Summer 8-2022

Mental Health Counselors' Perceptions of Professional Identity as Correctional Counselors in an Integrated Behavioral Health Care Setting

Jeanel L. Franklin
jlfranklin013@gmail.com

MENTAL HEALTH COUNSELORS' PERCEPTIONS OF PROFESSIONAL IDENTITY AS CORRECTIONAL COUNSELORS IN AN INTEGRATED BEHAVIORAL HEALTH CARE SETTING

by

Jeanel L. Franklin

B.S. December 2015, Old Dominion University

M.S.Ed. August 2018, Old Dominion University

A Dissertation Submitted to the Faculty of
Old Dominion University in Partial Fulfillment of the
Requirements for the Degree of

DOCTOR OF PHILOSOPHY

COUNSELING

OLD DOMINION UNIVERSITY
August 2022

Approved by:

Ed Neukrug (Chair)

Angela Eckhoff (Methodologist)

Mark Rehfuss (Member)

ABSTRACT

MENTAL HEALTH COUNSELORS' PERCEPTIONS OF PROFESSIONAL IDENTITY AS CORRECTIONAL COUNSELORS IN AN INTEGRATED BEHAVIORAL HEALTH CARE SETTING

Jeanel L. Franklin
Old Dominion University, 2022
Chair: Dr. Ed Neukrug

This study explores the professional identity of clinical mental health counselors employed as correctional counselors in an integrated behavioral health (IBH) setting. Previous research has documented the attitudes, perceptions, and experiences of mental health counselors working in IBH as well as their experiences engaging in interprofessional collaboration. However, researchers have yet to explore how clinical mental health counselors in correctional settings perceive their professional identity and what aspects of their professional roles impact their identity development. This study utilized an interpretive phenomenological approach (IPA) to describe, understand, and interpret the meaning of four correctional counselors' perceptions of their professional identities while operating in a Southeastern County jail. The researcher utilized individual interviews and audio/video logs to collect data on participants' experiences. Data was analyzed using Smith and colleagues' (2009) six step process of IPA data analysis. Key findings indicated that correctional counselors' unique work environment, collaborative work relationships, and multiple foci of their mental health role contributed to professional growth and identity development. Additionally, participants experienced a transitional process where they adapted their counseling styles to the needs of the setting and population as well as integrated their experiences as correctional counselors into their pre-existing professional identities.

Practical implications for counseling trainees, counselor educators, clinical supervisors, mental health counselors and LPCs as well as directions for future research are discussed.

Keywords: mental health counselor, correctional counselor, professional identity, integrated behavioral health, interpretative phenomenological approach

To all who guided, encouraged, and supported me throughout my academic and professional journey, this is for you. Thank you for cultivating my love of learning!

TABLE OF CONTENTS

Page

LIST OF TABLES

CHAPTER 1

INTRODUCTION TO THE STUDY

This chapter provides a brief overview of the study's topic, purposes and goals of the study, research questions, and definitions of common terms used throughout the manuscript.

Overview of Background Information

Professional identity is an important aspect of professional development that unites individuals within a discipline under a common set of values, beliefs, assumptions, and philosophical orientations (Burns & Cruikshanks, 2018). For the profession of counseling, this identity consists of a philosophical orientation toward human development, prevention, and wellness (Burkholder, 2012; Mellin et al., 2011). These unique values are what set counseling apart from other helping professions such as psychology, social work, and nursing.

Throughout history the counseling profession has grown and diversified, as counselors gained employment in a wide range of settings. As a result of working in different settings and servicing specific populations, counselors began to differentiate themselves from one another. This differentiation led to the creation of counseling specialty areas (e.g., school, clinical mental health, rehabilitation, career, etc.) each with their own emphasis on certain skills, knowledge, and professional orientations to helping (CACREP, 2021; Neukrug, 2022). This specialized training, as well as experiences in the field, socializes counselors differently resulting in distinct professional identities across specialty areas.

This multitude of individual counseling identities has impacted cohesion within the profession contributing to professional issues such as licensure portability (Kaplan & Gladding, 2011), disaffiliation of professional organizations (Colangelo, 2009; R. Wong, personal communication, March 27, 2018), and an unclear identity for the profession of counseling

(Myers et al., 2002). Attempts to clarify and define the profession of counseling have been made by the American Counseling Association (ACA) in collaboration with other counseling-related professional organizations (Kaplan & Gladding, 2011). One of the most historical attempts was *ACA's 20/20: A Vision for the Future of Counseling* which established a basic definition for counseling, standardized licensure title, and scope of practice statement. ACA hoped that these efforts would help clarify the profession and strengthen cohesion among counseling specialty areas (Kaplan & Gladding, 2011). However, despite these efforts to increase unity and tie counselors to a shared professional identity, specialty areas within counseling continue to develop unique professional identities. Based on the history and development of the counseling profession, it is clear that counselors within specialty areas, including mental health counselors, experience a unique professional identity within the larger identity of the profession (Burns & Cruikshanks, 2018).

Mental Health Counselor Professional Identity

The mental health counseling field has developed as a distinct counseling specialty area and over time distinguished itself from other areas of counseling such as community and agency counseling (Colangelo, 2009), addictions counseling, and rehabilitation counseling (Neukrug, 2022). Mental health counselors receive specialized training that covers a wide range of skills and knowledge so that they can assist individuals with their emotional and mental health needs. This broad skill set has allowed mental health counselors to gain employment in a variety of community settings such as inpatient facilities, hospitals, correctional facilities, social service agencies, and private practices (Neukrug, 2022).

Mental health counselors differ in the roles, services provided, and populations served across settings. These differences impact the professional identity development of mental health

counselors resulting in distinct identities that are unique to employment settings as counselors tend to define their professional identities based on their roles, the populations they serve, and the settings in which they provide services (Mellin et al., 2011). Research has shown that mental health counselors working in integrated behavioral health care (IBH) settings operate in a multitude of roles (Berkel et al., 2019; Glueck, 2015) contributing to distinct experiences within IBH, which set them apart from mental health counselors employed in other settings such as community mental health agencies and private practice.

Mental Health Counselors in Integrated Behavioral Health

The health care system has recognized a need to shift its approach to individual treatment from one in which health care disciplines are siloed and operate separately from one another to one that integrates health care professions to better address the physical and mental health needs of the public (Daniels et al., 2009). This emphasis on integration has led to an increase in employment for mental health counselors in primary care and other health care settings (Glueck, 2015; Johnson & Freeman, 2014; Neukrug, 2022).

The blending of mental and physical health disciplines has created a unique work environment for mental health counselors as they adapt their training, roles, and skills to function alongside medical providers. Mental health counselors in IBH settings have noted differences in logistics, roles, services provided, theories of treatment, and attitudes toward collaboration between mental health and medical disciplines (Berkel et al., 2020; Glueck, 2015; Pomerantz et al., 2009) which can create barriers to provider collaboration. Additionally, mental health counselors in IBH have noted that they tend to operate primarily from consulting and educating roles when working in IBH as well as provide brief, short-term services based on the physicians' determination of need (Glueck, 2015).

In addition to the increased employment of mental health counselors in healthcare systems, correctional and social justice systems have noted a need for increased mental health care for inmates (Davis & Cates, 2017; DiCataldo et al., 2021; Kupers, 2015). Previous studies have documented the unique roles and responsibilities of mental health counselors working in corrections (DiCataldo et al., 2021; Matz & Lowe, 2020). However, these studies only explored how correctional counselors spent their time engaged in various duties. Few studies have explored how correctional counselors perceive their professional identity when operating in their professional role (Carrola et al., 2016) and virtually none have examined how their professional role in corrections influences their counseling identity development.

The distinct roles and experiences within IBH and correctional settings may impact mental health counselors' perceptions of their professional identity thus influencing how they conceptualize and communicate their professional roles and responsibilities. Understanding how mental health counselors in IBH roles within correctional environments perceive their professional identities can provide direction for counselor educators, clinical supervisors, and other mental health counselors on how to support the professional identity development of mental health counselors in these settings.

Purpose Statement

Although previous research has focused on the unique professional identity of counselors (Prosek & Hurt, 2014; Woo et al., 2016) and the attitudes, perceptions, and experiences of working in IBH settings for mental health professionals in general (Glueck, 2015; Johnson & Mahan, 2019), there is a gap in knowledge regarding how mental health counselors perceive their professional identity in these settings and what aspects of their professional roles in IBH impact their professional identity development. Additionally, even fewer studies have examined

how mental health counselors working in corrections experience their professional identity and impacts on their identity development. The primary aim of this phenomenological study was to address this gap in knowledge by describing and interpreting the meanings of mental health counselors' experiences of their professional counseling identity while operating in IBH roles within a correctional setting. The secondary aim of this study was to explore how mental health counselors' experiences of their professional roles as correctional counselors influenced their professional identity development.

Research Questions

The researcher developed the following research questions to guide this qualitative inquiry and address the aims of the study:

1. How do mental health counselors, working as correctional counselors within an integrated behavioral health care system, perceive their professional identity?
2. How do mental health counselors' experiences of their professional roles as correction counselors in IBH influence their counselor identity development?

Both research questions were explored using individual interviews facilitated by the researcher and video/audio logs recorded by the participants.

Study Specific Terms

For the purposes of this study, *mental health counselors* are individuals who provide clinical mental health services for the purposes of addressing mental health needs. They have obtained professional training in clinical mental health counseling and meet professional standards and practices as defined by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) and the American Counseling Association (ACA).

Correctional Counselors are individuals who provide mental health services in correctional settings (e.g., jails, prisons, etc.). They work with inmate populations toward the goal of increasing healthy capacities that assist inmates with successful management of mental health symptoms post-incarceration (Kupers, 2015). They perform a variety of duties in their correctional counselor role including assessment, discharge planning, treatment planning, individual and group therapy, supervision, administrative tasks, and clinical documentation (DiCataldo et al., 2021). They also collaborate with other health providers and security/correctional staff within the setting to provide holistic and integrative care.

Counselor trainees are pre-professionals who are in educational or training programs to learn about the skills and clinical practice of mental health counseling.

Professional counseling identity is defined as an individual's view of self as a professional, that provides a cognitive frame of reference for performing professional roles and responsibilities as a counselor (Woo et al., 2016).

Professional identity development is a continuous process of growth that occurs throughout an individual's professional career and involves integrating one's professional education and training with personal attributes, such as values, beliefs, and personality characteristics, within the context of a professional community (Burkholder, 2012; Gibson et al., 2010).

Integrated Behavioral Health (IBH) is defined as medical and mental health care providers working simultaneously, within a single health care system, to treat individuals' mental and physical health needs (Agency for Healthcare Research and Quality, n.d.; Pomerantz et al., 2019).

Interpretative Phenomenological Analysis (IPA) is a qualitative research approach aimed at examining how particular individuals construct meaning from a particular experience (Smith et al., 2009). The conceptual framework for this methodology is grounded in phenomenology, hermeneutics, and idiography.

CHAPTER 2

LITERATURE REVIEW

The goal of this chapter is to provide background information for key components of the present study. This background information is used to situate the present study within the current body of knowledge for counseling, mental health counseling, integrated behavioral health care (IBH), correctional counseling, and professional identity development.

First, I provide relevant information pertaining to the identity of the counseling profession including distinguishing features between helping professions (e.g., counseling, social work, psychology, and psychiatry), the profession's development throughout history, the definition of counseling, and similarities and differences between counseling specialty areas. Next, information regarding the unique features of mental health counseling is given. This includes an overview of the historical development of mental health counseling and features of mental health counselors that distinguish them from other counseling specialties. Then, attention is given to the settings in which mental health counselors provide services with a particular focus on IBH and correctional work environments. Afterward, an overview of counselor professional identity development and mental health counselors' identities in IBH settings is provided. Finally, relevant literature and the need for the present study is addressed.

Defining the Counseling Profession

There are many helping professions that address the mental health needs of individuals. Professions such as counseling, social work, psychology, and psychiatry all address these needs in similar yet different ways. The differences among these helping professions can be seen in the focuses of their training and professional duties. For example, psychiatrists have a background in medicine and focus their services on diagnosing and treating psychological disorders with

medication, while social workers are trained to provide services that address social and family systems (Neukrug, 2022).

Although differences among these helping professions exist, there is considerable overlap in professional duties, services provided, and employment settings. Social workers, psychologists, and counselors all provide counseling and psychotherapy to a variety of individuals and can be found working in many of the same settings such as schools, hospitals, and private practices (Neukrug, 2022). The overlap between professional duties and employment settings among these helping professions can make it difficult for the public and other professionals to discern what the unique characteristics are for the counseling profession.

This overlap is, in part, due to the shared history among these helping professions. Examining the history of how the counseling profession developed, highlights how the counseling profession was able to distinguish itself from other helping professions by establishing its own professional orientation, values, and approaches.

A Brief of History of Counseling

Counseling is a relatively new profession compared to social work, psychology, and psychiatry which were developed during the 19th century to address the social and mental health needs of individuals. It originated from social reform movements, early vocational guidance activities, increased use of assessment instruments, and the development of the first comprehensive approach to therapy which took place during the 1800s (Neukrug, 2022).

During the 1800s social workers, psychiatrists, and educators led social reform movements that advocated for more humane approaches to helping individuals who were poor, destitute, and/or mentally ill (Neukrug, 2022). Previously, these individuals were viewed as immoral and untreatable resulting in poor helping approaches that involved long-term placement

in facilities. Along with the social reform movements, there was a rise in industrialization and immigration creating an increased need for vocational guidance.

The increase in vocational guidance occurred during the same time psychologists were focused on the development of laboratory science. This resulted is numerous psychological and educational tests that could assess differences between individuals (Neukrug, 2022). These tests were then incorporated in vocational guidance approaches to assist individuals and institutions with making more informed career decisions.

The final reform movement that took place toward the end of the 1800s that helped create a foundation for the counseling profession was the development of the first systematic, comprehensive approach to psychotherapy. Freud's theory of psychoanalysis challenged the public's beliefs regarding how mental illness develops by positing that emotional problems had a psychological basis (Neukrug, 2022). As Freud's theory became widespread, the public became more receptive to psychological concepts and began to conceptualize their experiences in psychological ways.

The emphasis on humane treatment approaches, ability to measure individual differences to inform decision making, and the development of comprehensive theories for psychotherapy during the 1800s, created the foundation for the emergence of the counseling profession.

The Beginnings of the Counseling Profession

In the early part of the 1900s Frank Parsons, known as the founder of vocational guidance in the United States, directed the movement of vocational guidance toward an emphasis on knowing oneself, individualized treatment, being genuine, and assisting individuals with decision making (Neukrug, 2022). Parson's principles for vocational guidance would later influence the major beliefs and theoretical orientation of the counseling profession.

Not only did Parsons influence the focus of vocational guidance approaches to include both moral and occupational needs of individuals, but he also influenced how and to whom these services were offered. In 1910, vocational guidance counselors were increasingly serving youth in school settings. However, once vocational guidance counselors were in these settings, they recognized a need to address students' educational and psychological needs (Neukrug, 2022). Since the focus of vocational guidance counseling had broaden and was no longer solely on occupational needs the new profession called guidance counseling (i.e., school counseling) emerged.

Although the counseling profession had its roots in vocational guidance and guidance counseling in schools, it was not until the spread of psychotherapy and mental health clinics during World War I that counseling began to emerge as a profession.

The Emergence of the Counseling Profession

Public mental health needs grew during World War I, as more and more soldiers with psychological problems returned home to the United States. This created a high demand for mental health professionals, accessible treatment facilities, and short-term treatment approaches that could quickly address psychological concerns (Neukrug, 2022). It was during this time of increased mental health need that counseling began to appear as a distinguished profession.

Academic institutions began to offer a master's degree in counseling to those who wanted to pursue positions as psychological assistants in mental health clinics (Neukrug, 2022). Individuals with this degree possessed training in counseling techniques and assessment, making them an appropriate match for the individuals served by community-based mental health clinics. Additionally, psychological theorists began developing shorter-term approaches for psychotherapy one of which was specific to the profession of counseling.

In the 1930s, E. G. Williamson developed the first comprehensive theory of counseling called the *trait-and-factor theory*, which was based on ideas from Parsons and involved five steps (i.e., analysis, synthesis, diagnosis, counseling, and follow-up). Although originally designed for vocational counseling, the theory was soon modified and used for counseling and psychotherapy approaches (Neukrug, 2022). During the 1940s, Carl Rogers, who originally practiced from a psychodynamic perspective at a guidance center, also developed a non-directive, client-centered approach to psychotherapy that was short-term and practical. Rogers' approach was humanistic and emphasized genuineness making it a good fit for the foundational values, beliefs, and theoretical orientations of the counseling profession. It was the adoption of Rogers' theory that allowed the counseling profession to establish a professional orientation that was separate from vocational guidance.

The Expansion and Differentiation of the Counseling Profession

Once the counseling profession emerged with its own orientation toward humanistic and non-directive ideals, the profession continued to develop and expand its identity. During the 1950s, counseling began incorporating developmental theories into its treatment approaches. These theories normalized human experience and assisted counselors in helping individuals as they encountered predictable tasks at different life stages (Neukrug, 2022). With a developmental focus, the counseling profession was able to adopt an attitude of non-pathology toward mental health setting the profession apart from fields like psychology and psychiatry which tend to emphasize the causes, diagnosis, and treatment of mental illness (Neukrug, 2022).

Now that the counseling profession was established and had increased in recognition there was a need to create a professional home for counselors. Thus, the American Personnel and

Guidance Association (APGA), what would later become the American Counseling Association (ACA), was established. After APGA was created other professional counseling associations began to emerge, reflecting the growing diversity of counselors in the field.

The counseling field began to diversify as the variety of employment settings available to counselors increased. Counselors were beginning to provide services at college counseling and career centers, community agencies, and vocational rehabilitation centers in addition to schools and mental health clinics (Neukrug, 2022). This expansion in employment settings contributed to the formulation of counseling specialty areas as counselors in these different settings served specific populations and addressed different mental health needs. The emergence of specialty areas led to differentiation and diversification within the counseling profession.

Professionalism in the Field of Counseling

As the counseling profession continued to expand and diversify a need for professional standards developed resulting in the establishment of a professional ethics code, standards for counselor training programs, and professional credentials. These professional standards would help define the scope of the counseling profession and allow the profession to regulate itself.

In 1961, APGA assisted in increasing the professionalism of counseling by developing the first ethical standards for practice (Neukrug, 2022). The development of a professional ethics code defined the expectations of professional practice for all counselors regardless of specialty area. Once creating standards for practice, the profession then focused on standardizing training and credentialing for counselors.

Due to the increase in specialty areas, numerous training programs had been developed to accommodate the educational and preparation needs of counselors. This created a need to regulate the training of counselors to ensure that the ethical standards of practice were being

upheld. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) was formed in 1981, for the purposes of establishing and managing the standards for the profession of counseling (Neukrug, 2022). Once the profession had established standards for training and ethical practice, states and professional organizations began offering credentials to counselors to show that they had achieved specific competency requirements.

During the later parts of the 20th century, counselors could obtain a generic national certificate as a Nationally Certified Counselor (NCC) and gain certifications to show their achievement of additional training in their specialty area (Neukrug, 2022). In 1976, Virginia was the first state to offer professional licensing to counselors and other states soon began to also offer licensure to counselors.

At the end of the 20th century, counseling had fully established itself as developed profession. It had a professional orientation grounded in humanism, possessed values of growth and development, and provided individualized approaches to mental health. The profession had also created professional standards to define its scope of practice and create unity among its diverse specialty areas. In the next section, I discuss what the counseling profession looks like in the 21st century.

The Counseling Profession Today

The counseling profession has continued to experience expansion and diversification reflected in the addition of three professional divisions to ACA and the disaffiliation of two of its largest associations since 2000. Currently, ACA has a total of 18 divisions as well as four regional organizations and 56 branches in the United States and internationally (ACA, 2021a; Neukrug, 2022). These professional organizations represent the various specialty areas within counseling and aim to enhance professional identity development and practice by providing

leadership, resources, and information to address the unique needs of their members (ACA, 2021a).

The diversification within the profession has contributed to the broadening of professional experiences for counselors resulting in a multitude of professional counseling identities. Thus, it is important to define the distinguishing characteristics between counseling specialty areas.

CACREP Specialty Areas

CACREP currently provides master's level, educational standards for seven specialty areas. These areas include school counseling, clinical mental health counseling, college counseling and student affairs, career counseling, rehabilitation counseling, addictions counseling, and marriage, couple, and family counseling (CACREP, 2021). The populations served, training emphasis, and credentialing titles for these specialty areas are briefly described below.

School Counseling. School counselors are trained to provide counseling and guidance services to students in elementary, middle, and secondary schools (Neukrug, 2022). School counselors can obtain state credentialing to practice as a school counselor. Additionally, they can become NCCs, ASCA-certified school counselors, and national certified school counselors as well as licensed professional counselors (LPCs) in most states, with additional coursework.

Clinical Mental Health Counseling. Clinical mental health counselors receive training to provide counseling or psychotherapy to individuals experiencing life problems, emotional difficulties, or mental health disorders (Neukrug, 2022). They often work in a variety of community agencies or provide services through private practice. Clinical mental health

counselors who graduated from CACREP-accredited programs are eligible to obtain the NCC and LPC credentials.

College and Student Affairs Counseling. College counselors receive specialized training in college student development and student affairs practices. They provide counseling and administration services in a variety of higher education settings such as college counseling centers, career centers, residence life, student advising services, and multicultural student services (Neukrug, 2022). Similar to school counselors, college counselors can become NCCs and with additional coursework can obtain their LPC.

Career Counseling. Career counselors receive specialized training in career development, attitudes toward work, employment trends, and career characteristics (CACREP, 2021). They work in a variety of settings including high schools, colleges, social service agencies, employment and staffing agencies, and private practice. Career counselors can also obtain certification through the National Career Development Association (NCDA) as a certified career counselor (CCC), certified career services provider (CCSP), certified master of career services (CMCS) (NCDA, 2021).

Rehabilitation Counseling. Rehabilitation counselors are trained to provide a variety of services to individuals with physical, emotional, and developmental disabilities (Neukrug, 2022). They tend to work in state vocational rehabilitation agencies, unemployment offices, or private rehabilitation agencies. Rehabilitation counselors can obtain certification through the Commission on Rehabilitation Counselor Certification (CRCC) as a certified rehabilitation counselor (CRC). Additionally, rehabilitation counselors can become NCCs and with additional coursework could obtain their LPC.

Addictions Counseling. Addiction counselors receive specialized coursework on a range of addictions such as drugs and alcohol, eating disorders, and sexual addition (Neukrug, 2022). Their training programs also focus on diagnosis, treatment planning, and the role of psychopharmacology in treatment. Addiction counselors can receive state certification and are able to be nationally certified as master addiction counselors (MACs). They can also obtain LPC credentialing with additional coursework.

Marriage, Couple, and Family Counseling. Marriage, couple, and family counselors receive specialized coursework in systems dynamics, couples counseling, family therapy, family life stages, and human sexuality to prepare them for their work with couples and family systems (Neukrug, 2022). Like clinical mental health counselors, marriage, couple, and family counselors also can be found in a variety of community agencies and in private practices. All 50 states provide licensure requirements for marriage, couple, and family counselors; however, these requirements can vary drastically from state to state.

Training Across Specialty Areas. In addition to coursework in a specialty area, all counselors receive core coursework in professional orientation and ethical practice, social and cultural diversity, human growth and development, career development, the helping relationship, group work, assessment, and research and program evaluation as part of their programs (CACREP, 2021). Since all counselors who attend CACREP accredited programs receive this core counseling coursework, they possess foundational counseling skills and knowledge needed to perform the various roles and responsibilities to function as counselors in all types of settings. This core coursework also socializes and orients all counselors to the values, ideals, and beliefs of the counseling profession contributing to unification across specialty areas.

American Counseling Association's 20/20 Vision

The continued expansion and differentiation among counselors' specialty areas have contributed to professional debates regarding whether counseling is one cohesive profession or a collection of specialty areas (Mellin et al., 2011; Woo et al., 2016). It has been well established in the counseling literature that the profession needs a unified, cohesive identity which could assist in resolving professional issues such as licensure portability, reimbursement parity, and increased professional recognition (Burns & Cruikshanks, 2018; Kaplan & Kraus, 2018).

As a result of this recognized need, in 2005, ACA proposed their *20/20: A Vision for the Future of Counseling* initiative (Kaplan & Gladding, 2011). The initiative outlined tasks that the profession needed to address to increase cohesion within the profession. Over the next several years, members from 31 professional counseling organizations worked together to identify and address various topics that would help move the profession forward. The identified topics fell into the following broad categories: strengthening identity, presenting as one profession, improving public perception and advocating for professional issues, portability, promoting the research base, students, and promoting client welfare and advocacy (Kaplan & Gladding, 2011). These topics reflected the desire of the counseling profession to create a sense of cohesion and represent itself to the public as one, clear profession. One major step toward improving public perception, involved creating a joint definition for counseling.

Definition of Counseling. Once a shared vision for the future of counseling was established, the professional organizations were tasked with creating a clear, concise definition for counseling that could be used when communicating with external audiences outside of the counseling field (e.g., clients, the public, and legislators). Prior to the development of a joint definition, definitions for counseling had been determined by others, both internal and external to the profession. These definitions, which reflected that group's particular perspective of

counseling, were often lengthy, cumbersome, and incomplete (Kaplan et al., 2014). These definitions also contributed to public misconceptions of counseling creating the need for counselors to educate others on their roles and scopes of practice. Having a joint definition of counseling could help bridge the gap in understanding between counselors and those without counseling backgrounds by clearly outlining what counseling is.

The final joint definition of counseling 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). This statement was intended as a basic definition that generally described what counseling is and specialty areas were encouraged to add their own clarifying statements to elaborate on their specific roles and areas of expertise. ACA disseminated the joint definition to education programs, licensure boards, and book/test publishers to create standardization and unification among the profession (Kaplan et al., 2014).

Unified Yet Diverse

ACA's 20/20: A Vision for the Future of Counseling initiative aimed to unify the profession of counseling by establishing a shared vision for the future of counseling and joint definition that broadly yet clearly described what counseling is. These attempts at establishing cohesion within the profession served the purposes of presenting a clear professional identity, unifying the profession, and increasing public clarity regarding the profession.

Although ACA has taken steps to unify its various divisions, the counseling profession continues to diversify itself with the establishment of new professional organizations each with a specialized counseling focus and unique professional identity. Each division of ACA has their own professional philosophies and organizational needs that can, at times, differ from the

professional goals and agendas of ACA. These differences can lead to disaffiliation from the parent organization and create further separation within the profession.

Disaffiliation. From the beginning of ACA's 20/20 initiative, the America School Counseling Association (ASCA) disagreed with ACA's assumption that one counseling professional identity existed and in 2018 chose to disaffiliate from ACA due to conflictual organizational and philosophical differences (R. Wong, personal communication, March 27, 2018). The following year, the American Mental Health Counseling Association (AMHCA) also disaffiliated claiming that ACA was too broadly focused and attempted to treat all counseling specialties the same making it difficult for the parent organization to meet the individual needs of its divisions (Colangelo, 2009).

The disaffiliation of ASCA and AMHCA provide examples of how the experience of professional identity can vary across counseling specialty areas. Mental health counselors who work in specialized settings and with specific client issues may come to develop and experience their professional identities differently. Although it is assumed that there are commonalities in counselor professional identity (ACA, 2009), how professional identity is experienced by individual counselors is likely to reflect their specialized training and socialization within their work settings (Mellin et al., 2011).

Similarities and Differences of Specialty Areas. Several similarities exist across counseling specialty areas. All counselors enrolled in CACREP accredited programs receive foundational coursework that orient new counselors to the common values, philosophical beliefs, professional practices, and basic skills and knowledge of the profession. This provides counselors, regardless of specialty area, with a similar orientation to the profession of counseling as well as a beginning foundation for their professional identity development. In addition to

similar coursework, most counselors can obtain professional credentialing which allows them to communicate their obtainment of professional standards and their association with the counseling profession to the public. However, the types of credentials, credentialing bodies, and processes for obtaining credentials can vary across specialty areas.

Although commonalities in professional training, philosophical orientation, and professional values exist across specialty areas there are differences in scopes of practice, professional roles, credentialing processes, and professional issues that impact each specialty area in unique ways. These differences influence how individual counselors experience their professional identities and contribute to the development of unique professional counseling identities across specialty areas. In the next section, the history and unique components of mental health counseling are discussed.

History of Mental Health Counseling

Mental health counseling, which grew out of the vocational guidance movement of the 1900s, has a shared history with school, rehabilitation, college, career, and addictions counseling (Neukrug, 2022). Although several legislative and social reform movements influenced these specialty areas, there are clear historical events that distinguish these specialty areas from one another. A brief outline of the key events that helped form mental health counseling as a distinct specialty area are discussed below.

The Beginning

As mentioned previously, the profession of counseling emerged from the vocational guidance movement that occurred during the early 20th century. During this time vocational guidance counselors focused on identifying individuals' traits, through assessment instruments, to match individuals to potential jobs (Neukrug, 2022). This approach to vocational guidance

assisted individuals with make informed vocational decisions that were aligned with their natural ways of being. During the 1930s, post-World War I, research in mental health and mental health treatment increased as the federal government began to fund these activities (Neukrug, 2022). This funding for mental health reflected the growing need for treatment approaches that could be effective short-term. As the 20th century progressed, treatment approaches for addressing the social, emotional, and mental health needs of individuals shifted toward a humanistic perspective.

Increased Need for Mental Health Counselors

During the 1940s, with the rise of Carl Roger's client-centered approach, mental health counseling approaches became increasingly insight-oriented, optimistic, and relatively brief (Neukrug, 2022). This shift in approach allowed mental health counselors to meet the growing treatment demand of soldiers returning from World War II. As a result of this growing need and a shortage of mental health counselors, several influential acts were passed that increased funding for research, training, prevention, diagnosis, and treatment pertaining to mental health (Neukrug, 2022). As a result of this funding, the mental health field was able to increase its knowledge basis to prepare mental health counselors to effectively meet a variety of mental health needs.

Another major shift in the mental health field occurred during this time, as psychotropic medications became more widely used. This allowed individuals to manage their mental health symptoms, resulting in fewer hospitalizations, but increased the need for community-based mental health care (Neukrug, 2022). During the 1960s, the Community Mental Health Centers Act was passed thus providing funding for the establishment of community mental health centers. This increase in community mental health centers across the nation allowed individuals

to receive a variety of mental health services at lower costs. With an increase in access to mental health services in the community and the deinstitutionalization movement of the 1970s, mental health counselors were able to meet the public's mental health needs in ways that were client-centered and least restrictive.

Establishing a Mental Health Counseling Identity

As mental health counseling continued to expand throughout the 1970s and early 21st century, the field of counseling began to focus on creating professional standards that could help define and regulate the profession's various specialty areas. In 1976, Virginia became the first state to offer professional licensure to counselors, including mental health counselors, which publicly established mental health counseling as a profession. The following year, AMHCA became a division of ACA which provided mental health counselors with an organizational home (Messina, 2016). The creation of AMHCA formally established mental health counseling as a new counseling professional identity, with unique professional experiences and needs.

Moving out of the 20th century, the delivery of mental health services would change as managed care organizations (MOCs) became the primary health insurance providers for individuals. MCOs specified which providers individuals could see and how long they could receive services leading to a disparity in the reimbursement for mental health services compared to other health providers thus, limiting mental health counselors' employment opportunities (Letourneau, 2016, Neukrug 2022). However, reimbursement parity increased with the passing of several acts beginning in 1996 which mandated medical insurance companies to include mental health services and mental health counselors under their coverage. Along with reimbursement parity, mental health counselors advocated for increased state licensure laws

which would allow them to be independent providers and collect third-party reimbursement (Neukrug, 2022).

Mental health counselors were able to set themselves apart from other counseling specialties by finding their niche in community-based, mental health care. As a part of this system, mental health counselors encountered a variety of public mental health concerns that required them to expand their skill set to include short-term treatment approaches (Neukrug, 2022). Mental health counseling also gained public recognition as a profession when AMHCA and state licensure processes were established. Licensure continues to be a key distinguishing component in mental health counselors' professional identities as other counseling specialties are required to take additional coursework to meet state requirements. The next section describes mental health counseling in the present and outlines the knowledge, skills, and scope of practice for mental health counselors.

Mental Health Counseling Today

Currently, mental health counselors can obtain professional licensure, practice independently, and collect third-party reimbursement in all 50 states (ACA, 2021b). They can be found in a variety of settings such as private practice, outpatient mental health clinics, hospitals, in-patient residential facilities, prisons, and government facilities (US Bureau of Labor Statistics, 2021). Additionally, mental health counselors are included as providers for a variety of health insurance plans (Neukrug, 2022). This increases the public's access to mental health counseling allowing mental health counselors to address a variety of mental health needs.

As the 21st century progresses, mental health counselors continue to distinguish and strengthen their unique professional identity by advocating for the advancement of mental health counseling. One of these efforts includes addressing licensure portability across state lines,

which continues to be a professional issue due to the lack of uniform licensure standards at the state-level (Kaplan & Kraus, 2018; Letourneau, 2016). Current licensure processes will be discussed later in this chapter. Next, a brief depiction of clinical mental health counseling is provided.

Defining Clinical Mental Health Counseling

Although closely related to the CACREP specialty areas of addiction and rehabilitation counseling, clinical mental health counseling is distinctly different. While addiction and rehabilitation counselors focus specifically on addressing individuals' concerns related to addiction or vocational problems, clinical mental health counselors are trained to address a broad range of social and emotional concerns to promote mental and emotional wellness (O*NET OnLine, 2021).

Clinical mental health counselors provide services to individuals, families, couples, and groups to address issues such as addictions, family and marital problems, stress management, self-esteem, anxiety and depression, developmental issues, career concerns, and many others (Neukrug, 2022; O*NET OnLine, 2021). Some clinical mental health counselors opt to specialize in certain mental health disorders (e.g., anxiety, depression, eating disorders, borderline personality disorder), while others choose to work with specific populations such as the elderly, college students, or children (US Bureau of Labor Statistics, 2021). Since mental health counselors work with a broad range of individual emotional and mental health concerns, they possess a variety of skills and knowledge which are detailed below.

Skills and Knowledge of Mental Health Counselors

As part of their master's level coursework, all mental health counselors have obtained general counseling knowledge in the eight core areas, outlined by CACREP. In addition to these

core areas, mental health counselors receive specialized training that prepares them to function in a wide range of clinical mental health settings (CACREP, 2021). The specific skills and knowledge areas are listed in Table 1 below.

Table 1

Specialty Coursework for Clinical Mental Health Counselors

Foundations	Contextual Dimensions	Practice
• History of mental health counseling • Theories and models • Biopsychosocial case conceptualization and treatment planning • Neurobiological and etiology of addiction and co-occurring disorders • Psychological tests and assessments	• Roles and settings • Etiology, treatment, and prevention • Mental health service delivery modalities • Referral • Diagnostic classification systems and processes • Crisis and trauma • Biological and neurological factors • Commonly prescribed psychopharmacological medications • Legal and Ethical practice policies • Professional organizations • Documentation practices • Third-party reimbursement	• Intake processes • Mental status exam • Treatment planning • Caseload management • Techniques and interventions for prevention and treatment • Collaborating with the legal system • Collaborating with other health care providers • Advocacy strategies

As a result of this specialized coursework mental health counselors are knowledgeable about mental health disorders, individual factors that impact mental health, treatment planning and service delivery, case management, coordinating care with other professionals, and standards of ethical and legal counseling practice. It is this specialized knowledge that assists mental health

counselors with developing their unique professional identities that set them apart from other counseling specialties.

Licensure

Professional licensure is another component that separates mental health counselors from counselors in other specialty areas. Licensure is the most restrictive form of credentialing, as compared to registration and certification, and signifies that an individual has met rigorous standards allowing them to practice in a particular field (Neukrug, 2022). Mental health counselors who have graduated from a CACREP accredited program are eligible to pursue professional credentialing as a licensed professional counselor (LPC) which indicates that one has met specific requirements, possesses training and skills to practice independently as a counselor, and receive third-party payments. Licensure not only provides mental health counselors with a professional title but also defines the scope of counseling activities that they are and are not allowed to perform (Neukrug, 2022).

Scope of Practice

A profession's scope of practice outlines the professional activities members are allowed to perform based on their level of education, training, and competency as determined by the state in which the professional is licensed to practice. Mental health counselors have a large scope of practice, compared to other counselors, since they are trained to perform a multitude of roles and tasks as part of the services they provide. The knowledge and skills obtained during their master's level programs, prepare mental health counselors to operate in roles such as counselor, supervisor, advocate, and consultant, as well as perform tasks such as assessment and diagnosis, case management, counseling and therapy, psychoeducation, crisis management, maintaining records, testing, and evaluating client outcomes (Neukrug, 2022). Additionally, mental health

counselors perform these various counseling activities on primary, secondary, and tertiary levels (i.e., preventative to restorative) depending on individual needs and the setting in which the mental health counselor is employed (Neukrug, 2022). Since mental health counselors work with a variety of populations and are employed in a wide range of settings, they often must adapt their roles and skills to provide effective services within a particular setting. This in turn, influences how mental health counselors come to define mental health counseling which will be discussed further in the next section.

Personal Definitions of Mental Health Counseling

Within the profession of counseling, state licensure boards and MCOs have created specific, technical definitions to describe what counseling is (Kaplan et al., 2014). However, research shows that counselors develop their own personal definitions of counseling which are influenced by the various contexts in which they operate. These personal definitions evolve over time (Gibson et al., 2010) and are influence by the counselor's role, populations served, and employment setting (Mellin et al., 2011; Woo et al., 2016). Like all counselors, mental health counselors conceptualize their professional identities based on the work that they do and the context in which they provide services (Neukrug, 2022). The settings in which mental health counselors operate dictate what services they provide, which roles they perform, and what populations they work with. As mental health counselors gain experience performing different roles and work with a variety of clients, their personal counseling definitions change which may impact how they view themselves as mental health counselors. Thus, it necessary to discuss employment settings for mental health counselors.

Settings

In 2020, 18% of mental health counselors were employed in outpatient mental health and substance abuse centers, 16% in individual and family services, 10% in hospitals, 9% in residential treatment facilities, and 9% in government facilities (U.S. Bureau of Labor Statistics, 2021). In addition to these settings, mental health counselors provide services in career and employment facilities, correctional facilities, nursing homes, health maintenance organizations (HMOs), religious and spiritual counseling agencies, youth services agencies, and many others (Neukrug, 2022). Although, mental health counselors can be found in a variety of places, recent employment trends indicate a rise in the presence of mental health counselors in primary care, inpatient hospitals, and other health care settings as a result of the health care system moving toward a biopsychosocial approach to patient conceptualization and treatment (Glueck, 2015). This new holistic, patient-centered approach to health care has led to the integration of mental/behavioral health and medical/physical health providers, thus creating a new setting for mental health counselors to operate in called *integrated behavioral health care* (IBH).

Defining IBH Settings

IBH settings include a range of facilities where medical and mental health providers interact to address an individual's health care needs. These settings can include in-patient residential facilities, primary care offices, hospitals, correctional facilities, and other places that provide health care services. Although IBH settings vary widely in the specific practices, techniques, and approaches to individual health care, they tend to be defined on a continuum based on the levels of integration and collaboration among medical and mental health providers (Pomerantz et al., 2009; CIHS, 2021).

The IBH Continuum

Coordinated care is the lowest level of integration, where collaboration is minimal and physical integration of providers is nonexistent (CIHS, 2021). In *coordinated care*, collaboration occurs at a distance (e.g., email, telephone), providers are in separate offices, and records are not housed within the same system. Providers operating at this level, treat the individual's health needs separately and have their own treatment plans. However, they may periodically share treatment updates with the individual's other health providers to coordinate services.

As IBH settings increase the physical proximity between medical and mental health providers, they move toward a higher level of integration called *co-location*. Providers are consider co-located when their offices are within the same facility or if they are within the same office space (CIHS, 2021). At this level, providers may have shared records systems, communicate regularly through email or in-person, consult with one another as needed, and collaborate during treatment planning. They also have a basic understanding of the roles and professional cultures of one another.

Integrated practice is the highest level of IBH. Integrative and collaborative practices are more extensive which influences how medical and mental health providers practice their professions and approach individual treatment. Providers in a fully integrated IBH setting have regular formal and informal team meetings to provide updates, consult, and collaborate with one another regarding individual care (CIHS, 2021). They work from one treatment plan and jointly monitor individual outcomes. At this level medical and mental health providers operate as a team that reflects the blending of roles and professional culture.

General Definition

Due to the variety of integrative models, IBH can be difficult to define as it encompasses a combination of treatment approaches and practices from increased communication and referral

to co-location and regular collaboration (Pomerantz et al., 2009). However, the defining characteristics of these models focus on the collaborative and integrative practices taking place within the IBH setting. IBH literature has broadly defined, *integrated behavioral health* as any system that combines approaches to individual care to address physical and mental health concerns (Pomerantz et al., 2019). Due to the variability in treatment approaches and professional practices across IBH settings, mental health counselors in IBH find themselves operating in multiple roles.

Mental Health Counselors Roles in IBH

Mental health counselors in IBH operate in complex system that requires them to utilize a multitude of interwoven roles to perform their various employment duties. Mental health counselors in these settings operate in roles such as counselor, teacher, consultant, referral coordinator, and program administrator/developer (Berkel et al., 2019; Glueck, 2015). They also provide counseling-oriented services such as individual and group counseling as well as brief mental health screenings and therapeutic interventions. They often must educate and collaborate with physicians, other IBH staff, patients, and family members to provide services and gain relevant information to inform their treatment approach. Additionally, they make referrals and coordinate with community providers to assist individuals with transitioning out of the IBH facility and into lower levels of care. Some mental health counselors are also involved with program administration and development to assist IBH facilities with improving integration practices (Glueck, 2015).

The various roles and tasks performed by mental health counselors in IBH often differ depending on the type and needs of the setting (Glueck, 2015). For example, a mental health counselor working in an outpatient primary care setting may operate from more of a counselor

role compared to a mental health counselor employed in an in-patient residential facility who may perform more referral coordination and case management duties. As mental health counselors gain employment in IBH settings that require them to operate in a particular role based on the needs of the setting and the population served, their perceptions of their roles as mental health counselors are likely to change. This creates a need to explore how mental health counselors define and perceive their professional identities within particular IBH contexts, such as corrections, where their experiences of their professional roles are likely to be different than other mental health counselors.

Mental Health Counselors Roles in Correctional Settings

Mental health issues and serious mental illness are prevalent within the correctional and social justice system (Davis & Cates, 2017; DiCataldo et al., 2021; Kupers, 2015; Matz & Lowe, 2020). As such, clinical mental health counselors play an essential role in corrections to meet the mental health needs of inmates as well as facilitate rehabilitation. Mental health counselors working in corrections (i.e., correctional counselors) encounter a wide range of mental health issues including substance abuse, suicidal ideation, schizophrenia, bipolar disorder, and major depressive disorder (Kupers, 2015). To address these mental health concerns, correctional counselors' primary function involves various clinical duties. Clinical duties can include providing individual and group therapy, conducting intake assessments, forming treatment plans, and writing discharge summaries (DiCataldo et al., 2021). Additionally correctional counselors can be responsible for tasks unique to the correctional environment such as responding to miscellaneous inmate requests, assessing inmates for housing (i.e., classification), release planning, inmate checks, security checks, and sex offender work (Matz & Lowe, 2020).

In addition to their clinical duties, correctional counselors are responsible for administrative duties and documentation. These activities do not directly involve inmate interactions and can include completing time sheets, personnel forms, attending to office needs, resolving technical issues, and participating in staff meetings (Matz & Lowe, 2020). These administrative duties and documentation are not directly related to inmates' mental health but can take up a large amount of correctional counselors' time. For instance, Matz and Lowe (2020) found that correctional counselors spent more time completing administrative duties than on treatment group work and professional development activities. This finding contrasts with DiCataldo and colleagues (2021) who found that correctional counselors spent 27.1% of their time on administrative duties and documentation compared to individual and group work, assessment, and clinical supervision. However, despite this discrepancy both studies noted that most of correctional counselors' time was spent performing administrative and clinical duties. Correctional counselors are also employed in leadership roles such as clinical supervisors and team or unit leaders (DiCataldo et al., 2021). As part of these leadership roles correctional counselors can utilize their skills and training to promote better treatment outcomes and facilitate working relationships across treatment providers and correctional staff.

Overall, correctional counselors operate in multiple roles requiring them to perform various clinical, administrative, and leadership duties. Some of these duties are unique to the correctional setting such as assessing inmates for classification, conducting inmate/security checks, and attending to various inmate requests. Additionally, correctional counselors' roles involve different foci compared to clinical mental health counselors employed in other IBH settings. For instance, suicide and self-harm are prevalent issues in corrections compared to community settings therefore correctional counselors' roles focus primarily on suicide

prevention and crisis intervention (Kupers, 2015). They also spend a large amount of time engaged in solitary activities such as completing documentation and preparing for interactions with inmates (Matz & Lowe, 2020). Since correctional counselors operate in a unique IBH role it is important to explore their perceptions of their role and how their experiences working in corrections as mental health counselors influences their professional identity.

Development of Professional Identity

Professional identity is defined as the beliefs, values, and assumptions that are unique to a profession (Burns and Cruikshanks, 2018; Neukrug, 2020). Professional identity provides counselors with an understanding of their scope of practice, roles, and functions, as well as their limitations, when practicing in the field. Counselors that have a clear professional identity can distinguish themselves from other mental health professionals and understand how their professional roles compliment the roles of other health care providers. This section discusses the general identity development of counselors and how mental health counselors develop their professional identities in IBH.

General Development

Professional identity development is a continuous, transformational process that begins during counselor training programs. Counselor trainees learn the profession's expectations, language, and culture through a socialization process involving observation, supervision, consultation, and clinical practice (Gibson et al., 2010). Counselor trainees then integrate these learned professional values, beliefs, and assumptions into their own personal identities to establish a holistic professional counseling identity. This integration process occurs at both the intrapersonal and interpersonal levels as counselor trainees learn to self-evaluate their counseling

skills, internalize external feedback from other counseling professionals, and immerse themselves in the culture of the profession (Gibson et al., 2010; Woo et al., 2016).

When counselors enter the field, their professional identities continue developing as they integrate new experiences from working with specific client populations, continue their education through professional trainings, and interact with other professionals (Moss et al., 2014). These new experiences assist counselors with adjusting their expectations of their professional roles and skills from idealistic to more reality-based expectations which allows them to self-assess and adjust their professional practice (Moss et al., 2014; Prosek & Hurt, 2014). As counselors proceed with their professional careers, they continue integrating new experiences, knowledge, and skills into their professional identity which informs how they operate in their roles as counselors.

Mental Health Counselors Development Within the IBH Setting

Mental health counselors in IBH operate within a complex system that requires them to integrate a variety of new experiences into their current professional counseling identities. Since IBH roles are interwoven (Glueck, 2015) and professional practices and populations served vary across setting, mental health counselors' roles in IBH may not be distinctly defined. As a result of this lack of clarity regarding mental health counselors' professional roles and scope of practice within the setting, mental health counselors in IBH may have difficulties forming a clear professional identity.

Additionally, mental health counselors may lack previous knowledge, skills, and clinical experiences specific to IBH as their training programs may not provide adequate coursework and clinical experience for them to gain IBH competencies before entering the field (Johnson et al., 2015; Vereen et al., 2018). Mental health counselors that gain employment in IBH may feel

underprepared to operate in the numerous roles required by this complex system due to this gap in training and practice. This lack of IBH knowledge and experience can lead to frustration, role confusion, and difficulties integrating IBH experiences which can impede professional identity development (Berkel et al., 2020; Moss et al., 2014; Vereen et al., 2018).

Role Confusion in IBH

Role confusion occurs when a counselor's sense of professional identity is poorly defined, and they have not integrated the values, beliefs, and attitudes of their profession into their counselor identity, which impacts their ability to function effectively in their professional roles (Gibson et al., 2010). For mental health counselors in IBH that have not integrated the values, beliefs, and professional culture of their IBH setting into their professional identities may have difficulties operating in their IBH roles thus impacting client care and service delivery. It is important for mental health counselors to understand their professional roles and scope of practice, within IBH, to effectively communicate their professional identities and roles to physicians, IBH staff, patients, and families (Burns & Cruikshanks, 2018). An inability to clearly communicate one's professional identity and roles can impact collaborative practices in IBH.

How Mental Health Counselors Communicate their Identity

Mental health counselors operate in a variety of settings and provide a wide range of services which can contribute to misunderstanding among the public and other professionals about the specific roles, values, and functions of counselors. The public and other health professionals may hold certain assumptions about what services mental health counselors provide and the roles they perform which can lead to a narrow understanding of the how mental health counselors function in IBH settings which can create barriers to collaboration and utilization of counseling services (Berkel et al., 2020). Others within the IBH setting may

misinterpret the roles and functions of mental health counselors due to this limited understanding, thus creating the need for mental health counselors in IBH to explain their professional identities and advocate for their utilization (Berkel et al., 2020). This highlights the importance of have a clear understanding of one's own professional identity so that misinterpretation of mental health counselors' roles in IBH can be avoided.

An inability to clearly conceptualize and articulate one's professional identity when working in IBH can lead to other problems within the IBH setting such as role and responsibility confusion, power and status conflicts, and professional stereotypes (Mellin et al., 2011). When mental health counselors are unclear in communicating their professional identities and roles, other professionals may rely on stereotyped impressions of counselors (e.g., empathic, friendly, good listeners). Other professionals at the IBH site may also engage in power and status conflicts, such as assuming the leading role on a treatment team or valuing their profession's contribution to patient care over other professions' contributions. These problems contribute to misunderstanding and act as barriers to communication and collaboration between health care providers resulting in the underutilization of mental health counselors.

Mental health counselors who are employed in IBH settings interact with a variety of non-counseling professionals as part of their service delivery to patients. Mental health counselors in these settings rely on collaboration with other professionals to holistically address patient concerns. Thus, it is important to explore how mental health counselors in these settings perceive their professional identities as they are likely to conceptualize their identities and roles differently than mental health counselors in other settings. This knowledge could provide insight into how mental health counselors in IBH communicate their professional counseling identities

to others and could inform counselor education programs to provide support for mental health counselor identity development.

Adaptation within IBH

The role of mental health counselors in IBH is distinctly different from the roles of mental health counselors that operate in outpatient mental health settings (Glueck, 2015). Previous research has documented differences in office culture, use of time, services provided, theories of treatment, use of counseling skills, job titles, and duties (Berkel et al., 2020; Pomerantz et al., 2009). These differences create the need for mental health counselors to adapt the knowledge and skills learned during their training programs and post-graduate clinical experiences so that they operate effectively within this system.

Additionally, mental health counselors must adapt to and integrate the professional values, beliefs, and assumptions regarding health and wellness as they unite with medical professions to provide care (Glueck, 2015; Pomerantz et al., 2009). This adaptation process can enhance professional identity development as well as lead to other benefits for mental health counselors which are discussed in the next section.

Benefits of working within IBH settings

Studies have found that mental health professionals (e.g., counselors, psychologists, social workers) generally express positive attitudes toward collaboration and experience satisfaction when working in IBH (Berkel et al., 2020; Glueck et al., 2015; Johnson & Mahan, 2019). Mental health counselors perceived their role in IBH as necessary and beneficial as they can offer preventative care, reduce mental health stigma, and increase access to mental health services (Glueck et al, 2015). They also express value regarding the opportunities to teach others

about mental health (Berkel et al., 2020). These positive experiences within IBH contributed to mental health professionals feeling appreciated for their contributions to the treatment team.

Not only do mental health counselors experience satisfaction in IBH but they also perceive these experiences as beneficial to their professional growth and identity development. IBH creates opportunities for mental health counselors to learn from and about different health care professionals through collaboration which contributes to professional growth, increased confidence, and strengthened professional identity (Johnson & Mahan, 2019). Mental health counselors in IBH are also able to expand their general medical knowledge and enhance their clinical and conceptualization skills through their collaborative and consultive interactions. As mental health counselors are exposed to other health care professions, they have opportunities to observe distinct differences and similarities which reinforce and help clarify their professional role, scope of practice, and responsibilities leading to an enhanced understanding of their professional identity within IBH (Reese, 2019).

Challenges within IBH settings

Although mental health counselors experience benefits from their IBH encounters, they also experience a variety of challenges as they learn to adapt and integrate themselves into the IBH setting. Mental health counselors experience a loss of autonomy when they shift into fully integrated IBH settings as they are no longer the sole provider responsible for monitoring an individual's mental health (Pomerantz et al., 2009). Some research suggests that they also experience a lack of understanding and appreciation for their role, constraints on time, professional power hierarchies, and underutilization of mental health services (Berkel et al., 2020).

Mental health professionals and trainees have identified numerous challenges to IPC including the need to address and negotiate power differentials, lack of resources, time constraints on service delivery, and professional stereotypes (Berkel at el., 2020; Winters et al., 2016). In other words, mental health counselors may be undervalued and misunderstood resulting in the minimization of the mental health role and an unequal distribution of power and resources on the interprofessional team. This could be due to the lack of knowledge and preconceptions among non-counseling health professions regarding the roles of mental health counselors in IBH. These and other challenges can create tension and distrust among treatment providers impeding their abilities to communicate and collaborate effectively (Johnson et al., 2015). These and other challenges can impede mental health counselors' professional relationships with others at the IBH site and well as impact their professional development as they can become frustrated and unwilling to collaborate with other health care providers.

Need For Current Study

The mental health field has recognized a need to educate and prepare mental health professionals, including mental health counselors, for operating in the unique systems of integrated health care (Johnson et al., 2015; Johnson & Mahan, 2018) as well as correctional environments (Kupers, 2015). As a result, research regarding IBH and mental health professionals has primarily focused on strategies for incorporating integrated or interprofessional curriculum, competency development, and clinical experiences for trainees in multiple health care disciplines.

Numerous studies have provided guidance on how to incorporate interprofessional competencies and collaborative practices into training programs to prepare mental health counseling trainees as well as trainees from other health care disciplines for IBH (Blue et al.,

2015; Brewer & Flavell, 2018; Cox et al., 2014; Johnson et al., 2015; Johnson et al., 2017; Kent & Keating, 2015; Reese, 2019; Roberts et al., 2009). In addition to providing suggestions for program development, several studies have also examined the perceptions, attitudes, and experiences of trainees involved in these programs (Cox et al., 2014; Johnson et al., 2015; Roberts & Foreman, 2015; Vereen et al., 2018). Although these studies provided valuable guidance on how to include the specialized skills and knowledge for IBH practice into training programs as well as how health care trainees perceived their interprofessional experiences, the primary aims of the research were program appraisal and exploring multiple health care trainees' (e.g., human services, counseling psychology, speech language pathology, mental health counseling, dental hygiene) experiences and attitudes toward interprofessional collaboration. This focus on trainee development excludes the experiences of post-graduate mental health counselors currently employed in IBH.

Some studies have explored the experiences, perceptions, and attitudes of post-graduate health care professionals in IBH settings to address this gap in the literature. However, these studies focused on counseling psychologists (Berkel et al., 2020) and behavioral health providers, in general (Glueck, 2015; Johnson & Mahan, 2019). Additionally, the aims of these studies were to explore the preparation and training needs, experiences of roles in IBH, and attitudes toward collaboration for mental health professionals. This focus on identifying the training needs, roles in IBH, and experiences with interprofessional collaboration of mental health professionals in IBH creates a gap in knowledge regarding the unique experiences of mental health counselors in IBH settings. Although there are commonalities between mental health disciplines (e.g., psychology, social work, counseling, psychiatry), each profession has its own values, beliefs, and philosophical orientations that distinguish these professions from one

another (Mellin et al., 2011; Neukrug, 2022) highlighting the need to explore mental health counselors' experiences in IBH separately from other professionals.

Even though previous research has indicated that teamworking within IBH can enhance the professional identity development of mental health counselors (Reese, 2019), few studies have explored how mental health counselors perceive their professional identity when operating in IBH roles and even fewer studies have explored how mental health counselors in correctional counseling roles experience their professional identity. Additionally, IBH settings are broadly defined and vary in the levels of collaborative and integrative practices employed. Correctional environments also differ in their purposes and structures across settings (e.g., jails, prisons, specialty courts) creating the need to explore how mental health counselors' roles within particular IBH settings (e.g., corrections) influences their professional identity development as mental health counselors. Understanding how mental health counselors experience their professional identities in correctional settings could assist these counselors with adjusting to the unique roles, challenges, and workplace culture within corrections.

The current study aimed to address these gaps in knowledge through utilizing an interpretive phenomenological approach (IPA). This approach allowed me to describe the perceptions of professional identity and roles of mental health counselors in one correctional setting as well as interpret the meanings of these experiences.

CHAPTER 3

METHODS

This chapter first discusses the conceptual framework for the study's qualitative method as well as researcher positionality and trustworthiness strategies employed. I then describe characteristics of the site and participants included in the study as well as rationales for their selection. Next, procedures for data collection and analytic methods are discussed.

Conceptual Framework

Since previous research has minimal addressed mental health counselors' experiences of their professional identities within the context of IBH and correctional settings, a qualitative design is appropriate for exploring this topic in depth. This study utilized an interpretative phenomenological approach (IPA) to describe, understand, and interpret the meaning of mental health counselors' perceptions of their professional counseling identities in IBH settings, specifically corrections. The goal of IPA is to describe participants' experiences and interpret the meanings of their narratives within the context of their world. This approach was best suited for the current study as it assisted the researcher with exacting meaning and interpreting mental health counselors' perceptions of their professional identities as correctional counselors. A traditional phenomenological approach might not capture the depth that is intended for this study since the focus was on a particular experience for a specific group of mental health counselors.

In IPA, participant meanings are uncovered as the researcher engages in discourse (e.g., interviews) with the participants and gathers participant narratives (Lopez & Willis, 2004; Shinebourne, 2011). These meanings are then interpreted by the researcher while considering the context of the participant and the researcher. IPA is grounded in phenomenology, hermeneutics, and idiography (Smith et al., 2009). These lenses allow the IPA researcher to focus on

describing, extracting participant meaning, and interpreting the meanings of participant experience throughout the research process.

Phenomenology

Phenomenology is the study of human experience and individuals' perceptions of these experiences. IPA uses aspects of Husserl's philosophical approach to describe the content of participants' lived experiences with the phenomenon of interest. IPA aims to explore particular experiences as experienced by particular individuals (Smith et al., 2009). A phenomenological lens allows researchers to attend to the unique experiences of individual participants while also identifying essential features of the experience, which can be compared across cases. In order to describe experience phenomenologically, individuals must bracket, or separate, themselves from the phenomenon and reflect on their perceptions of the phenomenon (Smith et al., 2009). This process involves an awareness of one's assumptions and preconceptions regarding the phenomenon which distract from the essence of the experience.

IPA inquiries aim not only to describe the core concepts of the phenomenon but also identify the embedded meanings of individuals' experiences (Lopez & Willis, 2004; Shinebourne, 2011; Smith et al., 2009). Heidegger, Merleau-Ponty, and Sartre extend Husserl's phenomenological philosophy to include a focus on the influence of context on the meaning making of our experiences. As such, IPA researchers view individuals as embedded and immersed in their particular context which influences their perceptions of their experiences (Smith et al., 2009). In other words, individuals are embedded in their realties thus the context (e.g., social, cultural, political, etc.) of their world must be considered to understand the meanings they ascribe to their experiences. In this study, the researcher sought to elicit thick descriptions from participants regarding the context of their lived experience.

Hermeneutics

Hermeneutics provides IPA researchers with a theory for interpreting the meanings of experience in a holistic way (Smith et al., 2009). IPA views interpretation as an iterative process where the researcher shifts between focusing on the whole and parts to examine the relationships and context of participants (Smith et al., 2009). Hermeneutics also considers the relationship between participants and researcher. The researcher has prior experiences, assumptions, and preconceptions that will influence how they make meaning of participants' experiences. In IPA this process involving the researcher is known as co-constitutionality or double hermeneutics. Double hermeneutics is a process that occurs when the researcher is attempting to construct meaning of the participant attempting to construct meaning from their experiences (Lopez & Willis, 2004; Shinebourne, 2011; Smith et al., 2009). As a result of this double hermeneutic process, the interpretations that the researcher formulates about participant experiences of the phenomenon are an integration of the meanings disclosed by both participant and researcher (Lopez & Willis, 2004). This helps to thicken and add value to the interpretation phase of analysis.

Although the double hermeneutic process of IPA creates opportunities for researcher bias to be introduced, it is critical that researchers remain reflexive and use bracketing to limit the influence of their preconceptions when describing participant experiences (Shinebourne, 2011; Smith et al., 2009). In this study, the researcher utilized hermeneutics during the analytic phase by considering the relationship of individual parts with the overall phenomenon when examining data line by line, case by case, and across cases. The researcher also utilized reflexive journaling to bracket out and remain aware of assumptions and preconceptions that could bias the description of participant experiences.

Idiography

Idiography guides IPA research by emphasizing the particular, in contrast to the general. Focusing on the particular involves in-depth analysis of each case and purposefully focusing the study on a particular experience for a particular group of people in a particular context (Smith et al., 2009). This allows IPA researchers to situate participants in their unique contexts and conduct a detailed, in-depth examination of each case. For this study, the researcher intentionally selected a small, homogenous sample of participants from one IBH site within the correctional system to focus on the level of detail in their lived experiences pertaining to the phenomenon of interest. No attempts were made to generalize claims from this study to large populations or groups of people. The focus of this study was on describing and interpreting the meaning of a particular experience for a specific individual as it related to the experiences of other individuals and the overall phenomenon of interest.

Researcher Positionality

It is impossible for researchers to eliminate their previous knowledge on the topic of interest. In IPA, this previous knowledge is deemed valuable as it guides the research process in meaningful directions to produce useful knowledge during interpretation phases of analysis (Hays & Singh, 2012; Lopez & Willis, 2004). It is necessary for the researcher to make preconceptions known and describe how they are influencing the research process (Lopez & Willis, 2004).

As a White, cisgender, female in higher education I hold certain privileges that may impact my interpretations of participants' experiences. These identities provide a lens through which I interpret all of my experiences including experiences with participants. Several of my identities (i.e., White, cisgender) are part of society's dominant group, which may influence how

I make sense of the experiences of participants with nondominant identities. My personal values of communication and education may also bias my focus as a researcher.

I also have previous experience and knowledge regarding interprofessionalism. I worked for one year at an IBH student-led clinic during my master's counseling program and have conducted several studies on various facets of counselor trainees' experiences with integrated care. My personal experience and prior knowledge may impact my neutrality throughout the research process as I may have conscious and unconscious expectations for participants' experiences. However, despite my previous IBH experience and knowledge, I am not as familiar with the correctional system nor organizational structure of jail operations. Several strategies, described in the following section, will be utilized throughout the study to minimize my potential bias and misinterpretation of participant experiences with the phenomenon of interest.

Trustworthiness

Strategies must be employed to reduce the researcher's influence (i.e., bias) to ensure the credibility, confirmability, and authenticity of qualitative research findings (Creswell & Poth, 2018). The researcher utilized strategies such as reflexive journaling, member checking, triangulation of data sources, thick description, and peer debriefing throughout the research process to minimize researcher bias and increase trustworthiness. I kept descriptive and reflective journal entries during the data collection and analysis phases of the study to record details of research activities to add thick description and record subjective assumptions, impressions, and attitudes experienced throughout the process for researcher reflection (Hays & Singh, 2012). I also utilized member checking to ensure that participants' responses and experiences were accurately captured during data collection and analysis (Creswell & Poth, 2018). Participants were provided individual interview and video/audio log transcriptions as well

as written descriptions of preliminary themes and interpretations to check for accuracy. I triangulated interview data with participant video/audio logs to aid in thick description of participant experiences. Finally, peer debriefing was employed throughout data collection and analysis to provide additional perspectives that I may have overlooked.

Site Setting

I selected one IBH site within the correctional system for participant recruitment to increase the homogeneity of the study sample. Thus, the focus of the study was on mental health counselors' experiences of their professional identity within this particular IBH setting. At the time of this study, participants were employed at a mental health unit housed under inmate health services for a county jail located in Southeastern Virginia. Inmate health services operated under the county sheriff's office and contained both health services and mental health units.

The health services unit was directed by one registered nurse (RN) and staffed one doctor of medicine (MD), one director of nursing (DON), one nurse practitioner (NP), several RNs, and several licensed practical nurses (LPN) who provided standard medical care to the inmate/detainee population in the jail. Medical health professionals also provided additional services that addressed health promotion, acute medical conditions, and continuing treatment of chronic medical conditions. Medical health professionals would also make referrals to outside medical facilities for individuals experiencing acute illness as the unit was not designed as an infirmary.

The mental health unit was coordinated by one LPC and had several residents in counseling on staff. Mental health counselors that worked within this unit provided a variety of mental health services to the jail's inmate/detainee population. They conducted mental health intake assessments as part of the jail admission process to determine the level of ongoing mental

health care for every individual. They also offered individual counseling, upon request, and crisis intervention as needed. Part of the mental health counselors' role within this setting involved collaborating, consulting, and referring individuals to medical providers within the organization, higher levels of psychiatric care (e.g., psychiatric hospitals), and community mental health providers to address the holistic health care needs of individuals housed in the jail.

Site Selection

The mental health unit within inmate health services was purposefully selected by the researcher based on the level of integration and types of interprofessional collaborative practices that occurred within the setting. The researcher pre-screened the site to ensure that it met the definition for IBH as outlined by the present study. This definition ensured that participants operated within an IBH system and thus had relevant lived experiences regarding the study's topic.

Physical and mental health providers at the site were co-located, meaning that both medical and mental health services were housed within the same facility, thus working simultaneously. Co-location increased the integration of medical and mental health services at the site, which is conducive to interprofessional collaborative practices (Brewer & Flavell, 2018). The site was deemed interprofessional based on the representation of multiple health care professions (e.g., medical and mental health) and types of health care services offered, which included standard medical treatment, mental health, dental, podiatry, optometry, and chronic infectious disease treatment. The site also utilized interprofessional collaborative practices in the forms of daily treatment team meetings which included staff from health services and mental health units, informal hallway consultations, and in-house referrals. Based on these characteristics of the site, the researcher determined that this setting met IBH criteria.

Gaining Entry

The researcher gained access to the site by contacting a colleague, via email, who was currently employed in inmate health services. The colleague served as an informant, regarding the site and staff, and a facilitator for initial communication between the researcher and the mental health services coordinator. The researcher informed the colleague of the study's purposes, participant inclusionary criteria, criteria for IBH, and data collection procedures. The researcher and colleague then scheduled an informal meeting to discuss the professional backgrounds of the mental health counselors on staff, levels of integration, and interprofessional collaborative practices at the site. Once the researcher determined that the site operations and potential participants were appropriate for the study, the colleague was informed. A site visit was arranged by the colleague for the researcher to tour the mental health unit and meet the mental health counselors on staff.

Participants

Participants were recruited from a mental health unit that provided services for a county jail located in Southeastern Virginia. Mental health counselors working within this unit provided a variety of mental health services for the jail's inmate/detainee population. Participants all had at least master's level degrees in mental health counseling, possessed either an active credential as an LPC or Resident in Counseling, currently provided mental/behavioral health services, and had been employed for at least one year at an IBH setting. These criteria ensured that participants had direct experience with the phenomenon of interest.

Participants were identified by the researcher as mental health counseling professionals based on their obtainment or near obtainment of the LPC credential (i.e., resident of counseling). The researcher purposefully sought out mental health counselors with this credential, or in the

processes of obtaining the credential, based on the assumption that these individuals would be more likely to possess a deeper understanding of their professional counseling identity and would be better able to conceptualize and articulate their experiences compared to counselor trainees, who are still developing professionally. Mental health counselors who have obtained the LPC credential or are in the process of residency hold graduate degrees, have post-graduate experience in the mental health field, and uphold professional counseling standards as assumed by their active credential status. Additionally, LPCs can practice independently and collect insurance reimbursement. Thus, participants in this study minimally possessed knowledge, skills, and experience in providing mental health services.

The researcher purposefully selected a convenience sample of five participants from the site. Upon obtaining approval from the Institutional Review Board (IRB) at Old Dominion University, the researcher contacted mental health counselors from the mental health unit to invite them to participate in the study. The researcher provided individuals with a participation invitation letter and consent form (see Appendix A and Appendix B). Once participants gave informed consent and agreed to participate in the study, the researcher began data collection.

Data Collection Procedures

The researcher collected data in two phases. I kept descriptive and reflective journal entries throughout the data collection process for thick description and reflective purposes. Data collection methods and procedures are described below.

Phase One: Individual Interviews

The primary researcher conducted individual interviews with each participant to gather in-depth information regarding participants' perceptions of their professional counseling identity in the context of IBH as well as how their professional roles in IBH might impact their

professional identity development. I conducted interviews virtually via Zoom, at each participants' request, to maximize their convenience and comfort with the interview setting. Participants were contacted via email to schedule a mutually agreeable time and date to conduct the interview. Individual interviews were semi-structured and lasted approximately 60 minutes.

During the interview, participants were asked questions about their professional background, roles in IBH, and perceptions of professional counselor identity. The interview protocol contained twelve preset questions (see Appendix C). Five questions were developed to gather information on participants' professional backgrounds (e.g., professional credentials and titles, years of experience in the counseling field and IBH, and counseling specialty areas) to provide context for describing and interpreting their experiences during data analysis. Seven open ended questions were developed to gather detailed, rich information on participants experiences with the phenomenon under study. Additional interview questions were asked as needed to clarify and gather details about the participant's unique experiences. Individual interviews were audio recorded for transcription purposes. The interviewer obtained verbal consent to record from participants prior the start of the interview. Transcription services (e.g., www.temi.com) were used to transcribe the audio recordings. The researcher reviewed all transcriptions with their accompanying audio recording to check for accuracy.

After interview transcriptions were created and checked by the researcher, the transcriptions were sent to participants via email for member checking. The researcher removed identifiable information from transcriptions prior to member checking and destroyed audio recordings upon completion of the study. Once member checking of all transcripts was completed I met with a peer debriefer to begin data analysis of phase one data.

Phase Two: Video/Audio Logs

Participants were asked to complete one, video/audio log for the purposes of providing supplemental data on their experiences with the phenomenon. This method of data collection provided thicker descriptions regarding participants' experiences with the phenomenon as well as additional context and insight that aided the researcher during data analysis. Participants may also have been more comfortable openly expressing their experiences in an unstructured format compared to individual interviews as they had more time to reflect on and articulate their responses (Hays & Singh, 2012).

All participants received an email containing video/audio log instructions and prompt (see Appendix D) three days after the completion of their individual interview. Participants were asked to describe and reflect on their daily experiences, thoughts, and feelings related to their professional counselor identity and roles at the site. The researcher provided participants with an individualized Zoom meeting link to facilitate the recording and submission of their video/audio log. Participants were instructed to use the meeting link to record their video/audio log and end the meeting when finished with their recording. The researcher selected Zoom as the recording platform for the video/audio logs based on its ability to automatically compile recordings in the cloud without having participants submit their video/audio logs to the researcher via email, which increases submission rates and aids in date management.

Video/audio log recordings were transcribed upon submission using the Zoom transcription software. I then reviewed the video/audio transcriptions with their accompanying recording for accuracy. Transcription inaccuracies were corrected as needed. Transcriptions were sent to participants via email for member checking purposes. The researcher removed identifiable information from transcriptions prior to member checking and destroyed video/audio

recordings upon completion of the study. Once all video/audio logs were member checked and analyzed, the researcher met with the peer debriefer to discuss interpretations of the data.

Analysis of Data

The researcher utilized a hermeneutic analytical approach to describe and interpret the meaning of participants' perceptions of their professional counseling identity as correctional counselors in an IBH setting. More specifically, Smith and colleagues' (2009) six step process of IPA data analysis was used to guide the analytic process. Before beginning data analysis, the researcher identified a colleague to act as a debriefer throughout the analysis. The debriefer was needed to help minimize researcher bias as well as ensure multiple perspectives and interpretations were included in the analysis (Hays & Singh, 2012).

Step 1: Reading and Re-Reading

During this step, I immersed myself in the data by reading and re-reading the interview and video/audio log transcripts for one participant. Memoing was used to record initial observations of the data and bracket out these thoughts so that I could remain focused on the participants' experiences. Memos were recorded in a reflexive journal.

Step 2: Initial Noting

During this step, I conducted a close analysis of the data that focused on the semantic content and language of participants. The goal of this step was to describe the key objects of participant experiences and meanings of these objects for the participant (Smith et al., 2009). I also recorded interpretative notes that focused on making sense of the patterns in participant meaning. Descriptive, linguistic, and conceptual comments were recorded alongside the transcript using a table template suggested by Smith and colleagues (2009) for analytic organization. Descriptive comments identified key words, phrases, and explanations in the

content of participant accounts. Linguistic comments pertained to the use of language and the ways in which participants presented content and meaning. Lastly, conceptual comments focused on the participant's overarching understanding of the content they were presenting. Once exploratory comments were recorded, the researcher and debriefer met to discuss the initial analyses of the data.

Step 3: Develop Emergent Themes

During this step, I condensed exploratory comments into emergent themes. Themes were expressed as phrases which reflected both descriptions of the participant's experience and my interpretations (Smith et al., 2009). Emergent themes were recorded alongside the transcript and exploratory comments. Once emergent themes were developed, the researcher and debriefer met to discuss theme development and interpretations of the data.

Step 4: Searching for Connections

During this step of data analysis, I focused on how the emergent themes fit together. The goal of this step was to produce a structure that depicted the relationships and patterns among themes. Emergent themes were compiled and organized into clusters of superordinate themes. The researcher kept analytic memos throughout this process to record how clusters related to one another and how superordinate themes were developed. Once emergent themes were organized into clusters, I developed a table depicting the superordinate themes, emergent themes, and keywords associated with each emergent theme.

Step 5: Moving to the Next Case

I conducted steps one through four of the analytic process for each participant's interview transcripts and journal entries. I employed bracketing to put aside ideas and interpretations from previous participant analyses before moving forward in analyzing another participant's data by

recording my reflections and interpretations in a reflexive journal. This assisted me in treating each new case as its own and allowed me to remain open to new emerging themes.

Step 6: Looking for Patterns Across Cases

Once super-ordinate themes for all participant data were developed, I then examined the tables of individual participant superordinate themes and themes for patterns across cases. Individual themes were then clustered together based on conceptual similarities. I then assigned clusters a descriptive label which became the group themes. Group themes were then organized based on conceptual similarities thus becoming the superordinate themes. After this step, I developed a thematic table to depict the connections among superordinate group themes and themes. Participant quotes were recorded in the table for each theme.

CHAPTER 4

RESULTS

This chapter includes the findings and researcher interpretations of themes that were developed from an across-case analysis of data collected from individual interviews and participant audio/video logs. The data was analyzed using interpretative phenomenological analysis (IPA) processes discussed in Chapter Three. Findings are presented using a case within theme approach where supporting evidence from participants for each theme is discussed as opposed to a theme within case approach where themes for each participant are presented together (Smith at el., 2009). I selected the case within theme approach to highlight the commonalities across participant experiences as mental health counselors working in an integrated behavioral healthcare (IBH) setting (i.e., corrections).

First, I provide demographic information and detailed descriptions of individual participants to contextualize their responses to interview questions and audio/video prompt. Next, I present the findings of an across case analysis which is organized into four superordinate themes each containing related subthemes. I provide a description of the superordinate theme before presenting the group subthemes with descriptive examples (e.g., participant quotes) to provide support. At the end of the chapter, I will provide a summary of the findings as well as my interpretations of the data. All participants were assigned pseudonyms (e.g., P1, P2, P3, and P4) to ensure anonymity and confidentiality. Participant quotes are presented verbatim with minor editing for readability (e.g., um, like, repetition of words/phrases, stutters, etc. that reflect typical speech patterns and do not contribute to subtext meaning). Additionally, identifiable information (e.g., names of places and people) were removed from participant quotes to protect participants' confidentiality.

Descriptions of Participants

This study's sample included four participants who were currently employed at a Southeastern Virginia county jail. All participants possessed at least master's level degrees in mental health counseling and had at least one year experience working in an IBH setting. Demographic and background information pertaining to participants' professional credentials, employment titles, years of experience in counseling, years of experience in IBH, counseling specialty areas, and other relevant professional history were collected during individual interviews. A table of relevant participant demographics is included below (see Table 2) followed by additional detailed descriptions of individual participants.

Table 2

Participant Demographics

Participant	Gender	Race	Professional Credentials	Years in Current Position
P1	Male	White	Resident in Counseling	1
P2	Female	White	Resident in Counseling	2
P3	Female	Black	Resident in Counseling, CSAC	1
P4	Female	White	LPC, LMFT	5

Participant 1 (P1)

Participant 1 (P1) is a White man appearing to be in middle adulthood (i.e., age 40 to 65). In addition to his master's degree in clinical mental health counseling, he is continuing his education at the doctoral level in counselor education and supervision. P1's additional credentials include Resident in Counseling. He described his counseling specialty area as trauma

and more specifically the impacts of early trauma on personality and well-being during adulthood. P1 has at least 20 years of prior experience in law enforcement where the focus of his role was peer support and crisis intervention. He has been in his current position as Director of Inmate Health Services for one year. He presented in business casual attire, was energetic and engaged with bright affect and elevated mood.

Participant 2 (P2)

Participant 2 (P2) is a White woman appearing to be in early adulthood (i.e., age 25 to 39). She has been working in the mental health field, in general, for at least 8 years and has at least 3 years of experience working in clinical mental health counseling. P2 reported obtaining a bachelor's in social work prior to obtaining her master's degree in clinical mental health counseling. She has three years of experience working in IBH settings including previous employment at a residential treatment program. She reported working with a wide range of populations throughout her professional career. P2 identified trauma and specialized training in brain spotting as her counseling specialty areas. She is credentialed as a Resident in Counseling and her current employment title is Mental Health Professional. She presented in business casual attire, was engaged throughout the interview, and appeared slightly fatigued.

Participant 3 (P3)

Participant 3 (P3) is a Black woman appearing to be in early adulthood (i.e., age 25 to 39). She has a Master of Art in clinical community psychology, Master of Science in marriage, couples, and family counseling, and is continuing her education at the doctoral level in addiction psychology. P3 has been working in the counseling field for at least 13 years. She is credentialed as a Certified Substance Abuse Counselor (CSAC) and Resident in Counseling. Her specialty areas were identified as addiction and couples counseling. She has been working in her current

position as a mental health professional for one year and previously developed and managed a residential substance abuse treatment program at the jail. She presented in business casual attire, was energetic and engaged, with positive affect.

Participant 4 (P4)

Participant 4 (P4) is a White woman appearing to be in middle adulthood (i.e., age 40 to 65). She is credentialed as a Licensed Professional Counselor (LPC) and Licensed Marriage and Family Therapist (LMFT). P4 has approximately 12 years of experience working in the counseling field and identified marriage and family therapy, and corrections as her counseling specialty areas. She has been working in corrections for five years and her current title is Mental Health Director. Prior to her current employment, she worked in private practice. She presented in business casual attire, was engaged throughout the interview, and was soft spoken with positive affect.

Superordinate Themes and Themes for Group

IPA analytic methods as described in the previous chapter were used to develop superordinate themes and themes from individual participant themes. Once data was analyzed for each case (i.e., each participant), the individual themes for all participants were analyzed together for across case analysis. This analysis consisted of grouping together individual themes based on conceptual similarities. I compared thematic tables (see Appendix E, F, G, and H), developed for each participant, and identified similarities across cases by looking for similar keywords and emergent themes from the individual analyses. In other words, individual themes were deemed similar based on similar key words (see Appendix E, F, G, and H) as well as reviewing participant interview and audio/video log transcriptions for conceptual and descriptive similarities.

Potential group themes were then examined for participant support (i.e., frequency). Themes were eliminated from the final set of group themes if less than half of the participants did not have relevant themes to support the group theme. For instance, if two participants expressed similar individual themes but the theme did not emerge for the other participants then the individual themes for those two participants were removed from the group theme analysis. Conversely, if three participants expressed similar individual themes then these themes were grouped together and included in the final group superordinate themes and themes.

Once individual themes were grouped together based on conceptual similarities, I developed a descriptive label for the group theme. Group theme labels aimed at describing the content of common participant experiences in their roles as correctional counselors. Next, I utilized a similar clustering process to organize the group themes into superordinate themes based on similarities. Once group themes were clustered together, I then created descriptive labels that reflect the superordinate themes for the group. These superordinate themes generally reflected the content of participants' experiences which were derived from group themes that appeared related.

Four superordinate themes were developed from across case analyses: 1) Experience of Setting, 2) Work Relationships, 3) Mental Health Counselor Role, and 4) Professional identity. Each superordinate theme is discussed below along with descriptions of the group themes. Table 3 provides an overview of the superordinate themes, group themes, brief descriptions of the theme, and which participants demonstrated support for the theme.

Table 3

Superordinate Themes and Themes for Group

Superordinate Themes	Group Themes	Theme Description	Participant Support
Experience of Setting	Describing Work Environment	Participants generally described their work environment as fast paced, unique, unpredictable, and diverse.	All Participants
	Constant Communication	Participants noted constant communication from other staff through phone calls or emails.	All Participants
	Unclear/Misunderstood MH Role	Participants generally experienced misunderstanding from other staff due to an unclear/undefined mental health role within the setting.	All Participants
	Demands on Mental Health Counselors	Participants perceived increases in their workload due to additional tasks and requests from other staff for assistance in resolving crisis situations.	All Participants
	Coping	Participants noted a need for self-care strategies and boundary enforcement to cope with their work stress and manage their daily workload.	All except P4
Work Relationships	Teamwork Approach	Participants generally described elements of teamworking such as providing information on treatment updates, shared decision making, and dividing up work responsibilities.	All Participants
	Building Close Relationships	Participants reported needing to build close working relationships with the other staff to perform their duties.	All Participants
	Supporting Each Other	Participants generally focused on ways in which they supported each other within the mental health unit and other correctional staff.	All Participants

Mental Health Counselor Role	Focus on Safety	Participants primarily noted safety and suicide prevention as a salient focus of their role.	All Participants
	Focus on Prioritizing/Triage	Participants described decision making processes to help them prioritize their attention to tasks and requests as well as assessing client cases based on urgency.	All Participants
	Focus on Clinical Judgement	Participants generally discussed elements of clinical judgement that emphasized thorough assessments and quick decision making.	All except P3
	Focus on Educating/Explaining	Educating other staff and clients was a focus of participants' reflections when discuss their roles and interactions with others within the setting.	All Participants
	Focus on Helping/Support	Participants generally noted ways in which they provided support to others and described a motivation to help create changes.	All Participants
	Focus on Advocating	Participants noted a desire to advocate for additional mental health services as well as identified gaps in service provision.	All except P2
	Feelings of Satisfaction	Participants described their feelings of enjoyment and satisfaction derived from their role as mental health counselors.	All Participants
Professional Identity	Defining Professional Identity	Participants provided descriptions of how they personal defined themselves as counselors including personal qualities, specialty areas, and credentials.	All Participants
	Approach Toward Clients	Participants discussed their approaches when interacting with clients.	All Participants

Adapting to Environment	Participants generally described adjustments they had to make to their counseling styles to meet the needs of their setting population.	All Participants
Making Comparisons	Participants conceptualized their professional identities and development through comparisons to previous training and experience.	All except P3
Professional Growth	Participants generally noted aspects of professional growth and development as a function of working at their site.	All Participants

Superordinate Theme 1: Experience of Setting

The superordinate theme, *Experience of Setting,* focused on how participants described and experienced their work environment as well as strategies they employed to cope with the demands of their role and feelings of stress and exhaustion. Five themes emerged: 1) Describing Work Environment, 2) Constant Communication, 3) Unclear/Misunderstood Mental health Role, 4) Demands on Mental Health Counselors, and 5) Coping. All participants discussed descriptions of the correctional environment, communication within the setting, feeling misunderstood by others, and perceptions of their workload. All but one participant focused on strategies for coping with their work demands and stress.

Describing Work Environment

The theme *Describing Work Environment* emerged from participants' specific descriptors of the work environment which framed how they operated and experienced themselves within the correctional setting. Participants experienced their work environment as different and unique compared to previous employment settings and often used adjectives like "busy," "fast-paced," "unpredictable," and "diverse" when describing their work environment. For example, Participant 1 (P1) stated during his individual interview, "I will tell you it's just it is such a unique environment. It is so different." For P1 encountering malingering within the correctional setting distinguished this mental health setting from others. "One of the hard things we deal with is, we have a lot of people that are malingering. That will claim that they have a mental illness because we're in a unique environment." Other participants focused on the variability of events that occurred between days which contributed to experiencing this environment as different from other counseling settings. During her individual interview Participant 2 (P2) reflected on the uniqueness experienced each day:

> But it's just like breaking it down to you, I feel like even within the hour we've been talking I probably missed something because each day is just so, can be so different. There's never, like I can go in with a plan and that plan usually gets turned upside down by the end of the day. And it's like I'm a firefighter, like oh I gotta put out that fire, that fire, and that fire.

The unexpected nature of emergencies or crises within the setting was also noted by Participant 3 (P3) when she stated, "Things can happen at any given point. We have to TDO somebody you know things like that. So it's unpredictable, so anything can happen pretty much." For Participant 4 (P4) this unpredictability was described as, "There's never a dull moment. Um every single day is very, very busy, and you really don't know what you're going to get when you walk in every morning." P3 also described the work environment as busy when she reflected on her daily experience:

> I was busy from the time that I walked in here, until the time that I left. I didn't even have time to eat my whole lunch because we had to TDO people. It was just so much stuff going on.

All participants seemed to similarly experience their work environment as different than other counseling settings due to the unpredictable and variable nature of mental health events and high level of engagement in resolving crisis events.

Constant Communication

Communication within the correctional setting was a prevalent theme that emerged from participants' individual interviews and audio/video logs. All participants referenced incoming and outgoing communication with others at the site when asked to describe their typical daily experiences. The modes of communication varied such as incoming emails, a ringing phone,

attending meetings, or other staff members coming into the mental health unit office. These types of incoming communications were typical associated with issues or emergencies that others wanted the mental health counselors to address, as well as communicating updates on inmate treatment. P3 highlighted this association when she stated, “It could be a variety of things that can go on at any given moment with that phone constantly ringing, whether people are coming in and out, um letting us know things.” P2 also connected incoming phone calls with crisis alerts while also highlighting the quantity of incoming communication when she shared:

> If there's like things are just kind of going crazy, they'll call all the time. And this phone could be ringing, usually it's ringing off the hook. And we’ll be like oh my gosh the phone won’t stop ringing. It’s going crazy.

When participants spoke about the communication with others at the site there was a sense of being bombarded and that their attention was constantly being directed to another task or crisis. For P4 this was experienced as being tracked down and sought after: “So just constant you know. Just they track you down as soon as you enter.” P1 also spoke about how continuous the flow of communication was and attributed it the 24-hour operation of the jail:

> Because we are a 24-hour operation I receive things overnight, and you know so five o'clock in the morning I can start answering emails from people that have said, hey we had this problem overnight. We had an issue with a medical problem overnight or a mental health problem overnight.

Participants experienced communication within the work environment as constant from the start to the end of the workday. This continuous nature of communication within the setting seemed to overwhelm the mental health counselors and add to disruptions in their personal workflow. They

also associated incoming communication with a need for them to address a crisis or resolve a problem, which caused them to reprioritize their duties and plan for the day.

Unclear/Misunderstood Mental Health Role

Another prevalent theme that emerged pertained to a misunderstood or unclear mental health role within the correctional setting. When participants were asked about how others perceived their role as mental health counselors within the system, they described experiences of being misunderstood which was communicated directly and indirectly through their interactions with others at the site. Their perceptions of how their role was viewed were primarily negative. For instance, P1 stated, “They'll look right at us, at the counselors, including me and they're like well you're soft, you just don't know any better.” P2 also described experiencing negative perceptions from others and feeling like the mental health counseling role was misunderstood:

> I’m like they probably think I'm an A-hole for not going out and talking to them. Which is not true. It's just like if I went down all the time they called, I would never be able to get my job done. Like I don't think they fully understand what we do, and like the role that we play.

P4 also described others as not understanding the mental health counselor role, but believed the misunderstanding had improved throughout her time working at the site:

> I would say, for, from my perspective it's actually evolved over the time that I’ve been here. Mental health tends to be the catch all when medical staff, security staff, when they don't know what to do with someone. They're like hey mental health, just kind of like try to toss it our way. I feel like when I first came here that maybe there wasn't as much respect for the department. Not just because I don't feel like they necessarily understood mental health and how it plays a role in the correctional environment.

For participants this lack of understanding for their professional role contributed to additional work outside of their mental health scope as well as perceiving a lack of respect from the other departments within the jail.

Not only did participants experience misunderstanding of their role as mental health counselors but they also noted how mental health in general was misinterpreted by many staff members at the site. P3 attributed this general misunderstanding of mental health as contributing to feelings of panic from non-mental health staff members causing them to rely on the mental health counselors:

> They will call in a panic, like oh my God they're talking to the wall. So, versus it being like suicidal type stuff... But you know just when a person is having delusions, or you know hallucinating and things like that. People will panic over that, because they don't really know how to take it or what to do with it.

Participants found that they had to address this misunderstanding of mental health behaviors and their role as mental health counselors by clarifying what types of situations and mental health behaviors warranted their immediate attention. P3 described the distinction between suicidal behaviors and psychotic behaviors when she stated, “We’ll tell them hey they're talking to themselves, it's okay. As long as they're not hurting themselves.” Distinguishing between typical, non-harmful psychotic behavior and suicidal, harmful behavior was important for participants to communicate to others at the site as it helped clarify the purpose of their role within the setting.

Demands on Mental Health Counselors

All four participants experienced the mental health counselor role in corrections as demanding. P2 and P3 specifically talked about the demands on their attention due to the requests for their assistance in resolving perceived crises. P2 noted, “It's like people are always

wanting your attention and trying to pull you in so many different places." While P3 stated during her individual interview:

> It could be the least little thing, and people are calling, calling, calling because they don't know what to do. Or you know, to me it could be somebody talking to themselves or whatever like loudly, and but it's a panic culture so you know they don't really know how to deal with that or adapt with that, so they'll call us in.

Attending to other staff requests and calls for assistance increased the demands on the mental health counselors which added to feelings of exhaustion and stress. P2 reported feeling "really spent and drained at the end of the day."

While P2 and P3 specifically highlighted the demands on their attention, P1 and P4, who both held administrative positions, spoke about increased demands due to understaffing. During his individual interview P1 stated, "So our list looks very long. With the number of clinicians we have right now, we are really kind of scraping by just to keep up with that." P4 perceived that the demands on mental health counselors were a result of checks and balances within the system to ensure quality care and attributed the feelings of stress to an issue of understaffing within the mental health unit:

> There's a lot of checks and balances. To making sure that we all work together. Because we don't want anything to happen to any of the patients that are here. [brief pause] But I think that's where the stress comes in, especially when you're understaffed. That is getting better but, knowing that you don't have enough staff to handle all of it.

All participants perceived the mental health counselor role in corrections as demanding and attributed this to their need to work together with others within corrections to provide treatment

and address mental health issues. It is interesting to note that only participants that held administrative roles highlighted understaffing as a contributing factor.

Coping

This theme emerged from participants' descriptions of their role and their feelings toward their role as mental health professionals in corrections. All but one participant focused on the importance of managing personal emotions and reactions (i.e., coping strategies) as part of their work experience. For example, P3 talked about specific strategies she implemented to manage feelings of anxiety that occurred during busier times of the day.

> And I can feel, some days I can feel more anxious, you know what crazy days. And that is I have to kind of chill out or I'll get up and just take a walk and come back and sit down.

P1 also discussed intentional strategies he used with others to help alleviate the stress of work:

> I feel like it's necessary for me to balance it with a lot of humor and some empathy towards my clinicians because they're out there all day, every day, dealing with the stress of the inmates that they're working with and getting stress from staff members and other members, employees in jail.

Not only did participants describe specific strategies they utilized to cope with work stressors, but they also emphasized the need for self-care and boundaries as a mechanism for reducing and managing stress. This emphasis on self-care helped participants balance their professional roles and personal lives. P2 highlighted this need for self-care when she stated, "Because if I'm like off, really off balance that's just going to throw me off professionally, personally. So, I'm a lot more intentional with taking care of myself." P3 echoed this during her individual interview when she stated:

> But once I got on a good regimen and you know did a great self-care it helped me to be balanced, you know what I'm saying. So, I don't get flustered and stuff like that, like I have would have before.

For P1 self-care was discussed as something he prioritized for others and attended to as part of his administrative role:

> Another way is basically, making sure that their individual needs are taken care of. So, if they need time off of work or, what we find more in this facility is people starting to take on a lot more of the emotion that's going on in the facility. So, there's a lot of vicarious feeling that's going on. One of the things that I will do is tell people you know is recognize that. Um identify it, kind of process it with them, and then if I can get them out of the facility and get them home or give them a break, um I make that a priority for them.

Another form of self-care that participants described was setting professional boundaries and boundaries around communication with those outside of the mental health unit. P3 expressed appreciation for communication boundaries when she reflected on her supervisor's direct enforcement of these boundaries:

> You know what I love, my supervisor who runs the department, she has put boundaries in. So, when they call, unless somebody is suicidal or something they can hurt themselves or somebody else, she'll tell them okay we will put them on a schedule. We'll get down there today if we have time, but if we cannot we'll tell them, hey they're talking to themselves, it's okay as long as they're not hurting themselves. But we will put them on a schedule either for later today or tomorrow worst-case scenario. So that helps a lot versus

> us having to run here run there. We would never get work done. We would never get our clinical paperwork done which is very important.

P2 discussed the importance of knowing oneself in order to place boundaries as well as balancing the desire to be compassionate while enforcing boundaries with others at the site:

> It's really worked on me setting my boundaries as a clinician too. Knowing like hey I'm a rescuer so I like to fix things and help people and it's really helped me set strong boundaries for myself professionally and to kind of mold myself in that way. Like you can be kind and you can be a compassionate counselor by holding these boundaries and saying no and being strong and being firm.

P1 also discussed his need to place professional boundaries around caring for others personally:

> I don't get overly involved in their personal lives because I don't want, I want those appropriate barriers to be there. But at the same time, I am very concerned about their wellbeing and so I do ask questions about how their personal lives are going.

Although P4 did not discuss coping strategies nor self-care, she did highlight the need to uphold ethical boundaries when communicating about inmates' mental health with other staff when she stated, "You know you tell, you can explain and educate about mental health without divulging personal details about a specific client." Boundary enforcement was noted by all participants as a strategy for preventing additional work stress. All but one participant also noted their use of specific coping strategies that assisted them with managing increases in stress and anxiety throughout the workday.

Superordinate Theme 2: Work Relationships

The superordinate theme, *Work Relationships,* emerged from three themes: 1) teamwork approach, 2) building close relationships, and 3) supporting each other. These themes focused on

how participants viewed and approached their co-worker relationships both within the mental health unit and with staff from other departments (e.g., medical, security, classification). Participants spoke about their work relationships when responding to interview questions that asked about their typical day, services they provide to inmates, their roles within corrections, and their responsibilities.

Teamwork Approach

All four participants described working as a team with the other departments within corrections. They discussed participating in meetings and collaborating with others to identify solutions and treatment needs in both individual interviews and audio/video logs. Participants emphasized working cohesively and collaboratively with other departments to ensure inmate safety. P4 described an example of how collaboration was utilized during her individual interview:

> We would go speak with security and we would talk about those concerns and then together a lot of times we're able to come up with a plan that makes us feel comfortable, the safety and security is not jeopardized. So, working alongside them well is really important.

Communicating and collaborating with others was an important and salient aspect of the mental health counselor role in corrections. P1 viewed collaboration as a responsibility and an opportunity to learn from others. “We collaborate on a lot of things. I look at it as, I look at my responsibilities as a collaborative effort. Not only to learn from them, but also to help train them professionally.” For P2, cohesion among the different departments was noted as important for operating effectively as a team but was not always something that occurred. “But when we're a cohesive unit it can work very well and smoothly. Just doesn't happen all the time.”

Collaboration was not the only element of teamworking discussed by participants. All participants discussed attending daily meetings with the other departments to provide cases updates and discuss treatment directions. P3 described the format of these daily meetings during her audio/video:

> We have the morning meeting where we talked about, you know people that come in… any incidents in the jail that we need to be aware of, any new people that's on suicide watch. Ah we all, we all pretty much have like a roundtable discussion that talks about that.

Participants viewed these morning meetings as an opportunity to touch base with the other departments and prioritize their caseload for the day. All participants emphasized the importance of collaborating and working with the other departments as a team to provide mental health care and ensure inmates in custody of the jail were being kept safe. Working together with the other departments meant collaborating and frequently communicating any updates that might indicate a safety concern such as inmates displaying atypical behaviors or inmates being placed on suicide watch to ensure the goal of safety was being met.

Building Close Relationships

In addition to having team-oriented relationships, participants also focused on the quality and closeness of these relationships. P1 stated during his individual interview, “My natural leadership style is to [brief pause] take it to basically treat everyone as a family member.” P1 built close work relationships by attending to the personal lives and well-being of those he worked with. Other participants noted that frequent contact and shared decision making were additional aspects that helped build effective working relationships. For instance, when reflecting on her interactions with the classification department P2 stated, “We just kind of work hand in

hand. We have to have a working relationship with them cause if we don't, it would be more stressful than it already is." She noted that having these close working relationships helped improve the flow of information within the organization which in turn reduced her experiences of work stress. P3 also described the idea of working closely with other departments by providing an example of shared decision making between herself and the classification department:

> We'll talk about who would be a good fit there. And if people have disciplinary or other issues going on that's one of our patients we'll also work with them to see a good fit for where they need to go. So that's pretty much you know what we do. They'll call us and be like hey what do you think about this person they qualify for mental health housing and things of that nature. So, we interact with them a lot actually.

Frequent collaboration with the other departments helped build closeness in participants' work relationships and the ability to provide input on decisions helped increase a sense of cohesion which assisted participants in carrying out their duties with ease compared to more distant work relationships.

Not only did participants note the necessity of building effective working relationships but they also noted that these relationships took effort and intentionality to build. P4 discussed the effort spent in building effective working relationships during her individual interview:

> I've worked really hard at developing relationships because I feel like, my position was kind of [brief pause] there were a few different people that were in and out of my position before I came and so I'm not really sure that those relationships were developed. And so, over time, I feel like I've been able to establish good relationships in the security staff, especially the higher-level ranking security staff that has the power to make decisions

> that can affect change in terms of how we do things. I feel like they have come to trust me and the department, and so I think that we have a much better working relationship than we did when I first started.

All participants noted the importance of building close working relationships with others. Having close relationships helped participants carry out their work duties and roles within the setting and assisted them with operating as a team with the other departments.

Supporting Each Other

Another theme that emerged when participants described their work relationships was *Supporting Each Other*. This theme was primarily evident when participants described their relationships with their co-workers within the mental health unit. P2 and P3 focused on supporting each other within the mental health unit by sharing and dividing the daily workload. P3 provided an example of how daily tasks were divided among the mental health counselors when she shared:

> That's the other thing that you know, we'll flip flop who has telepsych. You just do telepsych and you come back to the schedule, we discuss where we split it up, or if you don't have telepsych you do the schedule and referrals.

Participants appreciated the positive support they gained from the ability to rely on one another and share the workload. P2 discussed her appreciation for the support received from her fellow mental health counselors when she stated:

> I don't [brief pause] think I could do this job without having a so positive support network. Like, if my coworker is just like I can't do it today. You know, I will do my best to help pick up the slack.

Participants seemed to value and appreciate the support received from their fellow co-workers particularly when their workload was increased and they felt overwhelmed. Support was also shown within the mental health unit through consulting and talking through clinical decisions with each other. P4 noted the usefulness of discussing ideas with the other counselors, even as a director. “Even though I’m the director, and you know I’m not an expert, I don't know everything. And it really does help to bounce even my own thoughts and concerns off of my residents.”

Participants not only focused on the support they gave and received from one another within the unit but also discussed ways in which they supported others, such as security staff. However, this type of support seemed to be a secondary focus for participants. As the director of inmate health services, P1 focused on providing support to both medical and mental health clinicians which is evident when he stated, “I will work with the clinicians to support them any way I can to make sure that we're seeing, that everybody that needs to be attended to that day is seen.” P2 also mentioned providing support to others during her individual interview, “Sometimes we’ll be support for deputies too if they're having a hard time.” Participants tended to show support when they noticed their co-workers having difficulties managing stress and other emotional reactions to the work environment. All participants focused on how they could support their co-workers by working together to complete daily work tasks.

Superordinate Theme 3: Mental Health Counselor Role

This superordinate theme contained themes that described the focus of participants’ mental health counseling role in corrections. Seven themes emerged from the across case data analysis: 1) Focus on Safety, 2) Focus on Prioritizing/Triage, 3) Focus on Clinical Judgement, 4) Focus on Focus on Educating/Explaining, 5) Focus on Helping/Support, 6) Focus on

Advocating, and 7) Feelings of Satisfaction. Participants were asked one question with three follow up questions during their individual interviews that elicited discussion of their roles, duties, and responsibilities within the jail. Participants also discussed aspects of their roles when responding to the audio/video log prompt, services they provided to inmates, descriptions of their typical day, and ways in which their work experience in corrections changed how they viewed themselves as counselors.

Focus on Safety

Safety was a prevalent theme discussed by all four participants. Participants' roles as mental health counselors primarily focused on ways in which to uphold the safety of inmates while in custody of the jail. Participants tended to focus on suicide prevention efforts and identifying risk factors when discussing their primary duties and interactions with inmates. For example, P4 identified suicide prevention as the main focus of her role as a director of mental health services:

> I do a lot about suicide prevention. You know, making it because that in a correctional facility suicide prevention is the biggest thing for mental health. So, making sure that medical staff, security staff, even my own mental health professionals, you know that they just recognize the signs, the risk factors.

For P4, ensuring that all staff members could recognize risk factors for suicide was an important aspect of her role. P3 also highlighted how safety and suicide prevention were prioritized over other mental health concerns when she stated, "The first thing is suicide prevention. You know safety first in here because that's one of the things we have to worry about and think about. So that's the that's the first thing."

Interestingly, participants not only focused on upholding client safety but also focused on the safety of themselves and other staff while working in corrections. When discussing the services she provided as a mental health counselor, P2 reported having to "worry for your own safety too" along with utilizing her clinical counseling skills during client assessments. She elaborated on this concern for personal safety by describing it as:

> I have to be aware of what's around me. Like is there an inmate with their top hole up or down. I'm like right next to them, they can throw something at me or hey what's going on behind me. Like I just like to have an idea of what's happening.

For P2, having an environmental or spatial awareness was an additional focus to ensure personal safety when operating in her role. P1 also discussed safety but focused on the safety of others including staff members when discussing his duties and responsibilities as a director of health services. He stated, "I am very concerned about their wellbeing and so I do ask questions about how their personal lives are going." He also described a sense of responsibility when it came to the safety of others during his individual interview when he stated, "I am very protective of the people that I am responsible for." For P1, his primary focus was on ensuring the safety of staff compared to the other participants who focused on their personal safety as well as client safety.

Prioritizing safety for all individuals in the jail was a primary focus of all participants roles. The aspects of safety that participants focused on and discussed differed based on their individual roles within the department hierarchy. In other words, participants who held administrative positions focused on the safety of staff as well as inmates by attending to staff members' personal well-being and educating all staff on suicide risk factors, while participants who were not in administrative positions tended to primarily focus on inmate and personal safety

while performing their roles. Regardless of employment positions, all participants discussed safety as a priority when preforming their roles within a correctional setting.

Focus on Prioritizing/Triage

Another focus of participants' mental health counseling role was performing triage or prioritizing cases based on urgency. This theme emerged from participants' descriptions of their roles and services they provided to inmates. All participants discussed assessing cases based on individuals' mental health needs and the urgency in which those needs should be met. For instance, P3 simply stated, "We make the psychiatry schedule based on the needs of the person." Participants described triaging as a decision-making tool that informed how they structured their daily schedule and prioritized unanticipated crisis events. P4 described this process when she stated, "It's a high paced, stressful environment. So just kind of take it as it comes and decide. Again, it comes back to that triaging and what's the biggest crisis, what's the most important." Participants utilized triaging and prioritizing cases to assist them with making decisions on where to focus their attention and efforts. P2 described criteria and risk factors that would indicate a more urgent case when she stated, "That's how we know this person Johnny needs to be seen ASAP. He's like actually psychotic. He refused everything. He's not interacting with anyone. That's someone I want to see sooner rather than later." Indicators of suicide risk, harm to others, and psychiatric medication needs were identified by participants as criteria that required more immediate attention compared to feelings of depression and anxiety.

Triaging and prioritizing cases was a salient aspect in how participants made clinical decisions regarding the order in which to attend to individuals' mental health needs and was a large part of their role as mental health counselors. P1 identified triaging as a primary aspect when he stated, "And so what we see what we the majority of what we're in what we're doing is

triaging. We triage the really urgent cases right away and that's where the majority of our resources go." Participants all utilized aspects of triaging and prioritization when making decisions regarding where to direct their resources and attention. They assessed cases based on urgency and need to determine which individuals required immediate mental health intervention.

Focus on Clinical Judgement

In addition to triaging and prioritizing, most participants also focused on aspects of clinical judgement when discussing their roles. P2 highlighted clinical judgement and decision making when asked about her experiences as a mental health counselor in corrections. She stated, "You really have to test some tough skills and making decisions like, oh crap I hope this is right." For P2, using clinical judgement was a prevalent aspect of her role. Participants emphasized assessment and quick decision making when discussing how clinical judgement was used within their roles. Participants described a desire to be thorough when gathering clinical information on inmates' biopsychosocial histories and when assessing for suicide risk. P1 emphasized the need to take additional time to form an in-depth conceptualization when he stated, "When we start to do our assessments, and we start to look at what we're being presented with, we start to dig a little deeper. We take more time." P2 also discussed thoroughness when conducting assessments, "I just like to get a full history on them if I haven't talked to them yet and to see how I can help them too." Being thorough when conducting assessments assisted participants in gathering additional information on inmates' mental health concerns which allowed them to identify ways that they could help. P4 also highlighted thoroughness when describing the process for evaluating inmates on suicide watch:

> If someone in the facility voices that they are feeling suicidal, whether it be to one of the mental health professionals, to a nurse, security, those individuals are placed on suicide

> watch. And so, then when we come in, we review their chart. We see if they have a history, then we go down and we speak with them and just basically do an assessment to just to get more information.

Participants not only described a need to be thorough when making clinical judgements, but also discussed a need to make decisions quickly and trust in their clinical decisions. P4 emphasized the importance of trust when making clinical decisions when she stated, "You have to be able to think quickly on your feet to make quick decisions. [brief pause] Trust yourself, trust your gut instinct."

P3 did not focus on aspects of clinical judgement when discussing her role as a mental health counselor and instead focused on educating others about mental health. However, the other three participants highlighted clinical judgement and decision making as a focus of their roles. These participants described a need to be thorough in their information gathering and identify solutions to concerns quickly.

Focus on Educating/Explaining

Another theme that emerged when discussing their roles and duties was *educating and explaining.* Part of participants' roles focused on educating others about mental health as well as explaining their mental health role to other staff members. All participants experienced the need to educate and explain mental health concepts and their role to both inmates and staff members. When it came to explaining their role to others, participants focused on using education and understandable terms to help others outside of mental health understand their role and scope of practice. P2 described the need to explain mental health concepts to others as well as outlined the scope of her role:

> My clinical people get the clinical language and even nursing you have to break it down for them too. So, it's a lot of kind of breaking down what, who we work with, and what we do, and how people are acting.

P2 conceptualized explaining and educating as "breaking down" mental health to others. P3 also noted the need to educate staff members on how to respond to mental health behaviors when she stated, "Then we're teaching them to call us and we'll go to come running versus hey this is how you handle this. You know, so we're trying to educate as well." Participants used education with staff members to increase their understanding of inmates' mental health and the role of mental health counselors in corrections.

Participants also used education to change others' attitudes and stereotypes. P1 discussed how he utilized education to help change staff members' attitudes toward inmates when he was describing the workplace culture among staff:

> The environment inside of the facility causes people to become very jaded very easily. They start to look at everyone, regardless of their gender, regardless of their ethnicity or the race, they just look at everyone as an inmate and all inmates are trying to get over on the staff or they're trying to assault staff. That's kind of a mindset that we fight on a regular basis. And from the counseling side of things when we look at that we try to talk to the staff members and try to kind of do some explaining.

Through providing explanations, participants were able to increase others' understanding of mental health. For example, P4 noted how by explaining the rationale behind decisions others were more accepting:

> If you take a minute to just say okay like this is this is what's going on, this is this is the rationale behind leaving this person on watch. A lot of times that makes them feel better

> and then they don't get quite as much pushback cause they understand why you're doing it.

By focusing on education as an aspect of their role, participants sought out opportunities to share their specialized knowledge of mental health with others at the site. For P3, educating others on mental health meant, "Teaching them something that they can actually utilize when we walk away from them." Education seemed to be a central focus of all participants' roles in corrections. Participants used their specialized mental health knowledge to educate other staff and inmates to increase their understanding of participants' mental health counseling role as well as mental health disorders and concepts.

Focus on Helping/Support

Another prevalent focus of participants' mental health counseling role was on providing help and support to both clients and co-workers. During their individual interviews and audio/video logs, all participants described a focus on helping others as part of their role. For P1 this meant "making sure that their individual needs are taken care of" which he stated while reflecting on ways that he showed support to staff members. P3 also discussed a primary focus on helping others when she described her primary goal when interacting with clients:

> I want to go in you know, like what can I do to help you? What can I do to help yourself feel better? What can I do to give you some hope today? What can I do to put a smile on your face when you're going through it?

For P3, identifying ways to uplift and help others seemed to be at the core of her role as a mental health counselor. This was also true for P2 and P4 who noted that the helping aspect of their roles led to feelings of enjoyment and satisfaction. P4 described how she derived positive feeling from helping when she stated, "I found that I really enjoy helping people grow. I get a lot of

pleasure and reward from that, just supporting people and seeing them work to achieve their goals." P2 also highlighted helping and providing support as enjoyable aspects of her role when asked directly about her feelings toward her role in corrections. She noted, "But I really it's just I like being there and helping and sometimes I feel fulfilled." P2 also contrasted these enjoyable aspects of her role with other aspects that were not as rewarding when she stated, "and other times it's like, oh crap there are certain things I didn't get done that I need to get done." Finding opportunities to support their co-workers and clients was central to participants' roles as mental health counselors. All participants discussed an orientation toward helping others which contributed to feelings of satisfaction and enjoyment.

Focus on Advocating

The theme *focus on advocating* emerged from the interview and audio/video log data from P1, P3, and P4. Interestingly, two of these participants held administrative positions (e.g., department director) in addition to being mental health counselors in corrections. For the P1 and P4, who held administrative positions, this theme described their focus on expanding mental health services within corrections as well as identifying additional community resources that could assist inmates with maintaining mental health post-incarceration. When asked about how his work in corrections had impacted his professional identity development, P1 noted an increased recognition of the need for mental health counselors and mental health programs in the criminal justice system. He also highlighted a discrepancy between the supply and demand for mental health services in corrections. This gap in services motivated P1 "to want to learn more, to want to ask more questions, to ask more process related questions." His focus on identifying and understanding this systemic problem motivated him to develop mental health programs that could better meet the mental health needs of inmates:

> We can build those services. Where people will not always get everything they want. We know that. But we can still provide the best services possible to at least help the most people that we can, to reach the most people we can.

For P1, the focus on advocacy for his role meant building programs and services within the jail that could meet the mental health needs of the population being served (i.e., inmates). For P4, advocacy was an integral part of her counselor identity which she spoke about when she was asked to describe herself as a licensed professional counselor. As she reflected on her work with inmates and role as an advocate she stated, "I just feel like advocating for them, being their voice, helping them figure out different paths, is very important to me."

This theme also emerged for P3 who focused on advocating by challenging both client and staff attitudes toward each other and mental health in general. When asked to reflect on how her work within corrections had influenced her professional identity development she stated:

> I try to bridge that gap or the animosity or that negativity based on what they've been taught or what they've seen or experienced to hey if people care about you, I don't care what color they are, where they come from, if they're in uniform. People do, there are people that care.

By challenging clients' attitudes toward the correctional staff, P3 encouraged clients to take advantage of the mental health and other services being provided at the jail. Additionally, when reflecting on her perceptions of how the correctional staff viewed the mental health unit she also shared, "sometimes those that may not have believed in mental health or have that old school mentality or whatever, being up in here can show them, hey you know what I'm starting to believe in this mental health thing." Here, P3 was able to challenge the beliefs of correctional staff to increase their trust in the mental health unit.

Unlike P1 and P4 who focused their advocacy efforts on increasing mental health services and access to services, P3 took a different approach toward advocacy by challenging others' attitudes toward mental health to improve trust and treatment outcomes. Although advocacy was not discussed by P2, it did emerge as a focus for P3 and both participants (i.e., P1 and P4) who operated in administrative roles within the health services department. These participants used advocacy within their roles to identify client service needs as well as increase trust between clients, treatment providers, and correctional staff to improve client investment in mental health services.

Feelings of Satisfaction

Another theme that emerged when participants discussed their roles within corrections was *Feelings of Satisfaction*. All four participants spoke about aspects of their roles and the working environment that were enjoyable. P3 specifically felt enjoyment from having the opportunity to expose inmates to counseling when she noted:

> I love working in the jail. I love those who are not the traditional therapy goers. I love those who are fresh to it. They might not consider therapy because they feel have this stigma of what it feels like, what it looks like, what it is.

For P2, the fast pace of the working environment and variety of tasks within her role were enjoyable aspects. While reflecting on her experiences as a mental health counselor in corrections she noted, "You do different things and that's one of the things that I do like about it because it keeps me going and on my feet during the day." P4 also highlighted aspects of the working environment and the population when she stated, "Personally I love counseling, but I would never want to work in private practice again. I just I love the fast paced, high pressure of this job. I like the population." For P4, the fast pace and working with an inmate population were

more enjoyable than her experiences as a mental health counselor in private practice. P1 also mentioned feeling satisfied with his role and experiences as a mental health counselor, during his audio/video log, when he reflected on the differences between counseling in a correctional system and other counseling settings:

> I think because of the nature of the physical environment, because of the nature of the people that we work with on a regular basis, not just colleagues or staff members but also the inmates who are in custody at the time, it's different. I like it though. I like how we view ourselves.

Participants experienced feelings of enjoyment and satisfaction from their roles and experiences as mental health counselors in the jail. They specifically highlighted the pacing of the work environment, the population, and the differences between their role in corrections compared to other counseling settings as aspects that led to work satisfaction.

Superordinate Theme 4: Professional Identity

The last thematic cluster that emerged from the across case analysis was *Professional Identity* and contained themes that described participants' perceptions of their counseling identity and professional identity development. This cluster consisted of five themes: 1) Defining Professional Identity, 2) Approach Toward Clients, 3) Adapting to Environment, 4) Making Comparisons, and 5) Professional Growth. Participants were asked two questions with one follow up question each to elicit information about their perceptions of their counseling identities and how their work within corrections changed their perceptions of themselves as mental health counselors. Participants were also prompted to discuss their professional identity in their audio/video logs.

Defining Professional Identity

When asked in their individual interviews to describe their professional identities, generally, all four participants identified themselves as a Licensed Professional Counselor or Resident in Counseling as well as including other aspects that they considered a part of their professional identities. Participants tended to focus on areas of interest or specialty, professional credentials, therapeutic modalities, and personal qualities when responding to this interview question suggesting that they had a wide sense of how they were conceptualizing their professional identity. For example, P1 focused on his area of interest to describe his identity when he responded, "I really like to focus on trauma, and I like to focus on early trauma and how that trauma impacts a person's overall personality and wellbeing as they're older." While P2 chose to focus on personal qualities such as "hard working and ethical and respectful." P4 also focused on personal qualities when describing herself as a mental health counselor, "I'm clearly a helper. I'm caring. I'm definitely an advocate for my patients. [pause] I'm very passionate about the work that I do." While P3 responded by noting her eclectic use of counseling theories:

> I use a little bit of everything based on who's in front of me and what's in front of me, what issues are there, and I think it works. You know it really does. It works. It helps to treat the whole person.

Although participants chose to focus on different aspects of counseling when describing their professional identities, there were additional personal characteristics and qualities that they highlighted throughout further discussion in the individual interviews and audio/video logs. For instance, during her audio/video log when reflecting on her desire to balance her personal life with her professional life P2 stated, "I think that is a part of my counselor identity, is balancing and boundaries and holding those boundaries and um while still treating my patients with respect." For P2 setting and enforcing boundaries as well as balancing her personal and

professional lives were salient aspects of her counseling identity. Additionally, P2 highlighted personal characteristics that she believed were common across counselors when she shared in her audio/video log:

> My goal is being intentional and authentic. And as so key as I think of being a counselor no matter where you work, whether it's private practice or here, because especially here, inmates can pick it up right away if you're not real.

She noted the importance of intentionality and authenticity as core characteristics to being a counselor regardless of employment setting. P3 also mentioned the importance of being authentic and genuine when she was asked to describe her feelings toward her professional identity development. She reflected, "I'm professional but I've learned that it's okay to be myself." P3's acceptance and integration of her personal self into her professional identity helped her develop her own personal counselor identity which is evident when she stated, "The more that I would feel comfortable with being myself, and I realized that I was getting a response to it, the more I became into my own as a counselor."

When defining and describing their professional identities, participants tended to list their specialty areas, preferred counseling theories, and personal qualities that they perceived as aligning with the counseling profession. Participants also emphasized authenticity and genuineness when describing their personal counseling identity.

Approach Toward Clients

All participants discussed their attitudes or approach when interacting with inmates in the correctional setting. This theme emerged from participants' descriptions of their experiences as mental health counselors in the jail as well as how these experiences have changed their professional identities. All but one participant (i.e., P3) noted the need to approach inmates with

an element of mistrust which was attributed to inmate malingering behaviors within the jail. P2 highlighted this when she reflected on ways in which her employment in corrections shaped her professional identity. For P2 approaching clients with mistrust was described as, “You have to have like a bullshit meter and who's malingering, who's not, and being able to catch that.” P1 also noted this need to be skeptical when interacting with inmates when he stated, “Is somebody legitimately fearful or are they just trying to get some type of enhanced service.”

A majority of participants noted the need to utilize a mistrusting attitude when working with inmates which contrasted with their training as mental health counselors. P4 highlighted the conflictual experience of wanting to approach clients from a nonjudgmental, empathic attitude and needing to also approach them from with a skeptical, mistrusting attitude:

> It's hard for us to trust them because in a correctional environment there's a lot of malingering … So as therapists we when we walk into any assessment or situation, we’re not trained to go in mistrusting our clients. But you have to get to a point in corrections where you still care about your patient, you have that empathy and respect, but you have to be suspicious and think are they lying, what is their goal. So that's a really hard thing to get around.

In addition to approaching clients with mistrust, two participants (i.e., P2 and P3) provided a counternarrative in their approach to clients. These participants discussed their utilization of a nonjudgmental or nonbiased stance when providing services to inmates. P3 specifically described herself as nonjudgmental when reflecting on her experiences as a mental health counselor in corrections. She stated, “There's never any judgment with me. People can have whatever charges or whatever and I don't look at them any different.” For P3, not focusing on an inmate’s charges helped her approach clients from a nonbiased and nonjudgmental stance. She

also perceived her fellow mental health counselors as utilizing this approach with inmates when she stated, “We always treat them fairly without judgment and we do our best.” P2 also discussed her attempts to approach clients from a place of understanding instead of judgement when she noted:

> I just tried to be genuine and just, as my term I say [chuckles] to like sit in the shit with them, like just kind of be there and try to put myself in their shoes as best that I can.

Adopting a nonjudgmental attitude was noted by P2 and P3 as an aspect of their counseling work with inmates. This attitude seemed to allow these participants to empathize and better understand the clients they were serving and tied into their conceptualizations of their professional identity.

P1, P2, and P3 all discussed their need to develop a skeptical attitude toward clients when working in corrections to avoid encouraging malingering behaviors. Adopting this type of attitude toward clients was counterintuitive to how participants were trained in their counseling programs, which often emphasize a nonjudgmental, nonbiased approach. P4 specifically noted the need to balance both mistrust and nonjudgement when working with inmates, while P2 spoke about her experiences with each type of approach. P1 and P3 discussed their approach toward clients from only one perspective (e.g., nonjudgement or mistrust). Based on participants’ descriptions of their attitudes toward clients, it seems they had to find ways to integrate both nonjudgement and mistrust into their conceptualizations of themselves as counselors when working with inmates.

Adapting to Environment

Another theme that emerged when participants were discussing their experiences working in corrections was *Adapting to Environment.* All four participants highlighted ways in which they had to adapt their professional identities and ways of being as mental health counselors to

accommodate for differences in population and setting. For example, P2 described having to adjust her presentation and tone of voice when providing services to inmates:

> I remember my first week here, my boss, I walked up to a cell and she was like, my tone was just like I was working with someone in private practice and not like an inmate And I was like hey I'm like really nice. And she's like you need to work on your tone because they will like fully take advantage of like you, in that situation. Like you're too nice. You need to be nice but not too nice.

P1 also experienced an adaption process where he had to adjust and build his counseling skills to make quick assessments and decisions to a variety of situations he encountered in the jail. When reflecting on his professional growth in his audio/video log he shared:

> What we've gotten used to is having to know your skills and understand your craft enough that you can walk into a dynamic and fluid situation and be able to kind of create an assessment in your head of what's going on, where it might be coming from, what needs to happen as quickly as possible in order to keep everybody safe.

Participants primarily noted having to adapt their counseling skills and personal counseling styles to the setting to overcome the challenges of working in corrections. During her individual interview, P4 simply stated, “There's challenges to treating mental health in a correctional facility.” The differences between counseling settings (e.g., private practice, inpatient, corrections, etc.) that participants had previously experienced as well as the variety of mental health issues they encountered within the jail seemed to be a central focus when participants discussed ways in which they adapted to being mental health counselors in corrections. P3 highlighted differences in her experiences of working in outpatient therapy and working in the jail when she reflected on her feelings about her current counseling role:

> I got bored with therapy, outpatient therapy. It was cool, but I really couldn't see myself doing that every day, all day. I've been there, done that, got bored with it, especially doing a traditional depression, anxiety. Now those that are incarcerated, who aren't normally therapized, I enjoyed that because that can be, it's just different, a dynamic set of issues there.

P3 enjoyed the differences and challenges of working with inmates in corrections compared to clients in private practice. Although she did not specifically highlight how she adapted to the correctional setting, it is implied that due to the differences in client presentation and variability in client issues that she had to adjust and build upon her clinical counseling skills similarly to the other participants.

Making Comparisons

Three participants made comparisons between how they envisioned conducting counseling and how they were trained in their graduate programs to how they were actually conducting counseling while in a correctional setting. P1 specifically highlighted differences between what he termed "traditional" counseling and ways in which counseling was conducted at the jail:

> It's not the traditional sitting down with a client for a 50-minute hour and 10 minutes of notes before you go to the next client. You may be talking to a client through a set of bars that just the day before assaulted multiple staff members.

P2 also noted differences between how she expected to operate as a mental health counselor and how she was currently conducting counseling:

> Gosh it's so different than what you're taught in school. You do wear so many hats and you get pulled in a lot of directions. It's like you're doing counseling but in a way your kind of doing social workish type stuff too.

For P2 her expectations of what counseling looks like in the field was attributed to what she was taught in her graduate program, which P4 specifically noted when she stated, “Corrections is a completely different world from what they teach us in school.” Participants seemed to initially develop their professional identity and expectations for what counseling looks like in the field based on what they were taught in graduate school which was not congruent with how they operated and provided counseling services within the jail. P1 tied this to his professional identity during his audio/video log when he noted the discrepancy between graduate school training and his actual experiences in the jail:

> Maybe it's not what we thought it would be when we were in school, when we were all taking in our different programs. We thought this is what my counselor identity is going to look like and that's not what it does where we are here.

For P1, as well as other participants, their conceptualizations of professional identity were informed by their graduate school programs and did not match their current roles as mental health counselors in corrections.

Although P3 did not make similar comparisons between graduate training and her current experiences as a mental health counselor in corrections, a majority of participants noted how their graduate programs influenced their conceptualizations of themselves as mental health counselors. These envisioned conceptualizations informed how participants developed their professional identities. When discussing their professional identities, participants often compared their training or “traditional” counseling to their current ways of conducting counseling which

caused them to expand their conceptualizations of what counseling is to fit their current ways of conducting counseling within the jail.

Professional Growth

All participants noted some aspects of professional growth and development during their individual interviews and audio/video logs. One interview question and one follow up question specifically targeted ways in which their experiences working as mental health counselors in corrections had changed how they viewed themselves as counselors. All participants mentioned aspects of how working in their current setting helped change and grow their professional identities. For P1 his main growth point was feeling prepared to work in any future counseling setting, "I honestly believe I could go anywhere, any service, any agency, any private practice and handle any client that walked in the door." For P1 based on his experiences working with such a diverse population helped him develop confidence in his counseling abilities which is evident when he referenced how he views himself and others within the mental health unit. He shared, "We view ourselves as better counselors than others, whether that's true or not that's debatable, but we view ourselves as better because we work in such difficult conditions and we not only do we survive those conditions, we thrive as counselors." P2 also echoed feeling strong in her clinical skills from working in corrections when she reflected:

> I think I'm just proud that I've taken a lot of risks in my career, and it's really grown me. And there's been a lot of difficult cases that I've dealt with, but it's really prepared me for this moment like where I'm at now and I think I'm a stronger more confident clinician because of that."

Not only did participants' experiences working in corrections help build their confidence in their clinical skills but they also noted a desire to continue growing their skills to meet the diverse

needs of the inmates they counseled. P3 noted her desire to continue learning when she stated, “It just helped me and to have a diverse population, a very diverse population, and it helped me to understand the importance of what I do. It makes me want to learn more and more and more.” Participants’ work with this particular population seemed to contribute to their professional growth. P4 also noted how supporting inmates to help them achieve their goals also helped her grow in turn. When reflecting on her professional development P4 shared:

> I found that I really enjoy helping people grow. I get a lot of like I get a lot of you know pleasure and reward from that, just supporting people and seeing them work to achieve their goals. And doing what I can to build them up and help them be better and I think in turn that helps make me better.

All participants identified ways in which their current experiences as mental health counselors in corrections and work with inmates had contributed to their professional growth and development. Participants particularly noted how working with a diverse population in a high paced environment contributed to growth in their clinical skills which in turn increased their confidence in their abilities to work in other counseling settings.

Summary of Findings

Four superordinate themes emerged from the groups theme developed during across case analyses. The first superordinate theme, *Experience of Setting*, described how participants experienced their day-to-day work setting. Participants described their work environment as fast paced, unique, and unpredictable due to the variability of daily structure from day to day. Participants were often asked to attend to unpredictable crisis situations in addition to other requests for their assistance from staff members. Participants perceived influxes of communication often indicated by a ringing phone which they associated with others needing

their help to resolve mental health related issues. This continuous flow of communication along with other's unclear understanding of their role contributed to increased demands for their attention which in turn added to their experience of the work environment as fast paced and unpredictable. Due to the nature of their role, the population they served, and other staff's misunderstanding of their role participants found that they needed to incorporate boundaries as well as additional coping strategies to help them balance their personal stressors and emotional reactions with their professional role.

The second superordinate theme, *Work Relationships,* described how participants perceived and approached their co-worker interactions. Overall, participants perceived themselves as being a part of a larger treatment team that included the other departments in corrections. Participants described ways in which they collaborated with other departments to identify solutions that would better address the mental health concerns of the inmates in their care. In order to have these collaborative relationships, participants noted their need to work closely with other departments and put in effort to build relationships so that teamworking could be possible. Additionally, participants focused on ways in which they could support their co-workers to help alleviate individual work stress.

The third superordinate theme, *Mental Health Counselor Role,* described the different focuses participants took when operating as mental health counselors in this setting. The primary focus of participants' roles as mental health counselors was on safety and suicide prevention. Participants noted that because they worked in a jail safety was not only their concern but also a concern of the facility. Working in this setting also caused participants to focus on their clinical decision-making skills so that they could quickly make decisions and prioritize cases based on need. Additionally, participants seemed to focus on educating others as a part of their role. They

also focused on helping and supporting those around them which led to feeling satisfied with their work in corrections.

The last superordinate theme, *Professional Identity,* contained themes that described participants' perceptions of their counselor identity and professional development. Participants described their unique counseling identities by highlighting personal qualities that aligned with the counseling profession (e.g., helping, caring, intentional, authentic) as well as defined their identity through their personal professional values (e.g., advocacy, boundaries) and specialty areas. They also described their approach to counseling and attitude toward clients. Most participants mentioned having to approach clients at the jail from a questioning or mistrusting stance due to malingering; however, half of the participants emphasized having a non-biased and non-judgmental attitude toward clients. Participants also had to adapt their counseling style and approach to fit the setting. Most participants reported making comparisons between how they imagined themselves providing counseling and how they were currently conducting counseling. Specifically, they compared traditional private practice to how they were counseling in the jail. Participants noted that they experienced professional growth and development from working in corrections which increased their confidence in their skills, contributed to learning, and helped them feel prepared to handle a wide range of counseling settings.

The next chapter will discuss how these findings compare to the current literature as well as provide implications for counseling students, counseling educators, clinical supervisors, mental health counselors, and licensed professional counselors (LPCs).

CHAPTER 5

DISCUSSION

This chapter begins with an overview of the study's purpose and methodology. Next, I compare key findings (i.e., superordinate themes) from this study to existing literature on professional identity, integrated behavioral healthcare (IBH), and correctional counseling. Then, I discuss the study's limitations and provide practical implications for counseling students, counseling educators, clinical supervisors, mental health counselors, and licensed professional counselors (LPCs). Finally, suggestions for future research studies are provided.

Overview of Study Purpose & Methodology

The purpose of this qualitative, interpretative phenomenological analysis (IPA) study was to explore and interpret the experiences of mental health counselors employed in an IBH setting (i.e., corrections) regarding their perceptions of their professional identity as well as how their experiences of their roles in this setting influenced their professional identity development. Numerous qualitative studies have explored how mental health counselors perceived and described their professional identity and identity development (Prosek & Hurt, 2014; Woo et al., 2016) as well as qualitative studies focusing on the attitudes, perceptions, and experiences of counseling students and mental health professionals in general working in IBH settings (Glueck, 2015; Johnson & Mahan, 2019). Although these studies helped identify training needs, roles in IBH, and experiences with interprofessional collaboration of mental health professionals they did not explore the unique experiences of mental health counselors separately from other health professions. Additionally, few qualitative studies have explored how mental health counselors perceive their professional identity in IBH settings and what aspects of their professional roles in IBH impact their professional identity development (Reese, 2019).

Although some studies have explored mental health counselors' professional identity in the context of IBH settings, even fewer studies have explored how correctional counselors' roles influence their perceptions of their professional identity and identity development. In a review of the existing literature, I was able to locate one study (i.e., Carrola et al., 2016) that explored how correctional counseling supervisors perceived their professional counselor and supervisor identities in a correctional setting. Therefore, the present study sought to fill this gap in the counseling literature by exploring the perceptions and experiences of professional identity for mental health counselors employed in corrections.

The first research question aimed to describe and understand how mental health counselors perceived their professional counseling identity while working in a correctional system. The second research question sought to explore how these mental health counselors' experiences of their professional roles in corrections influenced their professional identity development. Utilizing a qualitative, interpretive phenomenological analysis (IPA) approach, I examined transcriptions of individual interviews and audio/video logs for emergent themes and superordinate themes of individual participant cases. To address both research questions, I examined individual themes across participants to develop superordinate themes and themes for the group that depicted salient aspects of participants' perceptions and experiences of their roles as mental health counselors in corrections, their professional identities, and their identity development to address both research questions.

Participants described aspects of their work environment and experience working in corrections. They also discussed their interactions with their co-workers and other staff as well as their approach to building and maintaining these relationships. Participants also identified prevalent focuses of their roles as mental health counselors as well as their feelings regarding the

work that they did. Finally, they provided descriptions of their professional identities and discussed differences between other counseling settings (e.g., private practice) and corrections that contributed to professional growth and development.

Comparison of Superordinate Themes with Existing Literature

Four superordinate themes emerged within participants' reflections on their perceptions of their professional identity and their experiences of their roles in corrections: 1) Experience of Setting, 2) Work Relationships, 3) Mental Health Counselor Role, and 4) Professional Identity. In this section I will discuss how the superordinate themes of this study fit within existing research studies about professional counselor identity, mental health counseling in IBH, and correctional counseling.

Experience of Setting

All participants provided descriptions of their experiences and perceptions of their work environment. They experienced the environment as fast-paced, unique, unpredictable, and diverse. More specifically, participants in the current study highlighted the variability and unpredictable nature of situations that occurred throughout each day while working in corrections, which is consistent with participants in Berkel and colleagues' (2020) study who experienced their role in primary care settings as flexible and dynamic. The variety and quantity of day-to-day situations contributed to a sense of busyness for participants as they were frequently called in to help manage mental health crises as well as other requests for assistance from security staff. Similarly, to other IBH settings, correctional counselors experienced an increase in the frequency of appointments and pacing of services which were often determined by others (e.g., physicians, security staff, intake coordinators) based on patient needs (Glueck, 2015). In other words, participants in this study experienced their workday as busy and fast-

paced due to others requesting their services without previously scheduling appointments. Overall, participants' experiences of their work environment were similar to other mental health professionals working in medically focused IBH settings (Berkel et al., 2020; Glueck, 2015).

Another theme that emerged regarding participants' experiences of the correctional environment was constant communication. Communication and collaboration have been noted as integral parts of the service provision within IBH settings (e.g., Berkel et al., 2020; Matz & Lowe, 2020; Johnson et al., 2015; Wener & Woodgate, 2016); thus, it is not surprising that all participants in this study commented on their experiences of communication within their work setting. Participants experienced communication and collaboration at their site as constant and overwhelming particularly during crisis events. They felt bombarded with frequent phone calls from security staff which created disruptions in their workflow as they felt the need to attend to whatever pressing situation was at hand. This finding is interesting as it contrasts with previous studies that identified lack of communication as a barrier or challenge to interprofessional teamworking (Johnson et al., 2015; Wener & Woodgate, 2016). Correctional counselors in this study did not experience a lack of communication, but instead were overwhelmed by the frequency of collaborative contact which seemed to impede their workflow. Future studies may choose to explore correctional counselors' attitudes and perceptions toward interprofessional collaboration to shed light on how communication impacts their ability to perform their role and duties.

Another universal experience across participants in this study was a perception that their roles as mental health counselors were not fully understood, and in some instances devalued, by staff members from other departments. This undervaluing and misunderstanding of the mental health counselor role are commonly noted experiences in the IBH literature. For instance,

counseling psychologists in Berkel and colleagues' (2020) study reported experiencing a lack of understanding about their role when working with other health professionals (e.g., physicians, nurses, social workers, nutritionists, psychiatrists) which led to a minimization of their roles and poor collaboration. Pomerantz and colleagues (2009) also noted that role misunderstanding across professionals in IBH can lead to mental health professionals feeling unsupported or disrespected which impacts their confidence. Participants in the current study addressed misconceptions of mental health and their correctional counseling role by clarifying their scope of practice and explaining their role to others. This need to correct role misunderstanding through educating and explaining parallels the experience of participants in Berkel and colleagues' (2020) study who found that counseling psychologists had to educate both clients and physicians on what they did and how they structured their time.

Participants' experiences of role misunderstanding seemed to contribute to an increase in role demands. All participants described the correctional counseling role as demanding on their attention. For two participants this was directly attributed to requests from security staff to assist with what was perceived as a crisis situation. These participants noted that their attention was constantly being pulled in various directions to address situations that security deemed a mental health crisis but was not an actual mental health crisis based on the correctional counselors' definition. In other words, participants were routinely asked to attend to inmates that were not in danger of hurting themselves or others but were displaying serious mental health problems, such as psychotic symptoms. Although previous studies have explored how correctional counselors spend their time at work (e.g., DiCataldo et al., 2021; Matz & Lowe, 2020) these studies did not separately examine how much time correctional counselors spent responding to requests from security to check on inmates. Matz and Lowe (2020) did note that correctional counselors spent

almost as much time addressing miscellaneous inmate needs as they did providing mental health treatment, which suggests that correctional counselors experience additional demands on their attention outside of their primary mental health duties. The other two participants, who held administrative roles, both described the correctional counselor role as demanding but in terms of supply and demand. In other words, these participants highlighted understaffing within the mental health unit as contributing to increased demands. This finding is not surprising considering that existing literature on correctional counseling has noted an increase in mental health needs within the prison system (Davis & Cates, 2017; DiCataldo et al., 2021; Kupers, 2015). DiCataldo and colleagues (2021) suggest that early participation in a correctional setting (e.g., during practicum or internship) for counselor trainees increases the probability of deciding to work in a correctional setting during the early stages of their careers. Thus, counselor educators might consider offering additional knowledge about, and exposure to, correctional settings which could lead to increased desire for counselor trainees to work in the correctional system.

As a result of increased demands on their attention and frequent communication with staff, participants perceived their work setting as busy and unpredictable which led to feelings of stress and being overwhelmed. All but one participant found that they had to implement coping strategies and focus on their self-care so that they could manage the stressors of their work environment. This theme aligned with Cox and colleagues' (2014) who found that participants in their study had to develop internal coping strategies to manage the fast pace and disruptions of working in a medical clinic. However, unlike the counseling psychology students in Cox and colleagues' (2014) study, participants in the current study also noted a need to set and communicate boundaries with others particularly around communication and situations they

would respond to (e.g., suicidal behaviors and attempts). This need to enforce communication boundaries seemed to assist these correctional counselors with managing additional stressors and increases in workload that were associated with requests from correctional staff.

Work Relationships

Participants in the current study viewed themselves as being part of a team that utilized components of teamworking such as collaboration, shared decision making, and communicating treatment updates. All participants viewed collaboration and working cohesively with the other departments as integral components to a teamwork approach to treatment. Previous studies focusing on IBH, interprofessional collaboration (IPC), and interprofessional education (IPE) experiences for healthcare discipline students have documented the importance of teamworking skills for integrated care settings. For instance, in a systematic review of IPE literature, Kent and Keating (2015) found that the most cited learning outcome of these studies was teamwork and collaboration skills. Thus, it is not surprising that correctional counselors in this study viewed their role as part of a larger team that included medical and correctional staff. This sense of being part of a larger team seemed to be facilitated by participants' co-location with other departments within the jail, which allowed correctional counselors to implement teamworking strategies such as collaboration and team meetings. In a social constructivist grounded theory study aimed at exploring the IPC relationship building process between providers working in primary care, collaborating in the context of co-location was identified as an overarching theme that assisted providers with building interprofessional relationships (Wener & Woodgate, 2016). Similar to the current study, teamworking strategies and various communication methods (e.g., team meetings, phone calls, emailing) were implemented to so that providers could work together to enhance mental health services.

Another aspect of working relationships that participants experienced was the need to build close working relationships with others at the correctional facility. All participants noted the necessity of having close relationships with security and classification departments which helped them carry out their duties. This finding aligns with similar themes from Carrola and colleagues' (2016) qualitive, constructivist study which examined how correctional counseling supervisors' made sense of their role in the correctional setting. Participants in this study noted the need to develop positive working relationships with security staff through explaining how their mental health role could be utilized in corrections which in turn led to more effective collaboration (Carrola et al., 2016). In addition to purposefully building close working relationships, participants in the current study noted how frequent communication and shared decision making assisted them with building these relationships. Frequent collaboration with other departments helped participants increase a sense of closeness and cohesion in their work relationships. This can be explained by Wener & Woodgate's (2020) stage 3 (i.e., fitting-in) of their Stages of Interprofessional Collaborative Relationship Building which discussed how providers developed interprofessional relationships by increasing familiarity with one another through frequent communication. Participants in the current study seemed to intentionally focus on building close, familiar relationships with the other departments in the correctional facility which was conducive to effective collaboration and interprofessional teamworking.

Lastly, all participants noted aspects of support when reflecting on their working relationships. Support was primarily discussed in the context of how participants supported each other within the mental health unit by dividing their workload and consulting with one another. They expressed feelings of appreciation for the support they received. This finding ties into participants' professional identity development as described by Moss and colleagues (2014). In

their study, counselors who had gained increased confidence and freedom to accept their limitations expressed appreciation toward their professional networks that consisted of other counselors which supported their practice and clients. Similarly, to these counselors, correctional counselors in the current study often consulted with one another when they recognized a limitation in their competencies. In other words, they reached other to one another when they needed support and confirmation in how they were conceptualizing cases. In addition to receiving support from one another, participants also focused on how they provided support to other staff members outside of the mental health unit. This type of support seemed to be a secondary focus for participants and was generally related to the emotional well-being of other staff members. Participants seemed to perceive their correctional counselor role within the larger interprofessional team as a supportive role in which they identified ways that they could assist others with carrying out their own professional roles.

Mental Health Counselor Role

Participants in this study discussed several main focuses of their roles as correctional counselors. They also expressed feelings of satisfaction derived from their role and counseling work in corrections. Safety emerged as a primary focus of their role in corrections, which is not surprising given that safety issues are a primary concern in the correctional environment. All participants reflected on different aspects of safety such as personal safety, inmate safety, and other staff member safety. The different aspects of safety that participants focused on seemed to differ based on their individual roles, with those in administrative or supervisory positions focusing on staff and inmate safety and those not in these positions focusing on personal and inmate safety. In Carrola and colleague's (2016) study, correctional counseling supervisors noted an increased awareness of the personal safety for their supervisees given the potential for

violence within the setting. This focus on safety and security resulted in supervisors integrating safety responsibilities into their supervisory responsibilities. Similarly, to these correctional counselors, participants in the current study who held supervisory positions seemed to be concerned not only with inmate safety and security but also the safety and security of those they supervised. Additionally, participants in the current study also noted that inmate safety was prioritized over other mental health concerns in the form of suicide prevention and abilities to identify risk factors that could jeopardize safety. This emphasis on suicide prevention as a mental health concern is consistent with Kupers (2015) who noted that suicide and self-harm are prevalent issues in corrections. Participants tended to focus on safety first when operating in their roles as correctional counselors.

Participants also noted a need to prioritize and focus their efforts on triaging inmate mental health needs as a part of their role in corrections. This focus on triaging cases and prioritizing inmate concerns was used by participants to make decisions on how they should structure their daily schedule and attend to unanticipated tasks. Participants tended to rely on their assessments of urgency, individual mental health needs, and risk factors when deciding which cases to prioritize over others. This process of triaging and prioritizing client concerns, especially when managing complex cases, is common in collaborative care where mental health counselors must adapt their practice to accommodate large caseloads and a fast-paced working environment (Cox et al., 2014). Mental health counselors working in medical IBH settings prioritized individual cases based on biological, psychological, and sociocultural assessments, while correctional counselors in this study used risk assessments of imminent harm to prioritize individual cases. Additionally, triaging cases appeared vital to the correctional counselor role as it assisted them with deciding where to direct their limited attention and resources.

In addition to prioritizing and triaging, three out of four participants also noted their use of clinical judgement in the decision-making process as an aspect of their correctional counseling role. These participants emphasized thorough assessment and quick decision making as salient aspects of their clinical judgement. Previous studies have noted that conducting and forming assessments is a necessary part of the correctional counselor's role and found that a large amount of correctional counselors' time is spent completing assessments (DiCataldo et al., 2021; Matz & Lowe, 2020). Additionally, Kupers (2015) noted the importance for correctional counselors to generally assess inmates' healthy capacities (e.g., being on time, act disciplined, be reliable and trustworthy, etc.) to form treatment plans and goals that assist inmates with being successful post-incarceration. Participants in the current study seemed to use assessments to inform their clinical judgements which assisted them with making quick decisions as needed when carrying out their duties as correctional counselors.

An additional focus of the correctional counselor role was educating and explaining their roles and mental health concepts to both correctional staff and inmates. All participants spoke about ways in which they used education when operating in their roles and carrying out their duties. Participants educated others by explaining their scope of practice and breaking down mental health concepts into understandable terms. They also used mental health education to teach inmates coping strategies as well as to challenge and change attitudes toward mental health. This use of teaching as a tool to increase others' understanding of mental health is common to other IBH settings. For instance, in Glueck's (2015) study 90% of participants reported using consultation and teaching with other health providers, staff, and clients. Thus, it is not surprising that participants in the current study found opportunities to share their specialized

knowledge of mental health with others at the site which assisted them with increasing understanding of their role and purpose within the correctional system.

Helping and supporting others also emerged as a central focus of participants' roles within corrections, which is not surprising considering that counseling is a helping profession. Participants were oriented toward identifying ways in which they could help improve both inmates' and correctional staffs' moods as well as support them in achieving growth and wellness. Often times this help and support was presented as checking in with others on how they were feeling in that particular moment. Participants' role orientation toward helping and supporting may be partly explained by Degges-White and Stoltz's (2015) study investigating archetypal self-identity, meaning in life and life satisfaction for individuals pursuing clinical mental health counseling, school counseling, and counselor education. Clinical mental health counselors in this study identified strongly with the caregiver archetype compared to other archetypes suggesting that these counselors perceived themselves as having altruistic and compassionate traits (Degges-White and Stoltz, 2015). Although not directly expressed by participants in the current study, their focus on how they could assist others in improving their moods and situations within corrections combined with the sense of satisfaction and fulfillment they gained from being in a helping role implies that they perceived themselves as having these characteristics and chose to focus their correctional counseling role on helping and support so that it aligned with how they perceived themselves as counselors.

Not only did participants conceptualize their role around helping and supporting, but a majority of participants also focused on incorporating advocacy as part of their correctional counselor role. For the two participants that held supervisory/administrative positions, focusing on how they could build the mental health program within the correctional system as well as

identifying community supports was a form of advocating for inmates' mental health needs. Previous literature has noted advocacy as a part of mental health counselors' roles within IBH settings. For instance, participants in Cox and colleagues' (2014) study recognized health disparities for patients being treated for both mental and physical health concerns creating the need for advocacy efforts to meet the needs of an underserved population. Participants in the current study also noticed gaps in mental health service provision for inmates including a lack of individual/group counseling which was attributed to inadequate mental health staffing. Participants expressed the desire to expand mental health services in their correctional setting to include more consistent individual therapy for inmates beyond brief solution-focused interventions and assessments. In addition to recognizing service gaps, one other participant focused their correctional counseling role on reducing stigma by challenging staff and inmate attitudes toward mental health. This participant's focus on reducing stigma showed advocacy for the mental health field in general which resulted in increased trust in the mental health unit. This participant had a different perspective on ways to advocate for mental health most likely due to her position which was not an administrative one. Despite this participant's position within the institutional hierarchy, advocacy has been identified as an important duty for all mental health counselors and correctional counselors are in a unique position to promote the mental health needs of inmates to ensure better treatment outcomes (Davis & Cates, 2017).

Overall, when reflecting on their correctional counselor roles, participants expressed feelings of satisfaction for the work they were doing and the services they provided. More specifically, participants enjoyed the fast pace of their work environment, the variety of tasks within their role, and being able to provide counseling to an underserved population. This is not surprising considering that previous studies exploring perceptions of interprofessional

teamworking have documented that mental health professionals (e.g., counselors, psychologists, social workers) generally experience satisfaction when working in IBH settings (Berkel et al., 2020; Glueck et al., 2015; Johnson & Mahan, 2019). However, in these studies mental health counselors' role satisfaction seemed to stem from perceptions of their role as beneficial and feeling appreciated for their contributions to treatment teams, whereas participants in the current study seemed to derive the most satisfaction from the novelty of working within a correctional environment compared to other counseling settings.

Professional Identity

When it came to discussing their professional identities as mental health counselors in general, participants tended to have a wide conceptualization of their counseling identities. They described themselves as mental health counselors based on their areas of interest or specialty, professional credentials, therapeutic modalities, and personal qualities. Although participants referenced their areas of interest in counseling, credentials, and therapeutic modalities, they tended to reference aspects of their personal selves such as helping, being intentional, and authenticity, more often throughout their individual interviews and audio/video logs. Participants also emphasized having to be real or authentic suggesting that they had integrated aspects of their personal identities into their professional identity. This process of integrating personal and professional selves is part of counselors' professional identity development as described by Moss and colleagues (2014). Over time and with more experience, counselors begin to incorporate more of their personal selves into their counseling identities versus compartmentalizing their professional and personal identities. Correctional counselors in the current study had several years of counseling experience, including their practicum and internship experiences, and appeared to have reached a point in their professional development where they had begun

integrating more of their personal selves into their professional identity based on their emphasis of being authentic.

An additional theme that related to participants' professional identities was their approach toward inmates. When discussing their attitudes toward inmates as correctional counselors, three participants noted having to adopt an attitude of mistrust or skepticism due to malingering behaviors within the jail. In a similar study, Carrola and colleagues (2016) found that correctional counseling supervisors also took a similar approach when working with inmates. These correctional counselors noted how malingering and manipulation was a daily occurrence in corrections and that they were expected to detect incidents of deception to receive mental health services. This expectation to detect malingering created difficulty for correctional counselors since they were trained to be nonjudgmental toward clients (Carrola et al., 2016). This discrepancy between mental health counselor training and need to identify malingering behaviors explains the counternarrative that emerged for some participants in the current study. These participants emphasized their utilization of a nonjudgmental approach when working with inmates which aligned with how they conceptualized themselves as mental health counselors. Approaching clients from this perspective seemed to facilitate correctional counselors' ability to show empathy toward inmates.

Adjusting their approach to working with inmates was not the only adaptation participants had to make. Participants noted having to change their counseling styles (e.g., tone of voice and presentation) as well as build up certain counseling skills (e.g., clinical judgement and assessment) to meet the needs of the correctional setting and inmate population. In other words, correctional counselors had to adapt their typical ways of counseling, that were developed during their training programs and previous counseling experiences, to be able to operate

effectively in their roles within the correctional environment. Differences between IBH settings, including correctional environments, have been documented in previous research literature (Glueck, 2015; Kupers, 2015; Pomerantz et al., 2009). These types of integrated settings tend to have faster paced environments and more frequent appointments compared to more traditional counseling settings (e.g., private practice). Thus, creating the need for mental health counselors to adapt their existing skill sets to provide brief, solution focused treatment as well as the ability to shift between client conceptualizations. These work environment changes can have an impact on mental health counselors' professional development and job satisfaction as they transition from more traditional settings to IBH settings. In a study conducted by Moss and colleagues' (2014), early career counselors expressed frustrations with having to adapt their expectations of what counseling looked like to the realities of working within the field. This frustration contributed to job dissatisfaction during the middle of their careers. Conversely to this finding, participants in the current study seemed to have positive perceptions of the adaptation process and viewed the differences between traditional counseling settings and the correctional environment as an enjoyable challenge that could help them growth. Participants may have viewed their adaptation process more positively than counselors entering more traditional settings since their role within corrections was less aligned with how mental health counselor roles are described in counseling training programs. This incongruence between counselor training and participants' roles within corrections may have assisted them with being more open to professional growth opportunities compared to early career counselors entering settings that are more aligned with how training programs portray mental health counseling roles.

Participants in this study, directly commented on the incongruence between how mental health counseling roles are described in training programs and their experiences of their roles

within corrections. Three out of four participants made comparisons between their previous training and counseling experiences when conceptualizing their professional identities and development. More specifically, participants described elements of an idealized counseling role that did not align with their current experiences as correctional counselors. This idealized conceptualization of counseling was developed during participants' training programs and impacted how they viewed themselves as counselors in corrections. Participants found that they had to expand their conceptualizations of counseling to accommodate for how they were operating as mental health counselors in their role. The discrepancy between participants' idealized counselor identities and their correctional counselor identities is similar to what beginning counselors experience when transitioning from graduate school to the field. Beginning counselors must adjust their conceptualizations of counseling to incorporate the realities of counseling in the field, which can be a frustrating process for counselors to go through as limitations are placed on how they get to define their professional identity within their work environments (Moss et al., 2014). For correctional counselors, this process of expanding their professional identity to include their current unique counseling roles was facilitated by adjusting their expectations for their counseling role so that they were more congruent with the correctional setting.

In addition to expanding their professional identities to include their unique roles as correctional counselors, participants noted other ways in which their role within corrections contributed to professional growth and development. Participants particularly recognized growth in their clinical skills as a result of working with a diverse population under the difficult conditions of providing mental health services in corrections. This recognition of skill development contributed to increases in their self-confidence resulting in a strong professional

identity that helped them feel more prepared to operate as mental health counselors in other counseling settings. This finding is consistent with previous IBH literature that has documented students participating in interprofessional education (IPE) experience increases in confidence and comfort with their clinical skills (Kent & Keating, 2015). These increases in confidence may be attributed to participants' gains in experience in the correctional setting which overtime lessened their self-doubts about their abilities (Moss et al., 2014). Additionally, working with a wide range of mental health issues within the correctional setting as well as successfully adapting to the structure of their work environment seemed to contribute to participants' experiences of professional identity development and growth.

Study Limitations

Although steps were taken to increase the trustworthiness and rigor of this study, it is important to review the inherent limitations when forming conclusions and applying the findings to other contexts outside of this study. The goal of IPA is to describe particular participants' experiences and interpret the meanings of their experiences within the context of their world, thus caution should be taken when attempting to compare and generalize this study's findings to other populations. Below, I address several study limitations as well as their potential impacts on the data analysis and key findings.

Researcher Bias

Unlike other phenomenological methods, the researcher's role in IPA is interpretative as the end goal of the analysis is to provide an account of the researcher's impressions of the meaning participants ascribe to their experiences (Smith et al., 2009). In other words, the researcher's interpretations and reflections are part of the analytic process. Although reflexive and bracketing practices were employed at key points throughout the study (i.e., post interviews,

before analyzing a new case), there were aspects of my personal and professional experiences that may have influenced my interpretations of participant experiences. For instance, my previous experience working as a mental health counselor in an IBH setting could have influenced my understanding of participant descriptions of their work environment and co-worker relationships. Additionally, I am a Resident in Counseling and am currently developing my own professional identity as a mental health counselor. These experiences as well as others that I was unaware of could have introduced bias that influenced my interpretations. I attempted to manage and reduce researcher bias by keeping a reflexive journal to process and record my personal thoughts, feelings, and preliminary interpretations when conducting the multiple rounds of data analysis. This journaling practice assisted me with recognizing personal biases as well as bracketing out my interpretations from previous case analyses. I also employed member checking of the superordinate themes with participants to ensure my interpretations of their perceptions resonated with their experiences. Finally, I engaged in peer debriefing with a research team member to check my interpretations throughout the analytic process.

Sampling

Due to the idiographic nature of IPA, the sample size for this study was intentionally small to allow for an in-depth analysis of individual participant cases. Additionally, a homogeneous sample of participants was sought to focus on a particular experience for a particular group of people in a particular context (Smith et al., 2009). This study sought to obtain a homogeneous sample by recruiting participants from one IBH site as well as setting specific inclusionary criteria for study participation (i.e., 18 years of age, an active credential as a Licensed Professional Counselor or Resident in Counseling, provided mental/behavioral health services, obtained a master's degree in mental health counseling, and employed for at least one

year at an IBH setting). Despite these attempts to obtain a homogeneous sample there were variations within the sample. Two participants held administrative roles at the site which influenced their responses to certain interview questions regarding their roles and responsibilities. Also, participants reported a variety of previous professional experiences that influenced their professional identity development. It was important to consider these individual variations when interpreting findings for the group as a whole. Future studies may choose to add additional inclusionary criteria to screen for differences in employment roles and previous professional/educational experiences.

Data Collection

The methods of data collection (i.e., individual interviews and audio/video logs) were reliant on participant self-report. These methods of data collection depended on participants' reflexivity and openness in disclosing information about their personal experiences. During the individual interviews, I relied on my interviewing skills obtained throughout years of counseling practice and previous research experience to build rapport and prompt participants to provide more in-depth descriptions of their experiences. However, it was the participant's decision to disclose as much or as little about their experiences as they felt comfortable. For the audio/video logs, participants were provided an open-ended prompt to focus their responses. However, participants could have interpreted the prompt differently and/or chosen to respond to certain aspects of the prompt and not others. As such, the audio/video log did not provide as much additional data as intended but served as a source to triangulate interview data.

Another potential limitation in data collection could have been participants' desire to impress the researcher or unwillingness to fully share unfavorable aspects of their experiences during their individual interviews and audio/video logs (Hays & Singh, 2012). For example,

when discussing their work environment, interactions with other departments, and aspects of their roles, participants noted negative elements (e.g., stress, overwhelmed) and chose not to expand further on these feelings but instead switched to focusing on positive elements (e.g., role enjoyment, satisfaction). This tendency to focus on the positive experiences of working in corrections may have limited the full range of participants' experiences being included in data analysis.

Implications

The current study sought to build upon current IBH literature to shed light on how correctional counselors experience their professional identities and how their roles within corrections impact their professional development. The findings from this study offer several practical implications as well as suggestions for further research in the areas of correctional counseling and counselor identity development. The following sections will discuss insights and strategies for counseling students, counseling educators, clinical supervisors, mental health counselors, and licensed professional counselors (LPCs) that can support professional identity development for those interested in IBH settings, particularly within corrections. Then, suggestions for future research studies will be provided.

Practical Implications

Correctional counselors in this study often made comparisons between their counselor training programs, private practice, and current employment setting. These comparisons highlighted gaps in counselor education programs that contributed to the development of certain expectations for counseling in the field and an idealized professional identity. Additionally, these expectations for what counseling "should" look like led to correctional counselors feeling underprepared to work in their IBH setting. Counselor trainees who are interested in

nontraditional counseling settings, such as corrections or other IBH settings, can better prepare themselves for post-graduate transition into the field by seeking out opportunities during their practicum and internship to gain experience working in nontraditional counseling settings. These experiences may be able to assist counselor trainees with developing a wider view of their professional identity earlier on in their counseling careers which could reduce feelings of frustration from the discrepancy between idealized expectations of counseling and the realities of fieldwork as well as aid in the adaptation process needed to operate in nontraditional settings.

Additionally, counselor educators can better support counseling students in their professional identity development by increasing the opportunities for student exposure to IBH and correctional counseling. These opportunities may be in the form of providing additional information about alternative counseling settings as a part of foundational coursework, adding additional courses that focus on preparing students for IBH settings, or encouraging students to pursue IBH and correctional sites for their practicum and internship experiences. Several benefits may result through increasing student exposure to IBH and correctional settings including increases in students' level of confidence in their counseling abilities, broadening students' expectations for counseling in the field, increased feelings of preparation for a variety of fieldwork experiences, and the development of a stronger counselor identity, all of which were benefits experienced by correctional counselors in the present study.

Clinical supervisors can also support the professional development of correctional counselors by attending to their transition and adaptation processes. Correctional counselors in the current study highlighted several challenges of working in corrections such as having to adapt their counseling styles to the population and correctional environment, learning to adopt a skeptical attitude toward inmates seeking help, and managing communication between

department through setting boundaries. Several ways that clinical supervisors in corrections can provide support are validating supervisees' experiences and frustrations with adapting to the correctional environment, assisting supervisees in boundary enforcement, creating opportunities for consultation, and prioritizing supervisees' self-care and emotional well-being. Participants in this study valued the support they receive from their supervisors, and each other within the unit, suggesting that additional support from other mental health counselors is beneficial to their professional development and role fulfillment.

Finally, the findings from this study provide useful practical implications for mental health counselors and LPCs working in IBH and correctional settings. Correctional counselors in the current study experienced several challenges while operating in their roles. These challenges included a misunderstood or unclear role, unexpected increases in their daily workload, constant communication and requests from other departments for their attention, and unpredictable disruptions to their workflow which contributed to increased work stress. As a result of this increased work stress correctional counselors had to implement internal coping strategies, attend to their self-care, and enforce boundaries in the work environment. This finding is important for mental health counselors and LPCs to keep in mind so that they can preemptively prepare themselves for the stressors of these environments and develop additional coping strategies and self-care routines to counteract the increases in work stress. Another key finding that assisted participants in carrying out their roles and duties was intentionally building close working relationships with others. Participants noted that having these close working relationships facilitated collaboration across departments. Mental health counselors and LPCs interested in working in IBH and correctional settings can ease some of the challenges of working on an interprofessional team by actively building close working relationships through increasing

familiarity among staff, focusing on opportunities to collaborate on client care, and identifying ways to show support to other staff members. Although, participants experienced challenges within the correctional setting they found their correctional counseling role rewarding and beneficial to their professional growth. Mental health counselors and LPCs may experience professional growth in IBH settings through adapting to the challenges of these work environments and gaining a wide range of experience working with the diverse populations of these settings.

Future Research

Due to the lack of literature regarding mental health counselors' experiences of professional identity in IBH and correctional settings, there are numerous directions that future research could explore. The current study sought to expand the knowledge basis and shed light on how correctional counselors perceived their professional identity when operating in an IBH role as well as how their correctional counselor role impacted their professional identity development. The key findings from this study reflect the perceptions and experiences of correctional counselors recruited from one county jail. Thus, future qualitative studies could build upon this research by exploring how mental health counselors operating in other correctional settings, such as prisons and specialty courts, perceive their professional identity and what aspects of their roles within these settings impact their identity development, since mental health counselors in these correctional settings are likely to function differently in their correctional counseling roles due to different job responsibilities and different nuances across client populations. Exploring correctional counselors' experiences of their professional identities in these different settings could illuminate subtle differences, as well as similarities, in how correctional counselors integrate and adapt their professional identities to align with their roles.

In addition to exploring the differences and similarities of correctional counselors across correctional settings, the findings from this study highlighted differences between mental health counselors in corrections and other IBH settings (e.g., primary care), particularly in experiences of their professional identity development. Future research could use the results of this study to develop a survey instrument to further compare mental health counselors' perceptions of their professional identity across various IBH settings as well as aspects of these roles that contributed to professional development.

As noted in the limitations section, this study's screening criteria included mental health counselors who operated in different hierarchal positions within the jail (e.g., administrator/supervisor and first-level mental health professionals). These different positions influenced how participants described the focus of their roles and responsibilities. For example, correctional counselors operating in administrative or supervisory positions included a focus on staff member well-being, ways they supported those they were responsible for, advocating for expansion of the mental health program, and staff safety. In other words, these participants tended to view their correctional counselor role as focusing on staff support, safety for all within the correctional environment, and systemic areas in need of advocacy while participants who held positions as first-level mental health professionals tended to describe their correctional counselor role as it related to their work with inmates. Future qualitative studies could explore these differences in correctional counselors' experiences of their roles and impacts on professional identity by separately analyzing participant data based on organizational position and comparing themes for each group. Additionally, future studies could include inclusionary criteria that would screen participants based on their type of position within corrections.

Lastly, correctional counselors in this study experienced a transitional process that involved adapting their counseling styles, building particular clinical skills, and changing their idealized counselor identity to align with their work environment, meet inmate mental health needs, and identity as a correctional counselor. This finding is supported by current IBH and professional identity literature that describes counselors' transitions into the field as well as into nontraditional settings. Future research can expand on the current study by further investigating this adaption and transition process as it applies to correctional counselors. This research avenue could potentially assist counselor trainees, clinical supervisors, and mental health counselors pursuing employment in corrections.

Conclusion

The findings from this study provide insight into the experiences of correctional counselors and how their roles impact their identity development. Correctional counselors' experiences of their unique work environment, collaborative work relationships, and multiple foci of their mental health role contributed to professional growth as they had to adapt to the needs of the setting and population and integrate their experiences as mental health counselors in corrections into their pre-existing counselor identity. This resulted in an expanded conceptualization of their professional identities and increased their confidence in their clinical skills. Counseling students, counselor educators, clinical supervisors, mental health counselors, and LPCs interested in pursuing and supporting correctional counseling can benefit from the key findings of this study. Although the current study provided additional knowledge and insight into the experiences of correction counselors and their identity development, additional studies are needed to further explore the differences in experience across organizational positions and other

correctional settings as well as how correctional counselors adapt their conceptualizations of counseling to operate effectively in corrections.

References

American Counseling Association. (2009). *20/20 statement of principles advances the profession.* https://www.counseling.org/news/updates/by-year/2009/2009/01/20/20-20-statement-of-principles-advances-the-profession

American Counseling Association. (2021a). *Divisions, regions and branches.* https://www.counseling.org/about-us/divisions-regions-and-branches

American Counseling Association. (2021b). *State licensing of professional counselors*. https://www.counseling.org/knowledge-center/licensure-requirements/overview-of-state-licensing-of-professional-counselors

Agency for Healthcare Research and Quality. (n.d.). *What is integrated behavioral health care (IBHC)?* The Academy: Integrating Behavioral Health & Primary Care. https://integrationacademy.ahrq.gov/products/behavioral-health-measures-atlas/what-is-ibhc

Berkel, L. A., Nilsson, J. E., Joiner, A. V., Stratmann, S., Caldwell, K. K., & Chong, W. (2020). Experiences of early career counseling psychologists working in integrated health care. *The Counseling Psychologist, 47*(7), 1037-1060. https://doi.org/10.1177/0011000019895495

Blue, A., Mitcham, M., Koutalos, Y., Howell, D., & Leaphart, A. (2015). Attaining interprofessional competencies through a student interprofessional fellowship program. *Journal of Interprofessional Care, 29*(3), 253–255. https://doi.org/10.3109/13561820.2014.954283

Brewer, M., & Flavell, H. (2018). Facilitating collaborative capabilities for future work: What

can be learnt from interprofessional fieldwork in health. *International Journal of Work-Integrated Learning*, *19*(2), 169-180.

Burkholder, D. (2012). A model of professional identity expression for mental health counselors. *Journal of Mental Health Counseling, 34*(4), 295–307. https://doi.org/10.17744/mehc.34.4.u204038832qrq131

Burns, S. T., & Cruikshanks, D. R. (2018). Independently licensed counselors' connection to CACREP and state professional identity requirements. *Professional Counselor, 8*(1), 29–45. https://doi.org /10.15241/stb.8.1.29

Carrola, P. A., DeMatthews, D. E., Shin, S. M., & Corbin-Burdick, M. F. (2016). Correctional counseling supervision: How supervisors manage the duality of security and mental health needs. *Clinical Supervisor, 35*(2), 249–267. https://doi.org/10.1080/07325223.2016.1214856

Center for Integrated Health Solutions. (2021). *Standard framework for levels of integrated care*. https://www.thenationalcouncil.org/integrated-health-coe/resources/

Council for Accreditation of Counseling and Related Educational Programs. (2021). *2016 CACREP Standards*. https://www.cacrep.org/for-programs/2016-cacrep-standards/

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Thousand Oaks, CA: SAGE.

Colangelo, J. J. (2009). The American mental health counselors association: Reflection on 30 historic years. Journal of Counseling & Development, 87(2), 234–240. https://doi.org /10.1002/j.1556-6678.2009.tb00572.x

Cox, J., Adams, E., & Loughran, M. J. (2014). Behavioral health training is good medicine

for counseling trainees: Two curricular experiences in interprofessional collaboration. *Journal of Mental Health Counseling, 36*(2), 115–129. https://doi.org/10.17744/mehc.36.2.c426q74431666762

Daniels, A. S., Adams, N., Carroll, C., & Beinecke, R. H. (2009). A conceptual model for behavioral health and primary care integration. *International Journal of Mental Health, 38*(1), 100–112. https://doi.org/10.2753/IMH0020-7411380109

Davis, T. O., & Cates, K. A. (2017). Mental Health Counseling and Specialty Courts. *Professional Counselor, 7*(3), 251–258. https://doi-org.proxy.lib.odu.edu/10.15241/tod.7.3.251

Degges-White, S., & Stoltz, K. (2015). Archetypal identity development, meaning in life, and life satisfaction: Differences among clinical mental health counselors, school counselors, and counselor educators. *Adultspan Journal, 14*(1), 49-61.https://doi.org/ 10.1002/j.2161-0029.2015.00036.x

DiCataldo, F., DeJesus, B., & Whitworth, D. (2021). Training needs of counseling trainees in corrections: A survey of clinical directors. *Journal of Counselor Preparation & Supervision, 14*(1), 1–23.

Gibson, D. M., Dollarhide, C. T., & Moss, J. M. (2010). Professional identity development: A grounded theory of transformational tasks of new counselors. *Counselor Education & Supervision, 50*(1), 21–38. https://doi.org /10.1002/j.1556-6978.2010.tb00106.x

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

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings.*

New York, NY: Guilford.

Johnson, K. F., & Freeman, K. L. (2014). Integrating interprofessional education and collaboration competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling, 36*(4), 328–344. https://doi.org/10.17744/mehc.36.4.g47567602327j510

Johnson, K. F., Haney, T., & Rutledge, C. (2015) Creating space for connection: Creativity in the classroom. Journal of Creativity in Mental Health, 10, 488-506. https://doi.org/10.1080/15401383.2015.1044683

Johnson, K. F., & Mahan, L. (2019). A qualitative investigation into behavioral health providers attitudes toward interprofessional clinical collaboration. *Journal of Behavioral Health Services & Research, 46*(4), 636–647. https://doi.org/10.1007/s11414-019-09661-9

Johnson, K. F., Sparkman-Key, N., & Kalkbrenner, M. T. (2017). Human service students' and professionals' knowledge and experiences of interprofessionalism: Implications for education. *Journal of Human Services, 37*(1), 5–13.

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 principles for unifying and strengthening the profession. *Journal of Counseling & Development, 89*(3), 367–372. https://doi.org /10.1002/j.1556-6678.2011.tb00101.x

Kaplan, D. M., & Kraus, K. L. (2018). Building blocks to portability: Culmination of the 20/20 initiative. *Journal of Counseling & Development, 96*(2), 223–228. https://doi.org/10.1002/jcad.12195

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2014). 20/20: A vision for the future of

counseling: The new consensus definition of counseling. *Journal of Counseling & Development, 92*(3), 366–372. https://doi.org /10.1002/j.1556-6676.2014.00164.x

Kent, F. & Keating, J. L. (2015). Interprofessional education in primary health care for entry level students — A systematic literature review. *Nurse Education Today, 35*(12), 1221-1231. https://doi.org/ 10.1016/j.nedt.2015.05.005

Kupers, T. (2015). A community mental health model in corrections. *Stanford Law & Policy Review, 26*(1), 119-158.

Letourneau, J. (2016). Celebrating 40 years of AMHCA by asking: What does the future hold for the profession? *The Advocate Magazine.* 3.

Lopez, K. A., & Willis, D. G. (2004). Descriptive versus interpretive phenomenology: Their contributions to nursing knowledge. *Qualitative health research, 14*(5), 726-735. https://doi.org/ 10.1177/1049732304263638

Matz, A. K., & Lowe, N. (2020). An exploration of correctional counselor workloads in a Midwestern state. *The Prison Journal, 100*(6), 769-786. https://doi.org/10.1177/0032885520968247

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*(2), 140–147.

Messina, J. (2016). Celebrating 40 years of AMHCA by asking: How did it come to be? *The Advocate Magazine.* 2.

Myers, J. E., Sweeney, T. J., & White, V. E. (2002). Advocacy for counseling and counselors: A professional imperative. *Journal of Counseling & Development*, 80, 394–402. https://doi.org/10.1002/j.1556-6678.2002.tb00205.x

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development, 92*(1), 3–12. https://doi.org/10.1002/j.1556-6676.2014.00124.x

National Career Development Association. (2021). *How to choose a credential*. https://ncda.org/aws/NCDA/pt/sp/credentialing_choose

Neukrug, E. (2022). *The world of the counselor*. Cognella Academic Press.

O*NET OnLine. (2021). *Summary report for: 21-1014.00 - mental health counselors*. https://www.onetonline.org/link/summary/21-1014.00

Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings, 16*(1), 40–46. https://doi.org/10.1007/s10880-009-9147-x

Prosek, E. A., & Hurt, K. M. (2014). Measuring professional identity development among counselor trainees. *Counselor Education & Supervision, 53*(4), 284–293. https://doi.org/10.1002/j.1556-6978.2014.00063.x

Reese, R. F. (2019). Augmenting master of counseling student learning outcomes through interprofessional education experiences with master of fine arts students. *Journal of Creativity in Mental Health, 14*(3), 357–371. https://doi.org/10.1080/15401383.2019.1623736

Roberts, L. D., & Forman, D. (2015). Interprofessional education for first year psychology students: Career plans, perceived relevance and attitudes. *Journal of Interprofessional Care, 29*(3), 188-194. https://doi.org/10.3109/13561820.2014.967754

Roberts, K., Robinson, K., Stewart, C., & Smith, F. (2009). An integrated mental health

clinical rotation. *Journal of Nursing Education, 48*(8), 454-459.

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis, 22*(1).

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

U.S. Bureau of Labor Statistics. (2021). *Substance abuse, behavioral disorder, and mental health counselors*. https://www.bls.gov/ooh/community-and-social-service/substance-abuse-behavioral-disorder-and-mental-health-counselors.htm#tab-3

Vereen, L. G., Yates, C., Hudick, H., Hill, N. R., Jemmett, M., O'Donnell, J., & Knudson, S. (2018). The phenomena of collaborative practice: The impact of interprofessional education. *International Journal for the Advancement of Counselling, 40,* 427-442. https://doi.org/10.1007/s10447-018-9335-1

Wener, P., & Woodgate, R. L. (2016). Collaborating in the context of co-location: A grounded theory study. *BMC Family Practice, 17*, 1–15. https://doi-org.edu/10.1186/s12875-016-0427-x

Winters, S., Magalhaes, L., & Kinsella, E. A. (2015). Interprofessional collaboration in mental health crisis response systems: A scoping review. *Disability & Rehabilitation, 37*(23), 2212–2224. https://doi.org/10.3109/09638288.2014.1002576

Woo, H., Storlie, C. A., & Baltrinic, E. R. (2016). Perceptions of professional identity development from counselor educators in leadership positions. *Counselor Education & Supervision, 55*(4), 278–293. https://doi.org /10.1002/ceas.12054

CHAPTER 6

MANUSCRIPT

Mental Health Counselors' Perceptions of Professional Identity as Corrections Counselors in an Integrated Behavioral Health Care Setting

Jeanel Franklin

Department of Counseling and Human Services

Old Dominion University

Edward Neukrug

Department of Counseling and Human Services

Old Dominion University

Angela L. Eckhoff

Department of Teaching and Learning

Old Dominion University

Mark Rehfuss

Department of Counseling and Human Services

Old Dominion University

ABSTRACT

Previous research has explored the attitudes, perceptions, and experiences of mental health counselors working in integrated behavioral healthcare (IBH) as well as their experiences engaging in interprofessional collaboration. However, researchers have yet to explore how clinical mental health counselors in other IBH settings, such as corrections, perceive their professional identity and what aspects of their professional roles impact their identity development. This study utilized an interpretive phenomenological approach (IPA) to describe, understand, and interpret the meaning of four correctional counselors' perceptions of their professional identities while operating in a Southeastern County jail. Key findings indicated that correctional counselors' unique work environment (e.g., fast paced, diverse, unpredictable), collaborative work relationships, and multiple foci (e.g., safety, triaging, clinical judgement, educating, helping, and advocating) of their mental health role contributed to professional growth and identity development. Additionally, participants experienced a transitional process where they adapted their counseling styles to the needs of the setting and population as well as integrated their experiences as correctional counselors into their pre-existing professional identities. Practical implications for counseling trainees, counselor educators, clinical supervisors, mental health counselors and LPCs as well as directions for future research are discussed.

Keywords: mental health counselor, correctional counselor, professional identity, integrated behavioral health, interpretative phenomenological approach

Mental Health Counselors' Perceptions of Professional Identity as Corrections Counselors in an Integrated Behavioral Health Care Setting

Introduction

Professional identity is an important aspect of professional development that unites individuals within a discipline under a common set of values, beliefs, assumptions, and philosophical orientations (Burns & Cruikshanks, 2018). For the profession of counseling, this identity consists of a philosophical orientation toward human development, prevention, and wellness (Burkholder, 2012; Mellin et al., 2011). These unique values are what set counseling apart from other helping professions such as psychology, social work, and nursing.

Throughout history the counseling profession has grown and diversified, as counselors gained employment in a wide range of settings (Neukrug, 2022). As a result of working in different settings and servicing specific populations, counselors began to differentiate themselves from one another. This differentiation led to the creation of counseling specialty areas (e.g., school, clinical mental health, rehabilitation, career, etc.) each with their own emphasis on certain skills, knowledge, and professional orientations to helping (CACREP, 2021). This specialized training, as well as experiences in the field, socializes counselors differently resulting in distinct professional identities across specialty areas.

This multitude of individual counseling identities has impacted cohesion within the profession contributing to professional issues such as problems with licensure portability (Kaplan & Gladding, 2011), disaffiliation of professional organizations (Colangelo, 2009; R. Wong, personal communication, March 27, 2018), and an unclear identity for the profession of counseling (Myers et al., 2002). Attempts to clarify and define the profession of counseling have been made by the American Counseling Association (ACA) in collaboration with other

counseling-related professional organizations (Kaplan & Gladding, 2011). One of the most historical attempts was *ACA's 20/20: A Vision for the Future of Counseling* which established a basic definition for counseling, suggested a standardized licensure title, and helped define the scope of practice statement. ACA hoped that these efforts would help clarify the profession and strengthen cohesion among counseling specialty areas (Kaplan & Gladding, 2011). However, despite these efforts to increase unity and tie counselors to a shared professional identity, subspecialty areas (e.g., integrated behavioral healthcare, corrections) within specialty areas (e.g., mental health counseling) within counseling continue to develop unique professional identities. Based on the history and development of the counseling profession, it is clear that counselors within specialty areas, including mental health counselors, experience a unique professional identity within the larger identity of the profession (Burns & Cruikshanks, 2018).

The mental health counseling field has developed as a distinct counseling specialty area and over time distinguished itself from other areas of counseling such as career counseling (Colangelo, 2009), addictions counseling, and rehabilitation counseling (Neukrug, 2022). Mental health counselors receive specialized training that cover a wide range of skills and knowledge so that they can assist individuals with their emotional and mental health needs. This broad skill set has allowed mental health counselors to gain employment in a variety of community settings such as inpatient facilities, hospitals, correctional facilities, social service agencies, and private practices (Neukrug, 2022).

Mental health counselors differ in the roles, services provided, and populations served across settings. These differences impact the professional identity development of mental health counselors resulting in distinct identities that are unique to employment settings as counselors tend to define their professional identities based on their roles, the populations they serve, and

the settings in which they provide services (Mellin et al., 2011). Research has shown that mental health counselors working in integrated behavioral health care (IBH) settings operate in a multitude of roles (Berkel et al., 2019; Glueck, 2015) contributing to distinct experiences within IBH, which set them apart from mental health counselors employed in other settings such as community mental health agencies and private practice.

The health care system has recognized a need to shift its approach to individual treatment from one in which health care disciplines are siloed and operate separately from one another, to one that integrates health care professions to better address the physical and mental health needs of the public (Daniels et al., 2009). This emphasis on integration has led to an increase in employment for mental health counselors in primary care and other health care settings (Glueck, 2015; Johnson & Freeman, 2014; Neukrug, 2022).

The blending of mental and physical health disciplines has created a unique work environment for mental health counselors as they adapt their training, roles, and skills to function alongside medical providers. Mental health counselors in IBH settings have noted differences in logistics, roles, services provided, theories of treatment, and attitudes toward collaboration between mental health and medical disciplines (Berkel et al., 2020; Glueck, 2015; Pomerantz et al., 2009) which can create barriers to provider collaboration. Additionally, mental health counselors in IBH have noted that they tend to operate primarily from consulting and educating roles when working in IBH as well as provide brief, short-term services based on the physicians' determination of need (Glueck, 2015).

In addition to the increased employment of mental health counselors in healthcare systems, correctional and social justice systems have noted a need for increased mental health care for inmates (Davis & Cates, 2017; DiCataldo et al., 2021; Kupers, 2015). As such, clinical

mental health counselors play an essential role in corrections to meet the mental health needs of inmates as well as facilitate rehabilitation. Mental health counselors working in corrections (i.e., correctional counselors) encounter a wide range of mental health issues including substance abuse, suicidal ideation, schizophrenia, bipolar disorder, and major depressive disorder (Kupers, 2015). In order to address these mental health concerns, correctional counselors' primary function involves various clinical duties. Clinical duties can include providing individual and group therapy, conducting intake assessments, forming treatment plans, and writing discharge summaries (DiCataldo et al., 2021). Additionally correctional counselors can be responsible for tasks unique to the correctional environment such as responding to miscellaneous inmate requests, assessing inmates for housing (i.e., classification), release planning, inmate checks, security checks, and sex offender work (Matz & Lowe, 2020). In addition to clinical duties, correctional counselors are responsible for administrative duties and documentation. These activities do not directly involve inmate interactions and can include completing time sheets, personnel forms, attending to office needs, resolving technical issues, and participating in staff meetings (Matz & Lowe, 2020).

Previous research has focused on the unique professional identity of counselors (Prosek & Hurt, 2014; Woo et al., 2016) and the attitudes, perceptions, and experiences of working in IBH settings for mental health professionals in general (Glueck, 2015; Johnson & Mahan, 2019). Additionally, previous studies have documented the unique roles and responsibilities of mental health counselors working in corrections (DiCataldo et al., 2021; Matz & Lowe, 2020). However, these studies only explored how correctional counselors spent their time engaged in various duties. Few studies have explored how correctional counselors perceive their professional identity when operating in their professional role (Carrola et al., 2016) and none

have examined how their professional role in corrections influences their counseling identity development. Understanding how mental health counselors in IBH roles within correctional environments perceive their professional identities can provide direction for counselor educators, clinical supervisors, and other mental health counselors on how to support the professional identity development of mental health counselors in these settings.

Purpose of Study

The purpose of this study was to explore and interpret the experiences of mental health counselors employed as correctional counselors in an IBH setting regarding their perceptions of their professional identity as well as how their experiences of their roles in this setting influenced their professional identity development. The primary aim of this study was to fill a gap in the literature as well as inform future research directions and offer practical implications for counselor trainees, counselor educators, clinical supervisors, and mental health counselors. The researcher developed the following research questions to guide and address the aims of the study:

1. How do mental health counselors, working as correctional counselors within an integrated behavioral health care system, perceive their professional identity?
2. How do mental health counselors' experiences of their professional roles as correctional counselors in IBH influence their counselor identity development?

Methods

This study utilized an interpretative phenomenological approach (IPA), as outlined by Smith and colleagues (2009), to describe, understand, and interpret the meaning of mental health counselors' perceptions of their professional counseling identities in a specific IBH setting (i.e., corrections). A traditional phenomenological approach might not capture the depth that was

intended for this study since the focus was on a particular experience for a specific group of mental health counselors, thus this approach was best suited for the current study.

Site Selection & Participant Recruitment

The researcher selected one IBH site within the correctional system for participant recruitment to increase the homogeneity of the study sample. Participants were recruited from a mental health unit housed under inmate health services for a county jail located in Southeastern Virginia. The mental health unit within inmate health services was purposefully selected by the researcher based on the level of integration and types of interprofessional collaborative practices that occurred within the setting. The researcher pre-screened the site to ensure that it met the criteria for IBH including co-location of providers, representation of multiple health professions, and utilization of interprofessional collaborative practices.

The researcher purposefully selected a convenience sample of five participants from the site to participate in the study. Participants all had at least master's level degrees in mental health counseling, possessed either an active credential as an LPC or Resident in Counseling, currently provided mental/behavioral health services, and had been employed for at least one year at an IBH setting. Upon obtaining approval from the Institutional Review Board (IRB) at Old Dominion University, the researcher contacted participants to invite them to participate in the study. Once participants gave informed consent and agreed to participate in the study, the researcher began data collection.

Data Collection Procedures

The researcher collected data in two phases. During phase one, the researcher conducted individual interviews to gather in-depth information regarding participants' perceptions of their professional counseling identity in the context of IBH as well as how their professional roles in

IBH might impact their professional identity development. Interviews were conducted via Zoom at the participants' request, were semi-structured, and lasted approximately 60 minutes. The researcher developed an interview protocol that contained twelve preset questions. Five questions aimed to gather information on participants' professional backgrounds (e.g., professional credentials and titles, years of experience in the counseling field and IBH, and counseling specialty areas) to provide context for describing and interpreting their experiences during data analysis. The remaining questions were open ended questions and aimed to gather detailed, rich information on participants experiences with the phenomenon under study.

Phase two of data collection consisted of participant video/audio log entries. Participants were asked to complete one, video/audio log for the purposes of providing supplemental data on their experiences. Participants were provided a prompt which asked them to describe and reflect on their daily experiences, thoughts, and feelings related to their professional counselor identity and roles at the site. The researcher provided participants with an individualized Zoom meeting link to facilitate the recording and submission of their video/audio log. Both interview and video/audio log recordings were transcribed using temi.com and Zoom transcription software, respectively.

Data Analysis

The researcher utilized Smith and colleagues' (2009) six step process of IPA data analysis to guide the analytic process. Before beginning data analysis, the researcher identified a colleague to act as a debriefer throughout the analysis to minimize researcher bias as well as ensure multiple perspectives and interpretations were included in the analysis (Hays & Singh, 2012). The researcher began analysis by reading and re-reading interview and audio/video log transcripts for one participant. Initial observations of the data were recorded by the researcher in

a reflexive journal to aid in bracketing. Next, the researcher conducted a close analysis of the data that focused on the semantic content and language of participants. Descriptive, linguistic, and conceptual comments were recorded alongside the transcript using a table template suggested by Smith and colleagues (2009) for analytic organization. Once exploratory comments were recorded, the researcher and debriefer met to discuss the initial analyses of the data. Next, the researcher condensed exploratory comments into emergent themes. Emergent themes were recorded alongside the transcript and exploratory comments. Once emergent themes were developed, the researcher compiled and organized emergent themes into clusters of superordinate themes. The researcher kept analytic memos throughout this process to record how clusters related to one another and how superordinate themes were developed. Once emergent themes were organized into clusters, the researcher developed a table depicting the superordinate themes, emergent themes, and keywords associated with each emergent theme. The above process was repeated for each participants' data. Once all individual data was analyzed, the researcher examined the tables of individual participant superordinate themes and themes for patterns pertaining to the group. Individual themes were clustered together based on conceptual similarities and assigned a descriptive label which became the group themes. Group themes were then organized based on conceptual similarities thus becoming the superordinate themes. After this step, the researcher developed a thematic table to depict the connections among superordinate group themes and themes. Participant quotes were also recorded in the table for each theme.

Findings

Four superordinate group themes emerged from across case analyses: 1) Experience of Setting, 2) Work Relationships, 3) Mental Health Counselor Role, and 4) Professional identity.

Table 1 provides an overview of the superordinate themes, group themes, brief descriptions of the theme, and which participants (i.e., P1, P2, P3, P4) demonstrated support for the theme.

Table 1

Superordinate Themes and Themes for Group

Superordinate Themes	Group Themes	Theme Description	Participant Support
Experience of Setting	Describing Work Environment	Participants generally described their work environment as fast paced, unique, unpredictable, and diverse.	All Participants
	Constant Communication	Participants noted constant communication from other staff through phone calls or emails.	All Participants
	Unclear/Misunderstood MH Role	Participants generally experienced misunderstanding from other staff due to an unclear/undefined mental health role within the setting.	All Participants
	Demands on Mental Health Counselors	Participants perceived increases in their workload due to additional tasks and requests from other staff for assistance in resolving crisis situations.	All Participants
	Coping	Participants noted a need for self-care strategies and boundary enforcement to cope with their work stress and manage their daily workload.	All except P4
Work Relationships	Teamwork Approach	Participants generally described elements of teamworking such as providing information on treatment updates, shared decision making, and dividing up work responsibilities.	All Participants
	Building Close Relationships	Participants reported needing to build close working relationships with the other staff to perform their duties.	All Participants
	Supporting Each Other	Participants generally focused on ways in which they supported each other within the mental health unit and other correctional staff.	All Participants

Mental Health Counselor Role	Focus on Safety	Participants primarily noted safety and suicide prevention as a salient focus of their role.	All Participants
	Focus on Prioritizing/Triage	Participants described decision making processes to help them prioritize their attention to tasks and requests as well as assessing client cases based on urgency.	All Participants
	Focus on Clinical Judgement	Participants generally discussed elements of clinical judgement that emphasized thorough assessments and quick decision making.	All except P3
	Focus on Educating/Explaining	Educating other staff and clients was a focus of participants' reflections when discuss their roles and interactions with others within the setting.	All Participants
	Focus on Helping/Support	Participants generally noted ways in which they provided support to others and described a motivation to help create changes.	All Participants
	Focus on Advocating	Participants noted a desire to advocate for additional mental health services as well as identified gaps in service provision.	All except P2
	Feelings of Satisfaction	Participants described their feelings of enjoyment and satisfaction derived from their role as mental health counselors.	All Participants
Professional Identity	Defining Professional Identity	Participants provided descriptions of how they personal defined themselves as counselors including personal qualities, specialty areas, and credentials.	All Participants
	Approach Toward Clients	Participants discussed their approaches when interacting with clients.	All Participants

Adapting to Environment	Participants generally described adjustments they had to make to their counseling styles to meet the needs of their setting population.	All Participants
Making Comparisons	Participants conceptualized their professional identities and development through comparisons to previous training and experience.	All except P3
Professional Growth	Participants generally noted aspects of professional growth and development as a function of working at their site.	All Participants

Experience of Setting

The first superordinate theme, *Experience of Setting*, described how participants experienced their day-to-day work setting. Participants experienced their work environment as fast paced, unique, and unpredictable due to the variability of daily structure from day to day. P2 reflected on how unexpected daily events made it difficult to schedule her day:

> But it's just like breaking it down to you, I feel like even within the hour we've been talking I probably missed something because each day is just so, can be so different. There's never, like I can go in with a plan and that plan usually gets turned upside down by the end of the day.

Participants experienced each workday as unique due to unexpected events which was also noted by P3 when she stated, “Things can happen at any given point. We have to TDO somebody you know things like that. So, it’s unpredictable, so anything can happen pretty much.” For P4 this unpredictability was described as, “There's never a dull moment. Um every single day is very, very busy, and you really don't know what you're going to get when you walk in every morning.”

Participants also experienced constant communication and were often asked to attend to unpredictable crisis situations in addition to other requests from staff members. Participants perceived influxes of communication often indicated by a ringing phone which they associated with others needing their help to resolve mental health related issues. P3 highlighted this association when she stated, “It could be a variety of things that can go on at any given moment with that phone constantly ringing, whether people are coming in and out, um letting us know things.” P2 also connected incoming phone calls with crisis alerts when she shared:

> If there's like things are just kind of going crazy, they'll call all the time. And this phone could be ringing, usually it's ringing off the hook. And we'll be like oh my gosh the phone won't stop ringing. It's going crazy.

This continuous flow of communication seemed partially due to security and other staffs' unclear understanding of the correctional counselors' role.

All Participants believed that their role and scope of practice, as well as mental health in general, was not fully understood by others in corrections and had primarily negative beliefs regarding how other staff perceived them. For instance, P1 stated, "They'll look right at us, at the counselors, including me and they're like well you're soft, you just don't know any better." P2 also described experiencing negative perceptions from others and feeling like the mental health counseling role was misunderstood:

> I'm like they probably think I'm an A-hole for not going out and talking to them. Which is not true. It's just like if I went down all the time they called, I would never be able to get my job done. Like I don't think they fully understand what we do, and like the role that we play.

The misunderstanding of participants' roles contributed to increased communication and additional demands for their attention. P2 specifically noted, "It's like people are always wanting your attention and trying to pull you in so many different places."

Due to the nature of their role, the population they served, and other staff's misunderstanding of their role, participants needed to incorporate boundaries as well as additional coping strategies to help them balance their personal stressors and emotional reactions. P3 listed some of the strategies she implemented to manage her feelings during busier times of the day:

> And I can feel, some days I can feel more anxious, you know what crazy days. And that is I have to kind of chill out or I'll get up and just take a walk and come back and sit down.

In addition to utilizing internal coping strategies, participants also emphasized the need for self-care and boundary setting to combat work demands. P2 highlighted this when she stated, "Because if I'm like off, really off balance that's just going to throw me off professionally, personally. So, I'm a lot more intentional with taking care of myself."

Work Relationships

The second superordinate theme, *Work Relationships,* described how participants perceived and approached their co-worker interactions. Overall, participants perceived themselves as being a part of a larger treatment team that included the other departments in corrections. Participants noted elements of collaboration that contributed to a sense of teamwork. P4 described an example of how collaboration was utilized across departments:

> We would go speak with security and we would talk about those concerns and then together a lot of times we're able to come up with a plan that makes us feel comfortable, the safety and security is not jeopardized. So, working alongside them well is really important.

For P2, cohesion among the different departments was noted as important for operating effectively as a team when she stated, "But when we're a cohesive unit it can work very well and smoothly." Participants also discussed other forms of teamworking such as attending daily meetings with the other departments to provide updates. Collaboration was an important aspect of working as a team for participants.

In order to have these collaborative relationships, participants noted that they had to intentionally put in effort to build close working relationships to facilitate teamworking. P4 discussed the effort spent in building effective working relationships during her individual interview:

> I've worked really hard at developing relationships because I feel like, my position was kind of [brief pause] there were a few different people that were in and out of my position before I came and so I'm not really sure that those relationships were developed. And so, over time, I feel like I've been able to establish good relationships in the security staff, especially the higher-level ranking security staff that has the power to make decisions that can affect change in terms of how we do things.

Other participants noted that frequent contact and shared decision making were additional aspects that helped build effective working relationships.

In addition to focusing on how to build co-worker relationships, participants sought out opportunities to support each other and staff members. Participants specifically supported each other by sharing the daily workload and consulting with one another. P4 noted the usefulness of discussing ideas with the other counselors when she stated, "Even though I'm the director, and you know I'm not an expert, I don't know everything. And it really does help to bounce even my own thoughts and concerns off of my residents." Supporting each other within the mental health unit was valued by participants as it helped them carry out their duties. For example, P2 discussed her appreciation for the support received from her fellow mental health counselors when she stated:

> I don't [brief pause] think I could do this job without having a so positive support network. Like, if my coworker is just like I can't do it today. You know, I will do my best to help pick up the slack.

Participants also discussed ways in which they supported others, such as security staff; however, this type of support seemed to be a secondary focus for participants.

Mental Health Counselor Role

The third superordinate theme, *Mental Health Counselor Role,* described the different focuses participants took when operating as mental health counselors in this setting. The primary focus of participants' roles as mental health counselors was on safety and suicide prevention. Participants noted that because they worked in a jail safety was not only their concern but also a concern of the facility. P3 highlighted how safety and suicide prevention were prioritized over other mental health concerns when she stated, "The first thing is suicide prevention. You know safety first in here because that's one of the things we have to worry about and think about. So that's the that's the first thing." Prioritizing safety for all individuals in the jail was a primary focus of all participants roles; however, the aspects of safety that participants focused on and discussed differed based on their individual roles within the department hierarchy.

Working in this setting also caused participants to focus on their clinical decision-making skills so that they could quickly make decisions and prioritize cases based on need. Conducting thorough assessments was noted by participants as an important part of making clinical decisions. P1 emphasized the need to take additional time to form an in-depth conceptualization when he stated, "When we start to do our assessments, and we start to look at what we're being presented with, we start to dig a little deeper. We take more time." Participants also described triaging as a decision-making tool that informed how they structured their daily schedule and

prioritized unanticipated crisis events. P4 described this process when she stated, “It's a high paced, stressful environment. So just kind of take it as it comes and decide. Again, it comes back to that triaging and what's the biggest crisis, what's the most important.”

Educating others also emerged as a central part of participants’ roles as correctional counselors. Participants experienced the need to educate and explain mental health concepts and their role to both inmates and staff members. When it came to explaining their role to others, participants focused on using education and understandable terms to help others outside of mental health understand their role and scope of practice. P2 noted how she had to simplify and explain clinical language:

> My clinical people get the clinical language and even nursing you have to break it down for them too. So, it's a lot of kind of breaking down what, who we work with, and what we do, and how people are acting.

Through providing explanations, participants were able to increase others’ understanding of mental health.

Overall, participants attended to various foci when operating as correctional counselors. They primarily focused on safety, clinical judgement, triaging, and educating others about mental health. In addition to these foci, participants also attended to helping others and advocating for mental health needs within corrections. These last two foci seemed to contribute the most to participants’ experiences of role satisfaction. For instance, P3 specifically felt enjoyment from having the opportunity to expose inmates to counseling when she noted:

> I love working in the jail. I love those who are not the traditional therapy goers. I love those who are fresh to it. They might not consider therapy because they feel have this stigma of what it feels like, what it looks like, what it is.

Professional Identity

The last superordinate theme, *Professional Identity,* contained themes that described participants' perceptions of their counselor identity and professional development. Participants tended to focus on areas of interest or specialty, professional credentials, therapeutic modalities, and personal qualities when describing their professional identities as counselors suggesting that they had a broad sense of their professional identity. For example, P1 focused on his area of interest to describe his identity when he responded, "I really like to focus on trauma, and I like to focus on early trauma and how that trauma impacts a person's overall personality and wellbeing as they're older." While P2 chose to focus on personal qualities such as "hard working and ethical and respectful." P3 also mentioned the importance of being authentic and genuine when she was asked to describe her feelings toward her professional identity development. She reflected, "I'm professional but I've learned that it's okay to be myself."

All participants discussed their attitudes or approach when interacting with inmates in the correctional setting. Three participants noted the need to approach inmates with an element of mistrust which was attributed to inmate malingering behaviors. For instance, P2 described this approach as, "You have to have like a bullshit meter and who's malingering, who's not, and being able to catch that." P1 also noted this need to be skeptical when interacting with inmates when he stated, "Is somebody legitimately fearful or are they just trying to get some type of enhanced service." Conversely to this approach, two participants emphasized a nonjudgmental approach. P3 specifically stated, "There's never any judgment with me. People can have whatever charges or whatever and I don't look at them any different." P2 also discussed her attempts to approach clients from a place of understanding instead of judgement when she noted:

> I just tried to be genuine and just, as my term I say [chuckles] to like sit in the shit with them, like just kind of be there and try to put myself in their shoes as best that I can.

Not only did participants have to adapt their approach when interacting with inmates, but they also had to adapt their counseling style and skills to fit the setting and population. For example, P2 described having to adjust her presentation and tone of voice when providing services to inmates, "I remember my first week here, my boss, I walked up to a cell and she was like, my tone was just like I was working with someone in private practice and not like an inmate." The differences between counseling settings (e.g., private practice, inpatient, corrections, etc.) that participants had previously experienced as well as the variety of mental health issues they encountered within the jail seemed to be a central focus when participants discussed ways in which they adapted to being mental health counselors in corrections.

Most participants reported making comparisons between how they imagined themselves providing counseling and how they were currently conducting counseling. Specifically, they compared traditional private practice to how they were counseling in the jail. P1 specifically highlighted differences between what he termed "traditional" counseling and ways in which counseling was conducted at the jail:

> It's not the traditional sitting down with a client for a 50-minute hour and 10 minutes of notes before you go to the next client. You may be talking to a client through a set of bars that just the day before assaulted multiple staff members.

P2 also noted differences between how she expected to operate as a mental health counselor and how she was currently conducting counseling:

> Gosh it's so different than what you're taught in school. You do wear so many hats and you get pulled in a lot of directions. It's like you're doing counseling but in a way you're kind of doing social workish type stuff too.

Participants noted how their envisioned counseling identities, which were developed during their training programs, were different than their current ways of conducting counseling which caused them to expand their conceptualizations of what counseling is.

Participants noted that they experienced professional growth and development from working in corrections which increased their confidence in their skills, contributed to learning, and helped them feel prepared to handle a wide range of counseling settings. For P1 his main growth point was feeling prepared to work in any future counseling setting, "I honestly believe I could go anywhere, any service, any agency, any private practice and handle any client that walked in the door." P3 noted her desire to continue learning when she stated, "It just helped me and to have a diverse population, a very diverse population, and it helped me to understand the importance of what I do. It makes me want to learn more and more and more." Participants' work with this particular population in corrections seemed to contribute to their professional growth.

Discussion

Although some studies have explored mental health counselors' professional identity in the context of IBH settings, even fewer studies have explored how correctional counselors' roles influence their perceptions of their professional identity and identity development (i.e., Carrola et al., 2016). With the increased demand for mental health professionals in the correctional system, it is necessary to understand how correctional counselors experience their professional identity in

the context of IBH and aspects of their roles that influence their professional development to better support their development and operation within this unique system.

Correctional counselors operate in a unique environment which was described as fast-paced, unpredictable, and diverse, by participants, due to the variability in daily structure and unpredictable crisis situations. This is congruent with Berkel et al.'s (2020) determination that mental health counselors working in IBH settings often operate in roles that are flexible and dynamic so that they can respond to the various mental health needs of the setting and population being served.

When operating in their dynamic and diverse role, participants noted that they focused primarily on safety, helping and supporting, and mental health education. These findings are consistent with previous literature regarding correctional counselor and IBH roles. Carrola and colleagues (2016) noted that maintaining both personal and inmate safety was an important focus for counseling supervisors and correctional counselors due to the high risk of harm and violence in correctional settings. This emphasis on safety as well as suicide prevention was prioritized over other mental health concerns. Additionally, participants' orientation toward helping and support may be partly explained by Degges-White and Stoltz's (2015) study investigating archetypal self-identity for individuals pursuing counseling. Clinical mental health counselors in this study identified strongly with the caregiver archetype compared to other archetypes suggesting that being compassionate and altruistic are common characteristics of mental health counselors. Participants chose to focus their correctional counseling role on helping and support so that it aligned with how they perceived themselves as counselors. Lastly, participants' focus on teaching others about mental health and their mental health is a common experience for mental health counselors working in IBH settings (Glueck, 2015). Thus, it is not surprising that

participants in the current study found opportunities to share their specialized knowledge of mental health with others at the site to increase understanding of their role and purpose within the correctional system.

Additionally, communication and collaboration are integral parts of service provision within IBH settings (e.g., Berkel et al., 2020; Matz & Lowe, 2020; Johnson et al., 2015; Wener & Woodgate, 2016). Conversely to previous IBH literature that has documented lack of communication as a barrier to IBH teamworking, participants experienced constant communication within the jail which was overwhelming for participants and impeded their workflow. This continuous flow of communication along with other's misunderstanding of their role contributed to increased demands for their attention, which created a need for participants to implement various coping strategies to manage the stress of their workload and environment. Participants specifically noted internal coping strategies, attending to self-care, and enforcing boundaries as strategies that helped them manage their demanding role. Similarly, Cox and colleagues' (2014) found that counseling psychologists in their study had to develop internal coping strategies to manage the fast pace and disruptions of working in a medical clinic.

Although participants experienced their work environment as fast-paced, demanding, and stressful they noted the importance of building supportive working relationships with each other as well as staff from other departments. Participants viewed themselves as being part of a team that utilized collaboration and shared decision making. Co-location of departments within the jail seemed to facilitate participants' frequency of collaboration and relationship building (Wener & Woodgate, 2016). Participants also focused on intentionally building working relationships with others to facilitate collaboration which is congruent with experiences of other correctional counselors (Carrola et al., 2016). Frequent collaboration and providing support to one another

helped participants increase a sense of closeness and cohesion which contributed to building effective working relationships.

When it came to discussing their professional identities and development, participants noted having to adapt their approach with clients, counseling styles, and clinical skills to match the needs of corrections and inmate population. Previous studies (e.g., Glueck, 2015; Kupers, 2015; Pomerantz et al., 2009) have documented differences between IBH settings, including correctional environments and traditional counseling settings. Mental health counselors transitioning into IBH and corrections experience an adaptation process during which they adjust their counseling practices to operate effectively in their roles. This transitional process can be frustrating for some counselors as they must expand their conceptualizations of counseling to integrate their experiences in these non-traditional environments (Moss et al., 2014).

Conversely the frustration counselors in Moss and colleagues' (2014) study, participants in the current study seemed to have positive perceptions of the adaptation process and viewed the differences between traditional counseling settings and the correctional environment as an enjoyable challenge that could help them growth. Participants particularly recognized growth in their clinical skills as a result of working with a diverse population under the difficult conditions of providing mental health services in corrections. This recognition of skill development contributed to increases in their self-confidence resulting in a strong professional identity that helped them feel more prepared to operate as mental health counselors in other counseling settings. This finding is consistent with previous IBH literature that has documented students participating in interprofessional education (IPE) experience increases in confidence and comfort with their clinical skills (Kent & Keating, 2015). These increases in confidence may be attributed to participants' gains in experience in the correctional setting which overtime lessened their self-

doubts about their abilities (Moss et al., 2014). Additionally, working with a wide range of mental health issues within the correctional setting as well as successfully adapting to the structure of their work environment seemed to contribute to participants' experiences of professional identity development and growth.

Limitations

Although steps were taken to increase the trustworthiness and rigor of this study, it is important to note the inherent limitations when forming conclusions and applying the findings to other contexts outside of this study. First, due to the interpretative role of the researcher in IPA there were aspects of my personal and professional experiences that may have influenced my interpretations of participant experiences despite reflexive journaling and bracketing practices. Secondly, this study sought to obtain a small, homogeneous sample by recruiting participants from one IBH site as well as setting specific inclusionary criteria for study participation to allow for an in-depth analysis of individual participant cases. Despite these attempts to obtain a homogeneous sample there were variations within the sample including participants' positions within the organizational hierarchy and previous professional experiences that influenced their professional identity development. Lastly, the methods of data collection relied on participant self-report which depended on participants' reflexivity and openness in disclosing information about their personal experiences. Therefore, participants may have chosen not to disclose certain aspects of their experiences within corrections.

Implications

The findings from this study offer several practical implications for counseling students, counselor educators, clinical supervisors, and mental health counselors. As noted by Moss and colleagues (2014), counselor trainees develop an idealized counselor identity during their

training programs which can lead to feelings of frustration when trainees enter the field. Similarly to beginning counselors, mental health counselors who gain employment in correctional and IBH settings must adjust their idealized expectations of counseling to match the unique work environment of these settings and adapt their counseling styles and skills to meet the needs of the populations they serve. Counselor trainees who are interested in correctional or other IBH settings can better prepare themselves for this transitional process by seeking out opportunities during their practicum and internship to gain experience working these settings. Additionally, counselor educators can better support counseling students in their professional identity development by increasing opportunities for students to gain knowledge and exposure to IBH and correctional counseling. Several benefits may result through increasing student exposure to IBH and correctional settings including increases in students' level of confidence in their counseling abilities, broadening students' expectations for counseling in the field, increased feelings of preparation for a variety of fieldwork experiences, and the development of a stronger counselor identity, all of which were benefits experienced by correctional counselors in the present study.

Participants in this study valued the support they received from their supervisors, and each other within the unit, suggesting that additional support from other mental health counselors is beneficial to their professional development and role fulfillment. Several ways that clinical supervisors in corrections can provide support are validating supervisees' experiences and frustrations with adapting to the correctional environment, assisting supervisees in boundary enforcement, creating opportunities for consultation, and prioritizing supervisees' self-care and emotional well-being. Additionally, mental health counselors entering correctional and IBH settings can prepare themselves for the demands of their mental health roles by developing

internal coping strategies, attending to self-care, setting boundaries, and building close interprofessional relationships to combat increases in work stress.

Not only does the current study offer practical implications but implications for future research studies. Due to the lack of literature regarding mental health counselors' experiences of professional identity in IBH and correctional settings, there are numerous directions that future research could explore. Future qualitative studies could build upon this research by exploring how mental health counselors operating in other correctional settings, such as prisons and specialty courts, perceive their professional identity and what aspects of their roles within these settings impact their identity development, since mental health counselors in these correctional settings are likely to function differently in their correctional counseling roles due to different job responsibilities and different nuances across client populations. Future studies could also expand on the current study by further investigating the adaption and transition process as it applies to correctional counselors. This research avenue could potentially assist counselor trainees, clinical supervisors, and mental health counselors pursuing employment in corrections.

References

Berkel, L. A., Nilsson, J. E., Joiner, A. V., Stratmann, S., Caldwell, K. K., & Chong, W. (2020). Experiences of early career counseling psychologists working in integrated health care. *The Counseling Psychologist, 47*(7), 1037-1060. https://doi.org/10.1177/0011000019895495

Burkholder, D. (2012). A model of professional identity expression for mental health counselors. *Journal of Mental Health Counseling, 34*(4), 295–307. https://doi.org/10.17744/mehc.34.4.u204038832qrq131

Burns, S. T., & Cruikshanks, D. R. (2018). Independently licensed counselors' connection to CACREP and state professional identity requirements. *Professional Counselor, 8*(1), 29–45. https://doi.org /10.15241/stb.8.1.29

Carrola, P. A., DeMatthews, D. E., Shin, S. M., & Corbin-Burdick, M. F. (2016). Correctional counseling supervision: How supervisors manage the duality of security and mental health needs. *Clinical Supervisor, 35*(2), 249–267. https://doi.org/10.1080/07325223.2016.1214856

Council for Accreditation of Counseling and Related Educational Programs. (2021). *2016 CACREP Standards*. https://www.cacrep.org/for-programs/2016-cacrep-standards/

Colangelo, J. J. (2009). The American mental health counselors association: Reflection on 30 historic years. Journal of Counseling & Development, 87(2), 234–240. https://doi.org /10.1002/j.1556-6678.2009.tb00572.x

Cox, J., Adams, E., & Loughran, M. J. (2014). Behavioral health training is good medicine

for counseling trainees: Two curricular experiences in interprofessional collaboration. *Journal of Mental Health Counseling, 36*(2), 115–129. https://doi.org/10.17744/mehc.36.2.c426q74431666762

Daniels, A. S., Adams, N., Carroll, C., & Beinecke, R. H. (2009). A conceptual model for behavioral health and primary care integration. *International Journal of Mental Health, 38*(1), 100–112. https://doi.org/10.2753/IMH0020-7411380109

Davis, T. O., & Cates, K. A. (2017). Mental Health Counseling and Specialty Courts. *Professional Counselor, 7*(3), 251–258. https://doi-org.proxy.lib.odu.edu/10.15241/tod.7.3.251

Degges-White, S., & Stoltz, K. (2015). Archetypal identity development, meaning in life, and life satisfaction: Differences among clinical mental health counselors, school counselors, and counselor educators. *Adultspan Journal, 14*(1), 49-61.https://doi.org/ 10.1002/j.2161-0029.2015.00036.x

DiCataldo, F., DeJesus, B., & Whitworth, D. (2021). Training needs of counseling trainees in corrections: A survey of clinical directors. *Journal of Counselor Preparation & Supervision, 14*(1), 1–23.

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

Johnson, K. F., & Freeman, K. L. (2014). Integrating interprofessional education and collaboration competencies (IPEC) into mental health counselor education. *Journal of Mental Health Counseling, 36*(4), 328–344. https://doi.org/10.17744/mehc.36.4.g47567602327j510

Johnson, K. F., Haney, T., & Rutledge, C. (2015) Creating space for connection: Creativity in the classroom. Journal of Creativity in Mental Health, 10, 488-506. https://doi.org/10.1080/15401383.2015.1044683

Johnson, K. F., & Mahan, L. (2019). A qualitative investigation into behavioral health providers attitudes toward interprofessional clinical collaboration. *Journal of Behavioral Health Services & Research, 46*(4), 636–647. https://doi.org/10.1007/s11414-019-09661-9

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 principles for unifying and strengthening the profession. *Journal of Counseling & Development, 89*(3), 367–372. https://doi.org /10.1002/j.1556-6678.2011.tb00101.x

Kent, F. & Keating, J. L. (2015). Interprofessional education in primary health care for entry level students — A systematic literature review. *Nurse Education Today, 35*(12), 1221-1231. https://doi.org/10.1016/j.nedt.2015.05.005

Kupers, T. (2015). A community mental health model in corrections. *Stanford Law & Policy Review, 26*(1), 119-158.

Matz, A. K., & Lowe, N. (2020). An exploration of correctional counselor workloads in a Midwestern state. *The Prison Journal, 100*(6), 769-786. https://doi.org/10.1177/0032885520968247

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development, 89*(2), 140–147.

Myers, J. E., Sweeney, T. J., & White, V. E. (2002). Advocacy for counseling and counselors: A

professional imperative. *Journal of Counseling & Development*, 80, 394–402. https://doi.org/10.1002/j.1556-6678.2002.tb00205.x

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development, 92*(1), 3–12. https://doi.org/10.1002/j.1556-6676.2014.00124.x

Neukrug, E. (2022). *The world of the counselor*. Cognella Academic Press.

Pomerantz, A. S., Corson, J. A., & Detzer, M. J. (2009). The challenge of integrated care for mental health: Leaving the 50 minute hour and other sacred things. *Journal of Clinical Psychology in Medical Settings, 16*(1), 40–46. https://doi.org/10.1007/s10880-009-9147-x

Prosek, E. A., & Hurt, K. M. (2014). Measuring professional identity development among counselor trainees. *Counselor Education & Supervision, 53*(4), 284–293. https://doi.org/10.1002/j.1556-6978.2014.00063.x

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage.

Wener, P., & Woodgate, R. L. (2016). Collaborating in the context of co-location: A grounded theory study. *BMC Family Practice, 17*, 1–15. https://doi-org.edu/10.1186/s12875-016-0427-x

Woo, H., Storlie, C. A., & Baltrinic, E. R. (2016). Perceptions of professional identity development from counselor educators in leadership positions. *Counselor Education & Supervision, 55*(4), 278–293. https://doi.org /10.1002/ceas.12054

Appendix A

Invitation for Study Participation Letter

Dear [name of participant],

My name is Jeanel Franklin and I am a current doctoral student at Old Dominion University. I am contacting you to extend an invitation to participate in a research study aimed at exploring mental health counselors' perceptions of their professional counseling identities in integrated behavioral health (IBH) settings. Your participation in this study is completely voluntary.

To be included in the study you must:

1) Have at least a master's degree in clinical mental health counseling
2) Have an active LPC or Resident in Counseling credential in Virginia
3) Provide mental/behavioral health services
4) Have current employment in an IBH setting for at least one year

If you elect to participate in this study, you are asked to participate in two phases of data collection. Phase one, will consist of an individual interview that is approximately one-hour long during which you will be asked questions about your professional background, roles and responsibilities at your place of employment, and perceptions of your professional counselor identity. In phase two, you are asked to reflect on your experiences of your professional identity and roles at your place of employment and complete a 5 to 10 minute video or audio log. After each phase, you will also be sent transcriptions of the interview and video/audio log as well as preliminary themes to check for accurate representation of your experiences. Follow-up interviews may also be scheduled as needed to gather additional information and/or clarify your responses.

If you are interested in participating in this study, please review the attached consent form. Should you have any questions, please do not hesitate to contact me at jfran054@odu.edu.

Appendix B

Consent for Research Participation

PROJECT TITLE: Mental Health Counselors' Perceptions of Professional Identity in Integrated Behavioral Health Care Settings

INTRODUCTION

I am inviting you to take part in a research study on the perceptions of professional counseling identity for mental health counselors working in integrated behavioral health (IBH). Before you decide to participate in this study, it is important for me to offer you information on why I am conducting this study and what it will involve. Please take the time to read the following information carefully and feel free to ask me if there is anything that is not clear or if you need more information.

In the current study, I aim to describe and increase understanding of how mental health counselors perceive their professional counseling identity when working in IBH settings, as well as explore what aspects, if any, of their professional roles in IBH support and/or hinder their professional identity development. To address these goals, I will collect data from you in two phases. Phase one consists of an hour-long interview that will be conducted in person, at a mutually agreed upon setting, or virtually via Zoom. For phase two, you will be asked to record one 5-10 minute video or audio log. Follow-up interviews, that will be conducted in person or virtually via Zoom, may also be scheduled as needed to gather additional information to clarify your responses..

RESEARCHERS

Responsible Principal Investigator:
Ed Neukrug, Ph.D., LPC (Chairperson)
Professor, Darden College of Education and Professional Studies
Department of Counseling and Human Services, Old Dominion University
Norfolk, VA 23529

Co-Investigator(s):
Jeanel Franklin, M.S.Ed, Resident in Counseling, NCC (Primary Researcher)
Doctoral Candidate, Darden College of Education and Professional Studies
Department of Counseling and Human Services, Old Dominion University
Norfolk, VA 23529

DESCRIPTION OF RESEARCH STUDY

Several studies have been conducted looking into the subject of mental health counselors' perceptions and experiences in IBH settings. However, none of them have examined how licensed professional counselors (LPCs) nor Residents in Counseling perceive their professional counselor identity in the context of IBH nor how their IBH roles may impact their professional identity development. This study aims to address this gap in knowledge using qualitative methods.

If you elect to participate in this study, you are asked to participate in two phases of data collection. Phase one, will consist of an hour-long individual interview during which you will be asked questions about your professional background, roles in IBH, and perceptions of your professional counselor identity. In phase two, you are asked to reflect on your experiences of your professional identity and IBH roles by recording one 15-30 minute video or audio log discussing your thoughts, feelings, and experiences as a mental health counselor at your place of employment. You will also be sent transcriptions of the interview and video/audio log as well as preliminary themes and data interpretations to check for accurate representation of your experiences.

If you say YES, then your participation will last for approximately one hour during phase one and approximately 15-30 minutes during phase two. Approximately four other mental health counselors will be participating in this study.

INCLUSIONARY CRITERIA

Prior to your participation in this study, you will receive an invitation for study participation letter via email containing a list of inclusion criteria for the study. To the best of your knowledge, you should be at least 18 years of age, possess an active credential as a licensed professional counselor or resident in counseling in Virginia, specialize in clinical mental health counseling, provide current mental/behavioral health services, and are currently employed at an integrated behavioral health facility. You will be excluded from this study if you do not meet these criteria.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, then you may face a minimal risk of minimal discomfort or unpleasant emotion as a result of reflecting on and disclosing your experiences. The researcher tried to reduce these risks by providing you with a list of counseling and mental health services. And, as with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: The main benefit to you for participating in this study is increased awareness and insight into your experiences of your professional identity in the context of your current place of employment. Others may benefit by the knowledge gained from your participation as the interpretations and meanings of your unique experiences in IBH could inform counselor education programs and integrated care operations, as well as improve interprofessional collaboration.

COSTS AND PAYMENTS

I want your decision about participating in this study to be absolutely voluntary. Yet we recognize that your participation may pose some inconvenience. We appreciate your time and value your input as we strive to explore this phenomenon. The researchers are unable to give you any payment for participating in this study.

NEW INFORMATION

You will be notified of any new information that would reasonably change your decision about participating, during this study.

CONFIDENTIALITY

The researcher will take reasonable steps to keep private information, such as interview transcripts and video/audio recordings, confidential. The researcher will remove identifiers from all identifiable private information collected. Additional steps will be taken to protect your confidentiality by destroying interview and video/audio log recordings upon the completion of the study. The results of this study may be used in reports, presentations, and publications; but the researcher will not identify you. Of course, your records may be subpoenaed by court order or inspected by government bodies with oversight authority.

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, your place of employment, or otherwise cause a loss of benefits to which you might otherwise be entitled.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then 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 are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Jeanel Franklin, the principal investigator, at 703-283-7054, Dr. John Baaki the current chair of Human Subjects for the College of Education and Professional Studies at Old Dominion University at 757-683-5491, or the Old Dominion University Office of Research at 757-683-3460 who 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 this form, the research study, and its risks and benefits. The researcher should have answered any questions you may have had about the research. If you have any questions later on, then the primary researcher should be able to answer them:

Primary Researcher:
Jeanel Franklin
703-283-7054
Jfran054@odu.edu

And importantly, by signing below, you are indicating YES, that you agree to participate in this study.

Participant's Printed Name & Signature	Date

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, 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 him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

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

Appendix C

Interview Protocol

Interviewee: Interviewer:

Date & Time of Interview:

Location:

Opening Script:

The purpose of this study is to describe and understand how you experience your professional counseling identity in an integrated behavioral health setting as well as how your roles in this setting influence your professional identity development. The purpose of today's interview is to gather information about your professional background, your perceptions of your professional counseling identity in the context of your work site, your professional roles at this site, and experiences with other health care providers. There are approximately twelve preset questions that we will discuss. I will also ask any follow-up questions as needed. Today's interview will last approximately one hour and will be audio recorded for transcription purposes. The recording will be destroyed upon completion of the study. Do you consent to being audio recorded? [obtain verbal consent]

Background Questions:

1) What are your current professional credentials?
2) What is your professional title?
3) How many years have you been working in the counseling field?
4) What do you consider your areas of specialty in counseling?
5) How many years have you been working in IBH?
    a. How many years have you been working at your current place of employment?

Interview Questions:

1) Tell me about a typical day from the beginning of your shift to the end.
2) How would you describe yourself as an LPC/Resident in Counseling?

   a. What feelings arise for you when you think about your professional identity development?
3) What mental health services do you provide to inmates?
4) What roles do you perform as a counselor in the mental health unit?
   a. Can you explain what duties and responsibilities you have as a part of that role?
   b. How do you feel about these duties?
   c. What is it like being a mental health counselor in the health services unit?
5) How do you think other health providers in the health services unit view your role as a mental health counselor?
   a. What gives you this impression?
6) In what ways has working in the health services unit at the Norfolk County Sheriff's Office changed how you view yourself as an LPC/Resident in Counseling?
   a. What aspects of your work experience influenced these changes?
7) What other information might be helpful to know to better understand your experiences that I did not ask about?

Closing Script:

Thank you for your time and participation during today's interview. I want to reassure you that your responses will be kept confidential and will not be discussed with your employer or others outside of the research team. You will be provided a transcription of today's interview, via email, to check for accuracy. If you believe your responses are not accurately captured in the transcription, please feel free to correct it. You will also receive an email containing instructions for the next phase of data collection which involves a video/audio log. Once you have completed phase two, you will be contacted to for a final follow-up interview. If at any time you have questions or concerns about your participation, please contact me at jfran054@odu.edu.

Appendix D

Video/Audio Log Instructions

For this phase of the study, you are asked to video or audio record one approximately *5-10 minute* log regarding your responses to the prompt below. The purpose of the video/audio log is to gather additional context and insight regarding your thoughts, feelings, and experiences as a mental health counselor in the mental health unit at the Norfolk County Jail.

Instructions:

1) Prior to recording your response, please check to ensure you have a stable internet connection, your computer or phone camera and microphone are in working condition, and that you are a in a location that is quiet and distraction free.
2) Next, please read the Video/Audio Log prompt listed below. Take some time to consider your response. When you are ready to record your response, click on the Zoom link listed below. Once you click on the link, a Zoom internet browser will open and ask if you would like to join the meeting. Click on "join meeting."
3) Once the meeting window opens, Zoom will *automatically* begin the recording. If you elect to only record your voice, then please ensure your camera is turned off. You can turn your camera off at any time by clicking the "stop video" icon located at the bottom left of the screen.
4) When you are finished with your video/audio log response, click "end meeting" located at the bottom right of the screen. Your video/audio recording will be automatically submitted and saved to the researcher's Zoom cloud. Only the researcher has access to this Zoom account. Your recording will be deleted upon the completion of this study.

Should you have any questions, please do not hesitate to contact me at jfran054@odu.edu.

Video/Audio Log Prompt:

Please reflect on and describe, in as much detail as possible, your daily experiences, reactions, thoughts, and feelings related to your professional counselor identity and roles within the mental health unit at the Norfolk County Jail. You may choose to describe your work routine, interactions with other health professionals, daily events, impressions, coworker relationships, etc. You may also choose to discuss other topics regarding your experiences not mentioned in this list.

Zoom Link:

[individualized zoom meeting link]

Appendix E

Table of Superordinate Themes and Themes for P1

Themes	Key Words
Work Environment/Culture	
Correctional Culture	Layers of control
Entering the Correctional System	Immersed
Descriptions of Work Environment	Strange, Unique, Harsh, Stressful
Description of Mental Health Population	Unique, Diverse, Variety
Corrections vs. Traditional Counseling Settings	Not traditional, Private Practice
Mental Health Supply and Demand	
Demand for Mental Health is Greater than the Supply	Need, Demand, Too many, Draining, Long list
Views of Services Provided	Limits, Disappointed
Future Expansion of Services	Expanding, Need for, The most
Value of Time	More time, a little quicker
Misunderstood Mental Health Role	
Need to Explain Identity/Mental Health Role to Others	Do not know, not understand
Benefits of Misunderstanding	
Expectations for Mental Health Counselors	Expect, Go down, Talk
Security Staffs' Views of Mental Health Counselors	Soft, Don't understand
Teamworking & Communication	
Teamwork	Collaborate, Learn from, Alongside
Personal View Toward Team Members	Appreciate, Respect, Value
Opportunities to Learn	Insight, Staff cases, Check, Consulting
Self as a Team Member	Family, Bulk of work
Separate Mental Health Team	Support, We, Work together
Collaborating/Communicating	Correspondence, Meetings, Calling

Roles and Responsibilities	
Administrative Responsibilities	Program, Continuity of Care, Oversee
Educating	Psychoeducation, Teach
View of Mental Health Role in Corrections	Safe Environment, Provide, Service
Safety as a Priority	Protective, Concern, Security
Empathy	Heightened sense, Toward
Providing Support	Work with, Providing, Individual Needs
Coping with Work Stress	Balance, Well-being, Appropriate Barriers
Clinical Judgement/Decision Making	
Thorough Assessing/Assessment	Dig a little deeper
Assessing Legitimacy of Inmate Mental Health	Malingering, Suspicion, On guard
Forming Case Conceptualizations	The history, Behavior, Root cause
Triaging is Primary Focus/Service	Urgent Cases, Majority, Higher level of Care
Inmate Housing Placement	Located, Can go in, Considering
Counselor Identity	
Comparing Current Counseling Identity to Envisioned Identity	Believe, Not in corrections, Environment
Defining Personal Counseling Identity	Represent, Work very hard
Impact of Setting on Counselor Identity	
Impact of Setting on Identity	Gets lost, Brings us back, Growth
Adapting Counseling Identity	Not what we thought, Evolve,
View of Self as Counselor	Questioning, Bias
Distinct Counselor identity	Tough, High standard, Higher esteem
Experience of Professional Identities in Current Setting	Perspective

Appendix F

Table of Superordinate Themes and Themes for P2

Themes	Key Words
Work Environment and Structure	
Safety	Aware, Worry, A lot happening
Perceptions of Work Environment	Fast paced, Different, Don't know
Feelings about Work Environment	I like
Time/Structuring Day	Day to day, Normal day, Plan, Schedule
Work Stress	
Work Stress	Keep it moving, So much going on
Feelings of Exhaustion	Tired, Draining, Spent
Preventing Burnout	
Preventing Burnout	Worked hard, know your limits
Self-care	More intentional, Throw me off
Taking Pause	Sit down, Deep breath, Shifting gears
Work-Life Balance	Relax, People Always wanting, Hit my limit
Setting Boundaries	Limits, Strong boundaries, Knowing, Pull you
Enforcing Boundaries	Not going out, Grow Strong, Being Firm
Work Relationships (Inside & Outside MH Unit)	
Working Relationships with Others (outside MH)	Good, They, Professional
Cohesion Across Professions	Smoothly, More work, Work closely
Lack of Understanding Across Professions	Don't, Fully understand, Take it seriously
Shifting Responsibility of Tasks	Pass, Put it on, Get out of
Other's View toward Mental Health	Don't care, Don't do anything
Co-Worker Relationships (Within Mental Health)	Guard down, Decompress with, Thankful for
Communication with Others	Responding, Passed down, Confirm, Email
View toward communication	Often, A lot, Won't Stop, Irritating

Overcoming communication barriers Team meeting	Break things down, Clinical language Make sure, What to expect, Review intakes
Professional Roles and Responsibilities Multiple Roles Role Switching Personal Definition of Professional Role Educating Managing Crisis Responsibilities/Duties Inmate Treatment	 Not our role, Talked to, [listing roles] Different hats, take a moment to pause How can I/we Help, Being there Open to, Big part of job, Talking to, Explain Emergency, Evaluate, Blow up, Calm Following Up, Assess, Triage, Refer Respect, People/Patients, Full History,
Clinical Judgement/Decision Making Clinical Decision Making Prioritizing cases/tasks Determining Genuine Mental Health Assessing SI	 Process with, Disagree, Accountability Seeing sooner, Risk of Suicide, Refused Get out of, Bullshit meter, Malingering Psychotic, Status, Attempt, Hopelessness
Professional Self/Professional Identity Professional Self/Professional identity Personal Self Presenting Self	 Boundaries, Person-centered, Grad School Who I am, Genuine, Personally, Authentic Confident, More professional
Professional Identity Development Professional Identity Development Professional & Personal Growth at Current Setting	 Risks, Learn, Open Mind, Encouraged Can handle, More confident, Test skills
Adapting to Setting Adapting to Current Setting Lack of preparation for setting Comparing Current Setting to previous experience	 Learn the process, Work on, Adjust Not taught, Didn't realize, Kind of like Don't do therapy, Private Practice, Different

Appendix G

Table of Superordinate Themes and Themes for P3

Themes	Key Words
Experience of Workday	
Descriptions of Workday	Different, Unpredictable, Pop up
Busy Days	Fast paced, On the go, Overwhelming
Disruptions	Pulled in, Have to, Throughout the day
Constant Communication	Constantly ringing, Calling, Check on
Managing Work Stress/Demands	
Coping with Work	Self-care, Boundaries, Chill out, Helps
Managing Time	Catch up, Scheduling, Needs, Severe
Perceptions of Setting/Client Population	
Perceptions of Client Population & Setting	Mental Illness, Diverse, Not Traditional
Panic	Abnormal, Panic, Don't know
Relying on Mental Health Counselors	Call us, Whole Jail, Necessary, Important
Addressing Mental Health Misconceptions	
Misunderstanding Mental Health	Don't really know, Psychotic
Educating about MH	Educate, Teach, Tell them
Challenging Stereotypes	Didn't expect, Show them, Bridge gap

Working as a Team Teamworking Shared Workload (MH) Providing Updates	 Meet, Work with, We, Talk We all, Split it up, Discussing Give Updates, Coordinate, Go over, Issues
Mental Health Counselor Role Perception of Mental Health Role Focusing on Safety Responsibilities Clinical Documentation Role Enjoyment/Fulfillment	 Support, Help, Keep Safe, Necessary First, All about Safety, Suicidal, Behavior Refer, Follow Up, Meeting, Monitor Paperwork, Every day, Documentation Love, Like, Enjoyed, Not the same
Approach to Counseling Non-Judgmental Approach Building Rapport Treatment Approach Providing MH Knowledge/Coping Strategies Focusing on Helping/Being a Positive Impact	 Never any Judgement, I don't, Any different No different, Just me, Open, Relatability Custom fit, Good fit, Need, Be willing Teaching them, Utilize, Learn, Break it down Feel better, Hope, Find good, What can I do
Personal Counseling Identity Personal Counseling Style/Approach Personal Professional Values Integrating Personal & Professional Selves Personal Qualities	 How I counsel, Eclectic, Part of my, Humor Importance, Being, Yourself, Learning It's okay, Be myself, Personality I'm, Friendly Person, Type of person, Care
Professional Development & Growth Professional Development Process Finding Professional Fit Specialized Education/Training/Knowledge Learning Counseling Experience	 Make sense, Frustrated, Tough, Worth it Niche, Takes time, Open minded, Bored Addiction, Degrees, My areas, Expertise Textbook, Hands on, Have knowledge, Open Done so much, Prepared, Helped me

Professional Growth	Diverse population, As a person, As a counselor

Appendix H

Table of Super-Ordinate Themes for P4

Themes	Key Words
Counselor Identity Defining Personal Counselor Identity Being a Positive Impact Feelings toward Current Counseling Role	 Helper, Caring, Advocate, Clinical Supervisor Change, Different path, feel fulfilled, Grow Enjoy, Love, What I do
Professional Growth and Development Professional Growth & Development	 Stuck, Day to Day, Develop more skills
Unexpected Professional Identity Unexpected/Un-Envisioned Career Path Corrections Overlooked as COUN Setting Comparing Envisioned/Ideal Self as Counselor Finding Professional Fit	 Never envisioned, Not the Identity, I thought Options, Grad school, Traditional counseling Originally imagined, Not the same Not for everyone, Environment, Population
Adapting Counseling Identity and Approach Adapting Counseling Identity Building Therapeutic Rapport (Mistrust & Warmth)	 Challenges, When we start, Evolved Not trained, Empathy, Respect, Suspicious
Unknown/Misunderstood Counselor Role Unknown/Misunderstood Counselor Role	 Catch all, Not much respect for, Hokey
Roles and Responsibilities Advocate Role Role as Service Connector/Referring Director/Administrator Role Educator Role Clinical Role	 Support, Being a voice, Figure out, Important Connect, Resources, CSB, Solutions focused Reports, Suicide Prevention, Improvement Educating, Staff, Make sure you understand Check on, Evaluating, Safety, Skills

Clinical Supervisor Role	What they're doing, Clinical, Direct
Work Stress Work Stress	Understaffed, Busy, Don't want to miss
Work Relationships Building Relationships Teamworking Reciprocal Support Communication Suicide Prevention Providing Rationale	Develop, Trust, Better working Collaborate, Closely, Alongside, As a team Get opinions, collectively, Concerns, Come to Emails, Constant, Getting phone calls Biggest initiative, Safety net Explain, Pushback, They understand
Clinical Judgement/Decision Making Clinical Judgement/Decision Making Thorough Assessment Triaging/Prioritizing	More information, Risk, Quick, Behavior Painting a history, Look at, Speak with them Biggest crisis, Safety and security, Higher risk
Work Setting/Environment Behavioral Population	Tough, Anger, Acting out, Power

VITA

Jeanel L. Franklin graduated *cum laude* from Old Dominion University in 2011, earning a Bachelor of Science in Psychology with a minor in Human Services. She then went on to earn a Master of Science in Education with a concentration in Clinical Mental Health Counseling from Old Dominion University in 2018 and became a National Certified Counselor. During her graduate studies, she gained interprofessional experience providing individual counseling services to uninsured adults at an outpatient medical clinic. Following her master's program, Jeanel continued gaining field experience working with elementary school children with behavioral issues as a therapeutic day treatment counselor. She continued her educational studies in 2019, pursing a doctoral degree in counselor education and supervision at Old Dominion University. While in her doctoral program, she served as a graduate research and administrative assistant for the Counseling and Human Services department.

Over the past five years, Jeanel has gained considerable mental health counseling and research experience at Virginia Beach Psychiatric Center, The Psychotherapy Center, Coast to Coast Counseling and Wellness Center, and Old Dominion University. She has presented her research at several regional and national conferences including the American Counseling Association's 2022 annual conference. She has recently earned her credential as a Licensed Professional Counselor in Virginia and will continue providing therapeutic services to adults experiencing anxiety, depression, grief, and life transitions.