., & McDaniel, S. (2016). Training the medical family therapist in an integrated care setting. In K. Jordan (Ed.), *Couple, marriage, and family therapy supervision* (pp. 371–389). Springer.

Tambling, R. R., Hynes, K. C., & D'Aniello, C. (2020). Are barriers to psychotherapy treatment seeking indicators of social determinants of health?: A critical review of the literature. *The American Journal of Family Therapy*, 1–16. https://doi.org/10.1080/01926187.2020.1867931

Tugendrajch, S. K., Sheerin, K. M., Andrews, J. H., Reimers, R., Marriott, B. R., Cho, E., & Hawley, K. M. (2021). What is the evidence for supervision best practices? *The Clinical Supervisor*, *40*(1), 68–87. https://doi.org/10.1080/07325223.2021.1887785

Utter, J., Ruiz, J., Farris, M., Lines, S., Jorgenson, K., & Pro, G. (2023). Integrating primary care services in outpatient mental health treatment facilities: National and state trends, 2015–2020. *Practice Innovations*, *8*(4), 296–304. https://doi.org/10.1037/pri0000214

Walker, T. J., & Renn, B. N. (2024). Models of integrated behavioral and mental health in primary care. In M. L. Malone, M. Bolt, J. Macias Tejada, & H. White H (Eds.), *Geriatrics models of care: Bringing "best practice" to an aging America* (pp. 167–175). Springer International.

Watts, S., & Stenner, P. (2012). *Doing Q methodological research: Theory, method & interpretation*. Sage.

Webler, T., Danielson, S., & Tuler, S. (2009). Using Q method to reveal social perspectives in environmental research. *Greenfield MA: Social and Environmental Research Institute*, *54*(1). https://www.betterevaluation.org/sites/default/files/Qprimer.pdf

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