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An Investigation of Healthcare Professionals' Perspectives on the Tasks of Mental Health Counselors in Hospital Settings

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**AN INVESTIGATION OF HEALTHCARE PROFESSIONALS' PERSPECTIVES ON
THE TASKS OF MENTAL HEALTH COUNSELORS IN HOSPITAL SETTINGS**

by

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ABSTRACT

AN INVESTIGATION OF HEALTHCARE PROFESSIONALS' PERSPECTIVES ON THE TASKS OF MENTAL HEALTH COUNSELORS IN HOSPITAL SETTINGS

Suelle Micallef Marmara
Old Dominion University, 2022
Chair: Dr. Gülşah Kemer

With the global mental health implications reported by the spread of COVID 19 (Javed et al., 2020) and the amplified mental health illnesses reported by the State of Mental Health in America (Reinert et al., 2021), there is an increased need to address psychological and emotional health along with physical health. Mental Health Counselors (MHCs) can be the next professional body to support the multidisciplinary teams within hospital settings to complement holistic care focusing on physical and emotional well-being. Researchers have demonstrated addressing the psychological needs of patients from their first admissions to the hospital has significant positive implications on their recovery outcomes as well as psychological, social, and relational well-being post-discharge (Zhang et al., 2016; Ng et al., 2007; Schoultz et al., 2015; McCombie et al., 2016; Hatch et al., 2011). Research on the effects of therapeutic intervention has effectively prevented PTSD in the general population when provided in the first month after trauma exposure (Bryant et al., 2008). Therefore, early therapeutic interventions in hospital settings to identify emotional and psychological reactions (Weinert & Meller, 2007) before discharging patients can significantly impact patients' post-discharge mental health. However, since counseling is a new profession entering the medical field, role confusion within multidisciplinary teams appears to impact counselors' effective integration into healthcare as they provide counseling services to hospitalized patients. Therefore, in this study, I address the

gap in the literature by exploring the perspectives and expectations of healthcare professionals on what MHCs do in hospital settings. This study was guided by a social constructivist paradigm utilizing an exploratory sequential mixed-methods design, concept mapping (Kane & Trochim, 2007). Healthcare professionals conceptualized MHCs' tasks in hospital settings to facilitate medical and mental health services and enhance patients' well-being in 104 statements grouped in 11 clusters forming three central regions. The three main regions include: "*Overarching Roles and Responsibilities of MHCs in the Hospital Setting*" (Region I) contained two clusters (i.e., 'Fundamental Roles and Responsibilities in the Hospital Setting,' & 'Specific Roles and Responsibilities in Different Hospital Units') of MHCs' tasks, while "*MHCs' Specific Roles in the Hospital Setting*" (Region II) entailed four clusters (i.e., 'Building Relationship with Patients,' 'Assessing/Evaluating Patients' Mental Health Status,' 'Assisting and Supporting patients with Physical, Psychological, and Social Challenges in Relations to their Medical Condition' & 'Educating Patients') and "*MHC's Roles and Responsibilities as a Multidisciplinary Team Member*" (Region III) hosted five clusters (i.e., 'Advocating for Patients in the Multidisciplinary Team,' 'Mediating Communication Between Healthcare Professionals, Patients, and Families,' 'Collaborating with Other Multidisciplinary Team Members on Patients' Care,' 'Training Other Multidisciplinary Members on General Wellness and Mental Health' & 'Offering Trainings and Emotional Support to Other Multidisciplinary Team Members'). The top three higher-rated clusters as being most important for participants were cluster 7 'advocating for patients in the multidisciplinary team,' cluster 5 'assisting and supporting patients with physical, psychological, and social challenges in relation to their medical condition,' and cluster 11 'offering training and emotional support to other multidisciplinary team members.'

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This dissertation is dedicated to my husband Pierre and my daughter Monique who unraveled their plans and uprooted themselves to a different country so that I could follow my dream. I am here because of your love, support, patience, and consistency in believing in me.

I love you both dearly!

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CHAPTER I

Introduction

This chapter outlines the problem, the purpose statement, and the study's significance through the research impact. I conclude with a brief overview of the research design and research question.

Background of the Problem

As the COVID-19 spread globally over the last two years, significant physical health morbidity drastically impacted mental health worldwide (Javed et al., 2020). In the United States, there was a dramatic increase in individuals reporting mental distress and mental health illness which harvested national attention, sharpening societal acknowledgment of the relationship between psychological and physical health (McGahey & Wallace, 2021). Subsequently, this increased awareness of the importance of well-being and mental health has taken on new urgency and can no longer be ignored. Although the most current data reported by different states in America was before the pandemic, it may not reflect the nation's current situation since the onset of the pandemic. Yet, providing a comparative baseline that highlights the increased need to address psychological and emotional health and physical health appears more critical. The State of Mental Health in America 2017-2018 report indicated an increase of 0.15% of adults suffering from serious suicidal thoughts from the previous report compiled in 2016-2017 (Reinert et al., 2021). The report also stated that youth experiencing mental depressive episodes (MDE) increased by 206,000, and youth experiencing severe MDE increased by 126,000 from the previous year. Additionally, the 2017-2019 state of mental health in America report also highlighted that 57% of adults and 59.6% of youth suffering from mental illness receive no treatment even though their health insurance covers 86% (Reinert et al., 2021).

This data indicates that access to care is not entirely related to insurance coverage but can also be related to awareness, accessibility, and availability.

McGahey and Wallace (2021) identify the omnibus approach to provide a ‘one-stop-shop.’ They highlight that many mental health illnesses initially manifest as physical symptoms treated by the medical provider and then refer the patient/client in-house for mental health evaluation. As opposed to outside mental health referrals, in-house referral reduces long delays in accessing services, as outdoor mental health professionals may have longer waiting lists or may not accept new patients (McGahey & Wallace, 2021). Hall and Hall (2013) extend the need to address the mental health needs and well-being in the medical settings by highlighting the implication of medical procedures, illnesses, and hospital stays as traumatic experiences that can have lasting effects. Patients impacted by medical trauma develop significant clinical reactions, such as anxiety, depression, PTSD, complicated grief, and somatic complaints. Additionally, they undergo secondary crises, including physical, developmental, existential, occupational, relational, spiritual, and self, leading to the need for ongoing support, growth, and healing. A qualitative study done by Erlandsson (1998) explored adjustment to illness and highlighted the medical trauma experienced by patients due to their condition. Participants in their study experienced the onset of their disease as a traumatic event. They claimed that the start of their illness coincided with the overwhelming anxiety triggered by the traumatic event hindering their ability to come to terms with their physical condition and influencing their withdrawal from social interactions (Erlandsson, 1998). Therefore, as Hall and Hall (2013) further asserted, while counselors are central in treating the aftereffects of medical trauma and helping clients experience post-traumatic growth, they can also support the prevention and assessment of medical trauma by working in the medical field setting.

Consequently, the merger of psychological and physical health services in the medical setting would help to create a comprehensive continuity of care and ease access to mental health treatment. In addition, providing counseling services in hospital settings could expand exposure and treatment (proactive, reactive, and crisis) to reduce the prevalence of mental health disorders that cost billions financially through expenditures and loss of work (McGahey & Wallace, 2021). However, since few MHCs are found in the hospital settings, role confusion among healthcare professionals appears to impact MHCs' effective integration into the hospital setting to provide counseling services. Therefore, increased awareness of how the MHCs can assist in the merger of psychological and physical health to improve patients' well-being will further clarify the MHCs' role in the hospital settings.

Counselors have a vital role in the general well-being of individuals as they are trained to build a therapeutic relationship that supports and empowers persons, groups, and families to reach personal goals focused on mental well-being, wellness, education, and career (Kaplan et al., 2014). This definition of the role of the counselor places all counselors working within different specialty areas, such as school counseling, clinical mental health counseling, student affairs, and college counseling, under one umbrella. From a broader perspective, counseling in the hospital setting is exclusive in several fundamental ways. First, counseling in hospital settings is a new area of practice requiring different counseling interventions and focus than in other settings concerning specific techniques and methods. To date, no research and scholarly work has outlined the distinct role and responsibilities that MHCs need to engage in to facilitate medical and mental health services and enhance patients' well-being in hospital settings. Second, since counseling in the hospital setting is a part of the entire process of providing medical care for patients, counseling activities must be coordinated with other professional services.

Therefore, MHCs in hospital settings need to practice as professional team members. All team members come from different professions and technical specialties, such as doctors, nurses, social workers, etc., holding different viewpoints, perceptions, and expectations about team functioning and other members' roles. These diverse role definitions and expectations influence how MHCs are perceived by other healthcare professionals on the team, including expectations of MHCs concerning their work. For example, a patient with a chronic diagnosis (such as cancer) could be offered counseling to process information and its impact on their mental wellbeing. Yet, other professionals on the team might view counseling as a service provided to patients to promote a cure, not for prevention. Such diversity in interprofessional collaboration can create ambiguity and contradictory expectations. Consequently, counseling in the hospital settings enacts a complex and often vaguely defined role affected by many conflicting demands and expectations, warranting further research on determining a better understanding of the role of counselors in hospital settings. Therefore, in this study, I aim to explore healthcare professionals' perspectives and expectations of the role of MHCs in hospital settings to facilitate medical and mental health services to enhance patients' well-being.

Purpose Statement

Although the counselors' role has been identified in the school and other mental health specialty areas, there is a gap in the literature to identify and clarify what the specific tasks of MCHs in hospital settings are. I did not identify any studies that attempted to understand counseling and/or counseling professionals' practices in the hospital settings and/or how healthcare professionals view the MHC's role in the hospital environment. The lack of research on the part of MHCs in hospital settings highlights the limited information mental health

counselors, counseling supervisors, educators, physicians, and other healthcare professionals have to integrate counseling services in the hospital settings effectively.

Thus, I conducted an exploratory study on the tasks of MHCs in hospital settings, focusing on the perspectives and expectations of healthcare professionals who had the experience and exposure of working within a hospital setting where a counseling service is in place. Specifically, I sought to understand the different tasks and responsibilities that MHCs in the hospital settings need to engage in to address the needs of patients in the hospital and facilitate continuity of services between the healthcare professionals in the hospital. This information offers further guidelines to MHCs and different professionals within the multidisciplinary team on the various services the MHCs can provide within hospital settings, leading to increased counseling referrals and better use of their services.

Significance of the Study

The current study results have various implications for counseling and/or healthcare professionals (e.g., doctors, nurses) research, as well as clinical and training practices of counselors, counseling supervisors, counselor and supervisor training programs, doctors, nurses, and other professionals in the multidisciplinary teams in the hospital settings. Additionally, the results can inform what contributions MHCs provide to the patient's care, leading to an improved holistic treatment that will benefit patients' health.

The results of this study are the first pragmatic research effort to explore, identify and understand how healthcare professionals perceive different and specific roles and responsibilities of MHCs in hospital settings. These findings can enhance hospital care by focusing on physical and mental well-being. Such an understanding can serve as the basis for counseling and/or healthcare professional (e.g., doctors, nurses) researchers to further explore this area by

replicating the proposed study with MHCs and other multidisciplinary professionals in different settings. Comparing and merging results will strengthen the ultimate goal of identifying the role of MHCs in the hospital settings for effective patient care.

The current study's findings also may advance knowledge on the appropriate scope and content of what MHCs do within hospital settings by perhaps challenging the existing misconceptions that might be impacting MHCs' presence and practices in most hospital settings. Therefore, the results may highlight misconceptions and provide further clarification to define what healthcare professionals expect from MHCs in hospital settings when compared to the professional training and identity of the MHCs in hospital settings. The results offer MHCs guidelines to understand their roles and responsibilities within the hospital settings as a part of multidisciplinary teams. Clarity on the MHCs' role in the hospital settings can inform supervisors and counselor training programs on how to prepare and train MHCs on the specific required tasks, expectations, and responsibilities within hospital settings.

Providing clarity on what MHCs can do in hospital settings may impact and enhance the overall care for the patients. Additionally, findings provide healthcare professionals (e.g., doctors, nurses, crisis clinicians, case managers) with information on the specific tasks and responsibilities of MHCs' within the hospital settings to address the needs of patients and hospital services. Thus, understanding the MHCs' specific tasks clears any possible misconceptions between professionals providing care to patients, leading to more patients being referred for counseling services as part of their treatment plan in the hospital. Offering clarity on what MHCs can do in a hospital setting and understanding what healthcare professionals expect may serve the dual purpose of increased counseling referrals starting from patients' admission to

the hospital and increased collaboration between counselors and multidisciplinary professionals during inpatient care.

Research Design

To explore the integration of counseling services in the hospital settings, I investigated healthcare professionals' perspectives on what MHCs' can do in the hospital settings from a social constructivist theoretical framework. Due to the limited research on this phenomenon and the belief that there is no one truth with possible errors in every reality, I used an exploratory sequential mixed-methods research design, concept mapping (Hanson et al., 2005). Through this exploratory sequential mixed methods research design, I studied the phenomena by collecting and analyzing qualitative and quantitative data (Creswell, 2015). As Kane and Trochim (2007) described, concept mapping aims to identify and organize the different thoughts of a group of people by integrating qualitative and quantitative components. This methodology was well-matched for this study because it produces and embraces diverse perspectives of multiple populations within a community, explores stakeholders' perspectives on the study's explored focus, and prioritizes participants' views while researchers facilitate the processes. Therefore, concept mapping was ideal for obtaining a conceptual understanding of the unique tasks of MHCs in hospital settings, where different professionals within these settings will generate ideas, sort them into meaningful groups, and engage in dialogues to interpret and finalize the results.

Research Questions

To achieve the purposes mentioned above of this study, I addressed the following two research questions: 1) According to healthcare professionals, what do MHCs do in hospital settings to facilitate medical and mental health services and enhance patients' well-being? 2)

What are the most important tasks of MHCs in the hospital settings as identified by healthcare professionals?

Definition of Terms

Counseling

Counseling is a professional relationship developed between counselors and clients focused on empowering diverse people, families, and groups to reach their established well-being, mental health, education, and career goals (Kaplan et al., 2014, p. 368). In this dissertation, when counseling is mentioned, it means providing the space for patients to build a therapeutic relationship with the mental health counselor to process personal needs that supports them in reaching emotional and psychological well-being in the hospital setting.

Mental Health Counselors (MHC)

Mental health counselors, also called clinical mental health counselors, obtain a degree in clinical health counseling or similar degrees. They are trained in conducting counseling for those people struggling with life problems, psychological and emotional issues, and/or mental health disorders (Neukrug, 2017). Their practice focus on the common ground of supporting the individuals through a therapeutic relationship to reach well-being. Thus, in this dissertation, counselors refer to MHCs working within hospital settings which are specifically trained in both the core areas of counseling (as defined above) and in the specialty area of mental health counseling that includes but is not limited to: psychological assessments, tests, techniques, and interventions for prevention and treatment of a range of mental health issues to support patients in reaching emotional and psychological well-being.

Healthcare Professionals

Healthcare professionals mean any person licensed or certified to provide health care services to people, and include but are not limited to a physician, nurse, dentist, optometrist, chiropractor, physical or occupational therapist, clinical dietitian, social worker, clinical psychologist, licensed marriage and family therapist, licensed professional counselor, speech therapist or pharmacist (Law Insider Dictionary, n.d.). A healthcare professional comprises professionals from different health professional backgrounds, having different but complementary skills that work towards a common objective. In this dissertation, healthcare professionals, multidisciplinary teams, and health professionals will be used interchangeably and refer to the different professionals, including physicians, nurses, crisis clinicians, social workers, dietitians, physical therapists, and case managers sharing the common goal of patients' cure and well-being.

CHAPTER II

Literature Review

This chapter provides a brief review of the existing literature on counseling in hospital settings. This review presents various reasons why MHCs are needed in hospital settings with clearly defined roles and responsibilities. Additionally, this chapter addresses the role confusion and complexities with other multidisciplinary professionals in hospital settings.

Why MHCs in the Hospital Settings

Way back in 1985, Brown and Smith highlighted the importance of having counselors in medical settings. They argued that medicine primarily focuses on patients' physical well-being while counseling is typically concerned with patients' emotional well-being. Counseling in the medical settings complements the patients' care to cater to the whole person. Brown and Smith also claim that the need for counselors in the medical settings appeared in patch fashion over the years, even though there has been widespread recognition of the clear distinction between "disease v. dis-ease" (Brown & Smith, 1985, p.77).

Over the last decades, one can observe an increase in psychosocial elements found in general practice consultations. It is a tendency for many individuals to express physical or psychological distress in an individual fashion. One person may describe turmoil through physical terms irrespective of whether its origin is mental or physical. At the same time, another person may express the same confusion in purely psychological terms. This establishes a one-dimensional view of illness that physicians and mental health professionals might have instilled (Rudick, 2012). Yet, literature informs us on the impact of one's physical functioning upon psychological state and vice versa because those suffering from psychological illness often report physical symptoms. Thus, how do we see patients? Do we see them as a body, a soul, a brain,

and a heart? Do we see them as a part or as a whole? (Rudick, 2012). So far, in the absence of counseling services in hospitals, life problems have become medicalized and treated accordingly. Doctors can prescribe pills, and counselors can offer insights and support patients over a broad field, including adjustment issues and skill development that support their general well-being.

Given the growing evidence between mental health disorders and disease activity, there is an increased requirement to engage in psychological intervention in the hospital settings where patients are seen and treated as a whole. Zhang et al. (2016) found a relationship between mental health disorders and disease activity in their study. They explored the influencing factors of illness outcomes and how stress facilitates the relationship between disease severity, anxiety, depression, and quality of life. They surveyed 159 hospitalized or attending tertiary hospital outpatient clinic patients with Crohn's disease (irritable bowel disease) with no history of mental disorder. Through Pearson product-moment correlation analysis of the Chron's disease activity index, the brief illness perceptions questionnaire, the brief coping operations preference inquiry, the perceived stress questionnaire, the hospital anxiety and depression scale, and the inflammatory bowel disease questionnaire to compare the relationship between disease severity, illness perceptions, coping strategies, stress, anxiety and depression and quality of life. Results indicated a significant positive correlation between disease severity and illness perceptions with maladaptive coping, stress, anxiety, depression, and quality of life. Illness perceptions were significantly positively correlated with disease severity, indicating that patients suffering from more symptoms felt their disease more hopeless. Therefore, researchers suggested that the more patients perceived their condition as profound, chronic, disturbing, and uncontrollable, the more emotionally distressed and the inferior quality of life they experienced (Zhang et al., 2016). In fact, stress management, adaptation to illness, and smoking cessation have long been viewed as

critical psychological interventions to be addressed in the care of medical patients and resulted in a reduction in sickness due to chronic illness (Peyrot & Rubin, 2007).

Moreover, the importance of addressing psychological interventions for several other diseases, including hypertension, chronic obstructive lung disease, and congestive heart failure, has also been acknowledged through a study done with 376 hospitalized patients suffering from a chronic obstructive pulmonary disease (Ng et al., 2007). Results identified associated comorbid depressive symptoms with more extended hospitalization stay, poorer survival, persistent smoking, poorer physical and social functioning, and increased symptom burden (Ng et al., 2007). With the absence of counselors in the hospital settings, patients' psychological and mental implications of their disease risk to be limited and treated only through the medical model. Thus, counseling in hospital settings provides the opportunity to see and treat patients as a whole and not parts of the whole.

What Can MHCs do in the Hospital Settings?

MHCs can provide emotional and psychological support that allows patients to vent and talk about their perceptions and understanding of the disease and its implication on the quality of life. The benefit of providing the room for venting, clarifying illness perceptions, planning, and positive reframing during counseling further supports Zhang et al.'s (2016) results. They found illness perceptions were directly associated with patients' stress as more flawed illness perceptions raised mental and emotional tension. Moreover, they found a negative correlation between positive reframing and planning and depression. In two other studies, patients who received additional cognitive behavioral therapy compared with the standard-care treatment of inflammatory bowel disease patients reported more significant improvement in their depression, anxiety, and quality of life (McCombie et al., 2016; Schoultz et al., 2015).

The importance of including counseling in the medical setting is also highlighted when one looks at the estimated 5 to 64% of patients who developed PTSD or related symptoms during their recovery from critical illness (Griffiths et al., 2007). Other studies also reported that several patients suffer significant long-term psychological disturbances during and following recovery from critical illness (Peris et al., 2011; Broomhead & Brett, 2002). These disturbances were reported immediately following their stay at the intensive care unit. Patients immediately started becoming aware of their body changes with little awareness of what brought them to that state (Turner et al., 1990). They had a minimal recall of pain and uncomfortable procedures endured, which appeared to cause subsequent frustration (Broomhead & Brett, 2002). Some started experiencing nightmares, hallucinations, and dreams with real memories associated with the early development of stress disorders (Jones et al., 1994). Extended follow-up of patients following intensive care admissions confirmed that many patients suffered from psychological consequences up to 12 months after being discharged from the hospital (Hatch et al., 2011). The exact nature of treatment/interventions to reduce the prevalence of intensive care-related PTSD has yet to be defined. Yet, cognitive behavioral therapy has effectively prevented PTSD in the general population when provided in the initial month after trauma exposure (Bryant et al., 2008). Therefore, without early counseling assessment, prevention, and interventions, we risk medical PTSD or other psychological/ emotional reactions to medical treatment/prognosis are diagnosed and treated following patients' discharge. According to Hall and Hall (2013), this is much later than the necessary time to address them.

Weinert and Meller (2007) also supported the need to identify possible psychological and emotional reactions, such as medical PTSD, before discharging patients. They argue that medical PTSD differs from other traumas as counselors can anticipate the trauma because counselors

understand where, how, and why it occurs. Counselors can characterize the stressor and intervene while the stressors occur rather than support patients after the stressors, unlike other traumas such as combat, childhood neglect, or physical assault. Counselors cannot prevent nor intervene during these stressors. Thus, by anticipating the possible medical trauma or PTSD, counselors can plan the prevention and intervention of its occurrence (Hall & Hall, 2013; Weinert & Meller, 2007). The need for counselors to be on the hospital ground supporting patients before experiencing any medical trauma or PTSD was further endorsed by Hatch et al. (2011). They highlighted the importance of psychological preventive measures that should start during intensive care unit (ICU) admissions to identify residual signs and symptoms of emotional disturbances in ICU survival patients before discharge. Thus, considering the adverse emotional reactions patients experience that can lead to medical trauma, we must examine the role of counselors in hospital settings (Hall & Hall, 2013).

Subsequently, Hall and Hall (2013) asserted that while counselors are central in treating the aftereffects of medical trauma and helping clients experience post-traumatic growth, prevention is one of the fundamental roles of the counseling profession. Through the prevention lens, the complete psychological care of patients becomes proactive rather than reactive. Thus, counselors can also support the prevention and assessment of medical trauma by working in hospital settings.

Unique Characteristics of the MHC's Role in the Hospital Setting

The role and focus of the MHCs in the hospital settings differ slightly from counselors' roles in the other specialty areas. Together with the clients' social histories, counselors mostly ask follow-up questions that mainly concentrate on their medical history in the medical environment. This means looking into any possible complications experienced medically and

exploring their internal experiences and emotional, spiritual, and physical impacts. While also, counselors look into the potential life changes resulting from the illness or medical procedure, including difficulty accessing preventive care from medical professionals (Hall & Hall, 2013). For example, suppose a MHC in a medical setting supports a patient who has domestic violence exposure at home. The MHC is initially alarmed and focuses on the clients' experience of domestic violence. In case the MHC in the hospital setting insist on focusing on the domestic violence aspect of the client's history, they risk failing to inquire about the client's experience and impact of the medical procedure, such as heart surgery or cancer prognosis, on their emotional, psychological, and social life. Thus, the MHC in the hospital setting will not primarily focus on domestic violence issues as they will miss understanding how this aspect of their medical history or current physical condition/diagnosis impacts their emotional, mental, and social well-being. They will integrate present medical, physical, and mental status within their social-emotional struggles affected by their domestic violence situation.

Additionally, Pestoff et al. (2016) described MHC as the 'spider-in-the-web' (p. 350). They describe MHC's role as acting as case managers who offer continuous support, build a relationship with patients, and provide a holistic, ethical, and psychological perspective to patients while being more available and accessible than the medical professions. When patients are going through genetics-related medical problems, Pestoff et al. (2016) further assert that MHC's role is essential in providing genetic risk assessment when patients are processing and deciding on clinical screening, prophylactic treatment, and considering and discussing reproductive options.

On another note, MHCs in the hospital setting can also address the staff's emotional and psychological stressors and needs. From the limited literature found on what MHCs do in the

hospital settings, Moeller (1992) highlighted the positive impact of enrolling a counselor to support nurses' emotional and psychological needs and stressors. MHCs can assist in strengthening the nurses coping skills, increased awareness and practice in self-care, and improving the overall effectiveness of the nursing care in the hospital. Moeller described the role of the employed counselor as focusing not on the patient's emotional support but on nurses' support to improve the care provided to patients. They described the role of the MHC to provide individual and group counseling to nurses, staff education on interpersonal communication skills, team building, conflict and stress management, and self-care. Thus, the counselors' role in the hospital setting can be more comprehensive than solely patient-focused. Counselors can also support the multidisciplinary professionals' emotional needs and stress impacting their patient care.

Yet, counselors in the hospital settings are rare, and their role is not yet scholarly and professionally defined, leading to confusion and overlapping functions with other related professionals working in these settings.

Conflicts and Ambiguity on what MHCs can do in Hospital Settings

Integrating with general healthcare professionals is not a new phenomenon for psychologists and psychiatrists. For decades, health psychologists have provided significant contributions to patients' care by addressing behavioral factors impacting their health (Pomerantz et al., 2009). Consultation and liaison to inpatient medicine and surgery were initially developed as a subspecialty of psychiatry but then expanded to include psychology which extended the psychological services to medical and surgical patients. They grew medical assistance to focus on psychiatric problems such as psychosis, depression, or complicating medical illness (Pomerantz et al., 2009). Considering that counseling is a younger profession

amongst the healthcare professions working within the hospital settings, it lacks research on integration or collaborative care in the hospital settings, leading to identity and role confusion/conflict.

The counseling professional identity has been a topic of discussion and question, especially since the counseling field has continued to evolve over the last several decades. The counseling field contains multiple sub-specialties. The two most prominent are school counseling and mental health counseling. Since research efforts have not explicitly attempted to identify a composite of aspects related to the counseling professional identity, counselors still experience difficulty articulating a clear and distinct professional identity (Calley & Hawley, 2008; Mellin et al., 2011). MHCs are continually asked about what they do and describe themselves (Spurgeon, 2012). The lack of distinguishing tasks, and overlapping roles with other related helping professionals, result in a shared identity for the counseling profession, which remains elusive (Mellin, et al., 2011; Cashwell et al., 2009). However, in an exploratory, a quantitative study examining counseling professional identity, 238 counselors (90 community counselors, 61 mental health counselors, and 50 school counselors) reported embracing a unified professional identity grounded in wellness, developmental, and preventive orientation towards helping people (Mellin et al., 2011). Participants in this study distinguished the roles of psychologists and social workers by perceiving psychology as emphasizing testing and social work as focusing on systemic issues. Their perceptions supported the definition of counseling defined by the American Counseling Association (2010a) devised to present a consensus definition of counseling. They described counseling as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career

goals.” (Kaplan et al., 2014, p. 368). Yet, no research has explored or defined the role of the counselor within hospital settings.

Conflict and complexities on what MHCs do in the hospital setting may also arise because counseling is a secondary service in a hospital setting. Therefore, the MHCs need to operate within a professional team dominated by the physicians’ authority to provide their services to patients. Moreover, counseling in a hospital setting is only one of many supplementary services in an extensive and multifaceted psychosocial and emotional organization whose primary function is to provide medical care. As supplemental professional services within the hospital, counseling always has to be related to the prior requirements of the medical treatment. The lack of MHCs in hospitals indicates that counseling is still not considered an essential service within hospital settings. This reality might be implicated partially because MHCs’ professional competence areas are challenging to recognize, or because of a lack of awareness of the role and work of MHCs, or since the MHCs do not deal directly with the patient’s apparent physical illness. However, to a greater extent, it may result from the prevailing tendency among many physicians to view patients as medical cases rather than as a whole person where the psycho-emotional needs are essential together with the physical demands.

In a hospital setting, doctors must have dominant authority, as it is a setting where life and death are crucial concerns. This authority has been formally granted to them by society and the hospital, meaning that the physicians’ role will typically overshadow other professionals working within the hospital. Consequently, the MHC must function within an authority system that places the counseling profession in a subsidiary position and forces it to shape out for itself whatever professional responsibilities it assumes. MHCs must continually demonstrate the value of their services to the medical profession and the hospital to strengthen understanding of their

role, the contexts, and counseling mechanisms leading to physicians' referral and prescribing practice. Thus, increasing the likelihood that more MHCs will start providing counseling services within the hospital settings.

No research has yet studied the effectiveness of integrating onsite counseling services in hospital settings so that other healthcare professionals in the hospital setting can acknowledge the value of their services. On the other hand, a growing body of research demonstrated the effectiveness of integrating behavioral and mental health care within the primary care setting in improving health outcomes (Pomerantz et al., 2009). A study on general practitioners' (GP's) perceptions of the impact of onsite counseling services in the primary care mental health services revealed several benefits to the general practice (Schafer et al., 2009). Researchers conducted initial surveys with 89 general practitioners in the locality, followed by semi-structured in-depth interviews with 8 G.P.s on preexisting counseling services. Participants for interviews were selected from two G.P. practices that scored well as opposed to the other that scored poorly on a currently shared care audit unrelated to their current evaluation. When G.P.s were asked to estimate a percentage of patients referred to the counseling service when diagnosed with mental health problems, they ranged from 1% to 100%. Of all the participants, 82% who referred their patients to the onsite counseling services claimed that they did not require them to refer their patients to secondary services. Therefore, onsite counseling services seemed to hold patients in primary care without the need for specialists or secondary services. In addition, three-quarters of participants in the survey claimed that patients benefited from onsite counseling service, with 50% believing that counseling led to a reduction in drug prescriptions. Six out of the eight participants in the interviews identified the decrease in drug prescriptions. They perceived onsite

counseling as beneficial in practice since its initiation by reducing psychoactive medication prescription, cost efficiency, and increased capacity.

Payrot and Rubin (2007) argue the importance of assessing feasibility regarding what it costs, not addressing psychosocial problems, or employing an ineffective approach to behavior change. Patients with psychological problems need health services intensively. If they do not change their behavior, the clinicians need to spend more time dealing with the situation at the next visit. Researchers indicate that dealing with the patients' concerns will not require extra time when done correctly (Payrot & Rubin, 2007). This might justify the possibility of long-term cost efficiency and not needing a specialist or secondary services, which was also identified by the participants in Schafer et al.'s (2009) study.

McGahey and Wallace (2021) describe the onsite counselors in the medical setting as the omnibus approach where patients are offered one-stop shopping. Besides assuming that most mental health illnesses appear initially as physical symptoms, the health care provider that treats the physical symptoms can refer to the onsite counselor instead of referring patients to outside mental health services (McGahey & Wallace, 2021). Consequently, referring to external mental health services delays their access to care due to the existing waiting list and the possibility of not accepting new patients. The outside referral is time-consuming, increasing the risks of aggravating the patients' behavioral and psychological well-being or prognosis. Additionally, participants in the study done by Schafer et al. (2009) identified an onsite counselor as advantageous to the patients' mental health. It provided a kind of a safety net for them. G.P.s claimed that they felt comfortable using basic counseling approaches knowing that support was available onsite when and if needed, leading to a holistic approach that focuses on their physical, psychological, emotional, and behavioral needs. Similarly, with mental health counselors in the

hospital settings, patients can receive a holistic approach that includes early therapeutic interventions to their emotional and psychological reactions to illness before discharge and without waiting until called by the outpatient integrated care. Early intervention can significantly impact patients' post-discharge mental health and support other professionals' services, such as doctors and nurses, who can reach out to the MHCs' service to look into patients' emotional needs.

Summary

Given the lack of research on the role of the MHCs in the hospital setting, in this chapter, I provided an overview of the relationship between physical and psychological well-being, addressed the need for MHCs in the hospital setting, identified some of the tasks and responsibilities of counselors in the hospital setting, and highlighted possible role confusion and complexities. In the current study, I attempted to explore and identify the perspectives and expectations of healthcare professionals on what MHCs can do in hospital settings to facilitate medical and mental health services and enhance the well-being of patients.

CHAPTER III

Methodology

This chapter offers a detailed description of the methodology employed to address the research questions of this study. The chapter includes the theoretical framework and the research design, Concept Mapping (CITE), detailing the steps that involve preparing for the study, including the sample in each round of data collection, generating ideas, structuring the generated ideas, and data analysis, and interpreting the maps. Next, I discuss the trustworthiness (testimonial validity) and conclude by highlighting the limitations of this study.

Theoretical Framework

In this study, I aimed to understand the specific tasks of counselors in hospital environments from the lens of different healthcare professionals within the multidisciplinary team working in the hospital settings. I used an exploratory sequential mixed-methods design (Hanson et al., 2005) concept mapping (CM; Kane & Trochim, 2007) from a social constructivist framework (Kane & Trochim, 2007) to address this purpose. CM allowed me to collect, combine, analyze, and interpret the qualitative and quantitative data to explore the phenomena (Anguera et al., 2018; Leech & Onwuegbuzie, 2009; Wachter Morris & Wester, 2018).

CM is a unique structured methodology from a social constructivism framework (Kane & Trochim, 2007). It organizes and mirrors diverse groups of people's ideas and perceptions to create insight, understanding, and agreement (Kane & Trochim, 2007; Rosas & Kane, 2012). It is seen as a mixed-methods design as it integrates qualitative (i.e., generation of statements/ideas) and quantitative data (i.e., generating visual maps) gathered from the stakeholders of the study area. In CM, participants are the main focus of the study, and they are involved in multiple rounds of data collection. In the initial phase, participants shared their views verbally or written

on the phenomena under study. Next, I (the researcher) transferred participants' views into quantitative pictorial maps to better understand their perspectives (Kane & Trochim, 2007; Trochim, 1989). I then facilitated a focus group for participants to generate concepts, sort ideas into clusters, interpret results, and decide on the utilization of maps (Kane & Trochim, 2007). Through the focus group process, I observed how each idea defined the phenomenon related to one another leading to a holistic representation of complex ideas (Trochim, 1989). Participants' views and their relationships are displayed in value plots and pattern matches. As a result, the visual maps provide knowledge of the issue and consensus on the way forward (Rosas & Kane, 2012).

Kane and Trochim (2007) highlight certain advantages offered by CM. CM requires participants to generate, sort, and shape data and interpret the results of the analyses. CM enables the researchers to collect data from any group and setting. It is suitable with small or big groups of participants making the group size not an issue. CM also involves the researchers integrating the different views using advanced statistical methods, such as visual representation, to generate a precise series of results. The last advantage is using a focus group's collaborative process to develop a framework to add to the existing knowledge about the phenomena (Kane & Trochim, 2007). The generated framework can further define the MHCs' tasks in the hospital settings in the current study.

I found CM as an ideal fit to address the research question of this study. Firstly, CM allows me to work with a small sample size and capture different healthcare professionals' voices, views, and beliefs within the multidisciplinary team about counseling in the hospital settings. With CM, I can facilitate the process for participants to organize their opinions into different clusters and involve them in a focus group to interpret the results. As a result, with the

implementation of CM procedures, participants were involved in every phase of data collection, analysis, and framework development. The developed framework can shed light on practical approaches counselors need in hospital settings to facilitate medical and mental health services and enhance patients' well-being. Data will finally provide more knowledge to MHCs and other health professionals on the role of MHCs in hospital settings to promote the best clinical practice that serves their patients.

Concept Mapping Steps

Kane and Trochim (2007) presented CM in six steps: (1) preparing for concept mapping, (2) generating ideas, (3) structuring the generated ideas, (4) concept mapping analysis, (5) interpreting the maps, and (6) utilization of maps. The sixth step focuses on developing an instrument from the first five steps. The scope of this study was to elicit knowledge on the role of the MHC in the hospital setting, and since the sixth step goes beyond the scope of the current research, I used only the first five steps to address the research question of concern. Yet, I discuss results ideas for utilizing the maps in Chapter 5, providing suggestions for practical applications, research implications, and data for future studies. Below, I present an outline of the concept mapping steps for the proposed research. The data for the current study were collected between January to April 2022.

Step 1: Preparing for Concept Mapping

I completed the following tasks of the first step of CM (i.e., define the issue, describe the study's focus, identify relevant participants, and the sampling method; Trochim, 1989; Kane & Trochim, 2007) as I devised the research proposal.

Define the Issue

The topic of interest addresses the lack of knowledge and research found on the tasks of MHCs in hospital settings. Lack of research and understanding leads to possible confusion between healthcare professionals in the multidisciplinary team, impacting the facilitation of services of different professionals within the multidisciplinary team (e.g., doctors, nurses, counselors) and the well-being of patients. In this study, I offer MHCs and healthcare professionals (e.g., doctors, nurses), counselor educators, and clinical supervisors information on what MHCs' can do in hospital settings to enhance medical and mental health services and enhance patients' well-being. Understanding the unique components and processes of MHCs tasks in hospital settings provides knowledge on what MHCs interventions would most facilitate the different services and effectively improve the well-being of patients.

Focus of the Study

A significant preparation step involved developing the domain of conceptualization. This step included my study focus which was then used to generate statements and brainstorming processes. The brainstorming focus produced the pool of participants' views analyzed in this study (Kane & Trochim, 2007). Therefore, in this study, my focus was to generate statements by professionals within the multidisciplinary team. Participants were asked to produce as many ideas as possible that describe their perspectives on unique tasks the MHCs can provide in hospital settings that support patients' medical and mental health services and enhance patients' well-being.

Selecting the Participants

The second essential part of the preparation step involved the researcher identifying and selecting participants who carry information to meet this study's purpose (Kane & Trochim, 2007). All participants were expected to have a clear and distinct perspective/viewpoint on the

tasks of MHCs in hospital settings. Therefore, to meet this objective, I decided to select participants from different professionals functioning in multidisciplinary teams within a specific hospital setting to control the potential effects of systemic and practice variations across hospitals. Possible systemic and practice variations may include patients' services, a flow chart of roles and responsibilities, hospital ethos and culture, and team dynamics.

I chose a hospital in Hampton Roads, Virginia, for the current study. I have been part of this hospital system since August 2020 as a mental health counseling intern and site supervisor. Thus, I have had the privilege and opportunity to know members of multidisciplinary teams. Furthermore, this hospital is an ideal fit for the current study for two main reasons: (1) This hospital already has MHCs services in place provided by MHCs interns that supply to both inpatient and outpatient units, and (2) the healthcare professionals are exposed to counseling within the hospital setting. This means that healthcare professionals at this hospital are exposed to the counseling services in hospital settings to provide data based on the different tasks of the MHCs in hospital settings based on personal experience rather than perceptions without experience.

Identifying the participants and defining the sampling strategy were essential for the preparation step. To better understand which healthcare professionals from the hospital to include in the current study, I conducted a brief survey with MHCs and MHC trainees working at the CRH. I asked them to identify which professionals within the multidisciplinary team they have regularly worked with. This brief survey identified the professionals who can elicit data based on their working experience with counselors at the hospital. Out of 13 participants, ten reported working primarily with nurses, doctors, social workers, case managers, and crisis intervention clinicians. Two participants also mentioned that they also worked with chaplains,

dietitians, and physical therapists on one occasion. Therefore, I recruited physicians, nurses, social workers, case managers, chaplains, crisis clinicians, dietitians, and physical therapists for the current study.

It was also critical to ensure participants had the necessary working experience to speak of their perspectives on MHCs' tasks in the hospital setting. Therefore, I also determined criteria for participant eligibility in the current study. Eligible participants were 1) at least 18 years of age and 2) doctors, nurses, social workers, case managers, chaplains, crisis clinicians, dietitians, and physical therapists with a minimum of six months of experience working with MHSc or MHC trainees providing counseling services at the hospital. I identified six months as an adequate period for enough exposure to counseling services in a hospital setting to explain the phenomenon of exploring the specific tasks of MHCs in the multidisciplinary team.

Once the Institutional Review Board (IRB) approval was received, I physically and via email reached out to the stakeholders at the hospital with the information sheet (Appendix A) on the study procedures, the purpose of the study, and the inclusionary criteria. In the information sheet, they were given a Qualtrics link leading to the informed consent (Appendix B), demographic survey (Appendix C), and the probe for the first round of data collection (Appendix D). In terms of sample size, CM indicates that at least 10 participants are needed to gather enough information for the researcher to produce robust results (Kane & Trochim, 2007). Therefore, I aimed to recruit as many participants as possible with a minimum of 10 participants using a purposive snowball sampling procedure.

Participants of the Study. A total number of 26 participants participated in different data collection steps of the study. Despite being ideal, participating in all steps of the data collection is not required in CM (Kane & Trochim, 2007). In the current study, 26 participants

participated at least one of the three data collection steps (100%), 10 participants participated in two data collection steps (38.46%), and five participants participated in all three rounds of data collection (19.23%).

Four participants were doctors (15.38%), six were nurses (23.08%), one was a nurse practitioner (3.85%), one was a lactation consultant (qualified as a midwife) (3.85%), two were chaplains (7.69%), one was a dietitian (3.85%), three were crisis clinicians (11.54%), two were physiotherapists (7.69%), four were case managers (15.38%), and two were social workers (7.69%). All the participants specified having direct working experiences with MHCs or MHC-trainees at the hospital chosen for this study (100%). Seven participants stated they have worked at the selected hospital for this study for the last six months to one year (26.92%), eight reported one to three years (30.77%), six reported between three to six years (23.08%), and six indicated more than six years (23.08%). Among participants, six reported practicing in their current profession for six months to three years (23.08%), three for three to six years (11.54%), one from zero to five months (3.85%), and sixteen for more than six years (61.54%). Fourteen participants claimed to have worked with counselors or counselor trainees before they started working at the selected hospital for this study (53.85%). In contrast, twelve indicated they never worked with counselors or counselor trainees before working at this hospital (46.15%). Eleven participants specified counseling services had been established for “years” at the previous hospital where they worked with counselors (42.31%). One reported counseling services had been established for “months” (3.85%), whereas two participants indicated not knowing how long counseling services were established in their previous hospital where employed (7.69%).

In terms of gender and race, eighteen participants were women (69.23%) and eight were male (30.77%). Eighteen identified as White (non-Hispanic; 69.23%), four identified as African

American/Black (15.38%), and three as Asian/Pacific Islander (11.54%). Seventeen participants claimed to have a European American background (65.38%), four identified with an African American ethnic background (15.38%), and three with an Asian Pacific Islander ethnic background (11.54%). One participant claimed to be an immigrant coming from Europe (3.85%), and one participant did not specify their ethnic background and reported as “other” (3.85%).

Due to the nature of the design, participation in all three rounds of data collection was a challenge. Thus, to support retention, I incentivized participants’ involvement in three rounds of data collection. I provided participants with the following incentives: each participant was offered a bag of candies in the first round of data collection and a \$15 Amazon gift card for participation in the second and third rounds of data collection.

Step 2: Generation of the Statements

The next step is the generation of statements representing the conceptual domain for the phenomena under study (Trochim, 1989). In this step, the aim was to obtain generated ideas through a brainstorming process done by the participants. Brainstorming in CM differs from traditional brainstorming. As opposed to the ‘everything goes’ conventional brainstorming nature, brainstorming is a targeted activity to produce all possible ideas, knowledge, and issues in response to a focus prompt set by the researcher in CM (Kane & Trochim, 2007). Thus, I devised a prompt to clarify the phenomenon under study and support participants in creating ideas. The prompt for this study stated: “Generate as many short phrases or sentences as possible to describe different tasks counselors can do in hospital settings. One specific task of a MHC in this hospital to enhance patients’ well-being and facilitate medical services is.” I pilot tested this prompt and all documents mentioned above and presented in the Appendices with individuals outside of academia to ensure how clear the information and directions were for the

participants (Kane & Trochim, 2007). Participants from the pilot study suggested that all the instructions and documents of data collection in this step were clear and easy to follow.

Although CM does not specify a limit to the number of statements each participant can generate, Trochim (1989) advises researchers to limit the number of statements utilized in Step 3 to 100 statements or less. A higher number of statements imposes severe practical constraints, including excessive time to input data, needless content redundancy, and group energy loss (Kane & Trochim, 2007). Therefore, I allowed each participant to develop a maximum of 100 statements to keep the researchers' editing and synthesizing process manageable.

To recruit participants for the generation of statements task, I physically approached healthcare professionals at the hospital. I provided them with the invitation letter for this study which contained a brief explanation of the CM process (Appendix A) and access to the Qualtrics link. Volunteering participants used the provided iPad to access the Qualtrics link, which took them to the study consent form (Appendix B), a short demographic survey (Appendix C), and the guidelines on the generation of statements task and a prompt (Appendix D). Volunteering participants who could not access the Qualtrics link when I approached them at the hospital were emailed the Qualtrics link to access it that same week. At the end of the task, I asked participants to leave their email addresses to be contacted for participation in the second round. They provided their email addresses through a separate Qualtrics link not connected to the study's data collection in order to protect their responses from identification.

Out of 26 participants who showed interest in participating in the study, 25 participants partook in the first round of data collection, resulting in a 96.15% response rate. Across the 25, four were doctors (16%), six were nurses (24%), one was a nurse practitioner (4%), one was a lactation consultant (qualified as a midwife) (4%), two were chaplains (8%), one was a dietitian

(4%), two were crisis clinicians (8%), two were physiotherapists (8%), four were case managers (16%), and two were social workers (8%). Out of these 25 participants, seventeen were women (68%) and eight were male (32%). Eighteen identified as White (non-Hispanic; 72%), four identified as African American/Black (16%), and three as Asian/Pacific Islander (12%). Sixteen participants claimed to have a European American background (64%), four identified with an African American ethnic background (16%), and three with an Asian Pacific Islander ethnic background (12%). One participant claimed to be an immigrant coming from Europe (4%), and one participant did not specify their ethnic background and reported as “other” (4%).

Among participants, six reported practicing their current profession for six months to three years (24%), three said practicing for three to six years (12%), one reported practicing from zero to five months (4%), and fifteen reported practicing their profession for more than six years (60%). Seven participants stated that they have been working at the chosen hospital for this study for the last six months to one year (28%), eight reported one to three years (32%), and six reported between three to six years (24%). Four indicated working at the hospital chosen for this study for more than six years (16%). All the participants specified having direct working experiences with counselors or counselor trainees at the hospital chosen for this study (100%). Fourteen participants claimed to have worked with counselors or counselor trainees before they started working at the selected hospital for this study (56%). In contrast, eleven indicated never worked with counselors or counselor trainees before working at this hospital (44%). Eleven participants specified counseling services had been established for “years” at the previous hospital where they worked with counselors (44%). One reported counseling services had been established for “months” (4%), whereas two participants indicated not knowing how long counseling services were established in their previous hospital where employed (8%).

Idea Synthesis

In the idea synthesis step, I reduced and edited the resulting set of statements. Using the provided Qualtrics link, participants generated a pool of 119 statements. I transferred all generated statements onto a Word document and numbered each statement. Then, I organized, edited, and split compound ideas to remove redundant statements while preserving the integrity of the generated ideas (Kane & Trochim, 2007). I consulted with another researcher (dissertation chair) familiar with concept mapping methodology to reduce researcher bias. Kane and Trochim (2007) suggest reducing the original pool of statements during the editing and synthesis process to approximately 100 statements to prevent excessive data input time and participant burnout during the structuring of statements data collection phase.

After multiple consultations with my dissertation chair throughout the editing and synthesis process, we created a final list of 104 statements. We synthesized the statements to maintain the conceptual richness, nuances, and value of the data generated by the participants. To test that each statement was clear, understandable, and relevant to the study's focus, I pilot tested the Structuring of the Statements task with two of my former nursing colleagues who worked at a different hospital than the one utilized to recruit participants for this study. They both felt the platform was user-friendly and had no issues to fulfill this task. Following the generation of statements step, I moved into the structuring the statements step of data collection.

Step 3: Structuring of Statements

In the structuring of statements step, participants sort the final pool of statements into categories and rate each statement based on their priority and importance to participants. The sorting task provides a better understanding of the interrelationship between statements that will lead to the conceptual domain structure (Kane & Trochim, 2007). Out of 25 participants in Step

2, nine chose to do Step 3 of the data collection. One new participant meeting the inclusionary criteria from the generated email sent out to all healthcare professionals at the hospital decided to participate in the structuring statements step of data collection. Eight were female (80%), and two were males (20%). Eight participants were white (non-Hispanic) with European American ethnic background (80%), one was African American/Black with an African American/Black ethnic background (10%), and one participant chose 'other' and did not specify any racial nor ethnic background (10%). Three participants were nurses (30%), two participants were doctors (20%), two participants were case managers (20%), one participant was a social worker (10%), one participant was a crisis clinician (10%), and one participant was a chaplain (10%). Two participants claimed of practicing their profession for six months to three years (20%), three participants indicated three to six years (30%), and five participants indicated more than six years of practicing their profession (50%). Three participants claimed to work at the hospital chosen for this study for more than six years (30%), two indicated three to six years (20%), and four showed one to three years (40%). One pointed to working at the hospital chosen for this study for six months and more (10%). All ten (100%) participants had direct working experiences with counselors or counselor trainees at the hospital. Six participants (60%) claimed to work with counselors or counselor trainees before their working experience at the hospital chosen for this study, whereas four (40%) claimed no working experience with other counselors or counselor trainees. Two participants worked for six months (20%), two worked for three to 6 years (20%), and two worked for more than six years with counselors before working at the chosen hospital for this study (20%). Three participants were unaware of how long the counseling service had been established in the previous hospital (30%), and three indicated it had been in place for 'years' (30%).

For the sorting task, the following guidelines and restrictions were provided to the participants (Appendix E); 1) each statement is placed into a category, 2) a statement cannot be placed into more than one category simultaneously, 3) all statements cannot be placed into one single category, and 4) a statement can be on its own within one category. Excluding these restrictions, participants were free to create as many categories as they deemed necessary. Participants were offered two options for completing the sorting task: 1) attend a small group session or 2) perform this stage online when they have time to complete the tasks. I provided several optional dates to join the small groups, but no participants attended. All ten participants chose to sort statements electronically through the provided Provenbyuser (provenbyuser.com) link to put the statements into conceptually meaningful categories based on their experiences and perspectives. A link directed participants to a short demographic survey followed by guidelines (Appendix E) on the sorting task along with the final set of statements that emerged from the editing and synthesis stage. The guidelines instructed participants to classify the final pool of 104 statements into different groups based on their understanding of the statements' interrelations and/or similarities and to provide a title representative of each of their categories (Trochim, 1989).

After sorting the statements, participants were directed to an automated Qualtrics link for the rating task. The rating task addressed this study's second research question; what are the most important tasks of MHCs in the hospital settings as identified by health professionals? Participants were instructed (Appendix F) to rate each statement according to its importance as pertinent to their professional practice on a Likert-type scale ranging from 1 (not important at all) to 5 (highly important). All ten participants who participated in Step 3 completed both the sorting

and rating tasks. Once data was obtained through the structuring of statements tasks, I began the data analysis process to create the initial concept maps.

Step 4: Concept Mapping Analysis

The core of the concept mapping process is analyzing and mapping data gathered from participants' sorting task. I started this step by structuring the data phase and ended by presenting a set of visual materials that provided me with a holistic picture of the participants' thoughts concerning their perceptions and expectation of what counselors can do in the hospital setting. The holistic picture generated in this step becomes the basis of the interpretation session in Step 5. The materials generated during the concept mapping analysis included maps and statement listings, pattern matches, go-zones, and other reports (Kane & Trochim, 2007). I utilized the statistical program R Editor (2019) to conduct multivariate statistical procedures that included a Group Similarity Matrix (GSM), a Multidimensional Scaling (MDS), and a Hierarchical Cluster Analysis.

Group Similarity Matrix (GSM)

Firstly, I entered the participants' data from the sorting task into a sort recording sheet to form a Group Similarity Matrix (GSM). In this step, I listed sorting data results by creating an Excel sheet where rows represented the participants' statements and columns represented the participants. Every participant generated a different number of conceptual groups (i.e., categories) of statements. I numbered each participants' categories and then assigned the number of the category to each statement within that grouping. For example, P2 sorted all the statements into 11 groups, so the maximum number of categories for P2 was 11; however, P1 had only six groups, so the maximum number entered into the GSM for P2 was 6. With this data set, I created a GSM an aggregated of the sorting data through R editor (2019). This was done to create a

square matrix displaying the number of participants that similarly grouped pairs of statements during the sorting task. The GSM represents the relational structure of how participants grouped the statements during the sorting task (Kane & Trochim, 2007). The more participants who paired statements into a category together, the higher the resulting value is for those statements in the GSM. A high value in the matrix signifies that the ideas are conceptually similar. In contrast, a low value in the matrix indicates fewer people placed those statements in comparable piles; hence, the statements with lower values are conceptually less similar. Thus, I observed and understood participants' perspectives of interrelationships among statements through creating the GSM.

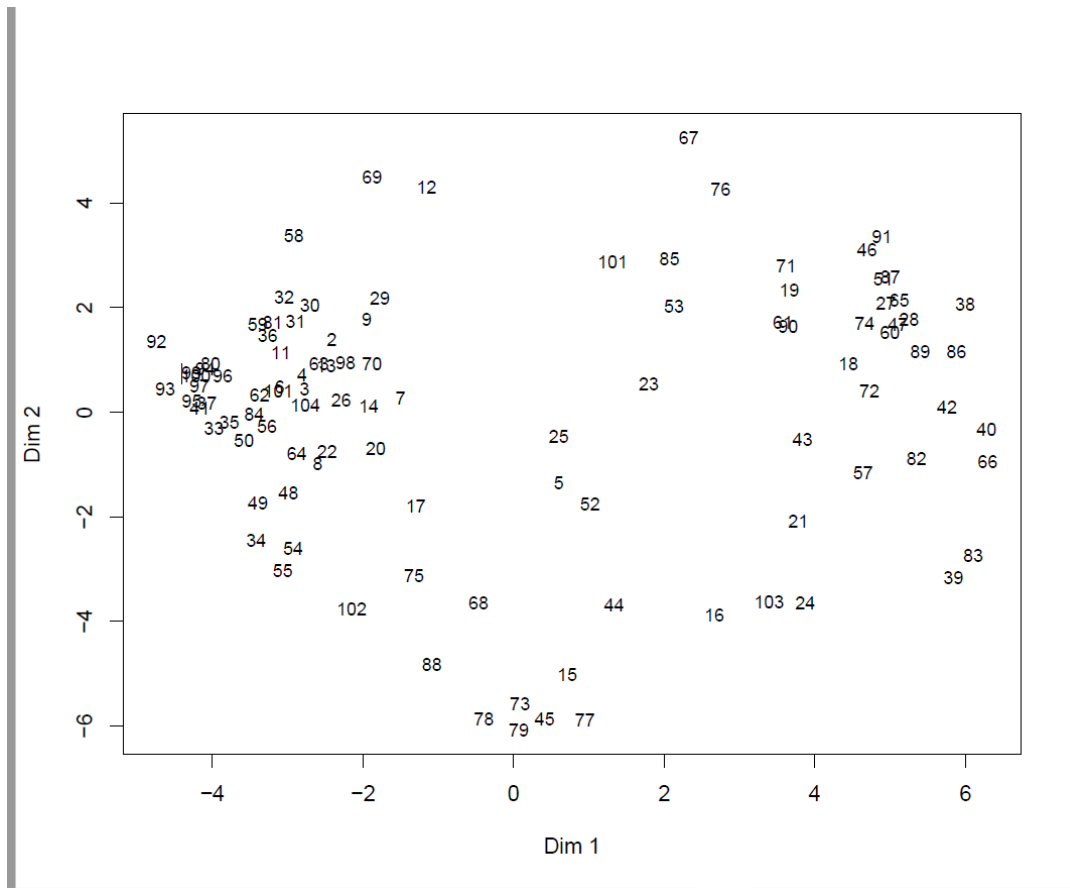
Multidimensional Scaling

Next, I utilized the GSM to conduct a two-dimensional, nonmetric multidimensional scaling (MDS) analysis for the 104 sorted statements and generated a point map in the R editor (see Figure 1), where dots show each statement's location on the map. The MDS also produced coordinate values for each statement's location on the maps. I looked for statements' proximity to each other on the point map as an indicator that participants placed those statements in similar categories. Statements that were repeatedly grouped into the same categories were located more closely together, which provides an initial picture of the clusters that will be identified in the concept map. Moreover, I reviewed the stress value, referring to the MDS's central diagnostic statistics. The stress value obtained showed the difference between the values in the GSM input and the distance on the point map. The range of stress values for most concept mapping studies indicated by Kane and Tronchim (2007) falls between 0.205 and 0.365, so the stress value of 0.212 in the R output indicated a good fit in the current study. The high-stress index may show more complexity in the similarity matrix than that can be demonstrated well in two dimensions,

suggesting a sizable variability in how participants sorted the statement or both (Kane and Tronchim, 2007). I used the stress indicator value to guide the point map level standing for the grouping data.

Figure 1

Point Map



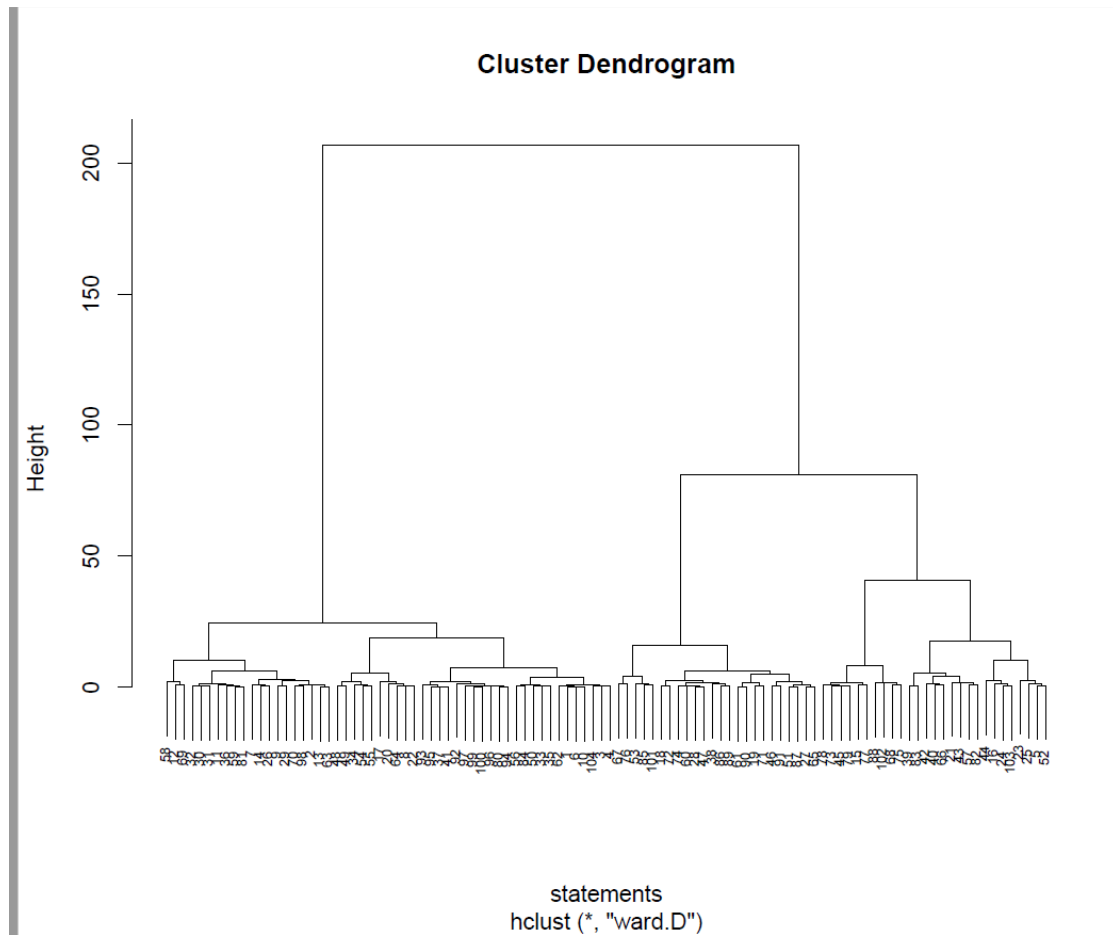
Hierarchical Cluster Analysis (HCA)

HCA groups participants' statements on the point map to form clusters of statements that reflect similar concepts. I used the coordinate values of the two-dimensional solution obtained from MDS to run a hierarchical cluster analysis (HCA) through the R editor (2019), yielding a cluster tree (see Figure 2). It organized all statements into a cluster tree that provided a concrete

visual representation of the clusters based on conceptual similarities (Kane & Tronchim, 2007). I simultaneously worked on the point map and dendrogram to identify the the statements' similarities to determine initial groupings that would become the clusters on the concept map (Kane & Tronchim, 2007). I started with the smallest pairs and triads groups, then looked more closely at the cluster tree which shows links across the statements, and kept observing/analyzing until the hierarchically highest cluster at the top of the map. In this step I created the first list of clusters and cluster maps that embody the data's underlying structures. I consulted with another researcher (dissertation chair) familiar with this methodology to ensure congruency between the map's positions and the assigned clusters.

Figure 2

Cluster Tree



Anchoring and Bridging Analysis

According to Kane and Trochim (2007), every statement must be placed somewhere on the concept map, and MDS distributes a place to a statement based on how many people sorted statements next to the statement. In such a case, that statement is called an ‘anchor’ (Kane & Trochim, 2007, p. 101) because its vicinity reflects the content. On the other hand, other statements can link two distant clusters on the map, called bridging statements. Bridging statements are when a statement is distributed in the middle of two clusters without any conceptual similarity. This may show that participants sorted those statements in various categories which were conceptually dissimilar, and the algorithm then placed that statement in an

intermediate position (Kane & Tronchim, 2007). Therefore, I observed any anchoring and bridging statements and consulted with my dissertation chair to identify if a statement is a bridging or an anchoring statement and decide how to proceed.

Analyzing the Data from Rating Task

I first calculated the mean score of each statement to analyze data from the rating task. After determining the final cluster solution, I used the rating task data to calculate the mean score for each cluster. The mean scores for each cluster rating showed the importance of each cluster to healthcare professionals. Additionally, I used frequencies to explore potential differences among healthcare professionals in terms of the importance of each cluster.

Selecting the Number of Clusters and Labels of the Clusters for the Preliminary Cluster Map

I applied the statement branches from the cluster tree and the point map to identify ten preliminary clusters. In this phase, I concluded the number of clusters to create a preliminary cluster map. Kane and Trochim (2007) argue that there is not a formula for selecting the number of clusters or limit the number of clusters to include in the preliminary cluster map. In this step, I identified different labels for each of the preliminary clusters utilizing each cluster's own content and other cluster's content as well as each participant's suggestions for the cluster labels from the sorting task. The aim of naming the clusters is to anticipate the discussion in the interpretation session (focus group; Kane & Trochim, 2007). However, before using the cluster solution in the formal interpretation session, Kane and Tronchim (2007) recommend that researchers have an auditor review the clusters. Thus, I first consulted with the dissertation chair and methodologist on the preliminary clusters and then sent the ten preliminary clusters and one by itself cluster to an external auditor. The external auditor was a counselor education faculty member who possessed experience with mixed methods designs and clinical and research

practices in IBH settings, who was qualified to offer feedback on the final clusters with their statements and their conceptual meaning and appropriateness (Kane & Trochim, 2007). I asked the auditor to review the statements, the cluster tree, and the point map and to offer feedback on the conceptual consistency across the statements within each assigned cluster, the labels given to each cluster, and any other suggestions or feedback they might have. The external auditor provided comprehensive comments about two statements and suggested a new cluster. After reviewing the feedback and consulting with the dissertation chair/methodologist, I moved two statements to another cluster for a better conceptual fit, changed one cluster label, and formed a new cluster with a new title. These last changes led to completing the preliminary cluster map for the formal interpretation session (focus group). The focus group included participants who agreed to participate in the third data collection phase.

Step 5: Interpreting the Maps

I facilitated the third phase of data collection (i.e., the focus group) synchronously via zoom due to the current global pandemic, which would inhibit in-person gathering for concept mapping tasks. I emailed all 26 participants, and five attended the synchronized focus group. Since participant retention is challenging in CM due to the significant involvement needed by the participants in the three different data collection rounds, a smaller sample of original participants was anticipated to participate in the focus group (Kane & Trochim, 2007). Additionally, the current increase and overwhelming demands on healthcare professionals from the COVID-19 pandemic made participant retention even more challenging. Yet, the five participants who attended the focus group were active and engaged in the session and contributed during the discussion, revision, suggestions, and consensus-seeking on the material presented.

Across focus group participants, four identified as white (non-Hispanic; 40%) and with a European American ethnicity (80%). In contrast, one participant identified as African American/black ethnic and racial background (10%). In this step, two participants were crisis clinicians (40%), one participant was a chaplain (20%), one participant was a social worker (20%), and one participant was a case manager (20%). Three claimed of practicing their profession for 3 to 6 years (60%), and two reported practicing their profession for more than six years (40%). For this study, all participants had direct working experience with counselors or counselor trainees at the current hospital. Four worked in this hospital for 1 to 3 years (80%) and one for more than six years (20%). Three participants (60%) claimed not to work with other counselors before working at the hospital chosen for this study, and two (40%) claimed to work with counselors before working at this hospital. None of them knew how long the counseling services had been established at the previous workplace.

To familiarize participants with the data, I emailed the preliminary clusters to the participants before the focus group session. It allowed participants to view the results from the CM analysis, relate the finalized results to the conceptual grouping, and reflect on if the results make sense. I started the focus group by presenting the focus group agenda (Appendix G), specific characteristics and/or norms of the focus group (e.g., the focus group was 60 minutes long, participants could keep their cameras off if they wished to stay anonymous), as well as asking permission to record the session for later review if necessary. I informed them that I would delete the recording from my computer once I finalized the analyses. Then, I summarized the first two data collection steps that led to the preliminary regions and their clusters. I introduced the point map and briefly went through the 11 preliminary cluster lists and the point map (see Figure 1). Then, I asked participants to observe how statements and clusters of ideas

relate to one another (Kane & Trochim, 2007). Participants reviewed each statement in each cluster and provided feedback, suggestions, or observations on how the statements within the cluster are conceptually similar or if any of the statements might not fit or belong to the cluster. This was followed by a group discussion on the suggested changes to reach a group consensus.

Finally, all participants were asked to review the preliminary cluster labels and regions and provide feedback or suggestion on how the label defines the group statements in the cluster. After some discussion, the focus group participants agreed to keep all the statements within the preliminary clusters and regions and accepted all the labels given to each cluster and region. Participants all agreed on a missing statement highlighting MHCs' task of providing psychoeducation to parents and family members within cluster 6 and revising the cluster label to 'educating patients and families.' However, since none of the 104 statements highlighted this specific task of MHCs, we could not do this suggested revision. The purpose of the focus group was not to add new data but for member checking that finalizes the generated data results from the first and second rounds conceptually. In addition, I invited the participants to conclude the results by engaging in discussions where they shared their thoughts on the statements, clusters, areas, and the map. Thus, this process addressed the first research question (i.e., according to healthcare professionals, what do MHCs do in hospital settings to facilitate medical and mental health services and enhance patients' well-being?), resulting in 104 statements conceptually grouped in 11 clusters within three regions (see Appendix J). I also kept a journal to list any impressions gathered from the focus group process in completing the results.

Trustworthiness

Researcher Epoch

The extent and quality of the relationship between me and the research can potentially threaten a study's trustworthiness (Hays & Singh, 2012). I am a former nurse and currently a doctoral counseling intern at the chosen hospital for this study, so I am immersed in the topic and the research site under study. Therefore, I kept a reflexive journal throughout all data collection methods and analysis to notice all possible biases, bracket all prior and current knowledge, and increase neutrality (Hays & Singh, 2012). This journal holds my reflections on how the research process impacted me. It also includes my thoughts on how participants, data collection, and analysis affect me professionally and personally. Besides, I also added any hunches about potential findings and descriptions of any original plan changes on data collection methods, sources, and analysis adopted. This journal was part of my audit trail. Therefore, these notes were a helpful reminder of why and how decisions, communication with various stakeholders and critical informants, and final themes were made in such a way (Hays & Singh, 2012). Additionally, I debriefed with peers to check for any biases and to remain neutral during the research process (Hays & Singh, 2012) while building testimonial validity to represent findings (Bedi, 2006). Using an external auditor to review the appropriateness of final clusters with the participants' statements further supported my neutrality and increased this study's validity and trustworthiness (Kane & Tronchim, 2007).

Testimonial Validity

I built testimonial validity to increase this research design's trustworthiness by agreeing with the participants' intended meaning and data interpretations. Bedi (2006) claims that testimonial validity refers to how phenomena are understood from the participants' perspectives

and through their own words instead of based on the researcher's preexisting biases (Bedi, 2006). Therefore, in this study, I established testimonial validity by inviting all participants to participate in the three rounds of data collection and interpreting the results from the procedures. This collaboration (member checking) increases the chances that this study's results accurately reflect participants' voices and intended meanings in the overall outlining themes (Hays & Singh, 2012).

Summary

This chapter outlined the research design that addressed the research questions. Specifically, I discussed how I carried out the five steps of CM procedures to address the purpose of the current study. I finalized the chapter with an overview of my intent to address trustworthiness in data collection and analyses.

CHAPTER IV

Results

In this chapter, I will present the CM results, specifically conceptualizing healthcare professionals' perspectives on the MHC's tasks in the hospital settings and quantifying the importance of those per healthcare professionals' practices. I pursued addressing two research questions for the purposes of the study.

Research Question 1: According to healthcare professionals, what do MHCs do in hospital settings to facilitate medical and mental health services and enhance patients' well-being?

Healthcare professionals conceptualized MHCs' tasks in hospital settings to facilitate medical and mental health services and enhance patients' well-being in 104 statements grouped in 11 clusters forming three main regions. The three regions are presented in Table 1.

Tabel 1

Region List

Regions	Clusters Title
Overarching Roles and Responsibilities of MHCs in the Hospital setting	1. Fundamental Roles and Responsibilities in the Hospital Setting
	2. Specific Roles and Responsibilities in Different Hospital Units
MHCs' Specific Role in the Hospital Setting	3. Building Relationship with Patients
	4. Assessing/Evaluating Patients' Mental Health Status
	5. Assisting and Supporting patients with Physical, Psychological, and Social Challenges in Relations to their Medical Condition
	6. Educating Patients
Roles and Responsibilities as a Multidisciplinary Team Member	7. Advocating for Patients in the Multidisciplinary Team
	8. Mediating Communication Between Healthcare Professionals, Patients, and Families

9. Collaborating with Other Multidisciplinary Team Members on Patients' Care
10. Training Other Multidisciplinary Members on General Wellness and Mental Health
11. Offering Trainings and Emotional Support to Other Multidisciplinary Team Members

Region 1: Overarching Roles and Responsibilities of MHCs in the Hospital setting

This first region consisted of two clusters (see Table 1), encompassing 29 statements representing MHCs' services to enhance patients' wellbeing. This region was located on the left mid-top area spreading to the mid-bottom area of the map.

Tabel 2

Region 1: Overarching Roles and Responsibilities of MHCs in the Hospital setting

Cluster #	Clusters Title
Cluster 1	Fundamental Roles and Responsibilities in the Hospital Setting
Cluster 2	Specific Roles and Responsibilities in Different Hospital Units

Cluster 1. *Fundamental Roles and Responsibilities in the Hospital Setting* included 18 statements emphasizing the different roles and responsibilities of MHCs in the hospital setting to enhance patients' overall mental wellbeing. This cluster described how MHC could provide emotional and psychological support to patients through their services to hospitalized patients (e.g., Statement 48: Provide behavioral health care services; Statement 50: Provide an avenue for the patient to voice their mental concerns while hospitalized; and Statement 8: Provide mental health support to patients).

Cluster 2. *Specific Roles and Responsibilities in Different Hospital Units* represented 11 statements identifying the need for MHCs' services in explicit units in the hospital settings. This cluster described how MHCs could support the unique needs of patients within these specific units (e.g., Statement # 98: Assist patients in their decisions over treatment especially extraordinary treatment like fertility counseling; and Statement # 92 Provides support to families of patients diagnosed with rare conditions or terminal diseases, assist mothers with childbirth issues; Statement # 97 Support patients going through cancer remission).

Region 2: MHCs' Specific Role in the Hospital Setting

The second region of MHCs' tasks in the hospital settings was mainly located on the upper left quadrant of the map. This region consisted of four clusters containing 38 statements that described MHCs' specific tasks implemented in providing their counseling services to enhance patients' wellbeing (see Table 2).

Tabel 3

Region 2: MHCs' Specific Role in the Hospital Setting

Cluster #	Clusters Title
Cluster 3	Building Relationships with Patients
Cluster 4	Assessing/Evaluating Patients' Mental Health Status
Cluster 5	Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition
Cluster 6	Educating Patients

Cluster 3. With 13 statements, *Building Relationships with Patients* identified unique characteristics and skills needed by MHCs to provide effective counseling services that foster a therapeutic relationship with patients; a relationship where patients felt supportive,

understood, attended, and acknowledged that promoted a safe environment [e.g., Statement # 58 Be empathic in their attitude and behavior; Statement # 30 Make the patient feel seen and heard, attend to emotions, be attentive to patients' needs (e.g., psychological, social, physical); Statement # 63 Be a confidant for patients].

Cluster 4. *Assessing/Evaluating Patients' Mental Health Status* included eight statements. This cluster described the role of MHCs to assess and evaluate patients' mental health status to identify patients' present and future psychological care, treatment, and interventions needed both in hospital and post-discharge (e.g., Statement # 73 Facilitate psychological assessments and provide supportive counseling accordingly; Statement #78 Assess if patient is safe or needs supervision or assistance with activities; Statement # 15 Evaluate patients' needs for further psych treatment; Statement # 44 Assess mothers to see if they are fit to be discharged and care for their baby).

Cluster 5. With 13 statements, *Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition* denoted how MHCs supported patients to process and face the challenges confronted by a new illness/diagnosis, treatment, loss, hospitalization, and future adjustments (e.g., Statement # 36 Help patient process what they are going through; Statement, # 81 Help patients deal with different challenges; Statement # 7 Help patients understand the different steps to take in their recovery; Statement # 1 Assist patients to process loss; Statement # 10 Assist/support patients adapting to lifelong conditions such as diabetes; Statement # 100 Assist/support patients in their process of adapting to amputations).

Cluster 6. *Educating Patients* involved four statements representing MHCs as educators. MHCs were given the role of educating patients by providing psychoeducation and clarification

on any missing information or misinformation about their illness and mental health wellness (e.g., Statement # 70 Be an educator and provide psychoeducation to patients when appropriate; Statement # 22 Provide patients with tools for mental health wellness; Statement #14 Initiate and teach coping skills to patients).

Region 3: MHCs' Roles and Responsibilities as a Multidisciplinary Team Member

The third region was situated in both the upper and lower right quadrants of the map. This region consisted of five clusters describing thirty-six MHCs' tasks implemented as multidisciplinary team members to facilitate services and enhance patients' wellbeing in the hospital setting (see Table 3).

Table 4

Region 3: MHCs' Roles and Responsibilities as a Multidisciplinary Team Member

Cluster #	Clusters Title
Cluster 7	Advocating for Patients in the Multidisciplinary Team
Cluster 8	Mediating Communication Between Healthcare Professionals, Patients, and Families
Cluster 9	Collaborating with Other Multidisciplinary Team Members on Patients' Care
Cluster 10	Training Other Multidisciplinary Members on General Wellness and Mental Health
Cluster 11	Offering Trainings and Emotional Support to Other Multidisciplinary Team Members

Cluster 7. *Advocating for Patients in the Multidisciplinary Team* included three statements that specified the MHCs' task to speak on behalf of patients. Cluster 7 identified the role of MHC as the patient's voice within the multidisciplinary team to facilitate services and enhance patients' wellbeing (e.g., Statement # 67 Advocate for patients' rights; Statement # 65

Be an informant to other health professionals on patients' needs; Statement # 91 Work within a team to achieve patients' best outcome).

Cluster 8. *Mediating Communication Between Healthcare Professionals, Patients, and Families* consisted of nine statements describing the MHCs' mediator task between patients, families, and healthcare professionals. This cluster raised awareness of the role of the MHCs as the bridge/link of information, understanding, and clarification between patients, families, and healthcare professionals [e.g., Statement # 19 Aid in communication between doctor, patient, and family; Statement # 71 "Put out fires" – be a mediator in the cases of tension between different stakeholders (e.g., patients, health professionals); Statement # 101 Establish rapport with patients and find out facts to add to the information other professionals gathered; Statement # 76 Be a link between the services and the patient at the hospital].

Cluster 9. *Collaborating with Other Multidisciplinary Team Members on Patients' Care* emphasized the need for MHCs to collaborate with other healthcare professionals to facilitate services and improve patients' overall care. Cluster 9 consisted of 20 statements describing how MHCs collaborated with healthcare professionals through the provision of different services they provided to patients, such as developing a patient safety plan, making and reviewing medication, aiding in diagnosis, and coordinating discharge planning [e.g., Statement # 83 Assistance in Temporary Detention Orders (TDO); Statement # 23 Help develop patients' safety plan of care, # 103 make and review medication recommendations; Statement # 47 Assist health professionals with identifying who will benefit from psychiatric consults; Statement # 57 Aid in discharge planning; Statement # 87 Communicate ideas on patients' needs/care to other health care providers as counselors are an extra set of ears to patients; Statement # 42 Support nursing staff with patients needing more therapeutic communication].

Cluster 10. *Training Other Multidisciplinary Members on General Wellness and Mental Health* comprised three statements suggesting how MHCs' can train healthcare professionals on how to provide emotional support to their patients during the provision of their services (e.g., Statement # 66 Be an educator to health professionals; Statement #38 Train staff on how to be emotionally supportive to patients; Statement # 89 Counsel other health professionals regarding patient's current issues).

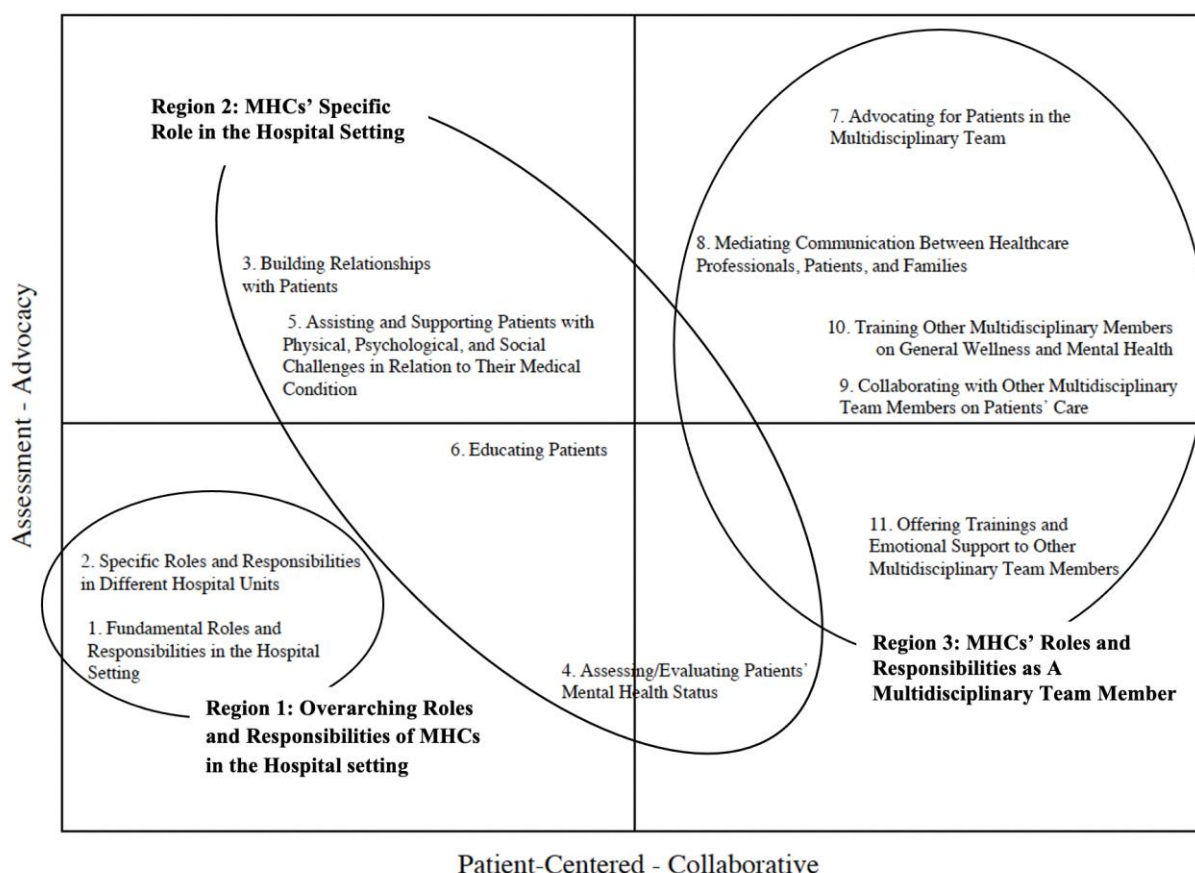
Cluster 11. *Offering Training and Emotional Support to Other Multidisciplinary Team Members* encompassed two statements describing the MHCs' tasks of providing healthcare professionals with personal emotional support and coping skills techniques that support their mental health and wellbeing (e.g., Statement # 86 Facilitate coping techniques training to staff and nursing team; Statement # 40 Provide training to staff on their own emotional well-being; Statement # 39 Provide emotional support to staff).

Two Dimensions of the Concept Mapping

The three regions entailing the different tasks of MHCs in hospital settings consisted of 11 clusters, which were displayed on two conceptually meaningful dimensions. Starting from the left side of the map to the right side, Dimension 1 appeared to include areas highlighting MHCs' patient-centered tasks to MHCs' tasks in collaboration with other healthcare professionals. On the other hand, running from the bottom of the map to the top, areas of clusters in Dimension 2 appeared to present MHCs' patient assessment to advocacy tasks (see figure 3).

Figure 3

Two Dimensions of the Point Map



Research Question 2: What are the most important tasks of MHCs in the hospital settings as identified by healthcare professionals?

To address the second research question, I ran a descriptive analysis of the rating data. I obtained the mean scores for each statement and the mean scores of each cluster to describe the importance level of clusters for the participants on a scale of 0 (Not important at all) to 5 (highly important). Each cluster's mean and standard deviation for all participants are presented in Table 4 below (Appendix K). For all participants' cluster mean scores ranged from 3.63 ($SD = 1.6$) to 3.82 ($SD = 1.63$). The three highest rated clusters as being most important for participants were Cluster 7: *Advocating for Patients in the Multidisciplinary Team* with a mean score of 3.82 (SD

= 1.63), Cluster 5: *Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to their Medical Condition* with a mean score of 3.82 ($SD = 1.62$), and Cluster: 11 *Offering Training and Emotional Support o Other Multidisciplinary Team Members* with a mean score of 3.81 ($SD= 1.62$).

Tabel 5

Cluster Ratings

Clusters	<i>n</i>	<i>M</i>	<i>SD</i>
1. Fundamental Roles and Responsibilities in the Hospital Setting	10	3.69	1.6
2. Specific Roles and Responsibilities in Different Hospital Units	10	3.63	1.6
3. Building Relationships with Patients	10	3.79	1.61
4. Assessing/Evaluating Patients' Mental Health Status	10	3.70	1.57
5. Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition	10	3.82	1.62
6. Educating Patients	10	3.68	1.57
7. Advocating for Patients in the Multidisciplinary Team	10	3.82	1.63
8. Mediating Communication Between Healthcare Professionals Patients, and Families	10	3.63	1.54
9. Collaborating with Other Multidisciplinary Team Members on Patients' Care	10	3.55	1.56
10. Training Other Multidisciplinary Members on General Wellness and Mental Health	10	3.74	1.6
11. Offering Trainings and Emotional Support to Other Multidisciplinary Team Members	10	3.81	1.62

Note: Highest rated clusters are bolded.

Summary

In this chapter, I presented the results of the concept mapping procedures and addressed the two research questions of this study. In the following chapter, I will discuss the findings of this study in the context of existing literature on different tasks of MHCs in hospital settings.

CHAPTER V

Discussion

In this chapter, I will discuss the results of the current study in view of existing literature and address the implications for MHCs, counselor educators, supervisors, and multidisciplinary professionals. Offering directions for future research, I will also discuss the current study's limitations.

The results of the present study addressed the following research questions: 1) According to healthcare professionals, what do MHCs do in hospital settings to facilitate medical and mental health services and enhance patients' well-being? 2) What are the most important tasks of MHCs in the hospital settings as identified by healthcare professionals? Thus, in the present study, I attended to the gap in the literature about the need for scholarly work that outlines the distinct roles and responsibilities that MHCs need to engage in to facilitate medical and mental health services in hospital settings. Being one of the first studies attempting to learn how healthcare professionals view MHC's role in the hospital settings offer opportunities to increase awareness of how MHCs can assist in merging psychological and physical health to improve patients' well-being. The merger of mental and physical health services in the medical environment would help to create a comprehensive continuity of care and ease access to mental health treatment. Providing counseling services in hospital settings can expand exposure and treatment (proactive, reactive, and crisis) that reduce the prevalence of mental health disorders (McGahey & Wallace, 2021).

In the following sections, I will discuss the three regions and respective 11 clusters, conceptualizing healthcare professionals' perspectives on the different tasks of MHCs in the hospital settings to facilitate services and improve patients' well-being.

Healthcare Professionals' Conceptualization of MHCs' Tasks in the Hospital Setting:

Areas and Clusters

Research question 1: *According to healthcare professionals, what do MHCs do in hospital settings to facilitate medical and mental health services and enhance patients' well-being?*

After completing the data collection and analysis procedures, I obtained three regions that outlined healthcare professionals' perspectives on the different tasks of MHCs to facilitate services and improve patients' well-being. *Overarching Roles and Responsibilities of MHCs in the Hospital Setting* (Region I) contained two clusters of MHCs' tasks, while *MHCs' Specific Roles in the Hospital Setting* (Region II) entailed four and *MHC's Roles and Responsibilities as a Multidisciplinary Team Member* (Region III) hosted five clusters.

Region 1. Overarching Roles and Responsibilities of MHCs in the Hospital Setting

Presented in two clusters, "Fundamental Roles and Responsibilities in the Hospital Setting" and "Specific Roles and Responsibilities in Different Hospital Units," healthcare professionals highlighted their perspectives on MHCs' fundamental roles and responsibilities across the hospital setting and other specific roles and responsibilities counselors could engage in specific hospital units. The clusters and their respective statements from this region instilled the understanding that healthcare professionals identified the need to integrate mental health care in the patients' overall care within the hospital setting. Although, to this day, no research has yet studied healthcare professionals' perspectives on integrating MHCs in the hospital settings, the importance of addressing patients' overall mental health and physical needs was similarly found in other studies done in primary care settings (Pomerantz et al., 2009; Schafer et al., 2009; Payrot and Rubin, 2007). In Schafer et al.'s (2009) study, general practitioners perceived onsite

counseling services in the primary care mental health services as beneficial in their general practice. Of all the participants in Schafer et al.'s study (2009), 82% referred their patients to onsite counseling services and believed that counseling was preventive. Subsequently, they did not need to refer their patients to secondary services.

Similar to Schafer et al.'s study (2009), the first cluster of the region, "Fundamental Roles and Responsibilities in the Hospital Setting," identified how healthcare professionals perceived the importance of MHCs supporting patients' overall mental well-being. Participants of the current study highlighted the need for MHCs to address patients' immediate/emergency/crisis mental health needs by delivering daily one-on-one counseling services. Likewise, McGahey and Wallace (2021) spoke about providing onsite counseling in the medical setting as the omnibus approach where patients are offered one-stop shopping aligned with the current study's findings. Based on the assumption that most mental health illnesses appear initially as physical symptoms, McGahey and Wallace argued the importance of healthcare providers treating patients' physical symptoms while also identifying and referring patients needing mental health support to onsite counselors instead of outside services. However, the healthcare professionals in the current study also identified MHCs as the professionals responsible for identifying patients who will benefit from mental health support and recommending healthcare professionals to refer patients for counseling/interventions. They recognized MHCs as accountable for advocating on behalf of the patient by prompting healthcare professionals to recommend therapeutic interventions to the patients. Thus, MHCs are considered responsible for catering to the overall mental well-being of patients. From patients' admission to discharge, MHCs are expected to identify patients' mental health needs and provide therapeutic interventions and necessary outpatient resources after discharge.

The second cluster of the region, “Specific Roles and Responsibilities in Different Hospital Units,” described specific tasks of MHCs within specific units in the hospital setting where patients needed more support due to the unique challenges that come with their specific medical condition. Healthcare professionals viewed MHCs as responsible for assisting and supporting patients at the emergency department, assisting prisoners, supporting long-term hospital stay patients, new mums, and mothers with childbirth issues, and helping patients with conditions such as COVID, and cancer remission, rare or terminal diseases. Participants described MHCs’ role in assisting these patients through the unique challenges of their new medical diagnoses. These may include assisting/supporting patients in processing their thoughts and emotions, further diagnostic information, and future medical decisions about their unique diagnosis. Researchers reported that supporting and helping patients in hospital units where patients are diagnosed with rare conditions or terminal diseases, cancer remissions, and dealing with life support choices improved patients’ overall mental health and quality of life (McCombie et al., 2016; Schoultz et al., 2015). In both studies, patients who received additional cognitive behavioral therapy compared with the standard-care treatment of inflammatory bowel disease reported more significant improvement in their depression, anxiety, and quality of life.

Moreover, as Griffiths et al. (2007) estimated that 5 to 64% of patients developed PTSD or related symptoms during their recovery from critical care units, the need to provide counseling to these patients within these specialized units in the medical settings amplifies. Other studies also revealed that several patients suffered significant long-term psychological disturbances during and following recovery from critical illness (Peris et al., 2011; Broomhead & Brett, 2002). Therefore, the current study's findings align with the literature identifying the need for

MHCs to provide therapeutic interventions to support patients in processing their hospital experience and medical condition that address patients mental well-being and quality of life.

Fertility counseling was another specialized area reported by the participants in the current study. This finding aligns with a cross-sectional online survey result from Sweden. Pestoff et al. (2016) identified genetic counselors as adding value in the clinical setting. They specifically described counselors as acting as the 'spider-in-the-web.' They are viewed as performing as case managers with a more holistic, ethical, and psychological perspective, offering continuous support and building a relationship with the patient. They are more accessible than medical geneticist doctors, who have the primary medical responsibility. MHC's role was found essential in providing genetic risk assessment when patients were processing and deciding on clinical screening, treatment, and looking into reproductive options (Pestoff et al., 2016).

In brief, in this region, healthcare professionals reported that MHCs were not only responsible for providing counseling services addressing the immediate mental health needs of the general patient population but also for advocating and supporting patients in specialized units in the hospital setting. MHCs are the professional body to provide these services. In other words, based on their working experiences with MHCs, healthcare professionals acknowledged the need for MHCs to be part of multidisciplinary teams in the hospital setting as they provide patients with opportunities to process their emotions and thoughts and address their psychological needs. Thus, healthcare professionals appeared to be shifting toward realizing and specifying the need to cater to patients' emotional needs and physical needs to improve patients' overall well-being.

Region 2: MHCs' Specific Roles in the Hospital Setting

The second region highlighted different specific roles of MHCs in providing their services in the hospital setting. Presenting in four clusters, “Building Relationships with Patients,” “Assessing/Evaluating Patients’ Mental Health Status,” “Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition” and “Educating Patients,” healthcare professionals described their perspectives on how MHCs’ specifically addressed patients’ overall mental wellness.

“Building Relationships with Patients” and “Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition” clusters focused on patients’ mental health and wellness. In “Building Relationships with Patients,” healthcare professionals reported unique characteristics and skills needed by MHCs to build therapeutic relationships with the patients. They addressed the need for counselors to be empathic in their attitude and behavior, where patients were emotionally supported, seen and heard, attended and encouraged to foster a safe environment. In fact, MHCs are trained and skilled in these identified attitudes because counselors strongly believe in developing a sustainable, effective therapeutic relationship as being the core of an effective therapy that activates change and lasting transformation (Bland, 2013). Thus, for the counseling professionals, building a good relationship with patients is considered the base from which all therapeutic work takes place (Hardy et al., 2007). This circumscribed view of the therapeutic relationship often distinguishes MHCs work/services from other healthcare professionals in the hospital settings who come from a medical model that is more disease/cure-focused.

In the “Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition” cluster, healthcare professionals described

how MHCs assisted patients with developing specific behaviors via different interventions that lead to wellness. Researchers suggested that psychological interventions provide a better quality of life, better disease management, and longer survival times (Zhang et al., 2016). MHCs' role in facilitating psychological interventions to promote mental health and wellness was observed through the identified tasks related to providing patients with additional insights and supporting them in understanding different stages of their recovery. For example, some participant statements included assisting patients with their progress while processing the challenges they faced with a new illness/diagnosis, treatment and loss, hospitalization, and future adjustments. All these identified tasks of MHCs may allow patients to vent, express, reflect and process, defeating psychological thoughts that impact patients' emotional well-being and overall recovery. This aligns with Hall and Hall's (2013) reports on the distinguished roles of MHCs. Some of these distinguished roles highlighted by Hall and Hall require counselors to look into any possible complications patients experience medically while exploring patients' internal experiences, such as their emotional, spiritual, and physical impacts and potential life changes. Similarly, Zhang et al. (2016) also reported creating a safe space for patients to vent, share their concerns, clarify illness perceptions, plan, and help them reframe during the counseling relationship positively improved recovery.

In addition to providing psychological interventions for patients to process their thoughts, emotions, physical impact, and medical information, healthcare professionals also recognized assessment and evaluation as other tasks within the provision of MHCs' care. This was exemplified in the "Assessing/Evaluating Patients' Mental Health Status" cluster, presenting MHCs' roles in assessing and evaluating patients' mental health status and their safety as well as identifying patients' present and future psychological care, treatment, and interventions that were

needed for both in-hospital and post-discharge. In this cluster, healthcare professionals identified MHCs' responsibility to facilitate psychological assessments to identify patients with possible psychological and emotional reactions to their situation, provide counseling and treatment, and refer them accordingly. The assessment role given to MHCs in hospital settings parallels Weinert and Meller's (2007) reports on the importance of assessing and identifying patients going through possible psychological and emotional reactions (e.g., medical PTSD) before discharge. Weinert and Meller discussed medical PTSD being different from other traumas and how counselors could anticipate the trauma through their assessments as they could also understand where, how, and why it occurs. They stated that counselors could illustrate the stressor and intervene while the stressors occur rather than support patients after the fact. Thus, by facilitating onsite psychological assessments and interventions, MHCs may be able to identify and intervene at the earlier stages of the stressors. Hall and Hall (2013) also talked about counselors' roles in assessing and evaluating the mental health status of patients. They viewed the assessment and evaluation tasks as part of counselors' preventive interventions. They argued that counselors working in hospital settings could also support the prevention and assessment of medical trauma as complete psychological care of patients becomes proactive rather than reactive, using a prevention lens. Thus, healthcare professionals' perspectives on MHCs' assessment and evaluation of patients' mental health status in the current study aligned with the existing literature.

In the "Educating Patients" cluster, healthcare professionals viewed MHCs as the patients' informants, where MHCs provided patients with psychoeducation informing and clarifying any misinformation about their illness. Previous researchers also identified psychoeducation as an important task for MHCs as they worked with patients (Zhang et al.,

2016; McCombie et al., 2016; Schoultz et al., 2015). They argued that MHCs could play a crucial role in encouraging patients to actively maintain their health by helping them to understand their diagnosis and health needs through psychoeducational interventions. In a study by Erlandsson (1998), patients suffering from tinnitus and Meniere's disease identified the need for support with necessary information about their conditions. Although patients felt free to consult with their medical doctors, they also reported experiencing some dissatisfaction with the medical information and health care, as they never had the opportunity to discuss their worries and fear. Thus, they identified the need to have psychotherapy at the early stages of their disease to enhance their self-awareness, better understand the disease, and help them face emotionally upsetting thoughts and reactions. Supporting these previous efforts, healthcare professionals in the current study also considered MHCs as the providers of resources, such as coping skills and tools of information to reach mental health wellness.

Clusters from Regions 1 and 2 complementarily highlighted MHCs' overall role grounded in wellness, assessment, prevention, and development. In this region, healthcare professionals' descriptions of supporting patients in their mental health and wellness through preventive and developmental interventions appeared to align with the American Counseling Association's (2010a) general definition of counseling. Counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., 2014, p. 368). Additionally, current findings were also parallel to Mellin et al.'s (2011) results, where community counselors, mental health counselors, and school counselors also viewed counselors' identities as grounded in wellness, development, and prevention.

On the other hand, neither American Counseling Association's (2010a) general definition nor Mellin et al.'s (2011) results specified assessment and evaluation as one of counselors' roles. In fact, Mellin et al.'s (2011) participants viewed assessment as the main role that distinguished counselors from psychologists and social workers, where they perceived psychologists attending to patients' pathological assessments to identify the psychiatric treatment and social workers focusing on systemic issues while counselors focused on wellness, development, and prevention. In the current study, healthcare professionals perceived MHCs to assess patients for further psychiatric treatment. However, these inconsistent findings may mean that healthcare professionals may not be as clear about what MHCs can and/or cannot do. Yet, they may also be highlighting new tasks needed by MHCs as part of the unique and specific role required within a hospital setting that differs from other settings. Lack of research on specific roles of MHCs in hospital settings compared to counselors' roles in community or school settings appear to leave MHCs' roles in hospital settings elusive (Mellin et al., 2011 & Cashwell et al., 2009).

Similarly, these findings also validate counselors' role ambiguity and confusion as multidisciplinary team members whose expected roles overlap with those of other related helping professionals. Therefore, this region provided more specific descriptions of how MHCs' role goes beyond providing counseling services to patients by extending to assessment, advocacy, and psychoeducation, making their role complementary and intertwined with the other services provided to patients. Through advocacy, assessment, and psychoeducation, MHCs appear to assist with closing the gap between different services received by patients, and more of these expected tasks are further defined in region 3.

Region 3: MHCs' Roles and Responsibilities as a Multidisciplinary Team Member

In Region 3, healthcare professionals highlighted MHCs' roles and responsibilities as multidisciplinary team members, presented in five clusters; "Advocating for Patients in the Multidisciplinary Team," "Mediating Communication Between Healthcare Professionals, Patients, and Families," "Collaborating with Other Multidisciplinary Team Members on Patients' Care," "Training Other Multidisciplinary Members on General Wellness and Mental Health" and "Offering Training and Emotional Support to Other Multidisciplinary Team Members." Healthcare professionals reported that MHCs facilitated communication between patients, families, and other healthcare professionals involved in the patient's care while training and supporting healthcare professionals on mental wellness. These tasks appeared to create an overarching role of aiding with the facilitation of all the services needed or received by patients leading to a holistic provision of care that can enhance patients' well-being.

"Advocating for Patients in the Multidisciplinary Team" and "Mediating Communication Between Healthcare Professionals, Patients, and Families" clusters described MHCs' informer task that closes the communication gap between the patients and healthcare professionals. Healthcare professionals perceived the MHCs as the patient's advocates responsible for being the patients' voice within the multidisciplinary team for the best interest of the patient and best patient outcome. Advocacy has a long tradition of being valued as an essential responsibility of counselors (Kiselica & Robinson, 2001). Since some healthcare professionals, at times, are too busy and time-constrained to get the complete picture of patients' emotional, psychological, or social needs, issues, or struggles, MHCs become the link of communication between patients, families, and healthcare professionals through advocacy. MHCs were reported to provide healthcare professionals with added information they might have

missed, creating a bridge between medical and mental health. Utilizing advocacy and mediating communication tasks, MHCs appeared to provide an opportunity to receive care addressing the medical, psychological, and mental implications of patients' diseases. Thus, MHCs assist with expanding the treatment of patients beyond the silo of the medical model. In other words, MHCs in hospital settings create a space/opportunity to see and treat patients as a whole and not parts of the whole. These findings on addressing psychological needs and the medical conditions paralleled Ng et al. (2007) and Zhang et al. (2016) studies' conclusions. Ng et al. identified associated comorbid depressive symptoms with more extended hospitalization stay, poorer survival, persistent smoking, poorer physical and social functioning, and increased symptom burden. At the same time, Zhang et al. reported a strong relationship between mental health disorders and disease activity. Consequently, critical psychological interventions have long been viewed as essential to be addressed in the care of medical patients and resulted in a reduction in sickness due to chronic illness (Peyrot & Rubin, 2007).

In addition to being the mediator that facilitates communication between patients, family, and healthcare professionals, healthcare professionals also view MHCs as skilled professionals to assist healthcare professionals in providing their patient care. The need for multidisciplinary team collaboration aligns with the World Health Organization's (WHO, 2010) recognition of cooperation between health care professionals in education and clinical practice. As stated in the WHO Framework for Action (WHO, 2010), interprofessional "collaborative practice happens when multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care. It allows health workers to engage any individual whose skills can help achieve local health goals" (WHO, 2010, p. 7). In fact, participants in the current study reported seeking assistance and collaborations

from MHCs to aid in diagnosing patients' behavioral concerns, recommend other services needed by the patients, and assist social workers' work with patients. The importance of multidisciplinary collaboration was also supported by Ghassemi (2017), as they further highlighted the importance of shared decision-making and interprofessional collaboration between doctors, nurses, mental health counselors, and social workers to support patients' treatment and recovery.

Additionally, healthcare professionals in the current study also sought out MHCs' assistance and collaboration on medication review. These findings also aligned with previous reports on counselors' responsibility for reassessing and recognizing when patients need to have their medications changed (Shallcross, 2012). Acknowledging counselors' lack of training with drugs, Shallcross stated that counselors were still responsible for collaborating with the medication prescribers to discuss patients' manifested symptoms and adverse side effects and share information that demanded immediate attention. Shallcross also highlights the need for counselors to notify other healthcare professionals when the medication is effective so that patients could gain the most benefit with the least harm.

Finally, healthcare professionals viewed MHCs' tasks in the hospital setting as more comprehensive than solely patient-focused. In the "Training Other Multidisciplinary Members on General Wellness and Mental Health" and "Offering Training and Emotional Support to Other Multidisciplinary Team Members" clusters, healthcare professionals reported seeking MHCs to train other multidisciplinary members on general wellness and mental health, while offering emotional support and training for personal mental wellness. Healthcare professionals sought out professional advice and training from MHCs on how they can emotionally support their patients. This expectation and identified need highlighted healthcare professionals'

appreciation for adding emotional/psychological awareness and skills into their services and overall patient care. Moreover, the “Offering Trainings and Emotional Support to Other Multidisciplinary Team members cluster” highlighted healthcare professionals’ acknowledgment of their own mental and emotional wellness while recognizing that MHCs responsible for training and supporting staff to develop coping techniques for their emotional well-being. Current study participants’ perceptions of MHCs’ role in the hospital focusing beyond patient care was in line with Moeller’s (1992) description of counselors' role in hospital settings. Moeller reported counselors to concentrate not only on the patient’s emotional support but also on nurses’ support to improve patient care. They discussed strengthening nurses’ coping skills and increasing awareness and practice in self-care positively impacting the overall effectiveness of their nursing care, leading to improved patient care. Similarly, to facilitate services leading to enhanced patient care, healthcare professionals in the current study also perceived MHCs’ roles as expanding from providing emotional and psychological support to patients to providing personal support and professional mental health training to other healthcare professionals.

Conclusively, the third region spoke about MHCs’ extended tasks implemented behind the scenes of the patient front yet still impacted patients’ mental well-being. As MHCs provide mental health training and emotional support to staff, advocating, mediating, and collaborating with other healthcare professionals on patients’ mental health needs, patients are directly impacted by the care that integrates mental health with physical health. Such unity in acknowledging all stakeholders’ (i.e., patient and healthcare professionals) needs and perspectives leads to all services complementing one another and increases patients’ satisfaction.

Further Discussion of Results Based on the Two Dimensions

In a general review of the map and the regions, the arrangement of the three regions displayed sets of tasks healthcare professionals needed MHCs to facilitate services and enhance patients' well-being. These regions were also laid out over two dimensions describing continuums of MHCs' patient-centered-collaborative (dimension 1) and assessment-advocacy (dimension 2) tasks. In the *Patient-Centered – Collaborative* dimension, healthcare professionals described MHCs' unique professional roles and responsibilities toward patients' mental well-being on a continuum, from providing direct emotional support through counseling to providing indirect services through collaborating with other healthcare professionals. In this process, MHCs were expected to offer direct services to the patients and progressively collaborate with healthcare professionals in patient care. They also support healthcare professionals in their professional and personal development per mental health awareness and wellness skills. On the other hand, the *Assessment-Advocacy* dimension is laid out on a continuum of MHCs' responsibilities, from assessing patients' mental health status, needs, treatment, and follow-up care to advocating for the patients as they also mediate between different stakeholders to enhance patients' care. This latter end of the second dimension appeared to specify MHCs' role in closing the gap between the medical and mental care for patients.

In conclusion, MHCs in hospital settings are rare; thus, their role and responsibilities are not yet scholarly or professionally defined. This study and its findings offer a framework for MHCs and healthcare professionals to describe and facilitate various MHC tasks to enhance patients' well-being. The framework outlines how MHCs could practice as team members within the multidisciplinary team, be integrated into patients' medical care, and coordinate counseling activities in collaboration with other healthcare professionals.

Relative Importance of Clusters Per Healthcare Professionals

Research question 2: *What are the most important tasks of MHCs in the hospital settings as identified by healthcare professionals?*

According to the healthcare professionals attended in the current study, the top three most important clusters defining MHCs tasks were “Advocating for Patients in the Multidisciplinary Team” and “Assisting and Supporting patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition” and “Offering Training and Emotional Support to Other Multidisciplinary Team Members.”

Comparisons of clusters’ ratings revealed that “Advocating for Patients in the Multidisciplinary Team” was the most important task of MHCs. Healthcare professionals reported MHCs’ advocacy task as essential for providing services and enhancing patient well-being. Through patients’ advocacy, MHCs may have brought forward information to healthcare professionals on patients’ different needs and created an opportunity for collaboration between healthcare professionals involved in patients’ care. Supporting an active communication between MHCs and other healthcare professionals by including the patient’s voice appeared to facilitate holistic patient care addressing medical, psychological, and social needs and support. Some healthcare professionals do not have enough time to sit with patients and explore their emotional and psychological needs and the physical treatment and interventions required from their services. In fact, Whittington (2000) reported that the time nurses spend in patient contact devoted to psychotherapeutic interaction was only 6.75 % of their daily work. Thus, this finding may signify the importance of MHCs’ role in advocating for the patients through providing the potential missing information in aiding the provision of holistic care and treatment to patients. Additionally, as part of this cluster, healthcare professionals also perceived MHCs as having the

necessary skills to bridge communication, clarify misunderstandings between different stakeholders, and work within a team to achieve patients' best outcomes.

Additionally, participants reported “Assisting and Supporting patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition” as the next most important task of MHCs to support their work. The emphasis on these two clusters may indicate that healthcare professionals in the hospital setting are starting to shift from viewing patients as medical cases to as a whole person where the psycho-emotional needs and physical demands are intertwined. Thus, these findings may highlight healthcare professionals' perspectives on their values to provide patients care that caters to medical and psychological needs and collaborate closely with MHCs as they share information addressing each patient's individual needs. This can be supported by the growing body of research in primary care settings that confirms the effectiveness of integrating behavioral and mental health care within primary care settings to improve health outcomes (Pomerantz et al., 2009). In fact, 82% of the general practitioners who participated in Schafer et al.'s (2009) study perceived onsite counseling in their primary care settings as beneficial because they did not need to refer patients to secondary services during follow-up patient sessions. Moreover, six out of eight also identified the need to address the emotional and psychological care in patients' care through onsite counseling as it also aids in reducing psychoactive medication prescription, cost efficiency, and increased capacity.

Finally, “Offering Training and Emotional Support to Other Multidisciplinary Team Members” were reported as the third most important task of MHCs. Thus, in addition to patient care, healthcare professionals said offering training and emotional support to other multidisciplinary team members is another critical task of MHCs per their professional roles. This finding was valuable since healthcare professionals valued the mental health and wellness

of the patients and asked to be trained in coping techniques and supported by MHCs for their own emotional well-being. Healthcare professionals' perspectives on how MHCs can also support the staff in their personal mental well-being align with previous research highlighting the importance of employing counselors to support nurses in their emotional and psychological needs and stressors (Moeller, 1992) study. Moeller's study showed that counseling support positively impacted and strengthened nurses' coping skills, increased awareness and practice in their self-care and improved their overall nursing care in the hospital.

Limitations of the Study

The present study results provided valuable information regarding different tasks of MHCs within a hospital setting as part of multidisciplinary teams from the perspectives of other healthcare professionals. However, like all other studies, the present study's findings must also be considered within the context of its limitations.

The first limitation of this study is its mixed methods design methodology, Concept Mapping (CM; Kane & Trochim, 2007). CM limits the study's focus on identifying unique components of MHCs' roles and processes in hospital settings gathered from one specific prompt. Participants were not asked different questions to help them address the research question from different angles. Moreover, even though CM can produce more robust data than a sole qualitative or quantitative method, causality cannot be inferred due to the non-experimental nature of the concept mapping approach. Similarly, although CM allows flexibility to move from one stage to another with different participants as needed (Kane & Trochim, 2007), retention has been a common issue in CM studies. The current study was not an exception. The data collection timeline impacted the number of participants joined in each round of data collection, limiting the consistent number of participants engaged in all three rounds of data collection. Some of the

participants from the first round of data collection indicated that they would be willing to partake in the second round if they were not as busy due to surges in COVID cases. Others claimed that they were not able to respond within the requested timeline. Thus, due to the time restrictions and surges in COVID cases, only a limited number of participants could have participated in the three rounds of data collection. As Kane and Trochim (2007) stated, consistency across the participants attending all three rounds may have improved the validity of the results.

Furthermore, although testimonial validity procedures were diligently utilized in this study, editing and syntheses of the statements and preliminary structuring of the statements may not have been entirely free from the researchers' interpretations of the data. If another group of researchers conducted the analyses, a different organizational structure of the results could have been generated.

Second, potential variables that were not controlled in this study may have influenced the findings. For example, the time participants have been exposed to the counseling services in the hospital settings, the different experiences participants have working with MHCs, and the diverse values professionals hold on the importance of psychological support and the physical care in the hospital setting are a few to mention.

Lastly, since this study only included professionals from one local hospital, the generalizability of the findings is limited to the healthcare professionals working in the specific hospital. Thus, the conceptualization of the healthcare professional's perspectives on the specific tasks of MHCs from this hospital must be reviewed cautiously, as they may not be generalizable to other professionals from different hospital settings. Moreover, this study only presents the healthcare professionals' perspectives on the MHCs' tasks, not including MHCs' perspectives. The involvement of the MHCs may have offered more comprehensive findings.

Implications of the Study

This study is the first pragmatic research effort to explore, identify, and understand how healthcare professionals perceived different and specific tasks and responsibilities of MHCs in hospital settings. The current study results have various implications for the counseling field, for MHCs and healthcare professionals (e.g., doctors, nurses), and as well as clinical and training practices of counselors, counseling supervisors, counselor and supervisor training programs, doctors, nurses, and other professionals involved in multidisciplinary teams in the hospital settings.

Implications for MHCs Clinical Practices

Considering the current lack of MHCs in most hospital settings and the lack of scholarly and professionally defined roles, the findings of this study inform MHCs about what healthcare professionals expect from MHCs in a hospital setting where counseling services are available. These expectations may also inform MHCs on what healthcare professionals may perceive as missing in patients' care and how MHCs' services can address these needs to enhance patients' well-being. Thus, this study informs MHCs on the potential scope and content of what MHCs can do within a hospital setting.

Based on the current study findings, MHCs may complement patients' medical care with psychological care by providing counseling, advocacy, collaboration, psychoeducation, and training services to patients, families, and healthcare professionals within the multidisciplinary team. They can be part of the healthcare team in each hospital unit to assess patients' emotional and mental health status and provide counseling and advocacy/consultation to other healthcare professionals on patients' needs and treatment. They may identify patients needing further emotional, psychological, and social support while providing early support and possible

preventive intervention (e.g., medical trauma). Thus, they may visit patients in specialized units to attend to patients with newly diagnosed, chronic medical conditions, and/or life-threatening diagnoses. In this process, MHCs may be an educator and an informant to provide patients with the needed psychoeducation and resources (e.g., coping skills to reach mental health wellness) and increase patients' satisfaction. MHCs may also provide crisis counseling in the emergency unit, as they may also offer crisis interventions in different hospital units. Thus, MHCs may provide emotional support and psychoeducational and advocacy support.

Additionally, MHCs may devise patients' psychological assessments and mental health status evaluations during patients' visits to plan and refer patients for further psychiatric treatment. Their assessments may identify patients' level of safety or potential harm to self and/or others to devise safety plans and treatment accordingly. MHCs may communicate their observations and assessments with other multidisciplinary team members involved in patient care. Similarly, when collaborating with other healthcare professionals on patient care, MHCs may be the patients' advocates and clarify any misunderstanding or address missing information to patients, families, and other healthcare professionals. MHCs may communicate directly with different stakeholders (e.g., nurses, doctors, and social workers) while also updating the patient's file with written information about patients' concerns. MHCs may review patients' files and aid in reviewing patients' medications based on their observations and assessments of the patients' condition and needs. MHCs may aid in discharge planning and connect patients with the necessary resources following discharge through such collaborative work. Thus, MHCs in the hospital settings may engage in various networking and collaboration with multiple healthcare professionals to provide patients with holistic care and treatment, fostering medical, mental, and social support.

Lastly, MHCs may also provide emotional support to healthcare professionals and provide training on overall mental wellness and coping techniques that will aid healthcare professionals in increasing awareness of how to support themselves and others emotionally. MHCs may implement different psychoeducational training for healthcare professionals to understand various emotional and psychological challenges and mental health issues patients face within their medical conditions. They may also provide training and updated information on the impact of hospitalization and long-term stay on patients' emotional and psychological health. Thus, they may train healthcare professionals on medical trauma and how they can aid in prevention, diagnosis, and treatment phases. MHCs may use the results of this study and include an information session about their role in the hospital setting in their training for healthcare professionals to aid in decreasing role confusion and increasing role clarity.

Implications for Clinical Supervisors ~~and Counselor Education Programs~~

Furthermore, the clarity on MHCs' roles in hospital settings informs clinical supervisors (i.e., site and university) and counseling training programs (i.e., master's and doctoral). Clinical supervisors may consider supporting and guiding MHC trainees in their collaborative and advocacy work in IBH settings for the best interest of their patients. They may support MHCs navigate through their collaborative work and provide a space for MHCs to consult on different options and resources available in the community for different patients' needs. Supervisors may also provide a space for the MHCs to process their client cases, treatment plans, and referrals during their supervision sessions and help them engage in shared decision-making as an essential tool to support patients' treatment and recovery. Since working with different team members and engaging in shared decision-making can sometimes be challenging, clinical supervisors may help

MHCs navigate these issues/dilemmas and assist them to determine the best way to respond to them in the best interest of the patients.

On the other hand, since site supervisors are part of the hospital team, they may want to be accessible to MHCs for emergencies. They may be accessible for MHCs to consult on various safety measures/decisions/referrals needed for patients' safety and provide a space to consult on ethical dilemmas brought by complex life decisions patients face. Furthermore, site supervisors may also use the finding of this study with the supervisors of other hospital professionals to increase awareness of the hospital environment, culture, roles, and functions of different multidisciplinary team members. For example, they might do workshops or monthly meetings to communicate various issues or challenges encountered between different professionals in their collaboration and facilitation of the services offered in patients' care.

Lastly, site and university supervisors may consider creating a safe space to provide empathy and compassion to MHCs by understanding the impact of using a constant emotional energy level in their therapeutic alliance and empathic responses with their patients (Bowen & Moore, 2014). The findings of this study highlighted the overarching task for MHCs to provide consistency and continuous emotional support through compassion and empathic responses intertwined in all their clinical practice. These tasks demand a constant emotional energy level in their therapeutic alliance and daily empathic responses to different patients with different life stories. Thus, MHCs are more susceptible to compassion fatigue or compassion satisfaction, affecting the MHCs' personal and professional functioning (Bowen & Moore, 2014; Moodley, 2010). Therefore, site and university supervisors can provide the space for MHCs to process their personal and professional growth in delivering compassionate and empathic responses demanded

by their role to address patients' biological, psychological, and social experiences in response to their medical condition.

Implications for Counseling Field and Counselor Education Programs

Professionals of the counseling field may use findings of this study to advocate, promote, and provide awareness on the impact of MHCs as part of healthcare professional teams in different hospital units in facilitating services and enhancing patients' overall wellbeing. Overall, such efforts lead us to consider a potentially major development in the counseling field and counselor training programs. These findings may suggest counseling field professionals, specifically counselor educators and Council for Accreditation of Counseling and Counseling-related Programs (CACREP), to consider developing and offering Counseling in Integrated Behavioral Health (IBH) settings as its own track/specialty area within counselor training programs.

More specifically, the findings identified crisis interventions, medication review, processing diagnosis, and implications of the medical condition on patients' social and psychological wellness as unique tasks for counselors in the hospital setting that differ from other counseling settings. Specifically, involvement and intervention in crisis, medical conditions, and psychopharmacology may be critical areas of training for MHCs doing their internship at IBH settings. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards require counseling programs to include disaster/crisis counseling (CACREP, 2016). Accredited programs are required to address this standard in various courses by intertwining the content as a thread in multiple courses in the program. However, programs may also decide either to incorporate this content within different courses or to offer it as a standalone disaster/crisis intervention course in the program. By weaving crisis intervention

content in different classes, programs may risk students not getting exposed to in-depth crisis counseling coursework or experiential learning that supports MHCs in utilizing crisis intervention skills, particularly in hospital settings. Thus, the unique nature of hospital settings demands MHCs to be skilled at responding to crises and supporting patients in the emergency units. Counselor training programs may consider imperative crisis counseling courses in their curriculum.

Furthermore, counselor education programs may also include training on psychopharmacology and medical conditions as well as their implications on patient wellness. Such content coverage may also highlight the importance of interprofessional education (IPE) in counselor training programs. Considering the identified need for MHCs to collaborate within a multidisciplinary team in hospital settings, counselor training programs may educate MHCs in collaborative practice, where they work closely with other healthcare professionals, families, patients, and their communities to provide the highest level of patient care. Practical collaborative work improves patients' situations and the situations of those involved in the patients' care (Ghassemi, 2017). Ghassemi further asserted that teaching MHCs different aspects of teamwork could help them develop the necessary skills to avoid pitfalls associated with interprofessionalism and reach better clinical decisions faster. Thus, counselor training programs may teach MHCs on the roles and responsibilities of different professionals within the multidisciplinary team as well as on the interprofessional communication involving when, how, and why to collaborate with other professionals to deliver a patient-centered approach.

In a similar vein, counselor training programs (i.e., master's and doctoral programs) may also train MHCs to navigate their professional relationships with healthcare professionals involving multiple roles, such as a colleague, educator, and counselor. For example, programs

may consider offering training to MHC trainees with public speaking skills and teaching techniques as they may need to devise and implement workshops on mental health wellness and coping strategies for their colleagues. At times, navigating these roles can also be challenging for MHCs, especially in cases where MHCs are not trained and/or skilled, such as in medication management. Thus, training programs may use the findings of this study as a guideline to provide role clarity to MHCs to support them by providing clear and defined boundaries regarding their distinctive roles as they justify their positions as counselors.

Implications for Healthcare Professionals

The findings of this study presented the need to have MHCs in hospital settings. Thus, healthcare professionals may use these findings to make good use of MHCs' services to provide holistic care and treatment to patients in hospital settings. They may collaborate with MHCs to develop Counseling Units within the hospital or Counseling Office in different hospital units to ease the accessibility of counseling services and address patients' medical and mental health needs conjointly. Having Counseling Units and/or Offices within the hospital, healthcare professionals can collaborate with onsite MHC to identify patients in need of counseling and MHCs' interventions to support and facilitate medical care. Healthcare professionals may consider referring patients for counseling consultations from admission to the hospital until their discharge as they collaborate with MHCs throughout this time on patient care and treatment. They may refer to the findings of the current study about how to address the mental health needs of their patients and who is the professional body that could facilitate those services and enhance patients' well-being to foster both the medical and the mental health.

Furthermore, since in the current study, healthcare professionals described what they observed as the tasks/roles of MHCs in a hospital setting, those professionals may also consider

challenging potential misconceptions about MHCs' place in the hospital settings and provide further clarification to other healthcare professionals who have never worked with MHCs as part of their multidisciplinary team. Similarly, healthcare professionals may utilize these findings to further emphasize and report the need for and critical work of MHCs to hospital administrators as well as local, state, regional, and federal health services boards. Lastly, the findings of this study also invite different healthcare professionals to consider adding interprofessional education (IPE) in their training programs. All healthcare professionals may be trained on the various tasks and responsibilities of different professionals within the multidisciplinary team, particularly MHCs, and learn to communicate and collaborate effectively for a common goal, patients' overall wellbeing.

Implications for Future Research

The current study was a preliminary effort to investigate and understand healthcare professionals' perspectives on the different tasks MHCs engage in to facilitate the various services at the hospital and improve patients' well-being. Researchers must replicate the present study with different samples of healthcare professionals from other hospitals not only in Virginia but also from other states in the U.S. Researchers may also examine MHCs and their perspectives on their tasks, roles, and/or responsibilities in the hospital settings to compare and observe similarities, differences, and complementary perspectives between different findings from different stakeholders. Especially studies with larger sample sizes and more diverse participant profiles may expand on the current study findings. Furthermore, despite having a wide variety of healthcare professionals involved in the current study, I could not observe potential differences across different healthcare professionals' perspectives. Thus, researchers may also consider psychiatrists, and psychologists' perspectives on the unique tasks of MHCs in

hospital settings to facilitate services and enhance patients' well-being. Finally, with a more detailed database obtained from those further studies, researchers can develop an instrument to assess MHCs' performances with different tasks in hospital settings. Such an instrument could be validated through exploratory and confirmatory factor analysis procedures to further the evidence-base for MHCs' work in the hospital settings.

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APPENDICES

APPENDIX A

Invitation to participate

Subject Line: An Investigation of Healthcare Professionals' Perspectives on the Tasks of Mental Health Counselors in Hospital Settings

Dear participant,

I am a doctoral candidate from the Old Dominion University Counseling Program. I am contacting you to invite you to participate in a study to explore your perspectives and expectations of how mental health counselors (MHCs) facilitate medical and mental health services and enhance patients' well-being in hospital settings. Participation in this study is voluntary. However, to take part in this study, you must be 1) at least 18 years of age and 2) a doctor, nurse, social worker, case manager, dietitian, chaplain, crisis clinician, or physical therapist who has a minimum of six months of experience working with MHCs or counselors-in-training at the hospital. You may benefit from participating in this study by gaining increased awareness and insight into what MHCs can do in the hospital setting to enhance patients' well-being and facilitate services. Your participation also will benefit others by adding to the existing literature on counseling in hospital settings.

About your participation:

If you choose to participate in this study, you are asked to complete a demographic questionnaire and a series of data collection procedures in three phases. Even though I request and encourage you to participate in all three steps, participation in each study phase is voluntary.

Phase 1. Generation of Statements (approximately 10 -15 minutes): This data collection phase will be completed as soon as you agree to participate in this study by going to the link provided hereunder. The link will open a document containing a demographic information form and a prompt to help you generate statements describing your perspectives and expectations of the role of counselors in hospital settings. At the end of this phase, you will express your interest in participating in the second phase of data collection.

Phase 2: Structuring of Statements (approximately 45 - 60 minutes). This data collection phase will be completed between 1st March and 20th March. You will be provided with optional dates to join small groups to sort the statement individually or opt to receive the package and electronically make the statement in your own private space. You will be given a package with printed generated statements onto small cards and a stack of empty envelopes during this meeting. You will be asked to sort them into categories that make the most sense to you. Then, you will also rate the statements based on the importance/value you deem for your professional practices. At the end of this phase, you will express your interest in participating in the last data collection phase, the focus group.

Phase 3: Focus Group Session (approximately 60 - 90 minutes). This phase of data collection will be completed around the end of March. In this online focus group, you will be asked to interpret the results from phases 1 and 2. The researchers will contact you via email to schedule the online focus group's date and time via zoom.

If you agree to participate in Phase 2 and Phase 3 (the focus group session), you consent to respect other group members' privacy. You agree not to inquire about other group members' names and keep information and responses expressed during the focus group session confidential.

We appreciate your time and value your input as we strive to explore this phenomenon. We will greatly appreciate it if you share your perspectives and experiences with us!

To participate in the first round of data collection, please click on the following link:
www.link.com

Should you have any questions, please do not hesitate to contact Suelle Micallef Marmara at smica001@odu.edu and Dr. Gulsah Kemer at gkemer@odu.edu.

Thank you for your consideration!

Sincerely,

Suelle Micallef Marmara, Ph.D. Candidate
Graduate Student Investigator
Old Dominion University
smica001@odu.edu

Gulsah Kemer, PhD, NCC, ACS
Responsible Principal Investigator
Old Dominion University
gkemer@odu.edu

APPENDIX B

Informed Consent Document

Old Dominion University

PROJECT TITLE: An Investigation of Healthcare Professionals' Perspectives on the Tasks of Mental Health Counselors in Hospital Settings

INTRODUCTION

We are inviting you to participate in a research study on how mental health counselors (MHCs) facilitate medical and mental health services and enhance patients' well-being in hospital settings. Before you decide to participate in this study, we must offer you information on why we are conducting this study and its involvement. Please take the time to carefully read the following information and feel free to ask the researchers if there is anything that is not clear or if you need more information.

The current study aims to increase understanding of the different tasks MHCs can do in hospital settings to facilitate medical and mental health services and enhance patients' well-being. To address this goal, we will collect the data in three phases. Phase one (10-15 minutes) of data collection will be conducted individually online using a Qualtrics questionnaire. In phase two (45-60 minutes), you will be provided with optional dates to join small groups to sort the statement individually or opt to receive the package and electronically make the statement in your own private space. You will be given a package with the necessary information and documents to accomplish sorting and rating tasks during this meeting. Phase three (optional; 60-90 minutes) will then be conducted in a group setting via an online meeting through Zoom.

RESEARCHERS

Graduate Student Investigator:
Suelle Micallef Marmara
Ph.D. Candidate
Old Dominion University

Gulsah Kemer, PhD, NCC, ACS
Responsible Principal Investigator
Old Dominion University
gkemer@odu.edu

DESCRIPTION OF RESEARCH STUDY

To the best of our knowledge, no other studies have been conducted to this date investigating healthcare professionals' perspectives and expectations of how mental health counselors can engage in hospital settings.

Suppose you decide to participate in this study. In that case, you will help us understand how MHCs can facilitate medical and mental health services and enhance patients' well-being in

hospital settings. This study will involve three phases of data collection. In the first phase, you will receive an email containing a Qualtrics link to a demographic questionnaire and instructions, asking you to generate statements that describe your perspectives on the tasks MHCs engage in your hospital setting. You will receive a package with the generated statements from phase one in phase two. You will be asked to sort these statements into categories that make the most sense to you. Then, you will also rate the statements based on the importance/value you deem for your professional practices. At the end of phase two, you will be asked to indicate your interest in participating in the study's last round. A focus group will be conducted with all interested participants via an online Zoom meeting in this third phase. During the focus group, you will be asked to interpret the phases one and two results. Before conducting the focus group, the researchers will contact you via email to schedule a date and time for the Zoom meeting.

If you say YES, you will receive an email containing a link to the Qualtrics questionnaires and instructions for completing the first task that will lead you to the following tasks. Round three will be conducted in a group setting via an online Zoom meeting. A minimum of 10 participants will be participating in this study.

INCLUSIONARY CRITERIA

You will complete a demographic questionnaire before completing the task in round one. To take part in this study, you should be 1) at least 18 years of age and 2) a doctor, nurse, social worker, case manager, dietitian, physical therapist and/or crisis clinician, or chaplain who have a minimum of six months of experience working with counselors or counselor trainees providing counseling services in the hospital.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, there is a small chance you may face a risk of discomfort or experience unpleasant emotions due to the introspection of your experiences. And, as with other research, there is some possibility that you may be subject to risks that have not yet been identified. The researchers will try to reduce these risks by providing you with additional mental health and/or other social services if you experience discomfort and would like further assistance.

BENEFITS: The main advantage of participating in this study is increasing your awareness and insight into how MHCs facilitate medical and mental health services to enhance patients' well-being in hospital settings. Others may benefit from your participation in this study as we hope to add to the existing literature base regarding counseling in hospital settings.

COSTS AND PAYMENTS

The researchers want your decision about participating in this study to be voluntary. Yet, we recognize that your participation may pose some inconvenience. The researchers cannot give you any payment for participating in this study. We appreciate your time and value your input as we strive to explore this phenomenon.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision to participate, they will give it to you.

CONFIDENTIALITY

The researchers will take reasonable steps to keep confidential private information, such as demographic data and contact information. Notably, the researchers will remove identifiers from all identifiable personal information collected. Data generated by participants will be de-identified upon collection and may be used for future research without additional informed consent from participants. If you agree to participate in the focus group session, you also consent to respect other group members' privacy. You agree not to inquire about other group members' names and keep information and responses expressed during the session confidential. However, researchers cannot guarantee focus group member confidentiality. You may opt to keep your camera off and leave no identifier during the zoom focus group. This study's results may be used in reports, presentations, and publications, but the researchers will not identify you.

WITHDRAWAL PRIVILEGE

Even if you agree to participate initially, you will be able to walk away or withdraw from the study at any time. Your decision will not affect your relationship with Old Dominion University or otherwise cause a loss of benefits to which you might otherwise be entitled.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, your consent in this document does not waive any of your legal rights. However, in the event of harm, injury, or illness arising from this study, neither Old Dominion University nor the researchers can give you any money, insurance coverage, free medical care, or any other compensation for such injury. If at any time you feel pressured to participate, or if you have any questions about your rights or this form, you may contact Suelle Micallef Marmara at 757-837-5492, Dr. Gulsah Kemer at gkemer@odu.edu, Dr. John Baaki (the Chair of the DCEPS Human Subjects Review Committee at Old Dominion University) at jbaaki@odu.edu, or the Old Dominion University Office of Research at 757-683-3460 will be glad to review the matter with you.

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand it, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Investigator:
Suelle Micallef Marmara
757-837-5492
smica001@odu.edu

And importantly, by signing below, you tell the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	Date
---	-------------

INVESTIGATOR'S STATEMENT

I certify that I have explained the nature and purpose of this research to this subject, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws and promise compliance. I have answered the subject's questions and have encouraged them to ask additional questions at any time during this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	Date
--	-------------

APPENDIX C**Demographic Questionnaire**

Please answer the following questions in the spaces provided.

1) I am 18 years old or over?

_____ Yes

_____ No

2) I identify as

_____ Female

_____ Male

_____ Non-binary

_____ Other (please specify): _____

3) My racial background is:

_____ African American/ Black

_____ Asian/Pacific Islander

_____ Hispanic/Latino(a)

_____ Native American/ Alaska Native

_____ White (non-Hispanic)

_____ Multiracial

_____ Other (please specify): _____

4) My ethnic background is:

_____ African American/ Black

_____ Asian/Pacific Islander

_____ Hispanic/Latino(a)

_____ Native American/ Alaska Native

_____ European American

_____ Other (please specify): _____

5) At Hospital, I practice as a

_____ Doctor

_____ Nurse

_____ Social Worker

_____ Case Manager

_____ Crisis Clinician

_____ Physical therapist

_____ Chaplain

_____ Dietitian

____ Other (specify) ____

6) I have been practicing within my profession for

- ____ 0 - 6 months
- ____ 1 to 3 years
- ____ 3 to 6 years
- ____ More than six years
- ____ None of the above

7) I worked at this Hospital for

- ____ 6 months
- ____ 1 to 3 years
- ____ 3 to 6 years
- ____ More than six years
- ____ None of the above

8) I have more than six months of direct working experience with mental health counselors or counselor trainees at this Hospital

- ____ Yes
- ____ No

9) I worked with mental health counselors or counselor trainees before I started working at this Hospital

- ____ Yes
- ____ No

If you answered yes to question 9, complete questions 10 and 11:

10) Before working at this Hospital, how long did you work with mental health counselors?

- ____ 6 months
- ____ 1 to 3 years
- ____ 3 to 6 years
- ____ More than 6 years
- ____ None of the above

11) How long were mental health counseling services established in your previous hospital setting?

- ____ months
- ____ years
- ____ Do not know

APPENDIX E

Round 2 Data Collection: Instructions for The Sorting Task

Dear participant,

Thank you for your participation in this study on “An Investigation of Healthcare Professionals’ Perspectives on The Tasks of Mental Health Counselors in Hospital Settings.”

This package contains the data generated from phase one. Please read the following instructions carefully for the sorting task and complete the sorting in suggested orders.

1. Sort the printed statements into a category based on the conceptual similarity of the statements.
2. Each statement needs to belong to 1 category **only**. If you feel that a statement may fit into several categories, you must select the category that best fits that statement.
3. Please note that a statement can be a category by itself.
4. After sorting all the statements into categories, kindly place each category under one heading by writing a word or a short phrase describing each category

APPENDIX F

Round 2: Instructions for The Rating Task

Please rate each statement on a scale of 1 = Not Important At All to 5= Highly Important based on how important you perceive the statement to be in facilitating services and enhancing patients' well-being in the hospital setting. Before rating each statement, please scan the entire list of statements to get an idea of which ones are of the highest and lowest importance. Once you begin rating the statements, please try to use the full range of rating values (i.e., 1 to 5).

1	2	3	4	5
Not important at all	Of Little importance	Neutral	Of Somewhat Important	Highly Important

Statement 1	1	2	3	4	5
Statement 2	1	2	3	4	5
Statement 3	1	2	3	4	5
Statement 4	1	2	3	4	5
Statement 5	1	2	3	4	5

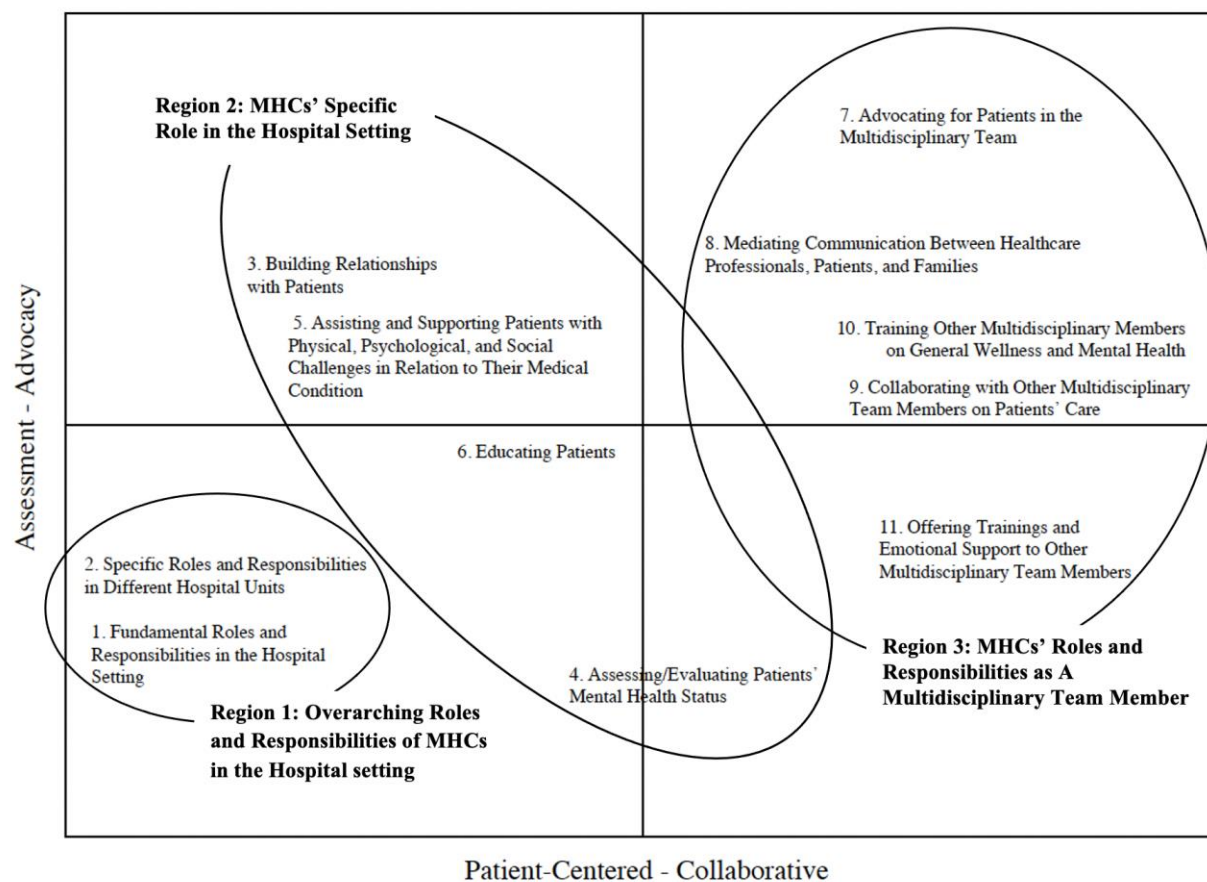
APPENDIX G

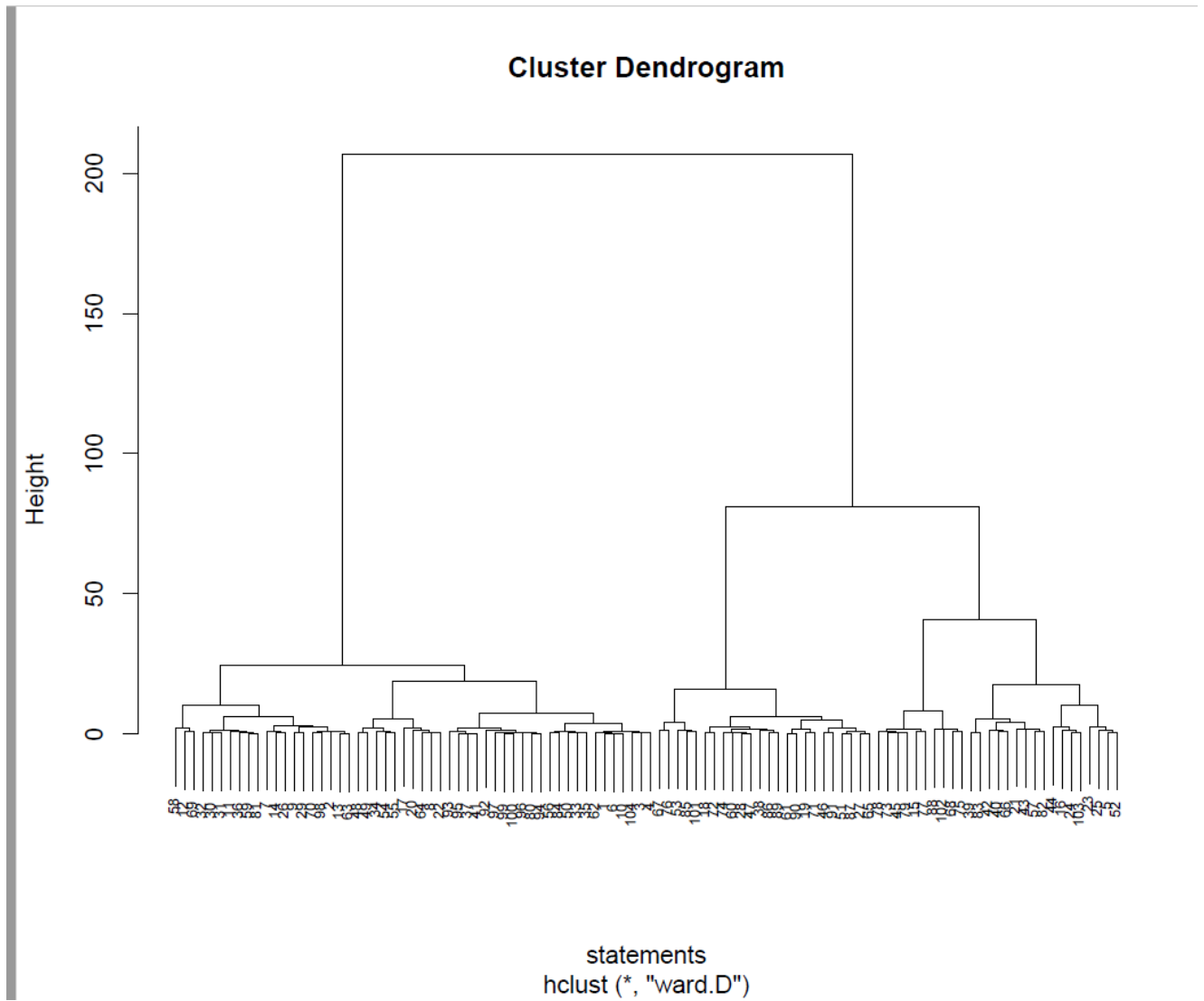
Round 3 Data Collection: Focus Group Agenda

- Welcome and Review the purpose of the study and focus group
- Summarization of the first two rounds of data collection
 - Presentation of Point Map
 - Presentation of Cluster Map
- Providing instructions about the third round of data collection that includes:
 - Examination of clusters' statements and labels
 - Review of regions' clusters and labels
 - Discussion and sharing any thoughts, observations about their perspectives on unique components and processes of different tasks MHC can do in the hospital settings to facilitate services and enhance patients' well-being.

APPENDIX H

Two Dimensions Clustered Point Map



APPENDIX I**Cluster Tree**

APPENDIX J

Region List

Region List

Regions	Clusters Title
Overarching Roles and Responsibilities of MHCs in the Hospital setting	1. Fundamental Roles and Responsibilities in the Hospital Setting 2. Specific Roles and Responsibilities in Different Hospital Units
MHCs' Specific Role in the Hospital Setting	3. Building Relationship with Patients 4. Assessing/Evaluating Patients' Mental Health Status 5. Assisting and Supporting patients with Physical, Psychological, and Social Challenges in Relations to their Medical Condition 6. Educating Patients
Roles and Responsibilities as a Multidisciplinary Team Member	7. Advocating for Patients in the Multidisciplinary Team 8. Mediating Communication Between Healthcare Professionals, Patients, and Families 9. Collaborating with Other Multidisciplinary Team Members on Patients' Care 10. Training Other Multidisciplinary Members on General Wellness and Mental Health 11. Offering Trainings and Emotional Support to Other Multidisciplinary Team Members

Clusters' Statements

REGION 1: OVERARCHING ROLES AND RESPONSIBILITIES OF MHCs IN THE HOSPITAL SETTING

Cluster 1: Fundamental Roles and Responsibilities in the Hospital Setting

- St 69 Provide therapeutic support to family in general
- St 48 Provide behavioral health care services
- St 49 Provide early intervention by identifying and providing effective early support to patients
- St 54 Provide patients with home resources
- St 55 Address acute mental health needs
- St 64 Meet with mental health patients daily
- St 8 Provide mental health support to patients
- St 93 Offer emergency support to address patients' immediate needs
- St 84 Provide patients with one-on-one services
- St 50 Provide an avenue for the patient to voice their mental concerns while hospitalized
- St 62 Provide counseling services to patients
- St 104 Be responsible for patients' overall mental wellbeing
- St 102 Advocate on behalf of the patient from a mental health standpoint
- St 68 Recommend patients for therapeutic interventions
- St 75 Assist in patient crisis management when needed
- St 25 Provide patients with outpatient resources after discharge
- St 3 Support patients with spiritual issues
- St 4 Support patients going through domestic issues

Cluster 2: Specific Roles and Responsibilities in Different Hospital Units

- St 98 Assist patients in their decisions over treatment especially extraordinary treatment like fertility counseling
- St 34 Provide counseling to patients at the emergency department
- St 95 Assist mothers with childbirth issues
- St 37 Provide group counseling to patients with common conditions like example with COVID19
- St 41 Support new moms
- St 35 Provide counseling to patients in inpatient, where patients have been in the hospital longer
- St 5 Assist with prisoners
- St 52 Facilitate outpatient mental health services
- St 92 Provide support to families of patients diagnosed with rare condition or terminal diseases
- St 97 Support patients going through cancer remission
- St 99 Assist/support patients making life support choices

REGION 2: MHCs' SPECIFIC ROLE IN THE HOSPITAL SETTING

Cluster 3: Building Relationships with Patients

- St 58 Be empathic in their attitude and behavior
- St 12 Inspire confidence
- St 32 Be supportive

- St 30 Make the patient feel seen and heard
- St 31 Listen to patients needing an ear
- St 59 Provide emotional support to patients
- St 26 Attend to emotions
- St 29 Increase patient satisfaction
- St 2 Provide encouragement to patients
- St 13 Support patients to relieve their anxiety
- St 63 Be a confidant for patients
- St 33 Be attentive to patients' needs (e.g., psychological, social, physical)
- St 11 Support patients in faith-centered life

Cluster 4: Assessing/Evaluating Patients' Mental Health Status

- St 78 Assess if patient is safe or needs supervision or assistance with activities
- St 73 Facilitate psychological assessments and provide supportive counseling accordingly
- St 45 Devise patients' psychological evaluations
- St 79 Assess if patient has mental capacity to decide for themselves
- St 15 Evaluate patients' needs for further psych treatment
- St 77 Assess patient's ability to participate with therapy
- St 88 Evaluate further mental health needs of the patients
- St 44 Assess mothers to see if they are fit to be discharged and care for their baby

Cluster 5: Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition

- St 56 Provide patients with additional insight
- St 36 Help patient process what they are going through
- St 81 Help patients deal with different challenges
- St 7 Help patients understand the different steps to take in their recovery
- St 9 Encourage patients in their progress
- St 80 Help patient deal with challenges of a new diagnosis
- St 94 Support/assist patients to accept loss
- St 17 Aid in facilitation of interventions vs. specific behaviors
- St 96 Support patients adapting and dealing with disabilities
- St 100 Assist/support patients in their process of adapting to amputations
- St 1 Assist patients to process loss
- St 6 Assist/support patients in their process of death and dying
- St 10 Assist/support patients adapting to lifelong conditions such as diabetes

Cluster 6: Educating Patients

- St 14 Initiate and teach coping skills to patients
- St 70 Be an educator and provide psychoeducation to patients when appropriate
- St 20 Be an informant to patients and provide them with the needed resources
- St 22 Provide patients with tools for mental health wellness

REGION 3: MHCs' ROLES AND RESPONSIBILITIES AS A MULTIDISCIPLINARY TEAM MEMBER

Cluster 7: Advocating for Patients in the Multidisciplinary Team

- St 67 Advocate for patients' rights
- St 65 Be an informant to other health professionals on patients' needs
- St 91 Work within a team to achieve patients' best outcome

Cluster 8: Mediating Communication Between Healthcare Professionals, Patients, and Families

- St 76 Be a link between the services and the patient at the hospital
- St 19 Aid in communication between doctor, patient, and family
- St 71 "Put out fires" – be a mediator in the cases of tension between different stakeholders (e.g., patients, health professionals)
- St 24 Facilitate communication with families
- St 101 Establish rapport with patients and find out facts to add to the information other professionals gathered
- St 72 Act as a bridge between medical and mental health
- St 85 Listen to concerns of patients and staff
- St 51 Provide written information about patients' concerns to be reviewed by other health care providers

Cluster 9 : Collaborating with Other Multidisciplinary Team Members on Patients' Care

- St 42 Support nursing staff with patients needing more therapeutic communication
- St 21 Provide mental health resources for registered nurses
- St 43 Assist health professionals in informing mothers on baby care assistance options once delivered
- St 83 Assistance in Temporary Detention Orders (TDO)
- St 82 Assist health professionals with Psych placement for patients
- St 47 Assist health professionals with identifying who will benefit from psychiatric consults
- St 23 Help develop patients' safety plan of care
- St 18 Help health professionals to establish patients' mental and behavioral capacity
- St 90 Recommend health professionals for other services needed by patient
- St 27 Give nurses and other healthcare providers a different point of view on the patient and the situation
- St 103 Make and review medication recommendations
- St 74 Communicate with other staff about patients' mental health interventions
- St 16 Aid in diagnosis of behavioral concerns
- St 53 Coordinate outpatient services
- St 57 Aid in discharge planning
- St 60 Strategize patients' care with other health professionals' services
- St 61 Assist/help other health professionals in patients' care
- St 46 Assist social workers' work with patients
- St 28 Offer health professionals different, more up to date ideas for the best care for the patient
- St 87 Communicate ideas on patients' needs/care to other health care providers as counselors are an extra set of ears to patients

10: Training Other Multidisciplinary Members on General Wellness and Mental Health

St 38 Train staff on how to be emotionally supportive to patients

St 89 Counsel other health professionals regarding patient's current issues

St 66 Be an educator to health professionals

Cluster 11: Offering Trainings and Emotional Support to Other Multidisciplinary Team Members

St 86 Facilitate coping techniques training to staff and nursing team

St 40 Provide training to staff on their own emotional well-being

St 39 Provide emotional support to staff

APPENDIX K

Rating Data

Rating Statements

Field	Mean	Std Deviation	Variance	Count
St 2 Provide encouragement to patients	3.92	1.64	2.69	10
St 3 Support patients with spiritual issues	3.31	1.54	2.37	10
St 9 Encourage patients in their progress	3.77	1.62	2.64	10
St 7 Help patients understand the different steps to take in their recovery	3.54	1.5	2.25	10
St 8 Provide mental health support to patients	4	1.66	2.77	10
St 22 Provide patients with tools for mental health wellness	3.77	1.62	2.64	10
St 104 Be responsible for patients' overall mental wellbeing	3.46	1.65	2.71	10
St 12 Inspire confidence	3.62	1.55	2.39	10
St 14 Initiate and teach coping skills to patients	3.62	1.55	2.39	10
St 26 Attend to emotions	4	1.66	2.77	10
St 59 Provide emotional support to patients	4	1.66	2.77	10
St 29 Increase patient satisfaction	3.31	1.49	2.21	10
St 30 Make the patient feel seen and heard	3.92	1.64	2.69	10
St 50 Provide an avenue for the patient to voice their mental concerns while hospitalized	3.85	1.61	2.59	10
St 56 Provide patients with additional insight	3.69	1.54	2.37	10
St 89 Counsel other health professionals regarding patient's current issues	3.77	1.58	2.49	10
St 93 Offer emergency support to address patients' immediate needs	3.85	1.66	2.75	10
St 84 Provide patients with one-on-one services	3.54	1.6	2.56	10
St 101 Establish rapport with patients and find out facts to add to the information other professionals gathered	3.85	1.61	2.59	10
St 31 Listen to patients needing an ear	3.85	1.61	2.59	10

St 32 Be supportive	3.85	1.61	2.59	10
St 33 Be attentive to patients needs (e.g., psychological, social, physical)	3.92	1.64	2.69	10
St 58 Be empathic in their attitude and behavior	3.92	1.64	2.69	10
St 60 Strategize patients care with other health professionals services	3.85	1.61	2.59	10
St 61 Assist/help other health professionals in patients care	3.69	1.54	2.37	10
St 62 Provide counseling services to patients	3.92	1.64	2.69	10
St 63 Be a confidant for patients	3.77	1.58	2.49	10
St 65 Be an informant to other health professionals on patients needs	3.69	1.59	2.52	10
St 66 Be an educator to health professionals	3.62	1.6	2.54	10
St 67 Advocate for patients rights	3.85	1.66	2.75	10
St 102 Advocate on behalf of the patient from a mental health standpoint	3.92	1.64	2.69	10
St 1 Assist patients to process loss	4	1.66	2.77	10
St 94 Support/assist patients to accept loss	3.92	1.64	2.69	10
St 81 Help patients deal with different challenges	3.85	1.61	2.59	10
St 4 Support patients going through domestic issues	3.69	1.73	2.98	10
St 5 Assist with prisoners	3	1.52	2.31	10
St 6 Assist/support patients in their process of death and dying	4	1.66	2.77	10
St 11 Support patients in faith-centered life	3.38	1.6	2.54	10
St 17 Aid in facilitation of interventions vs. specific behaviors	3.23	1.53	2.33	10
St 13 Support patients to relieve their anxiety	3.85	1.61	2.59	10
St 36 Help patient process what they are going through	3.92	1.64	2.69	10
St 80 Help patient deal with challenges of a new diagnosis	4	1.66	2.77	10
St 95 Assist mothers with childbirth issues	3.85	1.66	2.75	10
St 41 Support new moms	3.62	1.55	2.39	10
St 43 Assist health professionals in informing mothers on baby care assistance options once delivered	3.46	1.5	2.25	10
St 48 Provide behavioral health care services	3.69	1.59	2.52	10

St 49 Provide early intervention by identifying and providing effective early support to patients	3.77	1.58	2.49	10
St 53 Coordinate outpatient services	3.08	1.54	2.38	10
St 55 Address acute mental health needs	3.92	1.64	2.69	10
St 57 Aid in discharge planning	3.23	1.37	1.87	10
St 75 Assist in patient crisis management when needed	3.85	1.61	2.59	10
St 82 Assist health professionals with Psych placement for patients	3.54	1.55	2.4	10
St 83 Assistance in Temporary Detention Orders (TDO)	3.38	1.6	2.54	10
St 96 Support patients adapting and dealing with disabilities	3.92	1.64	2.69	10
St 97 Support patients going through cancer remission	3.77	1.62	2.64	10
St 98 Assist patients in their decisions over treatment especially extraordinary treatment like fertility counseling	3.77	1.67	2.79	10
St 99 Assist/support patients making life support choices	4	1.66	2.77	10
St 100 Assist/support patients in their process of adapting to amputations	4	1.66	2.77	10
St 10 Assist/support patients adapting to lifelong conditions such as diabetes	3.85	1.66	2.75	10
St 52 Facilitate outpatient mental health services	3.77	1.62	2.64	10
St 64 Meet with mental health patients daily	3.15	1.56	2.44	10
St 34 Provide counseling to patients at the emergency department	3.31	1.43	2.06	10
St 35 Provide counseling to patients in inpatient, where patients have been in the hospital longer	3.62	1.64	2.7	10
St 37 Provide group counseling to patients with common conditions like example with COVID19	3.31	1.54	2.37	10
St 92 Provide support to families of patients diagnosed with rare condition or terminal diseases	3.92	1.64	2.69	10
St 69 Provide therapeutic support to family in general	3.69	1.59	2.52	10
St 21 Provide mental health resources for registered nurses	3.54	1.55	2.4	10
St 20 Be an informant to patients and provide them with the needed resources	3.69	1.59	2.52	10

St 25 Provide patients with outpatient resources after discharge	3.46	1.5	2.25	10
St 54 Provide patients with home resources	3.54	1.5	2.25	10
St 70 Be an educator and provide psychoeducation to patients when appropriate	3.62	1.5	2.24	10
St 15 Evaluate patients' needs for further psych treatment	3.62	1.55	2.39	10
St 16 Aid in diagnosis of behavioral concerns	3.69	1.59	2.52	10
St 18 Help health professionals to establish patients' mental and behavioral capacity	3.85	1.61	2.59	10
St 44 Assess mothers to see if they are fit to be discharged and care for their baby	3.46	1.5	2.25	10
St 45 Devise patients' psychological evaluations	3.54	1.45	2.09	10
St 73 Facilitate psychological assessments and provide supportive counseling accordingly	3.92	1.64	2.69	10
St 77 Assess patients' ability to participate with therapy	3.77	1.58	2.49	10
St 78 Assess if patient is safe or needs supervision or assistance with activities	3.77	1.62	2.64	10
St 79 Assess if patient has mental capacity to decide for themselves	3.77	1.62	2.64	10
St 88 Evaluate further mental health needs of the patients	3.77	1.62	2.64	10
St 103 Make and review medication recommendations	3.15	1.56	2.44	10
St 19 Aid in communication between doctor, patient, and family	3.62	1.55	2.39	10
St 24 Facilitate communication with families	3.77	1.58	2.49	10
St 71 'Put out fires' be a mediator in the cases of tension between different stakeholders (e.g., patients, health professionals)	3.23	1.42	2.02	10
St 85 Listen to concerns of patients and staff	3.69	1.54	2.37	10
St 74 Communicate with other staff about patients' mental health interventions	3.69	1.59	2.52	10
St 27 Give nurses and other healthcare providers a different point of view on the patient and the situation	3.54	1.5	2.25	10

St 28 Offer health professionals different, more up to date ideas for the best care for the patient	3.54	1.6	2.56	10
St 42 Support nursing staff with patients needing more therapeutic communication	3.62	1.69	2.85	10
St 46 Assist social workers' work with patients	3.31	1.54	2.37	10
St 47 Assist health professionals with identifying who will benefit from psychiatric consults	3.62	1.55	2.39	10
St 51 Provide written information about patients' concerns to be reviewed by other health care providers	3.62	1.55	2.39	10
St 72 Act as a bridge between medical and mental health	3.54	1.5	2.25	10
St 76 Be a link between the services and the patient at the hospital	3.69	1.54	2.37	10
St 87 Communicate ideas on patients' needs/care to other health care providers as counselors are an extra set of ears to patients	3.77	1.58	2.49	10
St 90 Recommend health professionals for other services needed by patient	3.62	1.55	2.39	10
St 91 Work within a team to achieve patients' best outcome	3.92	1.64	2.69	10
St 68 Recommend patients for therapeutic interventions	3.77	1.58	2.49	10
St 23 Help develop patients' safety plan of care	3.92	1.64	2.69	10
St 38 Train staff on how to be emotionally supportive to patients	3.85	1.61	2.59	10
St 40 Provide training to staff on their own emotional well-being	3.77	1.62	2.64	10
St 39 Provide emotional support to staff	3.85	1.61	2.59	10
St 86 Facilitate coping techniques training to staff and nursing team	3.85	1.61	2.59	10

Cluster Ratings

Clusters	<i>n</i>	<i>M</i>	<i>SD</i>
1. Fundamental Roles and Responsibilities in the Hospital Setting	10	3.69	1.6
2. Specific Roles and Responsibilities in Different Hospital Units	10	3.63	1.6
3. Building Relationships with Patients	10	3.79	1.61
4. Assessing/Evaluating Patients' Mental Health Status	10	3.70	1.57
5. Assisting and Supporting Patients with Physical, Psychological, and Social Challenges in Relation to Their Medical Condition	10	3.82	1.62
6. Educating Patients	10	3.68	1.57
7. Advocating for Patients in the Multidisciplinary Team	10	3.82	1.63
8. Mediating Communication Between Healthcare Professionals Patients, and Families	10	3.63	1.54
9. Collaborating with Other Multidisciplinary Team Members on Patients' Care	10	3.55	1.56
10. Training Other Multidisciplinary Members on General Wellness and Mental Health	10	3.74	1.6
11. Offering Trainings and Emotional Support to Other Multidisciplinary Team Members	10	3.81	1.62

Note: Highest-rated clusters are bolded.