AN ABSTRACT OF THE DISSERTATION OF

Nineka Dyson for the degree of Doctor of Philosophy in Counseling presented on September 24, 2021.

Title: Exploring the Experiences of Intake Professional Counselors: An Interpretative Phenomenological Analysis of the Perspectives of Professional Counselors Working as Intake Counselors in the Inpatient Psychiatric Setting.

Abstract approved: _____

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Inpatient psychiatric hospitals are critical to delivering community-wide acute mental health care. Professional counselors hold roles as intake counselors within the system of inpatient facilities (Werrbach, 2011). While they are essential to the processes within the system, there is no known research on intake counselors and their tasks of assessment within the inpatient psychiatric setting. Intake has traditionally been a function of professional counseling rather than a primary job. Intake counseling is covered as a job function in the literature but not as an overall job choice for professional counselors (Young et al.; Marsh 1999). The deficiency of guidance in the literature and the lack of emphasis on intake interviews are problems for professional counselors who act as intake counselors in the inpatient psychiatric setting. The researcher analyzed the experience of professional counselors that work as intake counselors in the inpatient psychiatric setting.

The research approach for both studies is Interpretative Phenomenological Analysis (IPA). IPA helps the researcher explore individuals' meaning-making about their experiences (Smith et al., 2012). The researcher recruited eight participants from across the United States.

The smaller sample size represents the field as inpatient psychiatric hospitals make up only 10% of the total inpatient facilities, and intake counseling consist of various professions. Participants for this study met the criteria of identifying as professional counselors with experience working in the inpatient setting as intake counselors. Intake counseling was also their primary job in this setting. The researcher utilized IPA data analysis as described by Smith et al. (2008). Strategies to increase trustworthiness in both studies included peer debriefing, reflexivity, thick description, and member checks (Lincoln et al., 1985).

The first study (*n*=8) explored the experience of professional counselors that work as intake counselors within the inpatient psychiatric setting. The findings of this study indicate that intake counselors experience: fulfilling a practical need to work as an intake counselor, struggling to cope with the lack of specific training, having an internal struggle between professional identity and system requirements, and containing emotion to cope with the stressors of working in the inpatient environment. Additionally, these counselors experience job sustainability as dependent on multi-dimensional openness and support.

The second study (*n*=8) explored participants' experience conducting intake assessments within the inpatient psychiatric setting. The findings of this study suggest that these counselors feel compelled to adapt the assessment to patient needs, use empathy as a gateway to connect with patients and families, grapple with complex safety concerns during the assessment, and feel overwhelmed by the system and desire relief from other staff.

Implications for this research are directed toward foundational knowledge and support of professional counselors that are intake counselors within the inpatient psychiatric setting. The findings emphasize the challenging work done by these counselors and its personal and

professional impact. Therefore, implications are geared toward professional counselors, supervisors, counselors in training, and the inpatient system.

Exploring the Experiences of Intake Professional Counselors: An Interpretative Phenomenological Analysis of the Perspectives of Professional Counselors Working as Intake Counselors in the Inpatient Psychiatric Setting

by
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Dean of the College of Education

Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Nineka Dyson, Author

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Dissertation Overview

Inpatient psychiatric treatment is vital to providing intensive mental health care for the community. Inpatient care is the highest level of care for people experiencing a mental health crisis; the referrals for crisis care come from outpatient providers, families, and self-referrals (Werrbach, 2011). The crisis can include suicidal or homicidal ideation, self-harm, physical aggression, and even medication management (Kovac, 2012). To determine if a patient will meet the criteria for admission, intake counselors perform intake interviews. Professional counselors that are licensed and pre-licensed perform the intake interview and fill jobs as intake counselors. They are pivotal to the intake process in the psychiatric hospital, as they usually have the first interaction with the patient at the facility.

Although they are essential to the inpatient psychiatric setting, there is no known research on professional counselors that work as intake counselors in this setting. Traditionally, intake is a function of professional counseling and not a primary job. Literature covers intake counseling as a job function but not an overall job for professional counselors (Young & Cashwell, 2017; Marsh 1999). The lack of guidance in literature and minimal emphasis on intake interviews creates a challenge for professional counselors that work as intake counselors in the inpatient psychiatric setting.

While the literature for intake counselors in inpatient settings is absent, literature is available for intake in the outpatient setting. The literature on outpatient intake interviews can provide a glimpse into what is involved in an intake for these counselors. The intake interview is the foundation for treatment in the outpatient setting (Freeburg & Van Winkle, 2011). The information obtained during the interview assists the counselor with case conceptualization and treatment planning (Guo et al., 2012; Sommers-Flanagan & Sommers-Flanagan, 2014).

Outpatient counselors use the intake interview to build rapport that continues to develop over several sessions (Seligman, 2012). However, the intake interview is formal and time-limited for intake counselors, resulting in intake counselors needing to develop a rapport with the patient quickly (Werrbach, 2011).

Intake counseling in the inpatient setting is unique. Intake counselors' work is setting specific and is one of the primary jobs for a professional counselor in the inpatient setting (Werrbach, 2011). Furthermore, the intake interview in the inpatient setting has a different purpose than the outpatient setting. The outpatient interview is less formal, and the counselor uses the interview to build rapport for continued engagement with the client (Polanski & Hinkle, 2000). Unlike the outpatient interview, the inpatient interview is structured and formal (Werrbach, 2011). Also, the purpose of the inpatient intake interview is to determine if a client will meet the criteria for hospitalization or require a referral to another site to meet the client's needs, such as an outpatient program (Osview & Munich, 2008; Werrbach, 2011). The experiences of intake counselors and their role have not been addressed in the literature and need to be explored.

Interpretative Phenomenological Analysis

Creswell and Poth (2018) describe the qualitative research approach as providing a holistic account of participants' meaning. The researcher used Interpretative Phenomenological Analysis (IPA) as the method of analysis for this dissertation. IPA allows the researcher to concentrate on the meaning of each participants' experience as the participants engage in a meaning-making process of their experience with the phenomenon (Smith et al., 2012). This hermeneutical interaction required the researcher to serve as a co-participant in the researcher (Smith & Osborn, 2008). Employing IPA helped the researcher understand the experiences of

intake counselors as professional counselors in the inpatient psychiatric setting and their perspectives on conducting intake interviews.

The researcher utilized semi-structured interviews to gather data for this study. In accordance with IPA, the interviews were transcribed and reviewed multiple times for insights into the participants' experiences. These insights were documented, and the researcher noticed themes among the notes logged within each transcript (Smith et al., 2012). After identifying themes in the individual transcripts, the researcher identified common themes within the group of transcripts. To promote the trustworthiness of the study, the researcher engaged in strategies identified by Lincoln and Guba (1985); specifically, member checks of themes, peer debriefing, reflexivity, and thick description.

Purpose

The purpose of this dissertation is to illustrate scholarly research using the Manuscript Dissertation format outlined by Oregon State University. The dissertation consists of two manuscripts. The title of Manuscript 1 (Chapter 2) is Exploring the Lived Experience of Professional Counselors that Work as Intake Counselors in the Inpatient Psychiatric Setting. Manuscript 2 (Chapter 3) is titled Exploring Intake Counselor Perspectives of Conducting Intake Interviews as Professional Counselors in the Inpatient Psychiatric Setting.

Implications of the research are to highlight the role of professional counselors who work as intake counselors and their inpatient psychiatric experiences. The professional counselors' experiences are important as inpatient psychiatric hospitals account for 10% of all hospitals in the United States, employing 10% of the professionals trained in mental health disorders (American Hospital Association, 2020; U.S. Bureau of Labor Statistics, 2021). Professional counselors have a job that is not addressed in the literature, and intake counselors must have representation in the field of professional counseling. Furthermore, the research aims to inform

training and supervision for professional counselors who want to or currently working as intake counselors in psychiatric hospitals. Their experiences of intake counseling inform practice and future research to guide this form of professional counseling.

Manuscript 1: Exploring the Lived Experience of Professional Counselors that Work as Intake Counselors in the Inpatient Psychiatric Setting

Manuscript one, chapter two of this dissertation utilized the qualitative approach of Interpretative Phenomenological Analysis (IPA) to understand the unique experience of professional counselors that are intake counselors in the inpatient psychiatric setting. For this study, the researcher defines the experience of being a professional counselor working as an intake counselor in the inpatient psychiatric setting. The central research question of this study seeks to answer is: "What is the lived experience of professional counselors working as intake counselors in the inpatient psychiatric setting?"

Professional counselors that work in the inpatient psychiatric setting as intake counselors have an important role in the community. Intake counselors link outpatient and inpatient care, serving a high acuity population (Osview & Munich, 2008). Intake counselors assess patients to assist them with receiving the appropriate care to meet their needs (Werrbach, 2011). Despite their importance, the counseling literature views intake from the lens of the outpatient setting, focusing on intake as the first session with a client (Marsh, 1999). The literature does not focus on the specifics of intake counseling in the inpatient psychiatric setting, as the focus of counseling has been long-term therapy and wellness for clients.

However, research exists on the experiences of nurses, psychologists, and psychiatrists in this setting (Sorgaard et al., 2007). The experiences of these professions provide some insight into what it is like to work in inpatient psychiatry. The research highlights the difficulty in balancing the demands of work and interpersonal relationships (Totman et al., 2011). On the

other hand, the relationships with staff working on the units were significant to enhancing feelings of support in the inpatient psychiatric setting (Sorgaard et al., 2007). While these experiences give a glimpse into the inpatient experience, they do not address the particulars of the experience of intake counselors.

This study's sample is comprised of participants who identify as professional counselors at the master's or doctoral level and work or have worked as intake counselors in the inpatient psychiatric setting. The researcher used listservs and social media pages dedicated to connecting professional counselors, such as the American Mental Health Counselors Association open forum and the Tele-Play Therapy Resources and Support Facebook group. The researcher used groups such as these to request participation for this study. The research method for this study is Interpretative Phenomenological Analysis (IPA). IPA allowed the researcher to gain a holistic perspective of the participants' experience in working as an intake counselor in the inpatient psychiatric setting (Smith et al., 2012). The researcher followed the recommendations of Smith and Osborn (2008) for data collection and analysis. Part of these recommendations includes a statement of the researcher's positionality with the phenomenon under study, semi-structured interviews, thematic data analysis, methods to enhance the study's trustworthiness, and discussion of limitations of the study.

Manuscript 2: Exploring Intake Counselor Perspectives of Conducting Intake Interviews as Professional Counselors in the Inpatient Psychiatric Setting

The second manuscript, Chapter 3 of this dissertation, is qualitative research using IPA for data analysis. This study explores the experiences of intake counselors conducting intake interviews in the inpatient psychiatric setting. For this study, the intake interview is generally defined as the process intake counselors use to gather information to determine if a patient will be admitted for inpatient psychiatric care or referred to an appropriate level of care. The central

research question is, “How do intake counselors experience conducting intake assessments as professional counselors in the inpatient psychiatric setting?”

Intake counselors work with patients in the inpatient psychiatric setting that actively have impairing symptoms. Intake counselors assess patients during the intake interview to determine the appropriate treatment setting. Literature does not address the intake interview in the inpatient setting but offers an understanding of what is needed for intake in the outpatient setting. Outpatient counselors conduct intakes during the first session with a client (Osview & Munich, 2008). The intake process includes developing a therapeutic relationship, collecting patient information and symptoms, and discussing the next treatment steps (Carlat, 2016). This process can be complicated for intake counselors due to the limited time they have with patients and the nature of the interview.

The inpatient interview is more investigative and formal than in the outpatient setting (Polanski & Hinkle, 2000; Werrbach, 2011). Unlike the outpatient interview, this interview does not lead to a treatment plan for the patient. Instead, the purpose is to supply the counselor with enough information to create a summary for the admitting physician to determine whether a patient will meet criteria or require another treatment level. Interestingly, intake counselors must gain this information with clients referred from outpatient or self-referred for being unable to function in their typical environment (Werrbach, 2011). The patients’ acuity level creates a different atmosphere for intake interviews than what has been explored in the literature.

Participants for this study are professional counselors at the master's or doctoral level who work as or have worked as intake counselors in the inpatient psychiatric setting. The researcher used Listservs and social media pages that link professional counselors to request participation for this study. The research method for this study is Interpretative

Phenomenological Analysis (IPA). IPA provides a way for the researcher to gain a holistic view of the participants' experience working as an intake counselor in the inpatient psychiatric setting (Smith, Flowers, & Larkin, 2012). In addition, the approach outlined in Smith and Osborn (2008) was used for data collection and analysis. The approach includes a statement from the researcher regarding interaction with the phenomenon under study, semi-structured interviews, thematic data analysis, methods to improve the trustworthiness of the research, and an explanation of the limitations of this study.

Thematic Relevance

The thematic connection of the two manuscripts is the exploration of professional counselors' experiences working as intake counselors in the inpatient psychiatric setting. In the first manuscript, the researcher describes how professional counselors experience working as intake counselors. Similarly, the second manuscript also focuses on intake counselors' experiences, but the focus is on intake counselors' experiences of engaging in intake interviews in the inpatient psychiatric setting. The research addresses the lack of research and best practices for this population. The themes identified in the study highlight difficulties working in the inpatient setting. The themes also provide insight into training and supervision for professional counselors in this role.

Organizational Structure of the Dissertation

The organization of this dissertation follows the manuscript style format required by Oregon State University. Chapter one provides an overview of the inpatient setting, the role of professional counselors as intake counselors, and the perspectives of intake counselors engaging in intake interviews in this setting. Chapter one also discusses the implications of this research. Manuscript one outlines the experiences of professional counselors that work as intake counselors in the inpatient psychiatric setting. In contrast, manuscript two addresses the perspectives of these

individuals in the intake interview process. The final chapter presents the results, conclusions, and discussion where the researcher delivers future research opportunities within the field of professional counseling.

Publication Options

There are two desired publications for this study. The first is the *Journal of Counseling and Development* (JCD) which is the journal for the American Counseling Association. The JCD includes research relevant to professional counselors of various specialties. The second journal is the *Journal of Mental Health Counseling* (JMHC). JMHC is the journal for the American Mental Health Counselors Association. The JMHC is a platform for the organization to address the practice and research associated with clinical mental health counseling. The focus of this publication is in-depth research on counseling practices, assessment, diagnosis, and clinical studies. The focus of these journals and the topic of the study align, as this dissertation brings attention to the experiences of counselors that work as intake counselors and their experiences engaging in intake interviews in the inpatient settings.

Glossary of Terms

Acute: Describes the severity of symptoms for a client.

High-Acuity Patient: A person that can no longer function in daily living and symptoms are too severe to manage in the outpatient setting.

Intake assessment: In-depth, primary tool for inpatient intake counselors to gather information to summarize presenting problem and history of a patient.

Level of care: Medical term describing the intensity of care being provided by a facility.

System: The interconnected network of administrators and executives within the facility that govern the work of intake counselors.

Chapter 2: Manuscript 1

Exploring the Lived Experience of Professional Counselors that Work as Intake Counselors in the Inpatient Psychiatric Setting

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Abstract

Inpatient psychiatric facilities employ professional counselors for an array of jobs. However, the professional counselors who assess people who can no longer function in their daily activities for inpatient admission are intake counselors. Although intake counselors are essential to inpatient systems, no known research exists exploring their lived experience as professional counselors in this job. This interpretative phenomenological analysis study explored professional counselors working as intake counselors in the inpatient psychiatric setting (n=8). The researcher found that professional counselors working as intake counselors experience: fulfilling a practical need to work as an intake counselor, struggling to cope with the lack of specific training, having an internal struggle between professional identity and system requirements, and containing emotion to cope with the stressors of working in the inpatient environment. The findings offer implications for counselors, counselor educators, supervisors, and future research.

Keywords: intake counseling, intake counselor, inpatient psychiatric, qualitative research

Exploring the Lived Experience of Professional Counselors that Work as Intake Counselors in the Inpatient Psychiatric Setting

The inpatient psychiatric treatment setting is unique in that it provides care for individuals experiencing severe mental health concerns that require extensive monitoring. Thus, inpatient treatment is the highest level of care for persons with mental health disorders. However, clients from the outpatient setting must meet the criteria before admission to this level of care. The foundational criteria for inpatient psychiatric treatment are to be a harm to self or others (Kovac, 2012). Primarily, suicidal or homicidal thoughts, severe agitation, self-harm, and other symptoms that are not safe to treat by professionals in the outpatient setting (Osview & Munich, 2008). The group that assesses for these criteria and documents symptoms is called intake counselors. Intake counselors are important to the inpatient system because they are the bridge between outpatient and inpatient care for clients (Universal Health Services, 2020).

Intake counselors are also important to professional counseling. They play a vital role in providing services to clients of outpatient mental health providers requiring a higher level of care. Intake counselors are the first to respond to requests for inpatient care from clients and providers in the community. As professional counselors, intake counselors also rely on their counseling skills to create a therapeutic environment in a limited amount of time. They utilize these skills to gain insight into the client's experience. The ability to build an alliance with the client and family quickly is essential in exploring the best way to assist a potential patient (Werrbach, 2011).

Counselors in outpatient settings have multiple sessions to develop this relationship. However, the intake counselor has less time to create a bond with the client but has to create a safe space for sharing experiences. The relationship establishes trust in the counselor and the admissions process. Also, the client becomes vested in their treatment and trusts that the

counselor has their best interest in mind when conducting the assessment. These important individuals have challenging roles, and their experiences need to be explored.

The role of an intake counselor is challenging because there is a lack of information to guide intake counselors. The available literature only describes intake counselors as part of facilities that provide rehabilitation and detox services, not psychiatric hospital settings (Marsh, 1999; Seligman, 1996; Hecker & Thorpe, 2015). Unfortunately, the research does not describe the experiences of intake counselors working in the inpatient psychiatric hospital setting. Another reason the role is challenging is the minimal emphasis on inpatient psychiatric intake counseling in counselor education.

For example, master's-level courses address the therapeutic process, including intake in outpatient settings, but not to the level required for a master's level counselor to understand the experience within the inpatient hospital setting (Young & Cashwell, 2017). Rosenthal (2003) develops guides to assist novice counselors with passing certification and qualifying exams. The guide only has a few lines regarding this population. It explains that intake is the first interview to determine how the organization can assist the client and provide a diagnosis if applicable.

In addition to Rosenthal (2003), Freeburg and VanWinkle (2011), and Werrbach (2011) highlight the skills required to perform the job successfully. Additionally, Rosenthal's (2017) fourth edition has removed the small discussion about intake for counselors. Oh et al. (2019) provide insight on cultural competence in outpatient specifically for the LGBTQ+ community. Likewise, Guo et al. (2012) only discuss how to conduct an assessment, not the actual job of an intake counselor; thus, limiting best practices within intake counseling. Literature provides a glimpse into the action of performing intakes as part of the client's initial session, but not the overall role of the job.

This non-representation in literature leads to questions about the availability of best practices for intake counseling. The best available practices address intake counseling through the lens of outpatient counselors working with a new client. Outpatient counselors conduct a bio-psychosocial assessment during the first therapy session with a client. The assessment includes the history of present illness, mental status exam, current symptoms, and additional information that may be required of the organization (Lorman, n.d.). The information obtained during this time informs the treatment and diagnosis of the client (Guo et al., 2011). However, more explanation is needed to determine the intricacies of intake counseling with high acuity patients.

Despite the limited information on best practices in intake counseling, job descriptions for intake counselors can provide insight into organizational expectations. Requirements to become an intake counselor include a Master's Degree in Counseling or a related field, CPR, and First Aid. Additionally, intake counselors receive training in passive physical restraint, defensive response strategies, and verbal de-escalation of aggressive patients. Some positions specify a license requirement in the state of work (Universal Health Services, n.d., Aurora Healthcare, n.d.). Intake counselors also must communicate effectively to provide in-person and telephonic services across the lifespan, including crisis intervention (Indeed.com, 2019). Although numerous career sites list the job requirements, the literature does not represent the intake counselors' experiences of what it is like to perform these various roles.

Although the literature is not representative of intake counselors, research exists describing the experience of inpatient psychiatric psychologists, psychiatrists, and psychiatric nurses. Rabu et al. (2016) studied the effect of providing therapeutic services on the personal lives of psychologists and psychiatrists. Inpatient psychologists and psychiatrists working in an inpatient hospital reported an interpersonal impact on their personal lives. Inpatient psychologists

and psychiatrists attribute the impact to an overcommitment to work, long hours, and organizational requirements for productivity (Rabu et al., 2016). These problems make it challenging to find time to interact with friends and family (Rabu et al., 2016). The ability to maintain a work-life balance is challenging for staff in the inpatient setting (Jenkins & Elliott, 2004).

While the experiences of inpatient psychiatric psychologists and psychiatrists provide insight into the inpatient psychiatric setting, their time with the patient occurs after admission to the facility. Based on the structure of most inpatient psychiatric hospitals, it is safe to assume that intake counselors and inpatient psychiatric nurses potentially share similar experiences due to their immediate direct interaction with high acuity patients, families, and hospital staff. Inpatient psychiatric nurse experiences portrayed in the research can provide insight into the experience of inpatient psychiatric intake counselors through providing understandings of hospital culture, the milieu, administration, and inter-staff relationships. For example, the nurses' experiences consist of high acuity and often difficult patients, impacting the staff's emotional and physical well-being (Sorgaard et al., 2007; Totman et al., 2011; Mellow et al., 2018).

Furthermore, inpatient psychiatric nurses expressed concerns about role ambiguity within the organization, staffing level concerns, and the fluidity of tasks and goals for the position at the administrative level (Sorgaard et al., 2007; Totman, Hunt et al., 2011). Permanent staff also must work with agency staff with limited experience during times of staffing shortages. On the other hand, the staff experienced their work as rewarding when seeing patients' level of functioning improve over time. They also enjoyed working with staff on the unit and have high regard for administrators that are present on the patient units (Sorgaard et al., 2007). Nurses' experiences are reasonably parallel to that of intake counselors in that both have limited contact time with the

patient and are the first to interact with new patients. However, intake counselors have even more limited time to perform their tasks and view patients through a different lens. Thus, these understandings are only partially comparable to intake counselors.

Professional counselors' that serve as intake counselors in the inpatient psychiatric hospital setting are unique and critical. The job of intake counseling is unique in that it is setting specific and is the primary job for a professional counselor. The criticalness is in the intake counselor helping an acute patient in need of care. Despite their uniqueness and critical nature of the job, there remains a lack of research about this population within the field of professional counseling. The experiences of professional counselors working as intake counselors in the inpatient setting has not been explored by previous research and needs to be explored.

Thus, the purpose of this phenomenological study is to explore the experience of intake counselors in the inpatient psychiatric hospital setting. The experience is generally defined as professional counselors that work as full-time intake counselors in a psychiatric hospital. By exploring the experience of intake counselors, we can better understand the intricacies of the job and the interpersonal impact of being in this role in the inpatient psychiatric setting. The hope is to provide a starting point for future exploration of the population that will benefit the field of professional counseling in the supervision and education of these individuals. The central research question guiding this study is, “What is the lived experience of professional counselors working as intake counselors in the inpatient psychiatric setting?”

Methods

The purpose of this study was to explore the holistic experience of professional counselors working as intake counselors in the psychiatric hospital setting. There is minimal research on the experiences of inpatient staff, and the literature review returned no information

on inpatient intake counselors. Considering that there is no known research on this population, and the researcher seeks to capture the stories of individuals, qualitative research is best for this study. Qualitative research is the method of choice when the researcher seeks to understand the phenomena from the participants' view through interacting with each participant.

In addition, researchers use this method to explore topics that have not been researched previously. The researcher places themselves in the world of the participant to gain a greater understanding of the problem being studied during data collection and interpretation (Creswell & Poth, 2018). Thus, this interaction provides a rich description to enhance the essence of the phenomena under study. Furthermore, qualitative research maintains the essence of the experiences of the intake counselors, providing rich descriptions that highlight this branch of professional counseling. Also, the exploration of this phenomenon empowers the participants to share their stories as professional counselors. The research gives a voice to a population that does not engage in the more well-known long-term type of psychotherapy.

The approach selected for this study is Interpretative Phenomenological Analysis (IPA). IPA allows researchers to explore the meaning-making of significant experiences in the lives of individuals (Smith et al., 2012). The method also provides space for exploring participants' positioning in the experience and the significance or lack thereof with the phenomena being studied (Smith et al., 2012). IPA also aligns with the social constructivist paradigm, as this study seeks to explore the participants' view of the phenomena and describe the collective experience of professional counselors working as intake counselors (Creswell & Poth, 2018).

Social constructivism guided the choice of the approach and research activities of this study. Creswell (2014) offers the understanding that constructivism seeks to "rely as much as possible on the participants' view of the situation being studied" (p. 37). This dependence

requires the researcher to forego what is assumed to be realty and seeking personal accounts that lead to a collective understanding of the lived experience. This study focused on the participants' experiences within their work settings, searching for the intricacy between the participants' views. The researcher used open-ended questions in the interview schedule, allowing participants to construct the meaning of their experience within the context of being an intake counselor as a professional counselor.

Researcher as Instrument

When using a constructivist lens for an IPA study, the researcher plays an active role in the meaning-making process. In IPA, the researcher asks participants to engage in a hermeneutical reflection of their experience (Smith et al., 2012). The participants are trying to make sense of their involvement with the phenomenon while the researcher is engaged in understanding how the participants are making sense of the experience (Smith et al., 2012). Thus, the researcher is the interpreter of this meaning-making (Tuffour, 2017).

Before data collection, it was important to uncover personal biases and assumptions due to previous experience as an intake counselor that may shape interpretations in this study (Creswell & Poth, 2018). The researcher worked as an intake counselor in a private psychiatric hospital for two years and moved into an administrator role prior to leaving this setting. The researcher experienced stress on the job that had personal impacts. However, it was a job that offered a unique experience.

The experience was unique in that the initial thoughts about starting in the inpatient setting brought excitement. The role was something outside what the researcher thought of as a job for a professional counselor. The researcher felt prepared to fulfill the duties of the role. Yet unprepared to deal with the personal impacts of the stress that came with the job. The stress was

in the form of the expectations that came with the job that sometimes led the researcher to work long hours.

Because of staff turnover, the researcher was allowed to choose shifts that allowed for time with family after the first six months. However, as a senior clinician in the department and later administrator, the expectation was to field departmental calls outside of the shift for departmental staff. Although the researcher loved to connect with colleagues, this became overwhelming when calls came back-to-back on weekends.

Joy was found in the interaction with other clinicians and staff to help the admissions department during high volume times. There was always a sense of camaraderie with staff when everyone was assessed by the end of the shift. In addition to the joy of working with hospital staff, there was great joy in admitting a patient who could not function in life and seeing them discharged with a smile on their face.

Participants and Setting

The guidelines for purposeful sampling detailed in Creswell and Poth (2018) were followed for this study. Purposeful sampling is the identification of participants that can provide insight about experiencing the phenomenon under study (Smith & Shinebourne, 2012; Polkinghorne, 2005). Additionally, this study uses a homogenous sample. A homogenous sample is a sample of participants that share the same characteristics (Smith & Shinebourne, 2012).

Participants are professional counselors that met the following criteria: (a) a master's or doctoral level professional counselor, (b) that is currently working in or has worked in the inpatient psychiatric setting as intake counselors, and (c) the participant's primary job function was or is intake counseling in the inpatient psychiatric setting. This study did not consider

professional counselors whose intake counseling work occurred in settings that only treat eating disorders, substance abuse, and rehabilitation services.

The researcher recruited from professional counseling Listservs and social media pages that serve professional counselors. Ten counselors contacted the researcher. Out of the ten counselors, eight continued to be participants for the study. Of those that could not participate, one did not meet criteria, another became ill and opted out of continuing. Smith et al. (2018) suggest a small homogenous sample for first-time IPA studies. However, the small sample size is representative of the field as there is a low number of inpatient psychiatric hospitals, and not all intake counselors are professional counselors. Additionally, Orcher (2016) recognizes the need for a smaller sample size due to the difficulty of locating participants that have experienced the phenomenon under study.

In this case, professional counselors that work as intake counselors in the inpatient psychiatric setting. In the United States, there are 6,146 hospitals (American Hospital Association, 2020). However, out of the 6,146 hospitals, 616 are psychiatric facilities (American Hospital Association, 2020). That is 10% of the total. Hence, accepting a smaller sample size was feasible for this study. The researcher engaged in snowball sampling to obtain additional participants. The process of snowball sampling was part of the Explanation of Research where the researcher asked perspective participants to assist with identifying participants for the study (Creswell & Poth, 2018).

The eight participants that met criteria are distributed across the Contiguous United States. All of the participants are licensed counselors, with some also serving as counselor educators or supervisors. Prior to becoming intake counselors, two of the participants had worked in the intake department.

Data Collection

Semi-structured interviews were used to gather data relevant to the participants' experiences as IPA is designed to assist the researcher in creating a thorough interpretation of participants' experiences (Smith & Shinebourne, 2012). In semi-structured interviews, the researcher presented direct questions to the participant but allowed space for a deeper conversation about the experience (Whiting, 2008). This openness included general conversation and allowed the participant to guide the interviewer (Whiting, 2008). However, the structure stemmed from the development of interview schedules. The interview schedules encouraged the fluidity of the interview while obtaining responses that align with the research question (Smith et al., 2012).

Data collection in qualitative research serves the purpose of informing the central research question (Creswell & Poth, 2018). In this case, the research question was: What are the lived experiences of professional counselors working as intake counselors in the inpatient psychiatric setting? To better understand the central question, sub-questions were created for this study (Creswell & Poth, 2018). The sub-questions were: (a) What is the experience of being an intake counselor as a professional counselor?, (b) How does a professional counselor experience training for intake counselors?, (c) What is the intake counselors' experience of support while working in this role?, (d) How is supervision experienced as an intake counselor?, and (e) How is the inpatient environment part of the experience of being an intake counselor?

Interviews were conducted virtually via Zoom. The interview questions focused on the sub-questions and provided space for open dialogue about the participant's experience (Whiting, 2008). The interview began with questions to obtain background information: (a) How many years have you been an intake counselor?, and (b) What led you to seek a position as an intake

counselor? Following the collection of demographic information, the participants were asked the following interview questions:

- How would you describe your work as an intake counselor?
- How would you describe your experience of being a professional counselor in this setting?
- How are learning and professional development part of your experience of working as an inpatient intake counselor?
- How are best practices part of your experience of working as an inpatient intake counselor?
- What is the supervision experience as an intake counselor?
- What is your experience with support while working in this role?

Data Analysis

IPA data analysis is designed to describe the patterns in participants' experiences that are reflective of what they experience and the way it is experienced. (Larkin, Watts, & Clifton, 2006). The hermeneutics of this study involves the researcher seeking to make sense of the participants' experience. In contrast, the participants are engaged in the process of meaning-making about being a professional counselor working as an intake counselor in the inpatient psychiatric setting.

Analysis of interviews followed the method outlined by Smith and Osborn (2008). Interviews were transcribed and themes identified after reviewing the transcripts multiple times. The first reading is used to summarize and notice convergence and divergence in responses. At this time, the researcher engaged in freestyle notetaking (Smith et al., 2009). However, comments were documented in the margins throughout the transcript, and this included notes of

anything that sparks interest or questions that arise while reading the transcript. For example, terms participants used to describe their experience and additional questions to expound on the experience. This process is followed for each participant (Smith & Osborn, 2008). During the second review of each transcript, additional notes were added to document the themes arising from the initial notes. The themes are descriptive comments that align with the participant's meaning (Larkin, Watts, & Clifton, 2006).

Then, the emergent themes for each participant were grouped chronologically into a table. This assists in finding connections between the themes. Next, the themes were ordered by concepts (Smith & Osborn, 2008). Then, the cases are compared to identify patterns across participants. Next, the cross-case themes are checked against the transcripts. Finally, a master table is created based on themes that emerged during the analysis (Smith & Osborne, 2008).

Trustworthiness

In qualitative research, it is important to promote rigor within the study. The assessment of trustworthiness promotes rigor in qualitative studies by providing readers with approaches that enhance the quality, authenticity, and truthfulness of the researcher's interpretations of participant interviews (Hays & Singh, 2012). To promote trustworthiness, the researcher used the strategies of Lincoln and Guba (1985) to address the credibility, transferability, dependability, and conformability of the research.

Credibility, as described in Lincoln and Guba (1985), is the confidence that the interpretations of the interviews accurately reflect the participants' perspectives. The credibility strategies that were used in this study are peer debriefing, member checks, and managing subjectivity. Peer debriefing is a method in which the researcher asks a peer that is not vested in the study to serve as the alternative voice for the researcher, identifying biases and offering

alternate views of the experience (Lincoln & Guba, 1985; Smith et al., 2009). Member checks were used in conjunction with peer debriefing during the analysis of data. The method of member checks involved the researcher requesting participants to review the identified themes for accuracy. The researcher continuously sought coherence between notes and themes with supportive data from the transcripts (Lincoln & Guba, 1985).

Subjectivity was managed by the researcher engaging in reflexivity (Levitt et al., 2017). Reflexivity highlights the impact of personal experiences, expectations, and biases about professional counselors that are intake counselors. The researcher engaged in journaling throughout the research process in an effort to bring the unconscious to the conscious (Levitt et al., 2017). It helped the researcher foster a genuine curiosity about the participants' experience as intake counselors and build a case for transferability (Hays & Singh, 2012).

Transferability is the ability of the researcher to provide detailed descriptions that allow readers to assess whether the methods of this study can be applied to other contexts, settings, and populations (Morrow, 2005). To enhance transferability, the researcher uses thick description of the researcher, participants, methods, and detailed results. Direct quotes from the participants and the researcher's notes will assist readers with determining transferability (Morrow, 2005; Lincoln & Guba, 1985).

Dependability refers to the consistency and reliability of the research methods and procedures of the study (Lincoln & Guba, 1985). The dependability of the study is accomplished by keeping an audit trail of the research process and any activities related to conducting this study (Morrow, 2005). Confirmability is the awareness that the researcher is part of the research process and is never truly objective (Morrow, 2005). Thus, the audit trail enhances the

confirmability as well by ensuring the analytic processes, data interpretation, and findings are evident in the data (Lincoln & Guba, 1985; Morrow, 2005).

Results

Participants shared their lived experiences of being intake counselors as professional counselors. Five themes emerged from the participants' data and the analysis. The shared experience of being an intake counselor was represented by the superordinate themes of: (a) fulfilling a practical need to work as an intake counselor, (b) struggling to cope with the lack of specific training, (c) having an internal struggle between professional identity and system requirements, (d) containing emotion to cope with the stressors of working in the inpatient environment, and (e) experiencing job sustainability as dependent on multi-dimensional openness and support.

We noted that some themes contained extensive data during analysis, were emotionally charged, and seemed more conceptually complex. These superordinate themes were further analyzed and described by a set of subordinate themes. This section discusses the superordinate and relevant subordinate themes of the participants' shared experience as professional counselors working as intake counselors in the inpatient setting.

Fulfilling a Practical Need to Work as an Intake Counselor

Being an intake counselor was not a primary goal for the participants. This theme explains the motivation and circumstances that led them to accept the role of an intake counselor. For these participants, their work as intake counselors fulfilled a more practical than an aspirational need. This role was not the focus while in graduate school, and sometimes its existence was unknown. Instead, the job was a path to meet financial obligations or satisfy a

desire to continue their work in professional counseling but outside of the realm of traditional therapy.

For instance, a participant describes the practical need to find a job after moving to another state, "[i]t was honestly the first thing that was available at the time when I relocated." As an educator, another participant expressed a desire to obtain new knowledge to enhance the ability to teach a course that involved assessment. The job also meets the desire to do something different and gain insight into intake counseling for educational purposes, "[s]o I decided to do it because I hadn't done it before, really. I did it and it served its purpose and I'm done with it now." However, after the participant felt confident in the knowledge obtained in the role this participant left the job.

Despite this experience, others wanted something outside of the long-term therapy role described in graduate school and found their niche in intake counseling:

> I just think I am one of those people who was never going to be a traditional therapist. I'm super interested in meeting people of all ages and stages of life, but I'm not interested in carrying them through a treatment plan process.

Not everyone that goes into professional counseling desires to engage in the traditional therapy described in graduate training.

Accepting the position of intake counselor was a sound career move that satisfied various personal and professional needs for the participants. Participants communicated security in fulfilling their practical needs but didn't realize that taking on the job would come with challenges. Challenging external and internal system interactions shaped their experience in this position. For example, the realization that their knowledge of intake was inadequate for the inpatient setting.

Struggling to Cope with the Lack of Specific Training

The next theme illustrates the participants' experience with inadequate training as intake counselors. They struggled to cope with the lack of training they received within their education before starting and while on the job. Participants found strategies to cope with the inadequate training that assisted them as professional counselors to care for those experiencing a crisis. Participants did not receive training to manage the range of behaviors they witnessed with patients on the job. Nor did the participants feel confident with accurately diagnosing patients with severe mental illnesses. Even with on-the-job training, there was an expressed deficit that the participants had to cope with by seeking outside training to maintain their professional acumen as intake counselors.

The participants' perceived deficit was in understanding the criteria for admission based on system guidance. They desired more training on proper diagnosis for the inpatient setting and an in-depth explanation of criteria for admission. Participants conveyed that criterion were sometimes vague in the inpatient setting and driven by insurance reimbursement considerations. One participant is licensed with years of experience in both the inpatient and outpatient settings. This participant expressed frustrations with needing more clarity on what is needed for admission:

> I would have liked to have had a more clear understanding of the exact criteria of admission. I think that ... I think it took me a few months even before I really felt like I even knew really well, because I knew the easiest ones, like has it been two days since you tried to kill yourself, or anything like that.

The lack of standardized criteria also blends with the participants' frustration that they did not feel prepared to be an intake counselor. Thus, prompting them to seek additional knowledge outside of the system.

As professional counselors, participants were aggravated by the vague criteria and lack of training to correctly diagnose patients within the inpatient setting. Thus, they coped by seeking training external to the system that would provide insight into the range of behaviors they witnessed. For example, a participant describes feeling underprepared as an intake counselor in the inpatient setting:

> [y]ou know, so it can be a thumbing through the book, but I just feel like I've had to learn outside of jobs, and you tend to pull full on my own experience and research further into disorders/illnesses.

Participants also engaged in continuing education seminars to enhance their knowledge of working with patients who can no longer function in their daily lives.

However, these trainings were not specific to intake counseling, nor did they include inpatient work. Instead, participants used the trainings to supplement their personal experiences on the job, "Those trainings, together with what we get to see in assessment rooms to deal with during the assessment helps." They personally sought educational resources, such as psychopathology texts, and continuing education that may seem to apply to the inpatient setting. These trainings helped them meet the system requirements as intake counselors by enabling participants to make setting specific diagnosis. Therefore, despite their perceived deficits regarding the system's training, the participants maintained their professional commitment to become knowledgeable in their work.

Having an Internal Struggle between Professional Identity and System Requirements

Participants also found it challenging to balance their identity as professional counselors and adhere to the system's requirements in this role. Thus, this theme describes the participants having an internal struggle between professional identity and system requirements. We recognized the intricacy of this theme during analysis and desired to capture the full experience of the participants. Therefore, two subordinate themes are provided to give voice to the challenges within this experience. Those subordinate themes are (a) advocating for self through the knowledge of professional identity and (b) reframing the idea of professional counseling in the role of an intake counselor.

The structure of the inpatient system as fast-paced, chaotic, and crisis-focused triggered an internal struggle for participants between upholding their professional identity and meeting system requirements. Their professional identity as a counselor is patient-oriented and practicing within the scope of their training. However, system requirements often required participants to focus on the system's global needs, not just the patient. The system's needs triggered conflict between departments and the participants. Ultimately, this leads them to advocate for themselves as counselors and reframe their idea of professional counseling in this setting.

Advocating for self through the knowledge of professional identity

As professional counselors, participants understand their role is to promote wellness in any setting and advocate for patients. While this is the understood role, participants also had to advocate for themselves and the wealth of knowledge they bring as professional counselors. The requirements placed on them by the system often included collaboration with other departments to decide if a patient should be admitted. At times, the participants perceived this collaboration

as one-sided. They often felt other departments ignored their competence as professional counselors.

The system did not hold intake counselors' decisions in high regard causing interdepartmental conflict. As a participant explains, "[t]he finance person should not be the one in charge." Another describes trying to admit patients because they are in dire need of help but nurses attempting to stop admissions to the unit:

> For example, intake and nursing, they usually don't get along. However, as much as you try to understand where the nurses are coming from, it's hard for them to understand that, “hey, intake counselors have a job to do.” Instead, they'll try to push patients away. Where we, as intake, we are trying to get patients in because we know that they need help.

This creates frustration for the participants, prompting them to question their role as counselors in this setting.

In addition to the interdepartmental conflict, participants experienced the system adding duties outside the scope of the job as an intake counselor. Thus, prompting participants to advocate for themselves. Ultimately, avoiding being taken advantage of, when possible, "I am not a psychologist for a reason and I'm not a social worker for a reason. I felt I was doing a lot of case management." This frustration swells for participants, as the system requires intake counselors to do more than what is defined by the participants' idea of the tasks of a professional counselor in this role.

The juxtaposition lies in a participant's experience of a healthy, less chaotic system developed through advocacy. Over time, their system now allows intake counselors to focus only on the patient and make independent admissions decisions:

> And then ultimately in our hospital, we have a lot of power, the doctors give us a lot of control of whether or not it's a decision to admit or not. And they put a lot of that on us, they have a lot of faith in our skills basically. So that being our specialty, if we feel that they need admission, then we notify the rest of the treatment team that that's our suggestion or recommendation. And then take over the process from there.

The system uplifts the participant as a professional counselor and sets the example for other departments to trust the clinical knowledge of intake counselors. Although the system was experienced as healthier than other participants stated, this participant joined the others in rethinking the role of a professional counselor in this setting.

Reframing the idea of professional counseling in the role of an intake counselor

The participants' experienced reframing the idea of professional counseling as an intake counselor in the inpatient setting. They were taught that counseling is long-term therapy, but this is not applicable for the intake counselor. Patient interaction is brief, and the focus was on assessing for admission to the hospital. Although, the system-based criteria for admission were vague for participants. The limited contact time is counter to the experience of seeing a patient for multiple sessions in outpatient settings. Thus, there was a pull to provide more care to the patient than an hour of listening for criteria to determine the patient's disposition.

However, participants had to suppress the desire to do more than assess the patient, "I've had a few sessions where I had to learn how to pose questions differently because it started turning into a therapy session and that's not what it's supposed to be." This reframing was in the way participants engaged in their role as intake counselors. In particular, understanding that the strategies used in outpatient settings could not be carried out fully in this setting.

Another participant believed the role of an intake counselor is similar to a traditional role for a professional counselor in the outpatient setting. Thus, the counselor has to realize the parallels of inpatient to outpatient work. Overall, the counselor's goal being to provide context-specific services. A participant provides insight into their irritation with the perspective that the role is not counseling:

> So there's this idea that counseling is long-term therapy, that's really an error that a lot of people make. I feel myself going onto a whole soapbox, but I think that is an error in judgment that a lot of people make and it really prevents them from recognizing the utility of the role. Yeah, you can help them. You can help them meet the goals of that treatment setting.

The skills of professional counseling are transferable. They define the way of being and practices for the participants as intake counselors.

Per participants' experience, training programs led them to think the idea of the work done by a professional counselor was long-term therapy. Participants were focused on the idea that counseling meant long-term therapy and following structured treatment plan in their work. However, as intake counselors, they found their skills applied to this role without meeting the criteria they previously held as fact. Not only were they applicable, but their skills as professional counselors were also essential to meeting the system requirements effectively. However, this does not mitigate the stress participants expressed that was part of working in intake counseling.

Containing Emotions to Cope with the Stressors of Working in the Inpatient Environment

The inpatient environment is experienced as demanding and stressful for participants. This theme focuses on the experience of participants containing emotions to cope with the

stressors of the environment. The fast-paced job, system-assigned tasks, and caring for high-acuity patients have a personal emotional impact that the participants cannot manage immediately. Their way of coping with the stress is through containment of emotional response to get the job done. The containment helped them to remain professional and continue with this work.

Unfortunately, the absence of immediacy in addressing their emotions while in this role had a significant personal impact. For participants, the forced containment of emotions meant a manifestation of mental and physical concerns:

> I hated it. I remember I was miserable. I was depressed. And that's when my weight gain started. I literally jumped dress sizes. I went from a size seven/eight to 12 to a 16, 18 within months of graduating. Like I went from regular dress size to plus and I remember looking at my graduation pictures to... Yeah.

The response to the emotional stress experienced within the job was not recognized until physical symptoms arose.

Another described how containment of emotion impacted personal relationships. The containment was a mechanism to dampen the sadness felt from patients and the frustration with lacking help from system:

> And then I honestly feel like this role has affected a lot of relationships. My relationships were not super stable. Job roles like these weren't super stable and they were making me not feel super stable. And that also spilled over into personal relationships too. I became just more and more shut down and unavailable, probably dismissive.

The unknown blocking done to cope in the inpatient environment interrupted participants' connection with loved ones. Sadly, this coping strategy blended into their personal lives, making it difficult to connect with others.

Additionally, participants focused on the task of their job as a way to cope in this role. The sense of purpose was used as a way to avoid unpleasant feelings in the moment while working with patients:

> Yeah, and mostly just, I have to focus on doing the assessment, and try to not worry so much about the long term stuff, because you can't do anything with that right in that setting.

Focusing only on the job tasks helped the participants make it through the difficulties within the inpatient environment.

There was a personal impact for the counselors as a result of their attempts to filter their feelings at work. They had to discover strategies to cope with the stress as they assimilated into the inpatient environment. Although the implemented coping strategies can be seen as unhealthy, it is a survival mechanism that helps the participants get through the day. However, support from others was experienced by participants as a major factor in staying in this role.

Experiencing Job Sustainability as Dependent on Multi-Dimensional Openness and Support

This theme describes how working as an intake counselor requires support and openness to receiving support to maintain working in this role over time. This experience of staying in the role due to receiving support from various sources makes the job tolerable. However, support is not always available for the intake counselor or equal. The unequal support attributes to the compounding frustrations in this role. Three subordinate themes provide insight into this

experience: (a) Feeling isolated within the system, (b) frustrated that support is not always equal, and (c) finding comfort in supportive relationships.

Feeling isolated within the system

Although intake counselors collaborate with other departments in the inpatient environment, they are not highly regarded by the system. As a result, they are often isolated by the very system they assist with efficient operation. Essentially, leaving them to feel rejected when they are not functioning at the epitome of the system's standards.

Participants explain system isolation as a critical evaluation of performance without additional assistance to alleviate some of the work done by intake counselors. The isolation feels like a personal attack:

> I don't want to say it is, but we are the least supported. They expect us to be perfect, yet we are human. When you error, it's like the worst thing you've done, the way it's presented.

The experience of isolation in the system weighs heavily on the intake counselors and lowers their perception of efficacy in their job.

Additionally, the system is not supportive in staffing appropriately for the volume seen by the intake counselors. Participants experienced a feeling of being devalued by the system due to experiencing inadequate staffing. They are the first to encounter high acuity patients but did not have the additional support of other staff to deal with the influx of patient arrivals.

> So, I was the only person in that office. If anybody had come in overnight, we're doing an intake, and sometimes if you get two or three overnight, then you're doing all of those back-to-back.

Facing the challenges of inadequate staffing increases the feelings of isolation by the system. Part of this isolation is the interdepartmental conflict within the facility.

Intake counselors receive the patients, assess, and work with other departments that were allowed to intimidate them if something was wrong after the patient was admitted. The conflict was anxiety-provoking because, again, the intake counselor is held accountable for something outside of their control:

> I mean, I don't think we get a lot of the flack for…a lot more responsibility, I guess. So, people dislike our decisions, and so then that puts us back on the bottom of the totem pole, because if we put a difficult patient on the unit, then that falls back on us.

The systemic challenges add to the participants' burden and cause them to question their ability to stay in this role.

However, a supportive system makes working in this role tolerable and lessens the feelings of isolation. In addition, the support from a healthy system transfers throughout departments and allows the intake counselor to be open to receive support from other departments:

> [J]ust in the system as a whole in the hospital, we have a lot more respect. I think I work in an exceptionally supportive hospital so the attendings are very open to, "This is your specialty, I'm a generalist, tell me what you think." Which is really cool.

Support is essential for the participants to feel that their role is important, and they are valued as part of the team within the system.

Finding comfort in supportive relationships

Participants relied on relational experiences to provide support during challenging times in the inpatient environment. These relationships provided comfort and made it possible for the participants to continue showing up for work despite the chaos within their job. The relationships consisted of family, supervisors, and general staff in the hospital.

Family support was vital for counselors to lessen stress after work. Family members did not understand the intensity of the work but served as a listening ear for the participants, “I have a really supportive boyfriend. He's great. So as much as I can tell him, I would without breaking HIPAA. So he would just listen and be like, “That's nuts. I don't know how you...”” The relief of sharing difficult experiences with family helped participants show up for work another day.

Supervisors also play a pivotal part in providing emotional support for intake counselors. The participants receive supervision that may be internal or external of the system, but the connection in supervision is critical for participants, “I seek help from somebody else who is also an LPC. In case we get a hard case, we're able to process. She listens to me, and I listen to her, and that helps a lot.” Supervisors who were present emotionally and physically in times of need for the participants assisted with their ability to move forward after a complex case.

Supportive staff help maintain a sense of emotional and job stability for participants as well. A participant experienced the support as having a "battle buddy." This term is used by a participant to illustrate the shared experience of watching over one another as intake counselors. This collective experience is shared among staff and participants through the bond of acknowledging that being an intake counselor in this environment is difficult:

> [y]ou know, if it weren't like for people who have been previous coworkers of mine. I never would have made it the limited amount of time I've… or a limited amount of days, months, years, I've made it at places.

Staff support through shared challenging experiences communicates to participants that they are not the only ones struggling in this environment.

Frustrated that support is not always equal

Despite some staff being supportive, participants feel frustrated that the support they provide is not always equal. Hence, the emergence of the theme describing participants feeling frustrated that support is not equal for them in this setting. There are times when the participants have to provide the same support to their colleagues in a similar way they support patients. The frustration with supporting other colleagues emotionally while at work prompted participants to wonder if staff were appropriate for the role. Additionally, participants were called on by the system to provide services to staff. Although, the same staff were unavailable when participants needed assistance.

Questioning the fitness of staff was an experience of assessing the fit of new staff because participants wanted to ensure they would have mutual support in this role. However, sometimes the participants find they are the containment vessels for the emotional flood of their peers in intake. This in conjunction with high turnover rates led participants to assess co-workers' mental fitness for intake counseling. An intake counselor that has remained in the job for over five years describes this experience as:

> [w]hen you're introduced to a new co-worker as these positions specifically turn over so often. You know, I'm looking for the, are you strong. Do you look like

> you can hold yourself together? And could you possibly hold me together, if I fell apart? Because that's possible too.

participants desired support to be equal in the department and not perpetually holding space for staff to vent in the same manner they are present with patients.

Furthermore, the system encouraged participants to fill gaps for other departments. This could mean physically assisting departments, despite the participants' workload. A participant described an encounter of restraining a patient trying to elope prior to leaving for the day because the unit staff were indifferent towards the situation, "…but we had CPI training. I actually wish my first and last time ever restraining a client. I don't want to restrain a client. I wound up putting the client in a figure four position." Along with physically helping other departments, participants were expected by the system to provide counseling services to other staff.

For instance, the participant that experienced a supportive system was expected to counsel hospital staff when needed:

> I mean, having to restrain someone is traumatic, so having to help debrief and counsel and provide support for those situations after the fact is it can be frustrating, because it just feels like, I mean, this probably is universal, but you're counseling and providing support, you're the one who is trained in that, so you're expected to know how to do it, for everybody, an, not just the patients.

However, the staff were not available to provide the participant the same services. Thus, the experience of a supportive system is contradicted by the support being unequal for participants.

Discussion

This research focused on the essence of participants' lived experience as professional counselors working as intake counselors within the inpatient psychiatric setting. The

participants' experiences provide insight into the practice of being a professional counselor in this role and within the psychiatric hospital environment. There is no known literature addressing the experience of intake counselors, and this study informs the profession. Thus, the themes will be discussed in the context of extant literature in inpatient nursing, clinical psychology, psychiatry, and outpatient counseling. Below is a discussion of themes that emerged from the analysis of eight participants' experiences in this interpretative phenomenological study.

The experiences of participants in this research are highlighted in the following themes: (a) fulfilling a practical need to work as an intake counselor, (b) struggling to cope with the lack of specific training, (c) having an internal struggle between professional identity and system requirements, (d) containing emotion to cope with the stressors of the inpatient environment, and (e) experiencing job sustainability as dependent on multi-dimensional openness and support. This study provides foundational research on intake counselors' experiences as professional counselors in the inpatient setting. The study also gives insight into the roles' personal and professional influence on the counselors.

Fulfilling a Practical Need to Work as an Intake Counselor

The first theme describes participants' experience of being an intake counselor, not within their purview during graduate school. The acceptance of the job came as a necessity to fulfill financial needs and enhance knowledge to meet professional goals. Participants initially used the job to satisfy financial needs moved to a new area or completed graduate school and needed to repay loans. Others worked in different sectors of professional counseling such as counselor education but desired to obtain specific knowledge within inpatient intake counseling to enhance their professional knowledge.

Struggling to Cope with the Lack of Specific Training

The next theme highlighted the participants' struggle to cope with the lack of specific training as intake counselors. Participants had a shared experience of discontent with the level of training they received in graduate school when they began work as intake counselors. In addition, the systems' training did not provide the training they hoped for regarding appropriate diagnosis. Thus, participants managed the perceived lack of training by finding trainings external to the system that could be used in their work as intake counselors.

The participants' experiences of lacking specific training for this role align with the focus of literature being on training for intake in outpatient settings (Young & Cashwell, 2017). The minimal literature that mentions intake counseling does so only in the sense of a task in outpatient counseling (Narins, 2019; Rosenthal, 2003). The enlightening experiences of the eight participants emphasized the importance of considering the setting when diagnosing patients. The participants' identity as professional counselors drives their desire for ethical diagnosis (American Counseling Association, 2014). Therefore, maintaining professional identity was expressed as essential to participants in this setting.

Having an Internal Struggle Between Professional Identity and System Requirements

The next theme speaks to the internal struggle between professional identity and system requirements. Participants embraced the values and norms of professional counseling, such as not working outside the scope of their training. However, they struggled when the requirements of the system conflicted with these values. Thus, participants had to advocate for themselves in the system. The system's requirements also led to them reframing their perspective of what it means to be a professional counselor as an intake counselor.

Rabu et al. (2016) explain within the inpatient patient, psychologists and psychiatrists are overwhelmed by the tasks imposed on them by the system. The stressful experience explained by Rabu et al. (2016) aligns with the participants' experience, as they were asked to perform tasks outside the scope of the job of an intake counselor. This role ambiguity adds to the job stress for participants, similar to the experiences of inpatient psychiatric nurses (Sorgaard et al., 2007; Totman et al., 2011). However, participants knew their worth to the system as professional counselors and challenged the assignment of tasks that were not part of their job.

Additionally, participants were initially focused on providing long-term therapy as counselors while in graduate school. However, that is not what this role entails. Instead, it is brief and assessment-oriented, which pushed the participants to reframe their idea of professional counseling to engage in intake counseling in the inpatient setting. Participants' experiences parallel Werrbach's (2011) understandings about differences in intake counseling and traditional therapy. However, this study highlights intake counselors' experiences in rich detail about the emotional connection with this work. Over time, participants understood that their learned counseling skills were pertinent when working through difficulties in the system and working with high acuity clients.

Containing Emotion to Cope with the Stressors of Working in the Inpatient Environment

Participants expressed difficulty managing the stressors of the system and high acuity patients. Consequently, the theme of containing emotion to cope with the stressors of working in the inpatient environment describes how they could continue working in this challenging role. Participants were not able to express their discontent while working with acute patients and the system. Mellow et al. (2018) found that nurses working with high acuity patients were emotionally and physically impacted in the inpatient setting.

For participants, this setting and the fast-paced culture of the system did not allow them to process their emotions in the moment fully. This containment of emotions eventually surfaced for participants as experiencing numbness in professional and personal relationships. Furthermore, some participants experienced physical impacts due to the stress of the job. They all expressed being unaware of the emotional impact but thankful for supportive relationships.

Experiencing Job Sustainability as Dependent on Multi-Dimensional Openness and Support

The final theme for this study explains how participants experienced job sustainability despite the challenges in their work through multi-dimensional openness and support. The participants' experience with support was multi-dimensional. Participants felt isolated within the system. In addition, participants often provided emotional support to other staff, but this support was not always reciprocated by other staff. Yet, participants found comfort in supportive personal and professional relationships.

Participants viewed support as essential for continuing in this line of work. Participants believed the system's culture was chaotic, often placing the needs of the intake counselor last. They reported feeling demeaned at times when they were not able to manage the influx of patients. Additionally, they would often lack enough staff to handle the system's additional duties placed on them. System support is vital to the welfare of inpatient staff (Jenkins & Elliott, 2004; Totman et al., 2011). Thus, the one participant that experienced a supportive system felt more satisfaction from their job.

Although the participants wanted support from the system, they often offered or provided emotional support to other staff. Sorgaard, Ryan, Hill, & Dawson (2007) describe the benefits of connecting with colleagues as a mitigator for job stress. However, participants as professional

counselors became frustrated with staff relationships. They emotionally supported staff during difficult times with patients, but the support was not always reciprocated to them. Most participants even questioned if other staff were emotionally strong enough to handle working in a challenging environment. Unfortunately, participants intervened with staff as they would for patients in crisis. Despite the challenging staff experience, they found comfort in supportive relationships.

These supportive relationships came in the form of supervisors that provided a listening ear and guidance, family, and those staff with shared feelings about the system. Although Sorgaard et al.(2007) found inpatient staff enjoyed connecting with colleagues, intake counselors only found the relationship supportive if there was a collective experience within the system. Otherwise, participants reached out to family members who understood the emotional drain participants experienced because of the job. This experience counters the experience of nurses not being open to receiving support and limiting interaction with families (Rabu et al., 2016). Supervisors also played a pivotal role in the participants' experience of support. Participants felt encouraged and able to maintain working as intake counselors when supervisors could provide emotional and professional assistance.

Limitations

Participants' locations were in various regions of the United States and were recruited via social media and LISTSERVs. However, a limitation is in the geographical regions of the respondents for the study. No participants stated they had worked in the western region of the United States. Thus, this region is not represented in this study.

The limitations in this study are centered around technology difficulties. Interviews and member checks were done using Zoom video and audio, with audio-only recording. The use of

Zoom enabled me to meet with participants face-to-face throughout the country during a global pandemic. However, there were some technical challenges during the interview and member check process.

Interviews were planned with participants based on their schedule, which meant some participants were home with children or at their office. One participant had children in the home and requested an audio-only interview, which limited reading non-verbal cues. This interview was shorter in duration than others. However, the interview was recorded in its entirety, and I was able to collect a wealth of information about the participant's experience within the shorter time frame

Internet connectivity with another participant was sporadic during member checks, causing my screen and the participant's screen to freeze. This issue was managed by using the dial-in feature on Zoom, emailing the participant the presentation for member checks, and keeping the video feature enabled. There were additional steps that participants had to take to stay engaged in the process, but they did not state any concerns with the additional step.

Implications

This research has meaningful and complex implications for the field of professional counseling. It gives voice to professional counselors that work as intake counselors within the inpatient setting. This study provides insight into the training, supervision, and emotional experience of being an intake counselor. The results indicate that the role of an intake counselor is multi-faceted and requires a different focus in training and supervision than working in the outpatient setting. In addition, advocacy highlighting the value of intake counselors in the system. Thus, the implications for this study are blended within counselor education and supervision. Additionally, this leads to implications for further research focused on intake

counselors. The section focuses on the importance of this study to the body of knowledge for professional counseling.

Results for this study indicate that training for professional counselors concentrates on outpatient settings and does not provide adequate training specifically for inpatient settings. Literature for counselor training for intake is outpatient-focused and does not provide for intake counselors (Marsh, 1999). Results suggest trainings should provide insight into setting-specific appropriate diagnoses, not just those encountered in the outpatient setting. In addition, intake counselors often begin working in this role with little knowledge of how this role differs from that of a traditional therapist. Training programs should explore these differences within the context of the transferability of counseling skills. Additionally, provide continuing education that is specific to intake counseling. Supervision is also an integral component to the success of intake counselors.

Supervisors internal to the hospital and external clinical supervisors that may only provide supervision for licensure need to be aware of the stressful nature of working as an intake counselor. Furthermore, supervisors were not always licensed professional counselors within the system. Results indicate inadequate supervision contributes to feelings of stress. Part of the stress is related to training and systemic issues. Role ambiguity within the system and staffing are major concerns with nurses in the inpatient setting (Sorgaard, Ryan, Hill, & Dawson, 2007; Totman et al., 2011). Results indicate this is a problem that intake counselors face alone. Support from supervisors is key to lessening stress for intake counselors.

The stress causes counselors' emotional strain that impacts them personally and professionally. Internal supervisors should focus on alleviating this strain by advocating for the counselors within the system to remain within the scope of their profession. Additionally,

internal supervisors have to be physically and emotionally present for the intake counselors. The presence is important to lessen feelings of isolation while doing this work.

At times, intake counselors required external supervisors for their license. Supervisors external to the system must examine how they conduct supervision with intake counselors, as they only see the patient once and not overtime. Based on the results, external supervisors should provide emotional support and educate counselors on advocating for themselves in a chaotic system. Both internal and external supervisors must be present in a counselor role as needed and promote self-care for intake counselors.

Furthermore, the results indicate a self-care routine is essential over time in this role. Results indicate that intake counselors will benefit from reciprocal supportive relationships and external to the system, such as family. Results also suggest supportive relational experiences can provide a comforting space in this setting. In addition, intake counselors have to be open to receiving support. The counselor must be mindful not to alienate those that may not understand the intensity of the job. While the world of an intake counselor is fast-paced, the counselor has to maintain a self-care ritual to avoid practicing while impaired. Self-care is something that is often discussed in professional counseling. However, the results show intentionality and oversight for self-care is necessary for intake counselors.

However, advocacy for systemic change is most important to address the inequities that require intake counselors to find routines to maintain sanity in a chaotic system. Results indicate that supervisors within the system advocate for intake counselors to have additional resources to limit stress for the intake counselor. Additionally, intake counselors that advocate for themselves with other staff, and supervisors experience staff being more respectful of the position of intake

counselors. Systemic respect for intake counselors is needed from the administration to lessen the ability for other departments to impede on the job of intake counselors.

Finally, further research is warranted to explore supervision and systemic changes for intake counselors in this setting. The participants described their supervision experiences, but the experience of the supervisors in this setting is unknown. This research may enhance knowledge about effective supervision and consultation practices in this setting. Additionally, future studies could examine how policy changes within the system that lessen feelings of isolation could impact the experiences of professional counselors over time. Ultimately, providing a framework to guide the work of intake counselors. This study is a building block for a body of knowledge devoted to the field of intake counseling.

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Chapter 3: Manuscript 2

Exploring Intake Counselor Perspectives of Conducting Intake Interviews as Professional Counselors in the Inpatient Psychiatric Setting

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Abstract

Intake counselors in the inpatient psychiatric setting use intake assessments to determine and document the severity of patients' symptoms upon arrival to the facility. Thus, intake assessment is an essential function of intake counseling in the inpatient setting. However, research is limited on intake assessment and not inpatient focused. This interpretative phenomenological analysis study explored intake counselors' perspectives of conducting an intake assessment in the inpatient setting (n=8). The researcher found that the counselors experience: feeling compelled to adapt the assessment to patient needs, using empathy as a gateway to connect with patients and families, grappling with complex safety concerns during assessment, and feeling overwhelmed by the system and desire relief from other staff.

Keywords: intake assessment, intake counseling, inpatient psychiatric, phenomenology

Exploring Intake Counselor Perspectives of Conducting Intake Interviews as Professional Counselors in the Inpatient Psychiatric Setting

The inpatient psychiatric treatment setting supports outpatient facilities by caring for individuals who need intensive monitoring due to severe mental health symptoms. Inpatient hospitalization is the highest level of care for seriously ill persons, requiring treatment and stabilization for unmanageable symptoms (Kovac, 2012). Therefore, despite exhibiting symptoms that may suggest a need for hospitalization, these patients have to receive an assessment to determine if the severity of their symptoms require the restrictiveness of inpatient psychiatric treatment (Ovsiew & Munich, 2008).

Primary conditions for inpatient care are that patients are at risk of harming themselves or others (Kovac, 2012). The most common criteria for treatment in this setting include suicidal or homicidal ideations, engaging in self-harming behaviors, and other symptoms that are not safe to treat by clinicians in other settings (Osview & Munich, 2008). Clinicians in the hospital setting who assess and document the severity of patients' symptoms during the intake interview are called intake counselors. For the hospital system, intake counselors are essential because they connect clients from outpatient care to inpatient services (Universal Health Services, 2020).

Likewise, intake counselors are significant to the field of professional counseling. Intake counselors deliver the first line of inpatient services to clients of mental health ambulatory care facilities and the community in response to appeals for a higher level of care. These counselors depend on their knowledge of professional counseling to quickly harness a therapeutic environment for patients. The capability to develop a relationship with the client is beneficial to ensuring the patient's report is accurate and provides enough information to determine the best recommendation for the patient (Werrbach, 2011). Counselors in outpatient settings have the opportunity to nurture this connection over time. However, intake counselors have an allotted

amount of time to connect with the patient while developing an environment for sharing intimate details about their experience.

Intake interviews are important to the intake experience for people seeking psychiatric treatment. The primary phases of the intake interview are building a therapeutic alliance, obtaining information about the patient and symptoms, and negotiating the next steps for treatment (Carlat, 2016). The therapeutic alliance relies on the counselor to develop trust with the client, which helps the patient with lowering defenses and is willing to share information that can inform an appropriate treatment decision (MacKinnon & Michels, 2015). Intake interviews also help the patient make an investment in their treatment while trusting the intake counselor will advocate on their behalf for the best possible treatment to lessen the patient's symptoms.

Unfortunately, the research is limited to intake counselors engaging in intake interviews in the psychiatric hospital setting. Thus, it is reasonable to explore the interview based on the outpatient setting. In the outpatient setting, the intake interview occurs during the first session with a client and includes a bio-psychosocial assessment (Freeburg & Van Winkle, 2011). Assessment refers to an evaluation that seeks to confirm the existence of a problem, the severity of the problem, and treatment options for addressing the problem (U.S. Department of Health and Human Services, 2013).

Inpatient intake interviews differ significantly from outpatient intake interviews. The predominant model of interviewing for outpatient settings is the biopsychosocial assessment (Hays, 2017). The bio-psychosocial assessment consists of questions to obtain information about: (a) the presenting problem; (b) a brief history of the presenting problem to include previous mental health services; (c) any history of substance use; (d) the family's history of mental illness; (e) detailed medical and mental health history; (f) any risk factors toward self and

others; and (g) the client's current level of functioning (Hays, 2017). The goal of the outpatient intake interview is to gain a better understanding of what led the client to therapy, treatment planning, and conceptualization of the client (Guo et al., 2012; Freeburg & Van Winkle, 2011; Hays 2017; Sommers-Flanagan & Sommers-Flanagan, 2014).

The assessment also includes observation of functioning or mental status examination. The mental status examination consists of the counselor's observation of the person's mood, affect, appearance, behavior, speech, use of language, thought process, thought content, cognitive functioning, insight, and judgment (Polanski & Hinkle, 2000). Thus, the tone is more conversational than formal.

In contrast, the inpatient interview process takes a more investigative tone and is time-limited (Werrbach, 2011). The interview requires the intake counselor to develop a working alliance with the patient quickly. The bond created in this limited-time assists with the patient communicating current symptoms. Questions focus on helping the intake counselor gauge the severity of symptoms for a summarized clinical presentation and recommendation for treatment (Jones, 2010; Werrbach, 2011). The intake interview serves as a determinant for an admission or referral decision from the admitting physician (Werrbach, 2011).

The information from the inpatient intake interview also serves as the foundation for treatment, but treatment is often undertaken by clinicians other than the intake counselor and often in teams. Despite this, the research only addresses the process towards the conceptualization of the client and does not discuss the intricacies of working with high acuity patients within the inpatient hospital setting (Sommers-Flanagan & Sommers-Flanagan, 2014; Freeburg & Van Winkle, 2011). Although the research on outpatient intake interviews is

essential to the counseling field, it does not provide an understanding of the experience of conducting intake interviews in the psychiatric hospital setting.

The role of an IC is challenging in terms of the intake interview because of the lack of information to guide intake counselors in the task of performing an intake interview for the inpatient hospital setting. The available literature only describes intake as part of facilities that provide rehabilitation and detox services, not psychiatric hospital settings (Marsh, 1999; Seligman, 1996; Hecker & Thorpe,2015). For example, Rosenthal (2017) develops guides to assist novice counselors with passing certification and qualifying exams. The earlier edition of the guide only has a few lines regarding intake interviews (Rosenthal, 2003). Additionally, Narins (2019) provides details of what is usually included in a psychological assessment during intake.

The guides explain that an assessment takes place during the first interview to determine how the organization can assist the client and provide a diagnosis if applicable. This non-representation in literature leads to questions about the availability of best practices for an intake interview in the inpatient setting. The best practices that are available address intake counseling through the lens of outpatient counselors working with a new client. However, the experience of conducting an intake interview in the inpatient setting needs more research.

The experience of conducting an intake in the inpatient setting is unique and critical to the job of professional counselors working as intake counselors. The job is unique in that the foundation and goals in this setting differ from the intakes performed during outpatient interviews. Despite the uniqueness, there is a lack of research about counselors' experience conducting intake assessments in the inpatient psychiatric setting within the field of professional

counseling. The perspectives of professional counselors working as intake counselors conducting intake assessments in the inpatient setting have not been explored and need to be explored.

Current research does not address the experiences of professional intake counselors nor the experience of conducting intakes in the inpatient setting. The quantitative studies that exist for the inpatient psychiatric setting are marginalizing and do not include professional intake counselors, only the experiences of nurses, psychiatrists, and psychologists (Sorgaard et al., 2007; Totman et al., 2011). Also, the studies that address intake interviews, such as Butts and Gutierrez (2018) and Freeburg and Van Winkle (2011) focus on the education on clinical interviewing needs of outpatient counselors but not the experiences of the counselor performing the task of conducting an intake interview.

Furthermore, other authors focus on engaging clients without concentrating solely on pathology, and the research is not within the professional counseling field (Guo et al., 2011; Timm, 2014). For inpatient intake counselors, this is counterintuitive to addressing the goal of the inpatient intake interview, which is focusing on the presenting pathology of the client. Thus, the existing research excludes the experiences of inpatient intake counselors, and this study will give voice to their perspectives of conducting intake interviews in the inpatient psychiatric setting.

Thus, the purpose of this Interpretive Phenomenological Analysis study is to explore intake counselors' perspectives of conducting an intake interview in the inpatient setting. At this stage in the research, the intake interview is generally defined as the process intake counselors use to gather information to assist with determining if a patient will be admitted for inpatient psychiatric care or referred to an appropriate level of care. By exploring the perspectives of intake counselors, we can better understand how intake counselors experience conducting intake

interviews in the inpatient setting and their thoughts, feeling, and meanings while assessing patients in this setting. Understanding this perspective may provide insight into current deficiencies and future needs with training and education for intake counselors. The central research question guiding this study is, “How do intake counselors experience conducting intake assessments as professional counselors in the inpatient psychiatric setting?”

Method

The purpose of this research is to explore the holistic perspectives of professional counselors conducting intake interviews in the psychiatric hospital setting. There is minimal information on the views of professional counselors conducting intake interviews, and the review of literature returned no information on the experiences of intake counselors performing intake interviews in the inpatient setting. Given the lack of research identified for this population and the researcher's desire to gather participants' individual perspectives, qualitative research is appropriate for this study.

Qualitative research is the ideal approach when the researcher desires to engage with each participant to understand the participant's experience. Likewise, this method is appropriate when exploring topics that have not been addressed by previous research studies (Creswell & Poth, 2018). By using this method, the researcher becomes part of the research during data collection and interpretation by positioning themself in with participants' environments to better understand the phenomenon of the research (Creswell & Poth, 2018).

Consequently, this collaboration enables the researcher to provide a rich description that enhances the essence of the phenomena under exploration. Additionally, qualitative research retains the core of the intake counselors’ perspectives of conducting intake interviews in the inpatient psychiatric setting. The researcher attempts to retain the individual experiences of the

intake counselors by providing rich descriptions that emphasize the perspective of intake counselors engaging in intake interviews.

The researcher used Interpretative Phenomenological Analysis (IPA) for this study. IPA helps researchers to describe how individuals make meaning of essential experiences in their lives (Smith et al., 2012). This approach also allows space for participants to discover their relationship with the knowledge, the importance, or lack of significance with the phenomenon under study (Smith et al., 2012). Besides, IPA supports the principles of the social constructivist paradigm that guides this study.

Social constructivism is the lens used for selecting the methodology and activities of this research. The theoretical underpinnings of social constructivism allow the researcher to trust in the participants' individual and collective perspectives of conducting intake interviews in the inpatient psychiatric setting (Creswell & Poth, 2018). To enter into the mindset of trusting the participants' report of their experience, the researcher has to first let go of what the researcher assumes to be reality. Then search for the participants' individual and descriptions of the lived experience.

This research focuses on participants and their interactions during the intake interview while searching for complexity between the participants' points of view. In the interview schedule, the researcher used open-ended questions that allow the intake counselors to express their perceptions of the experience in the context of conducting intake interviews in the inpatient psychiatric setting.

Researcher as Instrument

The researcher actively participates in the meaning-making process while using a constructivist lens in an IPA study. The IPA method requires the researcher to facilitate the process of participants taking part in a hermeneutical reflection of their experiences (Smith et al.,

2012). The participants attempt to understand their experience with the phenomenon as the researcher is seeking to recognize how the participants find meaning in the experience (Smith et al., 2012). Therefore, the researcher is the interpreter of the participants' reports of their experiences (Tuffour, 2017).

Prior to gathering data, the researcher must reflect on personal perceptions that can influence the interpretation of data collected during interviews (Creswell & Poth, 2018). After two years as an intake counselor in a private psychiatric institution, the researcher moved into an administrator post before departing. The researcher was subjected to work-related stress that had an impact on life outside of the facility. It was, however, a position that provided a once-in-a-lifetime opportunity to see what is taught in classes come to life during the assessment.

Many experiences brought laughter, sadness, and anger based on what was heard during assessments. The researcher laughed with kids having a difficult time but still found ways to experience a sense of fun during the assessment. For example, the researcher warned a child that she would restrain them if they tried to harm her in one instance; however, after an hour with the child, the researcher and child sang the latest hit song walking to the unit. So this was common with children despite the researcher being called to restrain children that staff could not de-escalate during their assessments.

Other instances triggered sadness and anger. These emotions were prompted by witnessing the tears of family admitting patients of all ages for various reasons. The researcher understood that admission was necessary for severe illness. However, the anger arose when the researcher felt patients should be admitted but had no power to override the decision-makers in her facility.

Participants and Setting

This study followed the purposeful sampling procedures outlined in Creswell and Poth (2018). Purposeful sampling helps the researcher identify participants that have experience with the phenomenon being researched (Smith & Shinebourne, 2012; Polkinghorne, 2005). Furthermore, the researcher desired a homogenous sample in which participants share the same characteristics (Smith & Shinebourne, 2012).

For this study, a homogenous sample included participants that identify as professional counselors and meet the subsequent criteria: (a) participants must have a master's or doctoral degree in counseling; (b) at present work in or have a history of working in the inpatient psychiatric setting as an intake counselor; as well as (c) have experience conducting intake interviews in the inpatient psychiatric setting for admission or referral to other services. The researcher did not consider professional counselors to participate in this study that have experience performing intake interviews in facilities that primarily treat eating disorders, substance abuse, and rehabilitation services.

The researcher enlisted participation in the study from professional Listservs and social media pages for professional counselors. Although Smith et al. (2018) suggest a small sample size for first-time IPA studies, the researcher desired to interview at least six participants that match the criteria for this study. Orcher (2016) also acknowledges the necessity for a smaller sample size due to the difficulties in finding persons that have experience with the research phenomenon. Ten people responded to the request for participants. However, one did not meet criteria, and another was unable to participate due to illness. Thus, eight participants participated in this study.

Due to the low number of psychiatric hospitals, and the possibility that not all staff that perform intakes are professional counselors, the sample size is appropriate. In the United States,

psychiatric hospitals are only 10% of all hospitals (American Hospital Association, 2020). Therefore, accepting a smaller sample size is practical for this study. Despite the feasibility of a small sample size, the researcher used snowball sampling to identify other participants. Snowball sampling is the process the researcher uses to identify additional participants (Creswell & Poth, 2018). The researcher asked participants to forward the initial communication to other potential participants that met the criteria for the study.

The eight participants are located across various regions of the Contiguous United States. All participants are practicing licensed counselors, with some working as counselor educators or supervisors. Two participants had experience working in the intake department prior to becoming intake counselors.

Data Collection

The researcher used semi-structured interviews to collect data about the participants' perspectives of conducting intake interviews in the inpatient setting. This method aligns with the IPA approach, as IPA intends to help the researcher by forming a thorough analysis of participants' experiences (Smith & Shinebourne, 2012). In semi-structured interviews, the researcher asks the participant questions and allocates space for a more in-depth discussion about the experience related to the study (Whiting, 2008). The room for participants to engage in meaningful discussion includes general conversation and guiding the interviewer during the interview (Whiting, 2008). However, the structure is in the creation of interview schedules. The interview schedule promotes the fluidity of the interview while obtaining responses that align with the research question (Smith, Flowers, & Larkins, 2012).

In qualitative analysis, data collection helps answer the central research question (Creswell & Poth, 2018). The research question guiding this research is: "How do intake counselors experience conducting intake assessments as professional counselors in the inpatient

psychiatric setting?" To better understand the central question, the researcher created sub-questions for this study (Creswell & Poth, 2018). The sub-questions are: (a) How do intake counselors experience engaging in intake assessments?, (b) How do intake counselors experience the intake process?, (c) How do intake counselors describe working with other staff during intake interviews?, (e) What is the intake counselor experience of working with patients during intake interviews?, and (f) How is the form and content, or changes to the form or content of intake interviews part of their experience?

The researcher conducted interviews via Zoom. The sub-questions guide the interview schedule and gives room for open dialogue about the participant's experience (Whiting, 2008). Before beginning the interview schedule, the researcher asked the following demographic questions: (a) How many years have you been an intake counselor?, and (b)What led you to seek a position as an intake counselor? Following the collection of demographic information, the participants were asked the following interview questions:

- How would you describe your experience of conducting an intake assessment in the inpatient psychiatric setting?
- What feelings arise when conducting an intake assessment in the inpatient psychiatric setting?
- How is the patient, and their unique characteristics, part of your experience of conducting intakes in the inpatient psychiatric setting?
- How are other staff part of your experience when conducting intake assessments?
- What guides your practice in conducting intake assessments in the inpatient psychiatric setting?

Data Analysis

The structure of IPA data analysis assists the researcher in explaining the patterns within participants' experiences that give insight into what the individual encounters and how it is experienced (Larkin, Watts, & Clifton, 2006). This study included the researcher undergoing hermeneutic exploration of the participant's experience during the interview. The researcher's exploration of meaning during the interview is based on an attempt to understand how the participants are experiencing the discussion of their search for meaning about conducting intake in the inpatient psychiatric setting. The researcher used the approach defined by Smith and Osborn (2008) for analysis of the interviews.

Smith and Osborn's (2008) method includes the transcription of interviews and multiple reviews of transcripts to identify themes within individual participant responses. During the first review of individual transcripts, the researcher summarized the data and be mindful of convergence and divergence in responses. Simultaneously, the researcher took notes to track ideas as they arose from the data in the margins of the transcript and comments about the data, including notes that spark interest or questions throughout the review of individual transcripts. All transcripts undergo this process. (Smith & Osborn, 2008). The margin is also the location of documentation for the second transcript review. This review included additional notes and the recording of themes derived from the initial notetaking. These themes are descriptive comments that align with the participant's meaning-making of the phenomenon under study (Larkin, Watts, & Clifton, 2006). Next, the researcher assembled themes into a chronological table, assisting the researcher with finding connections between the themes. Next, the development of a master table assisted with the comparison of themes across participants. These cross-case themes are verified using the transcripts, and a master table displays themes that emerged during the analysis (Smith & Osborne, 2008).

Trustworthiness

The enhancement of rigor is significant in qualitative research. The assessment of trustworthiness provides readers with approaches that enhance the quality, authenticity, and truthfulness of the researcher's interpretations of participant interviews (Hays & Singh, 2012). The researcher used the strategies of Lincoln and Guba (1985) to promote the trustworthiness of this study. Lincoln and Guba stress the importance of the researcher addressing the credibility, transferability, dependability, and conformability of the research.

Credibility, as defined by Lincoln and Guba (1985), is the assurance that the interview interpretations correctly represent the participants' experiences. The researcher used peer debriefing, member checks, and managing subjectivity are techniques to enhance credibility. Peer debriefing is a process in which a person not involved in the study serves as the devil's advocate for the researcher and helps identify researcher bias in the interpretation of interviews (Lincoln & Guba, 1985; Smith, Flowers, & Larkin, 2009).

Member checks also assisted with enhancing credibility during data analysis, as member checks involved the participants reviewing the identified themes to ensure they accurately reflected their perspectives of the experience. In addition, the researcher pursued consistency between transcript data and the researcher's notes, and the interpreted themes (Lincoln & Guba, 1985). Credibility also requires the management of subjectivity.

The researcher engaged in reflexivity to manage subjectivity (Levitt et al., 2017). Reflexivity illustrates the effect of personal perceptions, beliefs, and prejudices towards the work of conducting intake interviews of intake counselors. During the research process, the researcher engaged in journaling to bring the unconscious to the conscious (Levitt et al., 2017). Reflexivity also assisted the researcher in fostering a genuine curiosity about the participants' experience and helped to build a case for transferability (Hays & Singh, 2012).

Transferability is an assessment of whether the methods used in the study are applicable to other contexts, environments, and populations (Morrow, 2005). In order for future researchers to assess for the transferability of this study, the researcher provides thorough descriptions of the methods. Thick description of the researcher's positionality, sample, methods, and a thorough report of the results is used to improve transferability (Morrow, 2005; Lincoln & Guba, 1985).

Dependability denotes the consistency of the procedures used in the study (Lincoln & Guba, 1985). While confirmability is the researcher's awareness that it is impossible to be complete objectivity is impossible as an active participant in the research process. Dependability and confirmability require the researcher to use strategies such as the audit trail to contribute positively to the trustworthiness of the study. In dependability, the audit trail serves as a way to review the detailed explanation of activities within the research process (Morrow, 2005). The researcher provides evidence within the data for analytic processes and data interpretation as part of the audit trail information to address confirmability in the study (Lincoln & Guba, 1985; Morrow, 2005).

Results

Participants conveyed their experience of conducting intake assessments in the inpatient psychiatric setting. Following the analysis of data, the researchers identified the following themes: (a) feeling compelled to adapt assessment to patient needs; (b) using empathy to connect with patients and families amid complexity; (c) grappling with safety concerns during the assessment; and (d) feelings of relief contingent upon staff support. However, before addressing these themes, it is necessary to understand the context of intake counselors in the inpatient setting.

Context of Persevering as an Intake Counselor in the Inpatient Setting

Participants are professional counselors that have experience working as intake counselors in the inpatient environment. They persevered under intense stress and systemic barriers working in this setting. Although this work is stressful, some participants continue to work as intake counselors in the inpatient setting. Others utilized this role to gain insight into this area of counseling as a bridge to other areas in the field. While working in this role, participants experienced stress from the system, patients, and other staff. They had to manage these stressors to be effective in their job.

Managing this stress or the lack of management of stress has a personal impact on the counselor. Participants understand that the nature of inpatient hospitalization is one of working with patients in crisis. However, they were blind-sided by the global experience of being an intake counselor in this setting. They managed in this environment by trusting their professional self and supportive relational experiences. Unfortunately, the experience came with disappointment with the lack of support within the system.

Participants experienced the patient as an expected stressor. They knew they would be working with members of the community that were not able to function solely with outpatient services. However, the level of acuity surpassed their initial assumptions and training for this line of work. Participants experience feelings of overwhelm and frustration as they often were left to manage the patients' behaviors while simultaneously trying to create a space for patients to share some of the most challenging stories of their lives. Even during tense situations, the participants experienced the system culture as dismissive to their physical and emotional needs.

Participants were not prepared for the systemic stress based on the system's lack of support. Additionally, participants feel their job is not valued by the system they support from a financial and logistical standpoint. They also experienced isolation, as they often were recipients

of interdepartmental conflict when other departments attempted to override decisions to admit or refer the patient to alternative programming. The stress within the system filtered down to their colleagues. Participants were placed in positions to support staff as they supported patients emotionally. Amid the chaos within the role of an intake counselor, participants found solace in supportive relationships.

The support was experienced as both internal and external to the system. Internal support came from supervisors that were physically and emotionally present for the participants. Also, staff with shared experiences within the system helped the participants to continue in the role. These connections fostered feelings of support that paralleled the experience of support from family. The family may not understand the intricacies of the job but provided a space for the participants to share part of their experiences within the boundaries of privacy and confidentiality of patients.

Overall, the experience of working as an intake counselor in the inpatient setting is taxing. It takes an emotional toll that the participants were not prepared for to this extent. They were able to stay in the job because of professional self-advocacy and support. With these challenges, they still have the task of assessing patients for inpatient care, as assessment is the primary duty of the job. It is used to determine if a patient will be admitted to the facility, but this task comes with its difficulties linked to the system's culture. Above all, the participants persevered for the welfare of themselves and the patient. The themes below describe their experience of engaging in the assessment of high acuity patients.

Feeling Compelled to Adapt Assessment to Patient Needs

A theme that emerged during analysis was the participants feeling compelled to adapt the assessment to the needs of the patient. This adaptation was necessary to lessen the patient’s

anxiety in conjunction with reducing the participants' anxiety during the assessment process. The system creates the assessment methods. The instrument can be automated or completed using paper documents. Engaging in the intake assessment as structured by the system seemed more like an interrogation for participants and was not patient-friendly. The questions were intrusive whether the participants used a paper document or automated system for electronic records, "EPIC." Participants called the assessment "antiquated." This intrusiveness was anxiety-provoking for participants.

The flow of questions triggered participants' anxiety as they were concerned that they would trigger the patient already experiencing significant distress. Participants provided insight into the system requirement to complete the full assessment in the order given, "[a] 17-page packet of questions. I'm like, this is insane." The participants interacted with patients at the worst time in their lives, and the system required detailed information to decide a disposition for care. The length and flow of the questions prompted participants to personalize their approach to assessment.

A participant highlights finding a method that worked in the assessment. Going in order does not make sense for the participants:

> turn the pages and find that question, answer it, and then from there I would normally follow up on that subject, whatever subject they brought up so that it wasn't like. It just seems like a conversation.

The conversational tone of the assessment allowed participants to gain the information while conveying they cared for the well-being of the patient. Participants were more relaxed when they were able to personalize their approach.

The conversational tone and their own approach to assessment lessened the participants' anxiety as they try to mitigate triggering patients. The participants do this by avoiding unnecessary questions that have already been answered or ask questions that can be asked later in the process. For example:

> And then now I'm giving you homework essentially to do that because I mean, and that was where I disagreed with a lot of like, oh, get their insurance right off the bat. And I know you have to but at the same time you have somebody coming in off the street that's suicidal, they may not even know what their insurance is.

As another participant explains, information can be obtained from patients that are not coherent based on the way questions are asked:

> She was not in reality, having a little bit of word salad. I can't think of all the things. But you still want to ... When I first started, I would just be like, “Oh, I'm not going to be able to do an interview with that person”, and move on. But that's not true. Once you're there, you get comfortable with it and there's things that you can do. You can talk to people and get a little bit of information at least so you can pass on to the nurses.

Moreover, participants were able to build rapport quickly with the patient by personalizing their approach to assessment and maintaining empathy throughout the process.

Using Empathy as a Gateway to Connect with Patients and Families

The next theme addresses the empathy participants embraced and conveyed during assessment. Empathy is the gateway to connect with patients and families during the challenging process of assessment. The challenge for participants is assessing a patient with a loss of

functioning due to severe mental distress. While keeping in mind, this is a one-time opportunity to document the patient's concerns and history of illness extensively. The documentation is needed to determine a need for admission. Furthermore, participants may be meeting patients and families that are not aware of the purpose of assessment upon arrival to the facility. Thus, participants use empathy to build rapport quickly and provide education on the processes within the system.

The assessment process is short, and the system places time restrictions on the amount of time spent with the patient. The limited interaction calls for participants to connect quickly with the patient while simultaneously asking intrusive questions to the patient. During this brief period, participants consider what the patient has been through and communicate their concern for the patient. As one participant states, "[y]our meet them where they are, and you learn that like, how to build those relationships with the person in that short time that you're there, so they feel like they can trust you." Forging this relationship with the patient in this short time lessens the possibility that patients will be reluctant to provide the necessary information participants need to complete the assessment.

While relationship-building makes the assessment process easier for the participants and the patients, it also takes an emotional toll for the patients and participants. The participants are met with the challenge of being empathetic while completing an assessment that does not consider the patient's presentation in the moment. Participants describe their frustration with trying to balance empathy with system requirements:

> They are like, you are going to go line by line, you're going to fill out everything we've asked you on here and so that's really been a struggle to sit down for the interview and know I have 207 blanks to fill in about the situation, and between

> your crying and whatever other chaos we have to manage, we got to get through this and not to mention I'm kind of on a time crunch.

While they felt rushed, their focus was always on the care of the patient and family in their presence. This relationship requires the intake counselors to contain their feelings about the system's structure and stay present despite the dysfunction inside and outside the room.

Amid frustration with the system, there is also profound sadness as participants assess patients. Participants must work through their feelings in real-time based on the content that is discussed during the assessment:

> Remember Halle Berry on Gothika, when she had all the marks and stuff on her arm? When you got kids coming in with those kind of cut marks and sometimes have spelled words on their faces or arms, that's a different kind of like sadness for me. It doesn't interfere with my work with them, but I feel some kind of way.

Participants expressed they harness empathy to connect while working with high acuity patients remembering the humanity of each patient they encounter.

Furthermore, patients often present with their families during the intake assessment. Their presence is supportive and necessary for minors receiving an assessment. At times family members do not understand why the patient is at an inpatient facility, adding another layer of complexity to intake assessments. Participants understand the difficulty of seeing a loved one in crisis and sought to provide families with as much information as possible to help them understand the nature of psychiatric hospitalization. A participant provides insight into culture driving their desire to empathize with families and take the time to explain the process. In essence, lessening the families' anxiety about the patient receiving an assessment:

> And, the families don't understand, especially black families don't understand psychiatric admission or the process and what it all means. And, so trying to explain it to friends and family members who are terrified, I think that is hard, emotionally. It's fine, I do it.

The explanation of the purpose of inpatient assessment helps participants maintain a relationship with the patient and family and acquire the information they need to complete the task.

However, the connection can quickly turn into distance for some participants and a lack of desire to connect with the patient further. For example, a professional counselor with extensive experience in the field shares how she began to emotionally distance herself after witnessing a patient throw feces during her assessment:

> …he wanted to sprinkle his glitter during my assessment. He wanted to gift me with his present. At first that made me want to quit. I was like why did I go get two master's degrees? I was like what is the point?

Patients with behaviors such as this make assessment personally challenging for participants over time.

Participants experienced a universal pull during an assessment to connect with the patients and families as professional counselors. Nevertheless, managing the complexity of the assessment while holding a space for patients and families is emotionally demanding for participants. Developing relationships in a short time is key to completing the assessment. Although the relationship seems time-limited, the encounters with patients and their families remain with participants long after the assessment. Participants often remember these encounters because they are pressed to understand managing safety during an assessment.

Grappling with Safety Concerns during the Assessment

The remembrance of encounters lends to another theme addressing the safety concerns of participants. Participants grapple with managing safety as part of the assessment process in the inpatient setting. They explain the isolation as conducting intake assessments alone in a room with patients and sometimes family members. Participants begin this work knowing they work with patients with more challenging behaviors than those in the outpatient setting. However, they are confronted with figuring out how to complete a lengthy assessment for patients and being hypervigilant about their behaviors to maintain safety in the room.

With the varying intensity of symptoms for each patient, the participants experienced concern for their safety and the patients' safety during the assessment process. Additionally, the safety experience of working with other staff during assessment created a dynamic of splitting the participants' attention on safety into three elements, self, patient, and staff. These elements were notable within this theme and makeup the subordinate themes to further describe participants' experience of grappling with safety concerns during the assessment. The subordinates are: (a) independently managing personal safety, (b) changing the stance on personal safety, and (c) managing safety in the presence of other staff.

Independently managing personal safety

The first subordinate theme is independently managing personal safety, which focuses on the participants' personal safety during assessment. Managing personal safety without the help of the system was the experience of some participants. They understand that the nature of the job is meeting patients with little knowledge of their behavior patterns before their arrival. As a result, participants found themselves in situations where they had to contemplate actions to feel safe and not be harmed by unstable patients. However, the system does not provide an environment to

minimize the participants' anxiety when meeting with patients. Thus, personal safety is always in question for the participants.

Personal safety is always at the forefront for participants due to the isolative nature of the assessment rooms:

> [t]he small tiny environments and spaces that we've been stuck in to complete these assessments have felt like a security nightmare trap. I always make sure I'm closest to the door and there's not anything in my way of getting out of there.

Participants focused on strategies to ensure they would be able to leave the room if necessary. Such as, “Let’s move this around, put the stapler over here.” Establishing multiple preparedness plans should a patient pose a threat to their safety.

Plans were primarily where the participant chose to conduct the assessment. Even the most experienced participants expressed the desire to have a sense of security in the area for assessment. For example, a former police officer, now supervisor and educator, experienced anxiety when faced with the unknown of what a patient may be capable of during assessment:

> And, the patient was mostly still, but was getting really agitated with different people. And, I talked to them from the hallway, which is not typical, but that's what I felt I needed to do, so that's what I did.

Although they were trained to handle threats to self, they focused on avoiding being placed in an unsafe situation.

The participants' need to focus on personal safety without the system's assistance independently did not deter them from focusing on their patients. The decisions regarding personal safety happen while maintaining patient welfare. Although, their perspective of what it means to consider patient safety shifted in the inpatient setting.

Changing the stance on patient safety

This shift led to the subtheme of participants changing their stance on patient safety. While the participants feared for their safety, they remained committed to the welfare and safety of their patients. Patient safety entails the process of safety planning and referrals for those that do not meet criteria for admission and admitting those in need of inpatient care. Admission creates a dichotomy to the values of the intake counselor as a professional counselor during the assessment. The harsh reality is one of limiting the freedoms of the patient through admission to keep them safe.

Participants focused on safety plans for people that were not admitted to the facility but also found themselves having to deescalate patients being admitted for inpatient care, as highlighted by a participant that explains:

> They're like, Oh, I want to go home. And I was like, No, that's not an option. And sometimes I'm just like, “Well, we'll talk to the psychiatrist and see what they say.” And sometimes I'm just like, “No, it's not happening.” And I'm just using my judgment based on how I think they're going to respond to do that.

At times, this change in perspective about patient safety also meant searching patients for items that may pose a safety risk. A participant recalls, “I did have a really hard time with, like when we first go in, and I have to take their stuff away.” The stance of limiting patients’ freedoms is counterintuitive for participants as professional counselors.

However, one participant experienced a system that removed the concern of patient safety from the intake counselors. Instead, the system understood the security risks and the strain on the intake counselor when conducting intakes and chose a proactive approach:

> So they built us an ED for those kids, which was super cool. So it's ligature proof and all of that. And there's a security guard sitting in with us in our little mobile workstation. It's all glass, so we can see, and then there's individual rooms where the kiddos get assessed. So it's really cool.

The structure of the physical environment allows the focus to turn from safety to the patients' experience that led them to be assessed.

Participants were able to change their stance on patient safety after experiencing what it means to pay attention to patient safety in the inpatient environment. They understood that planning for patient restrictions was part of the process. Although, staff also play a role in understanding patient safety during assessment as an intake counselor.

Managing safety in the presence of other staff

The final subtheme describes the participants' experiences of managing safety in the presence of other staff during assessment. At times, the intake counselor has other staff present in the assessment room during intake. Adding people to the room lends to a need for the participants to be vigilant about the actions of the other staff present. Often, they had to manage safety during the assessment because of staff behavior. Staff can sometimes attempt to help with a patient, but they can aggravate patient behavior.

Participants explain that some staff are not trained for the immediate mental health crisis. They attempt to be helpful but at times negate the participants' plan based on the assessment. As a participant explains, a plan was created during an assessment to keep a patient safe without exacerbating their behavior. However, untrained staff interrupted the approved plan:

> [a]nd the nurses are, "I don't have any mental health training." So they're freaking out. And I tried to calmly explain and educate them on borderline personality

> disorders traits, and why this is happening. And the attending was spooked and ended up admitting her anyways.

The admission was counterproductive to the plan that the participant developed. In addition, participants were often aggravated by managing the behavior of staff during times when situations with clients were stressful.

The reactive nature of other staff enhanced the emotional intensity of assessments that were already draining for the participants. At times participants intervened due to staff conflict, shifting the attention standard patient care, “there were lots of fights on the unit. I’m talking about clinical staff and client.” A licensed counselor educator explains that she became despondent after stepping into multiple situations where the staff were her main safety concern.

Participants give attention to their safety, patient safety, and safety when other staff are present during a patient's assessment. Participants experience a conflict between their values as professional counselors and the awareness that the system does not always provide resources to support safety on various levels. Although, the values of the system may conflict with their identity. They begin to understand the need to balance abiding by their professional counseling identity tenets of patient autonomy and nonmaleficence by searching for safer alternatives with the values of the system. Balancing the system's values and tasks while maintaining safety during assessment increased the participants' stress during assessment.

Feeling Overwhelmed by the System and Desiring Relief from Staff

The final theme for this manuscript is feeling overwhelmed by the system and the participants desiring relief of tasks from other staff. The balancing of safety during assessment produces feelings of overwhelm as participants reflect on the additional tasks involved with conducting intake assessments in the inpatient setting. They feel overwhelmed by the system and

desire relief from the additional tasks from staff. Although they desire this relief, it is often not given. In addition, the planning of next steps with patients during assessment creates this feeling of overwhelm because depending on what is disclosed in the assessment, the participants may need to follow additional steps before moving on to the next patient.

Participants described these additional tasks as transporting patients to units, calling to schedule referral appointments, and treatment planning. For example, a participant explained their contemplation of next steps while with a patient when they realized the patient did not meet criteria and would not be admitted:

> If a patient is not admitted, we have a goal to set them, like a percentage of people leaving the hospital without patient appointments. That has been really, really tricky, especially on second or third shift, there's nobody available to make appointments with.

Another explained the thought of having additional steps when a patient needs to be admitted, "contacting the insurance and getting a chart put together, because that facility still uses physical charts." They are expected to respond to a multifaceted process of assessment with minimal help from the system.

The desired relief with tasks is not often provided by staff in the system. When staff can acknowledge the participants' feelings of overwhelm, staff help in practical ways, "[s]ometimes if we had somebody that needed somebody to sit with them, being able to come off the unit and sit with them for at least a little bit." The support given by staff when the participants become visibly overwhelmed is helpful. Still, it does not alleviate the stress of managing the additional responsibilities participants must complete for one patient.

Two participants described how their systems planned to alleviate the feelings of overwhelm based on the additional tasks that are recognized during assessment. For example, one participant worked at multiple sights during a week and explained:

> There was one or two of the off sites people actually would help with some of the insurance stuff. So that was always helpful, but then since you met with them, sometimes you'd have to follow up with what was going on.

The other participant describes having support staff available to complete additional tasks, " [i]t's just clinicians and support staff who take care of all of the direct admissions and that kind of thing. They're on getting administrative tasks done." The assistance these participants received allowed them to focus solely on direct patient care.

There is a spontaneous reaction when the participants need urgent assistance. Staff responds when there is apparent distress for the intake counselor or patient. However, the help received is not a systemic preventative solution to an issue or wellness driven. The assistance the participants receive from the system is only a temporary fix. However, participants in supportive systems recognize that assessing high acuity patients is stressful and try to provide staff to help with additional responsibilities that emerge during the assessment.

Discussion

This study was stimulated by the research question: How do intake counselors experience conducting intake assessments as professional counselors in the inpatient psychiatric setting? This study addresses the absence of literature regarding the professional counselors' experiences of intake assessment in the inpatient setting. Eight participants engaged in semi-structured virtual interviews to provide insight into their experiences of assessing patients in crisis. These patients could no longer function normally in their daily lives. Participants expressed the challenging nature of their work and barriers working within the inpatient psychiatric setting.

As professional counselors, participants felt the system of inpatient psychiatry was fast-paced and chaotic at times. In addition, the culture of the system had professional and personal impacts on the participants. As an intake counselor, these impacts were voiced by participants as needing to balance both internal and externally influenced emotionally charged conflicts. Participants experienced these challenges filtering over into their tasks of conducting the intake assessment. Their experiences within the assessment are voiced in four themes: (a) feeling compelled to adapt assessment to patient needs, (b) using empathy as a gateway to connect with patients and families, (c) grappling with safety concerns during the assessment, and (d) feelings of relief contingent upon staff support. Offering knowledge on this challenging experience provides an understanding of the complexities of conducting intake assessments in the inpatient setting and its effect on the professional counselor.

Feeling Compelled to Adapt Assessment to Patient Needs

Participants enter the intake assessment with patients understanding that this is possibly the worst time in a person's life. As a result, participants felt compelled to adapt the assessment to the patient's needs. The participants modified the way they asked the questions constructed by the system. This adaptation reduced the patient's anxiety as the questions are intrusive. Additionally, participants' anxiety was reduced during the intake assessment because they were less concerned about questions triggering patients. Existing literature focuses on what is needed in an assessment and the purpose of assessment (Freeburg & Van Winkle, 2011; Sommers-Flanagan &Somers-Flanagan, 2014; U.S. Department of Health and Human Services, 2013). This theme adds the emotional experience to employing an intake assessment. Furthermore, the theme provides a glimpse into what is necessary to effectively utilize the intake assessment in the inpatient environment.

Using Empathy as a Gateway to Connect with Patients and Families

During the complicated process of assessment, empathy is the key to connecting with patients and their families. Although the system-developed assessment does not consider the patient's current emotional state, the participants worked to be compassionate while performing the intake procedures. Participants expressed their dissatisfaction with trying to strike a balance between empathy and system requirements. Understanding the patient's feelings is essential to building the therapeutic bond between participants and patients. In this setting, the bond happens quicker than in outpatient settings. This bond development aligns with the description of building a therapeutic alliance described in MacKinnon and Michels (2015). However, this guide is not inpatient-focused, nor does it describe the emotional connection for intake counselors that this study provides.

Grappling with Safety Concerns during the Assessment

The next theme that emerged was participants' complex focus on safety. In outpatient settings, safety is a concern but not necessarily a primary consideration for a counselor. However, safety was a principal factor in conducting assessments in the inpatient setting for the participants as intake counselors. Participants considered multiple facets to safety, including their safety, what safety meant for the patient, and staying vigilant to safety concerns when other staff were present during assessments.

Participants had to focus on their safety during assessment because most systems did not provide resources to ensure personal safety while with a patient. Participants engaged in a risk assessment as patients arrived for an assessment. They also had to rethink the way they viewed safety for a patient. Ethically, they were focused on doing no harm and desiring patients to maintain their liberties. However, participants were conflicted on adhering to their ethical code

because not to harm meant imposing restrictions for the patient's safety. Osview and Munich (2008) mention the notion that the inpatient environment can be restrictive, but the emotional impact on the professional counselor is not addressed.

The participants focused on self and patient. But they also had to worry about other staff triggering the patient. The presence of staff created additional stress and made assessment difficult at times. Participants had to manage the behaviors of staff to complete the task of assessment. Although Osview and Munich (2008) address inpatient psychiatry, they do not highlight the struggle with staff during assessment. Participants experienced considerable challenges regarding safety with little to no help from the system.

Feeling Overwhelmed by the System and Desiring Relief from Staff

The final theme discussed in this study is the participants' feelings of overwhelm by the system and desiring relief from staff. Participants are emotionally invested and often thinking of multiple responsibilities that will need to be handled while in the room with a patient. These responsibilities are based on what the patient reports in session. Participants were often strategizing what the next steps were in the system's process as the patient shared the reason for seeking an assessment. The split attention described by participants is not covered in the literature and occurs at a surprising pace. Quick planning is unlike the assessment process described in the literature that occurs over time (Guo et al., 2012; Freeburg & Van Winkle, 2011, Hays, 2017; Somers-Flanagan & Sommers-Flanagan, 2014). The participants realize this is a part of the job, and staff may never be able to provide relief from the additional tasks of the system.

Limitations

Participants were recruited using social media and LISTSERVs from various parts of the United States. Unfortunately, there were no individuals who said they resided in the western

United States. As a result, this region is not included in this research. The study's shortcomings are mostly due to technological issues.

Zoom video and audio were used for the interviews and member checks, with audio-only recording. During a worldwide pandemic, I was able to meet with people face-to-face across the country via Zoom. There were some difficulties with internet stability during the interview and the presentation of themes with participants.

In addition, participants were interviewed based on personal schedules. One participant requested an audio-only interview because children were home. This hampered my ability to read non-verbals, and the interview was shorter in length than the others. However, the entire interview was recorded, and I was able to get detailed information about the participant's experience.

During member checks, connectivity was intermittent with one participant. This problem was solved by using Zoom's dial-in feature, emailing the presentation to the participant for member checks, and keeping the video capability turned on. The participant agreed to perform additional steps to remain involved in the process, but they did not appear to mind or express any concerns.

Implications

This study has important implications for professional counseling in the area of intake assessment. These results emphasize the significant work of intake counselors in the inpatient setting. The task of assessing high acuity patients is not comparable to conducting an outpatient bio-psychosocial assessment for a client. Assessing patients in the inpatient setting is complicated due to systemic barriers and the intake counselors' interactions with others during assessment. This study recognizes the difficulties with assessing patients in the inpatient psychiatric setting as an intake counselor. No known literature currently addresses intake

assessment within the inpatient setting. The results from this study provide insight into the strategies use by intake counselors during assessment and the difficulties they face in the system.

Based on the results, some system practices trigger unease during assessment for intake counselors. The system requires intake counselors to follow strict rules regarding how they assess patients in crisis. The system should allow intake counselors professional grace with how the intake assessment is conducted in the inpatient setting. Supervisors also need to be aware of these challenges and assist through advocating for intake counselors in the system. After all, they are finding a way to meet the challenges constructed by the system while working with high acuity patients.

In addition, intake counselors are hypervigilant during assessments. The results emphasize the need for adequate staffing to lessen feelings of anxiety for the intake counselor. Staffing is a challenge in the inpatient setting (Sorgaard et al., 2007). However, the results highlight the presence of staff lessens the distractions in an assessment for the intake counselor. Additional staff to help with the multiple tasks that intake counselors consider while conducting assessments will allow the intake counselor to focus solely on the patient and family seeking help. Ultimately, intake counselors will be less focused on safety and have the support desired while conducting assessments with assigned support staff.

This research begins to build scholarly knowledge for intake assessment in the inpatient psychiatric setting. However, more exploration is needed of intake counselors conducting assessments in the inpatient psychiatric setting. Further research for this population should emphasize the theoretical explanation of healthy systemic practices at the administrative level that alleviates the stressors of extensive multi-tasking during assessment.

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Chapter 4: General Conclusions

General Conclusions

The concentration within chapter four summarizes and links the two dissertation studies that explored the experiences of professional counselors within intake counseling. The thematic link derives from exploring the work of intake counselors in the inpatient psychiatric setting and the task of assessment while in this position. Professional counselors that had experience working as intake counselors within the inpatient psychiatric setting were invited to participate voluntarily in this research. Individual semi-structured interviews were conducted with eight participants that met the research criteria. Participants were interviewed via Zoom and located within various regions of the Contiguous United States. Interpretative Phenomenological Analysis (IPA) was the research method chosen for both studies.

Summary of Manuscript 1

The first study explored the holistic experience of professional counselors working as intake counselors in the inpatient psychiatric setting. The researchers identified five themes that emerged using IPA: (a) fulfilling a practical need to work as an intake counselor, (b) struggling to cope with the lack of specific training, (c) having an internal struggle between professional identity and system requirements, (d) containing emotion to cope with the stressors of working in the inpatient environment, and (e) experiencing job sustainability as dependent on multi-dimensional openness and support.

The intake counselors in this study expressed their initial reason for beginning in this line of work professional counselors was to fulfill practical needs. Intake counseling was not a dream job during graduate school. Furthermore, participants were initially unaware of the job unless they already worked in a position connected to the inpatient setting. These participants needed a source of income to repay loans and support themselves financially. In addition, participants

used the role to gain additional professional knowledge on intake procedures in the inpatient setting. Their time in this role was challenging.

Participants experienced frustrations with the lack of training to prepare them for doing the work of an intake counselor within graduate school and the system. Graduate level training was expressed as deficient by participants. They reflected on the initial difficulties with diagnosing severely ill patients versus those in the outpatient setting. Participants were not given adequate training to deal with the vast array of behaviors they experienced on the job with patients. Participants looked for educational resources such as psychopathology texts and continuing education with relevant portions applicable to the inpatient setting. These pieces of training minimized the stress of meeting the system requirement to use more severe yet accurate diagnosing in this setting.

Unfortunately, participants experienced multiple frustrations in this role. Despite taking ownership of their professional growth as intake counselors, they continuously experienced an internal struggle between maintaining their professional identity while meeting the system's requirements. Participants experienced a need to advocate for themselves in this environment. Often, they had to defend their range of practice as professional counselors. However, working in this environment called for participants to reframe their idea of what it meant to be a professional counselor within the role of an intake counselor. The requirements of the system and the learned perspective of professional counseling clashed for participants. Yet, they excelled by maintaining their professional identity in the context of their work as an intake counselor.

The difficulties with training, professional identity, and system requirements had an emotional impact on participants. Participants needed to contain their emotions to treat patients

with empathy and remain professional while meeting system requirements. Although, this containment led to participants mentally alienating themselves from family and noticing the manifestation of physical concerns. Participants expressed the onset of anxiety and depression because of the challenges they faced as intake counselors. Despite participants coping through containing their emotions, the behavior served the purpose of allowing them to continue in the chaos. The participants expressed that receiving support from others was essential for continuing the work of intake counseling. Receiving support from others was regarded by the participants as necessary to sustain their presence in this job.

Again, the inpatient setting is experienced as unhealthy by participants. There was a collective recognition across participants that their openness and receiving multi-dimensional support made the job more palatable. The experience of support was both internal and external to the system. The participants felt isolated in their role and unsupported by the system even though they were on the front lines. However, one participant had a different experience within their system. The administrators acknowledged their knowledge as professional counselors and often aided them when needed. Support came from people within the field, such as staff with similar experiences and the participants' family and friends. These support systems helped the participants to continue working as intake counselors longer than initially planned. In fact, a few participants are still intake counselors, with one now serving as a supervisor

Summary of Manuscript 2

The second study of this dissertation explored the experiences of the intake counselors during the intake assessment process in the inpatient setting. The context of this experience lies in participants experiencing their jobs as intake counselors as challenging and chaotic, yet manageable with support relationships. IPA was used in the analysis and the researchers identified four themes: (a) feeling compelled to adapt assessment to patient needs, (b) using

empathy to connect with patients and families amid complexity, (c) grappling with safety concerns during the assessment, and (d) feelings of relief contingent upon staff support.

The inpatient environment provided multiple challenges for a professional counselor working as an intake counselor. Training is not provided within the system nor during graduate school to address the needs of the intake counselor. The lack of training coupled with systemic, professional, and personal struggles in this line of work is emotionally demanding for the counselor. The participants could sustain the job's challenges by having support from within and external to the system. However, the tasks of assessment were experienced as a different challenging experience for participants.

Part of the challenge with assessment was in the structure of the form provided by the system. Participants felt compelled to adapt the system's structured assessment into a more semi-structured assessment to mitigate triggering a patient that is already in distress. Participants often considered that the assessment could aggravate the patient, which triggered anxiety for the participants themselves. To alleviate their anxiety and avoid aggravating the patient's symptoms, participants of their own volition decided when and how to ask questions. At times, this meant delaying obtaining non-pertinent information.

Participants explained that patients sometimes arrive with family, as the patients are experiencing a personal crisis. Participants expressed using empathy as a gateway to ask intrusive questions. In addition, empathy assisted participants with remembering the circumstances that led people to seek an assessment despite patient behaviors. Empathy also helped participants balance the system's additional tasks that can be mentally all-consuming with the need for patients' families to understand the inpatient environment. While trying to maintain

an empathetic stance during the assessment, participants had to be cognizant of potential safety problems while working with high acuity patients.

Participants grappled with safety concerns during the assessment. As intake counselors, participants tried to understand the risk to their safety, maintain patient safety, and manage safety when other staff's presence complicated the assessment. Thus, protecting self and others was another factor participants had to figure out while completing an assessment. They were anxious about the meaning of safety within these areas. However, safety for patients was counter to what they knew professionally. Safety in this environment meant placing restrictions on everyone present in the room, including themselves.

During the multitude of anxiety-provoking actions and thoughts for intake counselors during an assessment, participants experienced a desire for help. Participants are in a whirlwind of thoughts based on what they hear from patients and their families during an assessment. Feelings of overwhelm come upon participants as they conduct the assessment while strategizing the next steps before leaving the assessment room. One participant described having assigned support staff to help with some of the additional necessary tasks while assessing the patient. However, they are not in the room, and often staff must be paged to assist. Although the participants desired relief from other staff with additional tasks, they often came to the stark realization that they are alone, and help was not available.

Implications and Recommendations

The two manuscripts offer essential contributions to professional counseling, specifically providing knowledge into an area of counseling that has been overlooked in the literature. Limitations are a part of research, and those within this study do not hinder the contribution to the body of scholarly research. The distinctive insights of both manuscripts are important to the overall work of professional counselors. The manuscripts add to the knowledge of professional

counseling across counselor education and supervision. Acknowledging and understanding the experiences of intake counselors provides an avenue for counselor educators to discuss the work and application of counseling skills in the inpatient setting. It will also shed light on the role of intake counseling for counselors-in-training. Furthermore, supervisors can broaden their approach to supervision to meet the needs of intake counselors in the inpatient environment.

Enhancing Training for Counselors

According to the results of this study, professional counseling education focuses on outpatient settings and does not provide enough training for inpatient settings. Thus, trainings need to be enhanced by including specific considerations for intake counselors. The literature for intake counselor training is outpatient-focused and does not include intake counselors (Marsh, 1999). The results suggest that trainings should focus on setting specific diagnoses rather than just those seen in outpatient settings. In addition, intake counselors begin their careers with a limited understanding of how their position varies from that of a traditional therapist. These distinctions should be explored in the context of advocating for self as a counselor and applying counseling skills in this setting.

Supervision

The results of both studies highlight the importance of supervisors working with intake counselors. The nature of the job is fast-paced and stressful, which has a significant emotional and professional impact on the counselors. Furthermore, results suggest intake counselors may be less anxious if supervisors within the system are available for questions and prepare the intake counselors for what to expect in this setting. External supervisors that may provide oversight for licensure purposes for intake counselors should tailor supervision to meet the needs of the intake counselor. Since intake is not long-term therapy, supervision should focus on intake-specific

concerns such as the personalization aspect of intake counseling. Additionally, all supervisors should ensure their supervision style allows the intake counselors to ventilate and offer suggestions to improve their functioning in this role.

Culture Shift Needed Within the System

It would be amiss not to address the changes needed within the system. While the chaotic system within the results requires considerable systemic change, the results indicate that intake counselors would be less stressed in a healthier system. Administrators within the system should acknowledge the importance of the intake counselor. According to the results, intake counselors are essential to the system. After all, the system mandates that intake counselors be the initial point of contact for patients requesting admission. Thus, intake counselors are an essential component of the system's foundation.

Intake counselors will benefit from a system that provides adequate staffing specific to the department. Additional staff will allow the counselors to focus only on the patient, lessen feelings of overwhelm, and still meet their job requirements. Finally, the system must influence how other departments see intake counselors by establishing more supportive guidelines, honoring the professional acumen of intake counselors. Hopefully, policy changes will lessen the overbearing presence of other departments that attempt to influence the work of intake counselors within the system.

Limitations

Limitations exist even though these studies provide a wealth of insight into the lived experiences of intake counselors. A limitation is that the participants consisted of one male and seven females. He experienced stepping in for other departments to handle safety concerns because of his gender. It would be interesting to explore possible differences in the experiences with expectations of intake counselors based on gender. Additionally, there were no participants

from the Western Region of the United States. Research to focus on this region may assist with enhancing the awareness of similarities and differences with regional-specific challenges of intake counselors. Finally, the researchers worked diligently to limit bias in the design and analysis process of the studies. The researchers used debriefing and thick description to minimize potential bias in analyzing data.

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Young, J.S., & Cashwell, C.S. (2017). *Clinical mental health counseling: Elements of effective practice*. Thousand Oaks, CA: Sage.

APPENDICES

Appendix A

Oregon State University Research Approval Notice

Oregon State University
Research Office

Human Research Protection Program
& Institutional Review Board
B308 Kerr Administration Bldg, Corvallis OR 97331
(541) 737-8008
IRB@oregonstate.edu
http://research.oregonstate.edu/irb

Date of Notification	November 23, 2020		
Notification Type	Approval Notice		
Submission Type	Initial Application	Study Number	IRB-2020-0736
Principal Investigator	Deborah J Rubel		
Study Team Members	Dyson, Nineka; Pryor, John;		
Study Title	Exploring the Experiences of Intake Professional Counselors: An Interpretative Phenomenological Analysis of the Perspectives of Professional Counselors Working as Intake Counselors in the Inpatient Psychiatric Setting		
Review Level	FLEX		
Waiver(s)	Documentation of Informed Consent		
Risk Level for Adults	Minimal Risk		
Risk Level for Children	Study does not involve children		
Funding Source	None	Cayuse Number	N/A

APPROVAL DATE: 11/20/2020 **EXPIRATION DATE:** 11/19/2025

A new application will be required in order to extend the study beyond this expiration date.

Comments:

The above referenced study was approved by the OSU Institutional Review Board (IRB). The IRB has determined that the protocol meets the minimum criteria for approval under the applicable regulations pertaining to human research protections. The Principal Investigator is responsible for ensuring compliance with any additional applicable laws, University or site-specific policies, and sponsor requirements.

Study design and scientific merit have been evaluated to the extent required to determine that the regulatory criteria for approval have been met [45CFR46.111(a)(1)(i), 45CFR46.111(a)(2)].

Adding any of the following elements will invalidate the FLEX determination and require the submission of a project revision:

- Increase in risk
- Federal funding or a plan for future federal sponsorship (e.g., proof of concept studies for federal RFPs, pilot studies intended to support a federal grant application, training and program project grants, no-cost extensions)
- Research funded or otherwise regulated by a federal agency that has signed on to the Common Rule, including all agencies within the Department of Health and Human Services
- FDA-regulated research
- NIH-issued or pending Certificate of Confidentiality
- Prisoners or parolees as subjects
- Contractual obligations or restrictions that require the application of the Common Rule or which require annual review by an IRB

Appendix B

Participant Recruitment Email

Oregon State University Mail - Opportunity to Participate in Researc... https://mail.google.com/mail/u/2?ik=fbae7a2968&view=pt&search=...

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Opportunity to Participate in Research: Inpatient Intake Counselors

1 message

dysonn@oregonstate.edu <dysonn@oregonstate.edu> Sun, Dec 13, 2020 at 6:15 AM
To: "CESNET-L is a unmoderated listserv concerning counselor ed. & supervision" <CESNET-L@listserv.kent.edu>

Hello,

I am Nineka Dyson, a doctoral candidate at Oregon State University. I want to thank you in advance for considering to participate in this voluntary study. I am recruiting master's and doctoral level professional counselors for a qualitative research study about the experiences of professional counselors that work as intake counselors in the inpatient psychiatric facilities. This study intends to inform the supervision and training for intake counselors.

The information obtained during this research will be used for the partial fulfillment of my doctoral degree in Counselor Education through Oregon State University and future publication.

The title of this study is, "*Exploring the Experiences of Intake Professional Counselors: An Interpretative Phenomenological Analysis of the Perspectives of Professional Counselors in the Inpatient Psychiatric Setting.*"

This study focuses on professional counselors with a master's or doctoral degree who are currently working or have worked as intake counselors in a psychiatric hospital.

Please click here to review specifics for participation, overview of the study, as well as inclusion/exclusion criteria.

If you or someone that you know is interested in participating, please contact me directly via email at dysonn@oregonstate.edu or by phone at (404) 272-5488. You may also contact the Principal Investigator, Dr. Deborah Rubel at deborah.rubel@oregonstate.edu.

Thank you,

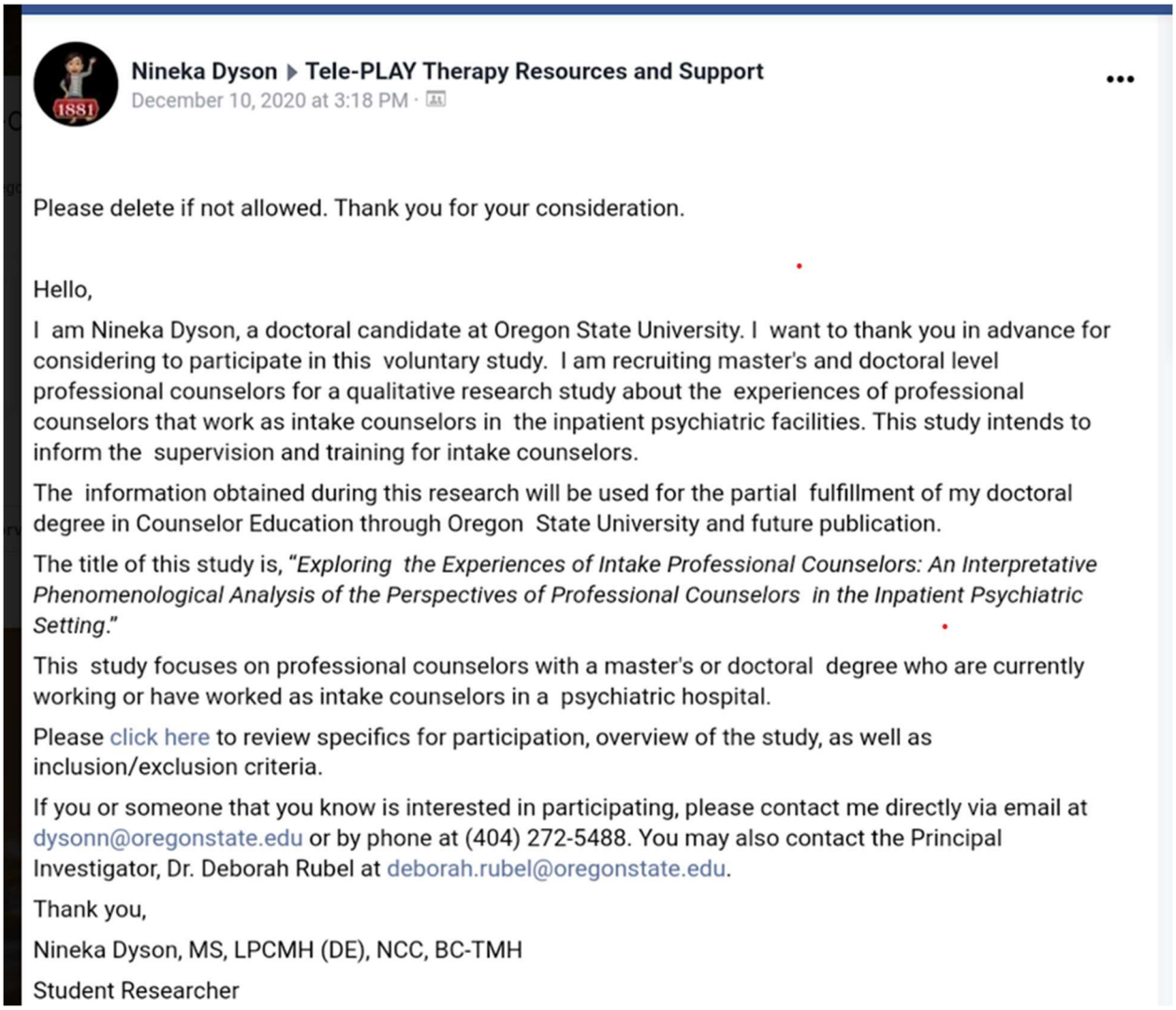
Nineka Dyson, MS, LPCMH (DE), NCC, BC-TMH

Student Researcher

Ph.D. Candidate

Appendix C

Social Media Post Example



Nineka Dyson ▸ Tele-PLAY Therapy Resources and Support
December 10, 2020 at 3:18 PM ·

Please delete if not allowed. Thank you for your consideration.

Hello,

I am Nineka Dyson, a doctoral candidate at Oregon State University. I want to thank you in advance for considering to participate in this voluntary study. I am recruiting master's and doctoral level professional counselors for a qualitative research study about the experiences of professional counselors that work as intake counselors in the inpatient psychiatric facilities. This study intends to inform the supervision and training for intake counselors.

The information obtained during this research will be used for the partial fulfillment of my doctoral degree in Counselor Education through Oregon State University and future publication.

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Thank you,

Nineka Dyson, MS, LPCMH (DE), NCC, BC-TMH

Student Researcher

Appendix D

Explanation of Research for Participants

Oregon State University

EXPLANATION OF RESEARCH

Study Title: Exploring the Experiences of Intake Professional Counselors: An Interpretive Phenomenological Analysis of the Perspectives of Professional Counselors Working as Intake Counselors in the Inpatient Psychiatric Setting
Principal Investigator: Deborah Rubel, Ph.D.
Study team: Nineka Dyson, Student Researcher
John Pryor, Peer Debriefer
Version: 11/07/2020

We are inviting you to take part in a research study.

Purpose: This study seeks to understand the experiences of professional counselors that are intake counselors in the inpatient psychiatric setting and their experiences performing intake assessments in this setting. The research aims to improve training and supervision for professional counselors who want to or currently work as intake counselors in psychiatric hospitals.

Criteria: To participate in this study, you will need to identify as a professional counselor, have at least a master's degree, work as or have worked as an intake counselor, and work or have worked in the inpatient psychiatric setting. You should not be a participant if you are an intake counselor in facilities that primarily treat eating disorders, substance abuse, or provide rehabilitation services.

Voluntary: You do not have to participate in this study if you do not want to. You can choose to participate now and change your mind at any time.

Activities: There will be two Zoom sessions. The first is a semi-structured interview. The second session will focus on member checks. Participants will be invited to review the transcripts with the student researcher for verification and clarification of statements. Participants will have one week to respond to the request to schedule a transcript review. These sessions will be scheduled within a week after receiving your response. If you choose not to schedule or fail to attend your scheduled review session, data will be used as collected.

Time: Your participation in this study will last about 2 hours over 3 months. The initial interview will take approximately 60 minutes. We will ask you to participate in a review of your transcript that will take about 60 minutes. The study will span no more than 3 months, and your responses will be kept confidential. Upon hearing from you, we will schedule a time to meet for the initial interview.

Risks: It is not the intention of this study to cause discomfort. Despite this, there may be discomforts associated with being in this study include recalling experiences that may make you uncomfortable during your time as an intake counselor. Also, this recall may lead to disclosure of sensitive information regarding third parties. We will stop the interview if you find that some

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experiences are difficult to discuss. You may also skip questions that you do not want to answer during the interview process. Oregon State University has no program to pay for research-related injuries. At any time, notify the researcher if you require emotional support. The researcher will assist you with locating mental health counseling referrals within your community.

Benefit: The design of this study will not benefit you directly. However, discussing your experiences as a professional intake counselor can be empowering. The study's collective benefit is the inclusion of the experiences of intake counselors within the inpatient setting. The understanding obtained from this study can benefit the training and supervision of professional counselors that work as intake counselors.

Confidentiality: All information acquired during this study will remain confidential to the extent permitted by law. All research records will be stored securely. This includes your interviews on Zoom. The Principal Investigator, Dr. Deborah Rubel, Student Researcher, Nineka Dyson, and Peer Debriefer, John Pryor, will have access to the data collected during the interview process.

Upon contacting the student researcher, you will receive a number that you will use in place of your name. Your email address and assigned number will be stored using the OSU Box drive. Your numbered Explanation of Research form will be in a separate OSU owned Box folder. The student researcher will document verbal consent during the initial interview on a copy of this form with your assigned number. The numbered form will be kept separate from transcripts and audio files, which will only have the number code. The OSU Google Drive will be used to store the number codes. To enhance confidentiality, we ask that you do not reveal your or anyone else's identifying information when sharing your experience during the interview process.

We plan to make the results of this study public, but we will not include your name or other information that identifies you. The information you provide will be kept confidential to the extent permitted by law. Regulatory agencies and Oregon State University employees may access or inspect records pertaining to this research as part of routine oversight or university business. Participant information gathered within the transcripts to develop themes may be used or distributed for future research to further inform the training and supervision of intake counselors; this includes data with identifiers removed. Any reports that are published or become public information will not include information that will make it possible to identify you as a participant in this study. Results and summaries of data will be reported in a manner so that you cannot be identified.

All research related materials will be retained for a minimum of 3 years post-study termination. Zoom recordings will be a requirement to participate in this study. The security and confidentiality of information collected from you online cannot be guaranteed. However, individual interviews will have unique passwords to start the session. Audio recordings will be destroyed after the verification and coding of the transcripts. The transcription documents will be retained for a minimum of 3 years post-study termination.

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The researchers are mandatory reporters. Thus, the researchers are required to report any information disclosed pertaining to potential abuse to proper authorities. Researchers will also report any threats of harm to self or others. In the event of suspected harm to self or others and abuse, identifying information will be disclosed to the appropriate authorities. Also, a report within the mandated time will be made to the Oregon State Institutional Review Board.

Study contacts: We would like you to ask us questions if there is anything about the study that you do not understand. You may contact the student researcher, Nineka Dyson at dysonn@oregonstate.edu or (404) 272-5488. You can contact the Principal Investigator, Dr. Deborah Rubel at deborah.rubel@oregonstate.edu or (541) 737-5973.

You can also contact the Human Research Protection Program with any concerns that you have about your rights or welfare as a study participant. This office can be reached at (541) 737-8008 or by email at IRB@oregonstate.edu

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By scheduling the initial interview with the student researcher, you are consenting to participate in this study. However, the student researcher will also confirm your understanding of this explanation of the research and obtain verbal consent prior to beginning the first interview.

☐ Interview Scheduled

☐ Verbal Consent Received

Appendix E

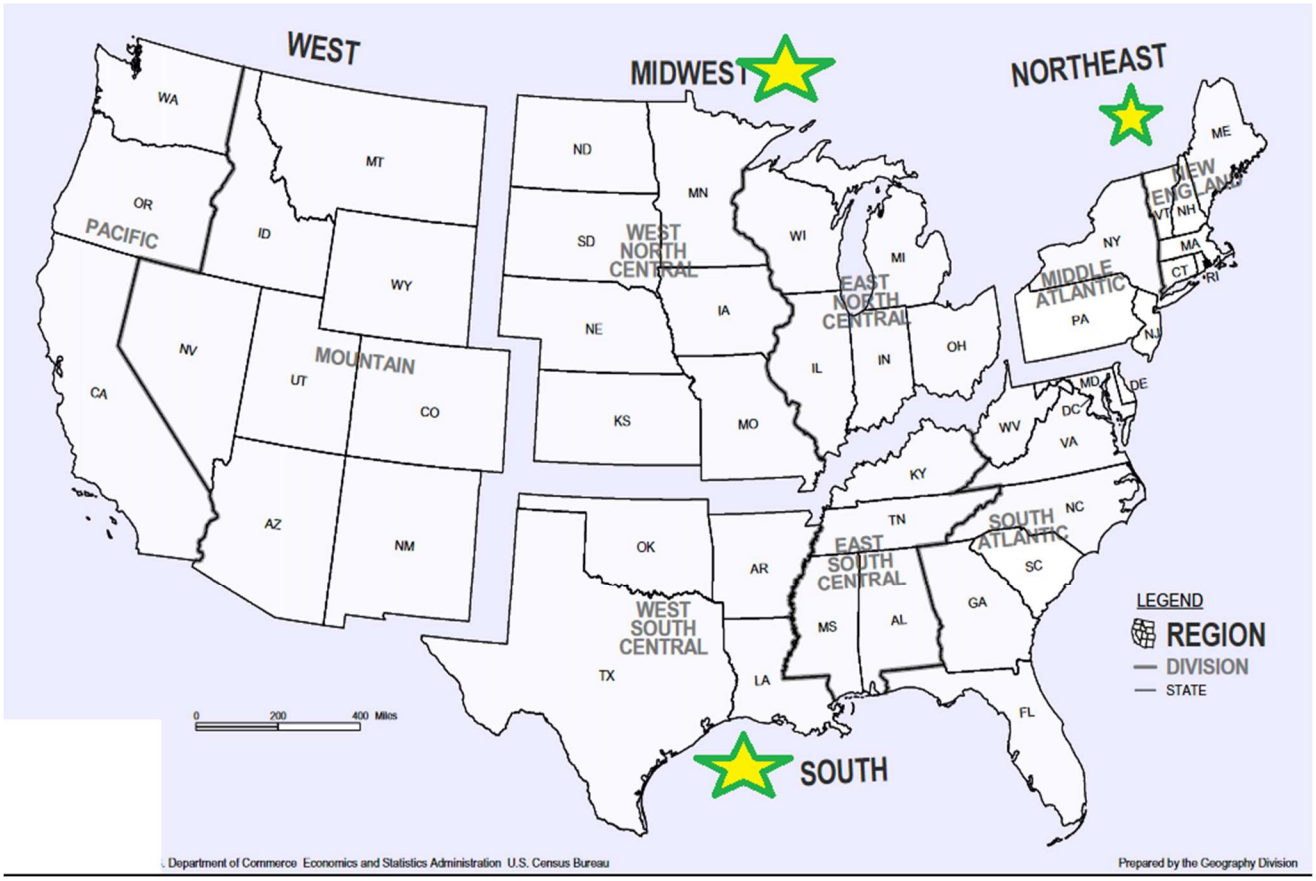
Interview Schedule

- How many years have/were you been an intake counselor?
- What led you to seek a position as an intake counselor?
- How many people are usually admitted per day?
- How many intake interviews do/did you complete in an average day?
- What is your experience with shift work as an intake counselor?
- How would you describe your work as an intake counselor?
- How would you describe your experience of being a professional counselor in this setting?
- How are learning and professional development part of your experience of working as an inpatient intake counselor?
- How are best practices part of your experience of working as an inpatient intake counselor?
- What is the supervision experience as an intake counselor?
- What is your experience with support while working in this role?
- How would you describe your experience of conducting an intake assessment in the inpatient psychiatric setting?
- What feelings arise/arose when conducting an intake assessment in the inpatient psychiatric setting?
- How is the patient, and their unique characteristics, part of your experience of conducting intakes in the inpatient psychiatric setting?
- How are other staff part of your experience when conducting intake assessments?

- What guides your practice in conducting intake assessments in the inpatient psychiatric setting?

Appendix F

Contiguous United States Regions



Appendix G

Manuscript 1 Noting and Emerging Themes Example

Page	Line	Initial Noting and Emerging Themes
1	7	The system has provided an automated tracking system for ICs to have a better idea of who needs an assessment.
1	7	Automated system for triage is helpful.
1	11	System supportive of community needs and provided a separate unit for intake to occur.
1	13	Feeling happy and appreciative that the system identified the need to provide a safe space for her and the patient during an assessment. Amazed that a facility has this available..This is a fantastic way to make sure everyone is safe and there are no questions as to what the patient is doing while she is finishing paperwork.
1	13	Appreciating a supportive system.
1	18	Feeling confident in her personal strategies to streamline the time for assessment.
1	20	Working with friends/family of the patient during assessment is part of the process. 'support person'
1	22	Being cognizant of the needs of the patient is important when building rapport during an assessment. **(Aware of Patient Needs)**
1	22	Valuing the patient and their uniqueness.
2	4	Personally developing a strategy for inquiry during assessment helps reduce the stress of the assessment for her and the patient. **(Personal Strategies)**
2	4	Personalizing the flow of the assessment.
2	6	Understanding that patients are not always truthful during assessment but she still has to do her job. Feeling indifferent about the patients that just want to have a break from their life, so they 'say yes to everything.'
2	6	Taking the patients' report as valid, despite the believability. Reliability of patient report?
2	7	Taking into account the whole person during the assessment and what the impact of the patient's environment.

2	7	Holistic view of the patient.
2	10	Feeling overwhelmed by the extent of the assessment. <P>'Gosh the assessment is long'
2	13	Feeling the assessment is time-limited but complex.
3	5	She finds that some people are 'playing the system' and she feels annoyed when the laws require her to admit patients that are only seeking refuge in the system.
3	7	Having compassion for patients and understanding their unique situation overcomes her feelings of annoyance with some patients.
3	9	Being empathetic with patients that initially spark feelings of indifference due to their repeated admission.
3	12	Explaining the levels of admission to patients and families is difficult. She has to manage her feelings of frustration with the system about resources lacking for additional care after inpatient. **(Managing frustrations with the system)**
3	12	Does this get in the way of her doing her job long-term? How are these feelings managed?
3	16	Feeling the need to balance information given to families and patients with 'compassion' for the patient's situation. **(EMPATHY)**
3	16	Honoring the patient through empathy.
3	18	Patients present in their most vulnerable state requiring empathy from her during assessment.
3	22	Feelings of empathy based on the understanding of patient's developmental stage. 'rational thought is not 100% online'.
3	22	Empathy through clinical knowledge.
4	2	Feelings of accomplishment when she is able to identify a child/ adolescent in need of care and provide services.
4	7	She feels she is 'approachable' and able to build rapport with patients quickly, which paves the way for them to share their experiences. Need for a non-judgmental attitude during assessment.
4	7	Needing to be non-judgmental and approachable. **(Counseling Skills)**
4	10	Becoming an ally to the patient is important when assessing for admission. Alliance opens the space for the patient to feel comfortable to share their experience.
4	14	Feeling frustrated when she allots time and resources to patient's that are not in need of inpatient care. 'quick counseling session'. In essence they are wasting time that can be dedicated to patients waiting.

4	14	Intolerance for patients that use the system.
4	17	Feelings of relief at times when she is overwhelmed and those perceived to be wasting resources provide her a break from high acuity clients.
4	17	Seesaw of emotion with repeat patients. **(Emotional impact)**
4	20	Feelings are multi-layered during assessments and can span from feelings of 'empathy' to 'skepticism' regarding the need for care.
5	1	Not focusing on self during assessment and blocking personal response to patients during assessment.
5	1	Operating in an emotional vacuum.
5	2	Feeling
5	2	Numbness to things that would effect counselors in outpatient.
5	5	She feels the stress is relieved for her and the patient when she keeps the patient informed during the assessment process and provides insight into each step along the way.
5	5	Educating the patient on the process is key.
5	12	Managing ethical concerns with patients during the assessment is challenging because the community is a 'small area'.
5	12	Having to manage ethical dilemmas within the system. The system lacks capacity to shield clinicians from dual relationships due to the size of the community.
5	14	Having difficult conversations with families when previous work causes an ethical dilemma during assessment. 'frequent flyer'
5	17	Including families in critical decisions about care is important and mitigates ethical concerns along with awkward situations.
5	20	Feeling hopeless when patients have multiple admissions. 'don't even know what to do with her at this point.'
5	20	Deficient care within the system for patients with repeat admissions.
5	21	Taking a personal interest in cases that have a familiarity and feeling responsible when she can't change the situation for the patient and family.
5	21	Feeling upset when the tool used to determine safety fails.
6	5	She integrates the hx of the patient with the presenting problem and acknowledges admission often can feed into the pathology of the patient, thus admission is not always best for certain patients 'wanted to be hospitalized and that was perpetually the behavior.'

6	5	Viewing the patient holistically.
6	11	Feeling helpless when patients present with multiple admissions with similar presenting problems as previous admissions.
6	11	Deficient care within the system for patients with repeat admissions.
6	14	Feeling helpless after the disposition to not admit is made and patients engage in an act that warrants admission.
6	14	Why personal response if following the guidelines set forth by the agency? Use of agency or system?
6	17	Feeling frustrated with staff that do not view the patient through a full lens and only see behavior not full pathology and cause patients' behavior to escalate.
6	17	Medical staff have narrowed view of patients.
6	22	Upset that other staff engage in assessment process with limited information and undo the work she has done to help a family with a patient that has challenging symptoms.
6	22	Medical staff are reactive and not helpful in emergent situations.
7	5	'Nurses' provide assistance with securing the patient and belongings for the safety of the patient/clinician.
7	8	'Attending' provides medical care and a brief assessment to determine the need for intake to proceed with assessment.
7	10	Grateful for the pre-work done by staff. This provides her with comfort in knowing what she can expect from the patient.
7	10	Medical staff are helpful with gaining information.
7	12	Staff assist with administrative tasks and safety.
7	17	Layered system of coordination with staff in the system but still feeling isolated.
8	5	System did not have best practices to start but relied on knowledgeable staff to generate practices for the job.
8	7	Feeling capable to handle multiple scenarios due to system having detailed information of procedures. 'flow charted out'
8	9	Happy she can focus on disposition not how to do the job.
8	10	Happy to be supported with best practices 'setting us up for success.'**(Divergent exp!)**
8	13	Reverence for supervisor because the supervisor was knowledgeable and supportive.

8	18	System driven metrics for success based on admissions and referrals to outpatient facilities after patient is evaluated.
8	18	System is numbers driven. **(System issues with productivity)**
8	19	System requirements cause stress when situations are outside her control. 'there's nobody available to make appointments with.'
8	20	Availability of external resources for patients is shift dependent. 'first shift'
9	2	Feeling afraid when she has to rely on the patient to make an outpatient appointment when she does not have the resources to ensure their safety when they leave the facility.
9	2	Mistrust of patients caring for themselves if not admitted.
9	6	Less anxiety about referring out with 'minors' because they have people she can rely on to keep them safe. The burden does not fall back on her if the patient causes harm.
9	7	Fear in sending adults out with a referral for safety reasons.
9	10	Personal preference of population based on her control of patient safety and welfare. Adults mean less control and follow-up than minors. 'There's nobody else in charge of them.'

Appendix H

Manuscript 1 Patterns Across Cases to Theme Development

Theme: Fulfilling a practical need to work as an intake counselor

~~Experiencing the practical fulfillment of a need to work as an intake counselor.~~

Participants found this line of work to fulfill various needs in their personal lives. This was not about a desire to be an intake counselor in the inpatient setting but to fulfill a curiosity, for financial reasons, or because they did not like the traditional therapy role.

P1: "I just think I am one of those people who was never going to be a traditional therapist. I'm super interested in meeting people of all ages and stages of life, but I'm not interested in carrying them through a treatment plan process. So brief encounters and quick troubleshooting. And hearing people's stories and situations that bring them to a certain point and then passing them on to the next stage and phase of treatment is all that's really piqued my interest in this field in general.

P2: I was in school, and my job reached out to my school looking for intake coordinators and counselors because they were short-staffed. That's how I ended up there.

P3: It was honestly the first thing that was available at the time when I relocated. So I said, okay, I'll try something new.

P4: So I decided to do it because I hadn't done it before, really. I did it and it served its purpose and I'm done with it now.

P6: So, I liked that and it was a little pay raise for me and I was just kind of trying to ... I don't know what my next step was going to be, but I was just kind of trying to try something else and I really liked it. Well, at first I really liked that I would be able to work my shift and go home and not have a million notes and all that kind of stuff, because my kids were little and still in school and stuff like that.

P7: For me, it was a good place to get my feet wet. I think you learn a lot by seeing the heavy end of mental health, working in inpatient.

P8: And I was not able to secure a full-time position in the [name]public schools. [School District] schools had dissolved. I did not get a position in [school district] and I needed a job. And so this job literally hired me three days after graduation. And so they had hired me and it had benefits. And so I had student loans from my first master's and I only had six months to defer and I remember I did not necessarily want the job but my income status dictated it. And I could probably collect my hours within two-and-a-half years. And that's what happened

P10: And then I've worked there and outpatient like private practice. And then also up on the inpatient floor, doing therapy there. And I prefer crisis work to any of it.

~~Wearing an emotional veil to cope with the stressors of working in the inpatient environment as an intake counselor.~~ (Theme: Containing Emotions to Cope with the Stressors of Working in the Inpatient Environment)

~~*Intake counselors as professional counselors wear an emotional veil to block them from the pain of working within the inpatient environment and with high acuity patients. A commonality amongst the participants is one of speaking about what occurred in some difficult moments but not naming the emotion attached to that experience.*~~

Participants contain their emotions to do the job. A commonality amongst the participants is one of knowing they are not indifferent to situations but containment is how they cope.

P1: And then I honestly feel like this role has affected a lot of relationships. My relationships were not super stable. Job roles like these weren't super stable and they were making me not feel super stable. And that also spilled over into personal relationships too. I became just more and more shut down and unavailable, probably dismissive.

P2: Besides that, we carry their pain. I mean, as much as we try not to, from having that countertransference, we are carrying loads and loads of issues.

P3: I will say I think I can handle anything now, but I'm glad I'm also not in that environment anymore because it was very, very stressful, at least in my opinion.

P4: None, really. I talked to my therapist about it when I needed to or I would tell my husband, like, Bro, it was rough today. He would be like, “You want us to leave you alone?” I'm like, “Please,” and that was... But, really, I think I was fine. I was okay. If my situation were different, I probably would've sought supervision, but it just wasn't like that, not for me.

P6: At first it was scary, but then I liked it. Because I felt like probably after I was there awhile and got more comfortable is probably what happened, but then I liked it because I felt comfortable helping the newer people and I enjoyed that. Yeah, and mostly just, I have to focus on doing the assessment, and try to not worry so much about the long term stuff, because you can't do anything with that right in that setting.

P7: A lot of times, I feel like no longer being in that field or in that position exclusively. I feel like if you can do inpatient mental health, you can do darn near anything. It was emotionally taxing for multiple reasons, but it was definitely, like I said, there were times where it was really rewarding and other times where it was "all we were doing was keeping our head above water" kind of thing. Of course, in our department, we were doing some UR stuff, the initial point of contact with insurance kind of things, and so there were all of those phone calls to deal with. It was just a lot of, I don't know. It was definitely a heavy thing to try and balance all of that.

P8: I hated it. I remember I was miserable. I was depressed. And that's when my weight gain started. I literally jumped dress sizes. I went from a size seven/eight to 12 to a 16, 18 within months of graduating. Like I went from regular dress size to plus and I remember looking at my graduation pictures to... Yeah.

P10: So some days are very, very stressful and some days are a good flow of catching your breath and doing your documentation and having time to eat lunch. Just as the experience of doing intake assessments, I find the harder ones, the ones where more family are involved, which is selfishly the harder ones. Obviously having their daily input is preferable because that means someone cares. But it's a lot of information to take in.But it wasn't one of those where I was like,

"Do we want to keep him until his birthday, just in case?" And he had supervision, he was a minor still, and his mom was onboard. So, if I had seen him freshly that day and there was no other assessment of him, I would've sent him home. But just the fact that when he was under the influence, he had made statements was just major, like, "It's a little unnerving. I don't know if I trust you." But it wasn't enough. I didn't have enough reason to keep him. If he had gone to an adult hospital that day, they would've sent him home

~~Feeling training is insufficient for this role. Experiencing the struggle to become prepared.~~
(Theme: Struggling to cope with lack of specific training)

Desiring focused training for intake counselors that is applicable to the job and advance on what is taught in graduate school. Some found the system provided some training that was focused on the job but not to the extent to prepare the counselors for the ever-changing environment.

P1: You better be doing that on your own time, or figuring out how to do that on your own, yourself. It is...all that is encouraged is a learn as you go process. But, I had to do my own learning with diagnosis. Like this is what bipolar walks and talks like. This is what Schizoaffective Disorder presents like .You know, so it can be a thumbing through the book, but I just feel like I've had to learn outside of jobs and you tend to pull full on my own experience and research further into disorders/illnesses.

P2: We get different kinds of patients all the time with different issues going on. Besides that, we also have trainings. Those trainings, together with what we get to see in assessment rooms to deal with during the assessment, helps with our processing and developing as intake counselors.

P3: I mean, obviously when you're in a psych hospital, it's a little bit different because sometimes you learn about things in school and then you never see those types of cases and then you go there, and then it's just like, I don't even know what to diagnose the person, because I've never actually had to do this. So that was a little bit different.

P4: I don't want to sound boastful, I know what I'm doing. The challenge for me in any role, is just the administrative tasks, because it's different from system to system or organization to organization.

P6: I would have liked to have had a more clear understanding of the exact criteria of admission. I think that ... I think it took me a few months even before I really felt like I even knew really well, because I knew the easiest ones, like has it been two days since you tried to kill yourself, or anything like that.

P7: There wasn't any. I mean that sounds so negative, but there wasn't any. "Read a book." That was more or less ... There were no CEUs. Nothing. Not any career development. Being somewhat of a reader, I always did that. There's not a lot of stuff to read about intake counseling, though. I mean that's the thing. There's studies here and there and whatever, but you're not going to pick up the Yalom book like you can for group work. It's a different situation.

P8: But that's why what I did I worked so hard. After my experiences there I really worked harder once I completed that experience towards my doctoral studies. Also, I've done lots of additional continuing education that I got documented. Just to try to address some of those deficits because I felt behind when I look at some of my peers as far as my clinical skills.

P10: So when I started, my training was different than it is now than just because the program has grown so much. So when I started, they were just starting to split social work and mental health into two separate departments. So I was trained under medical social work. So I got in all of it, how to give resources, how to conduct a potential physical abuse or a potential sexual abuse case. How to contact law enforcement and Children's Services and all of that, all the social worky stuff. And then in addition to how to do a crisis assessment for a suicidal, homicidal, or psychotic patient. So there was a lot of shadowing. I shadowed probably like two weeks worth of work.

Lacking knowledge of intake in the inpatient environment

P1: It was, you know, people are just like you know "There's basically there's outpatient, there's inpatient. There's the hospital setting, you know, or you could go into private practice that's really it." So, then when you find out there are these roles such as this to be discovered. I think the average person is probably not advertising it because they would never personally consider it themselves, or they don't know a lot about it. (Lines 96-101)

P4: For a new person in that role, a new counselor, I think they would find it really intimidating. It says that my internet connection is unstable. (Lines 130-132) Like that psychiatrist that I was talking about... I'm trying to stop, keep myself from saying her name, but she... Now, she and I, we would just get together and do whatever. We would go walk outside, and get ice cream together and she was always bringing me salads from the doctor's lounge. So, that was really nice. Lines (164-170)

P6: ... I think everyone should start out or at least have some training in a hospital setting, because after seeing the extreme situations and it's so much easier as a counselor to pick up on some of these things that are not super manic, in your face or totally delusional that is very obvious. I thought that would be very helpful. I don't know, I'm sure that's part of the question. (Lines 150-154)

Having an internal struggle between professional identity and system requirements

Counselors know their role is to promote wellness in any setting and serve as an advocate for patients, but the system created barriers that caused frustration and led them to question their role in this setting.

Professional identity

P1: So I would just say, that sounded really good on paper, but I'm glad that I just tried to follow my own code and compass, stay in my lane and scope of practice as an LPC and do what's best and most safe.

P2: For example, intake and nursing, they usually don't get along. However, as much as you try to understand where the nurses are coming from, it's hard for them to understand that, "hey, intake counselors have a job to do." Instead, they'll try to push patients away. Where we, as intake, we are trying to get patients in because we know that they need help.

P3: Even though you're an intake counselor, you're not doing counseling. So trying to separate the two, because I know sometimes when you're asking those questions, you're asking questions to get an answer, but I've had a few sessions where I had to learn how to pose questions in a

different way, because it started turning into a therapy session and that's not what it's supposed to be.

P4: I am not a psychologist for a reason and I'm not a social worker for a reason. I felt I was doing a lot of case management, and while I recognize that, that is part of what we do as counselors, that is not what I would like to spend most of my time doing. That was really aggravating to me. That's just not how I want to spend my time. I would rather be with patients, and I think I recognized that at some point...

P6: Well, yes, because there was one person that was not a therapist that seemed to be in like the total charge of everything and could override therapists and doctors and I did not agree with that or think that was right. The finance person should not be the one in charge, in my opinion.

P7: You know, I was just getting started out when I started. I don't know. The intakes are not supposed to be counseling sessions, and we had that repeated to us over and over.

P8: And so what she started working with me on is how I can advocate for myself and what my role was supposed to be doing with intake and then also what I was supposed to be doing as clinical mental health counselor. Had to work on was that professional identity because that was the problem.

P10: It's tricky because I think being a counselor in a medical setting is so new that you walk into a room in the ED and the nurses are like, "The social worker's here to talk to you." I'm not a social worker. I don't have anything against social workers. That's fine, but just for clarifying I'm not. So it's challenging to educate the staff population and sometimes the patients on who I am and what my training is and how that differs from social work. *Finding the inpatient setting requires a different focus than outpatient.*

ICs thought the inpatient setting requires a reframing of how you do your work as an counselor.

P1: …if I could compare it to like an outpatient setting or something like that to which I've dabbled in minimally. I'm like, y'all, this is most boring stuff I've ever seen. It is action packed, which is good for some people, the pace is rapid, it's not scheduled and uniformed. It's not predictable as some of those other roles can be and it's short. It's brief. So, a lot of heat. But, I don't think that's reflective in the field as much.

P3: Okay. What I would say with that is first, especially when you're dealing with really acute level patients, it's a lot... In my opinion, it's a little bit different just because when I was working in community mental health, it was one of those things like people were not always... You could do an assessment and see where people were with things, but with acute level patients, you really, really, really have to make sure everything is done correctly because in my opinion, it's like, you never want something to happen.

P4: So there's this idea that counseling is long-term therapy, that's really an error that a lot of people make. I feel myself going onto a whole soapbox, but I think that is an error in judgment that a lot of people make and it really prevents them from recognizing the utility of the role. I'm clear about what that role is for, that is to facilitate admission, or to make determination of about admission so that people can get stabilized and then they can return to their outpatient treatment

providers, because we're really wanting to have people be in the least restrictive environment to get their needs met.

P6: Well, to me, it's a lot different, because you're not really doing counseling. It's not a …To me, it didn't seem like a place to open up. You don't really want to open up so much right before they're going into the unit and everything. But and that's people are in their most vulnerable, most ... Well, like sick moments.

P7: You know, I was just getting started out when I started. I don't know. The intakes are not supposed to be counseling sessions, and we had that repeated to us over and over.

~~Multidimensional need for support to stay in the job~~ **(Theme: Experiencing job sustainability as dependent on multidimensional openness and support)**

Intake counselors have a need for support on many levels to help them sustain themselves emotionally in the job. One level of desired emotional support is with supervisors within the system. The supervisors play a role in whether the IC has positive experiences at work or negative. ICs rely on supervisors to provide clinical knowledge and emotional support during difficult cases. ICs without adequate supervision to hold this space felt isolated in the job. Lacking supervisory support causes stress. System support is also important, as ICs feel they are not valued in the system, despite them being the first to interact with patients that have severe illnesses. Another level of support is within the ICs family. Families try to be supportive but the ICs view of the job makes it difficult to connect with family while in this role. Staff support is important to the IC for emotional well-being and staff outside of the department can be helpful or another burden on the IC. Same for the ICs colleagues, other ICs. There is a need for mutual support in this role; however, sometimes the IC finds they emotional containment vessels for the emotional blasts of their peers in intake.

Feeling isolated within the system

P1: Lots of certain supervisors have just been like, this is what we have in mind. But when chaotic situations erupt as they so often do, it really just feels like the gloves are off, the handouts are gone, and no one is here to help you put out this fire.

P2: I don't want to say it is, but we are the least supported. They expect us to be perfect, yet we are human. When you error, it's like the worst thing you've done, the way it's presented.

P3: When I worked at one location, I literally wanted to quit, I think in two months because it was just so poorly run and they just were working you just like, just do this. Why aren't you... Like, this needs to be done on this time. (

P4: It can be really isolating, so I'll say that because we work alone. At my particular hospital, there's only one intake counselor on duty at once, unless you're training someone because we're a smaller, rural county hospital, but in a large hospital system. (Lines 85-88) And really, it was a bias from the psychiatrist and I was just like, “What are we doing? This isn't okay. And so it was more like, I'm in my feelings, then I need you to talk to me about this, kind of thing. And the nursing director was like, I mean, you're right. I don't know what to tell you. “The psychiatrists do what the psychiatrists do and we just let them do what they're doing, kind of thing” and I was like, that sucks.

P6: But that did not translate up. I didn't feel support at all from any of the up people, the business people. They seemed like when they would come in, it was just more about whether these things are going to be approved. (Because overnight you're busier because you're alone and you're doing everything. You maybe won't have as many interviews, but you're busy the whole time.

P7: There, for the last year or year-and-a-half, I worked the first six hours of my day by myself. I think it was six hours. That sounds right. So, I was the only person in that office. If anybody had come in overnight, we're doing an intake, and sometimes if you get two or three overnight, then you're doing all of those back-to-back.

Finding comfort in supportive relationships.

P1: You know, if it weren't like for people who have been previous coworkers of mine. I never would have made it the limited amount of time I've or a limited amount of days, months, years, I've made it at places.

P2: I seek help from somebody else who is also an LPC. In case we get a hard case, we're able to process. She listens to me, and I listen to her, and that helps a lot.

P3: I had a supervisor that I would talk to for supervision when I was working on getting my license. She was really helpful because sometimes I would have to deal with different things. But I feel like after my first year, I learned how to just leave it at work and just find other ways to do things for myself. So making sure that I'm making time to do things with my friends or do things with my family and things of that nature so that I'm not constantly thinking about work.

P4: Like that psychiatrist that I was talking about... I'm trying to stop, keep myself from saying her name, but she... Now, she and I, we would just get together and do whatever. We would go walk outside, and get ice cream together and she was always bringing me salads from the doctor's lounge. So, that was really nice.

P6: Well, my coworkers are very supportive and we even…Well, I still talk to quite a few now, but outside, we would even be helpful to each other. In and out of work. Oh, yes. There were several nurses. Like they would be in charge of the hospital at night and they were very supportive, helpful, even with my work. I wish I could remember it all.

P7: My wife's extremely supportive. I'm lucky I'm married to a hospital social worker, and while the jobs are very different, she understood the format.

P8: Or what else would happen is let's say she doesn't necessarily have time with me. I would get shifted to my coworker and I'm going to be honest with you. My coworker was very deficient. It was the blind leading the blind. It's like my coworker who was more senior than me was bachelors level education where it may have been seen innate did not .

P10: As far as support during your shift, I've always had managers who are like, "Call me at any time day or night, middle of the night." Even the first 20 assessments that I did by myself, my manager at the time required that we called her and I worked third shift at that point. So she got called all night long and she was totally fine with it. So just very gracious, I felt very supported when I started and I think that has led me to feel way more competent.

~~Frustrated that colleagues need emotional support.~~ Support is not always equal

P1: When you're introduced to a new co-worker as these positions specifically turn over so often. You know, I'm looking for the, are you strong. Do you look like you can hold yourself together? And could you possibly hold me together, if I fell apart? because that's possible too. You know?

P3: It was further away, so I didn't like the travel, but the team was so much more organized that it just made life a little bit easier. So I really just think it depends on really your team. Because it's going to be stressful regardless, but if you have a good team behind you, it doesn't make the day as bad.

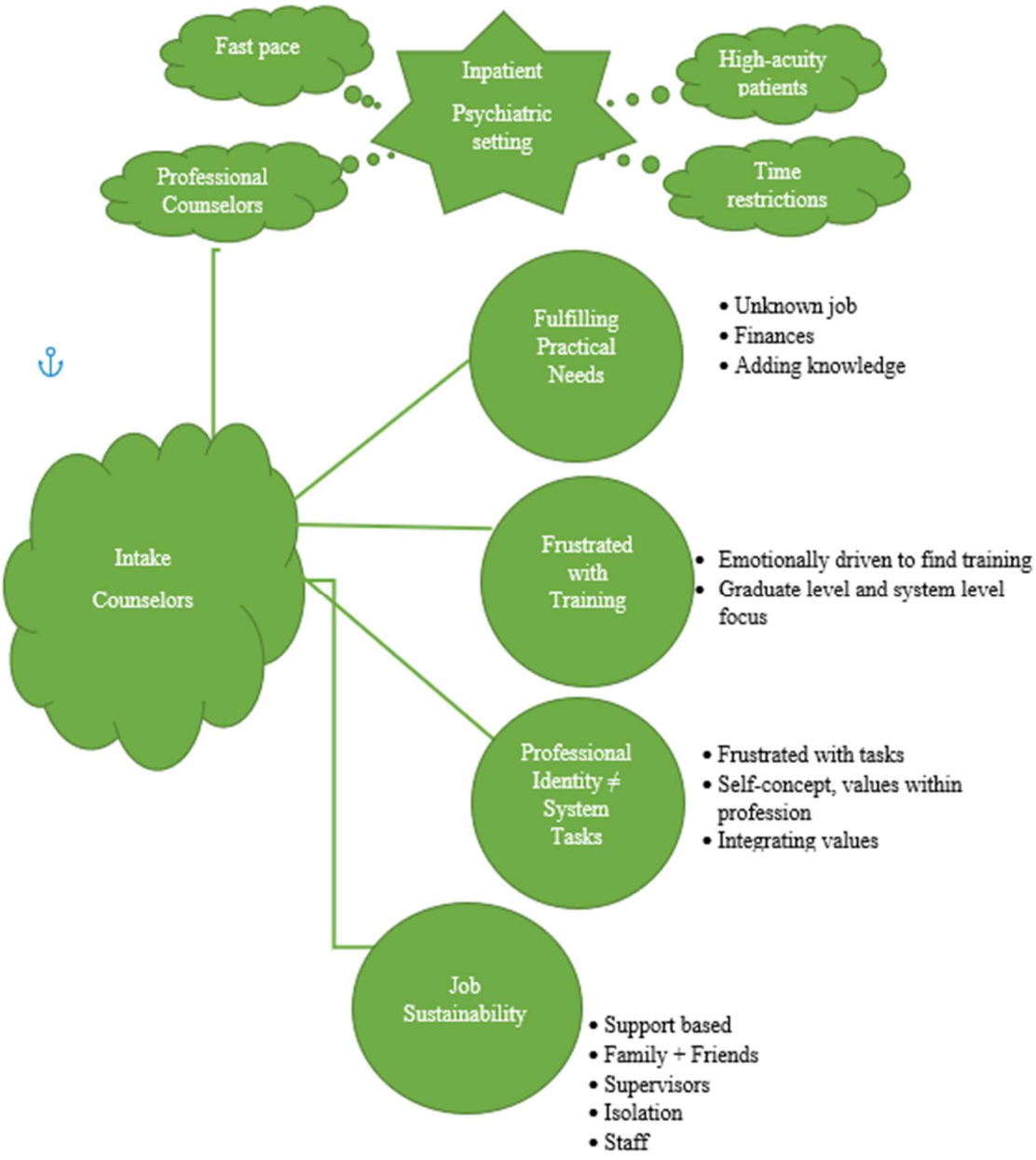
P4: I mean, he was just really mean, and I told my peer, I was like, What's up with this dude? And he was like, I don't know, but everybody keeps telling me the same stuff about him. And I was like, Yeah, I ain't with it.

P7: I mean I used to make the joke about, "What, you want to give me a butterfly net and want me to run out and just chase people? That's not my job," but I feel like there was blame placed that had no business being placed. I don't know.

P8: It was a situation where I remember my supervisor was like, "You're not Miss Muscles." But what happened, I was actually leaving for the day, it was on a Thursday, and I was wearing my badge. We had the badge that break always and a client was trying to elope for the unit. I remember client had blocked my way, and my sister tells the story much better than me, but we had CPI training. I actually wish my first and last time ever restraining a client. I don't want to restrain a client. I wound up putting the client in a figure four position. I remember we had to talk about what that was like. I remember I wound up processing it in supervision.

Appendix I

Manuscript 1 Theme Development



Appendix J

Manuscript 2 Noting and Emerging Themes Example

Page	Line	Initial Noting and Emerging Themes
1	11	Personal rhythm to assessment makes it easier than following the system developed order. Knowing the categories within the assessment makes it easier to maintain a conversational tone and empathetic environment for the patient. **(Personalize approach/Personal Rhythm(?)**
1	11	Maybe two codes? Personal rhythm and Memorizing for ease of use.
1	12	Assessment not digitized.
1	12	Antiquated assessment process.
1	15	She made an effort to remain empathetic during the assessment by making it more of a 'conversation', less of an feel of interrogation. **(Conversational Tone)**
1	15	Valuing the patient as a person. **(Empathy/Humanizing)**
1	19	Providing comfort during a time of uncertainty for the patient.
1	22	Need to create a welcoming safe environment for the patient to feel free to express what has led to seeking the intake.
2	5	Feelings of uncertainty when initially sitting with patient/family.
2	8	Awareness of self during intake to provide a welcoming, non-judgmental environment for the patient.
2	8	Point of reflection for her.(Side Note: Interview is helpful to her)
2	10	Self-judgment because she became desensitized to the patient and their problem after the 'first couple of months.
2	10	Becoming numb to the patients' presenting problems.
2	15	She feels **conflicted about desensitization,** but it is needed for self-care during the assessment due to the intense experiences patients share with her. 'rape or assaults or suicides or things like that'
2	15	Creating internal boundaries.
2	18	Aha moment for me during the interview! Maybe just summarize and ask participant to add to the previous response.

2	20	She treats everyone as an individual but finds some patients' cases 'more interesting' than others.
2	20	Valuing the patient as an individual. **(Using Empathy)**
3	1	Patients with severe illnesses make assessment difficult. 'Psychosis'
3	1	Complexity of the case determines the level of stress for the assessment.
3	2	'Meeting a person where they are'. Here she is balancing the desensitization with valuing the patient as a person. She is sensitive to the needs of the other.
3	2	Balancing personal response with professional response to patients. **Remaining Professional**
3	4	Assessments are time-limited and she has to build a relationship that allows the patient to feel safe enough to share their most difficult experiences.
3	4	System limits time with patients leading to her having to build rapport quickly. **(Time Restrictions)**
3	6	Difficulties within the assessment process are documented on the assessment to communicate how the patient presented.
3	6	Including patient's behavior during the assessment is part of the data needed by the system.
3	7	Mental status exam part of assessment.
3	9	She cares for each person as an individual not grouping them together as one. 'each person's characteristics bring something new'
3	16	Other staff determine if the experience with patients during assessment will be good or bad. 'cut out for being an intake counselor' **(Staff have an impact)**
3	20	Critical of staff that allowed assessments to compromise their ability to compartmentalize the work of assessing patients. **(Taking care of staff)**
3	20	Frustrating experience with staff that could not separate from patients after assessment.
4	1	Feeling frustrated, yet holding a space for staff in a similar way she does for patients. **(wanting help)**
4	4	Triggered by conversation.
4	8	Frustrated that she has to work with staff that need emotional support during assessments, leaving her to feel isolated and unsupported.
4	8	Having to provide emotional support to staff is frustrating.

4	8	Staff over-identified with patients leading to their own emotional crisis during assessments.
4	8	Absence of discussions about self-care within the system. **(System not supportive)**
4	13	She believes that 'Person' led assessments work best. Following the system chronology doesn't create a rapport with patients.
4	20	Honoring the patient as an individual and showing interest in their 'story' to complete the system generated assessment.
5	7	She seems hurt by not having staff that can handle the stress of the job and not knowing what it meant to do assessments before starting work.
5	7	Feeling emotionally isolated during assessment.
5	11	The work is intense and not the normal work of the profession.
5	13	Reflective of not being prepared for the emotional intensity of the work by graduate program. The need to be empathetic but learning to shelter self from absorbing the emotional experiences of patients.
5	13	Lacking training on the emotional impact of the job.
5	16	Triggered by the sadness of remembering the children she worked with, 'heartbreaking'.
5	17	Side note: I never said you have to have a good support system. Interesting that she translated the questions into a need to have a good support system. Good support is necessary within the job and assessment to maintain your own stability.
5	20	A sustained self-care schedule is necessary to survive. 'I would end up as a patient in the hospital'
6	3	Personally mandated self-care because the system is not going to take care of you unless you are a patient. 'you're going to end up in the same place.'

Appendix K

Manuscript 2 Patterns Across Cases to Theme Development

Context for Intake Counselor

- Work is hard
- Patients are expected to be challenging
- System creates additional tasks
- Supervisors helpful and not helpful

~~**System assessment needs to be tailored**~~

(Theme: Feeling Compelled to Adapt Assessment to Patient Needs)

-Forced, underlying anxiety provoking

-Too many questions but must complete

-Annoyance with system requirements for assessment

- Finding ways to save time.

The system tool was not conducive to implement with high-acuity patients as is. There was heightened anxiety about triggering a patient and trying to keep the patient calm to do the job.

P1: **Cumbersome assessment that is "Antiquated" anxious about line-by-line interview.** " I definitely had to try to find my own balance and evenness so I wasn't provoking any sort of additional reaction from them."

P2: **Hyper-focused on completing document but managing the patient. "Forcing" disclosure** I mean, we have a set of questions we ask. As long as we fill that set of questions, you're covered. We get those hard cases for our patients that are afraid of disclosing information, but the same goes by, the more you interview you are able to find ways of presenting that information in a way that they will unconsciously or consciously provide the information without forcing them to do that.

P3: **"Scared" lessening fear for patient.** At the hospital that I was at everything was paper. So I had to just turn the pages and find that question, answer it, and then from there I would normally follow up on that subject, whatever subject they brought up so that it wasn't like... It just seems like a conversation. I feel like that was the biggest thing that was helpful was when you made it... It's already a really difficult time for people when they're coming in for an intake assessment because they're normally scared.

P4: It's fine. They're short. We don't have a lot of time. What I did in outpatient in an hour or 90 minutes, I got 20 minutes, 12 minutes to do in the hospital. You get creative.

P6: Like I've got a certain order I would kind of do things in and certain ways that were not the order of the form, say things to make it not so awkward or kind of clunky or whatever and kind of mix it up, because it would be easier.

P7: I mean most of the time, it was fine. Sometimes I look back and laugh at it a little bit because there were times where people would give you "you know why I'm here" type answers. "Why are you asking me that again?", because some of it was repetitive

P8: But although it was routinized every assessment was still different. Like never the same despite the fact the form stayed the same.

P10: So usually I'll grab a laptop and pull up their chart and brief myself on what the history looks like and what they've already shared with other staff.

~~Focusing on maintaining empathy with difficult patients~~

(Theme: Using Empathy as a Gateway to Connect with Patients and Families)

Patients present with their unique characteristics, and some are more difficult than others due to their symptoms. The IC maintains composure during assessments focusing on supporting the patient emotionally through the process.

P1: Sometimes there's an additional behavioral component that I'm just like, you know, if grandma's describing you know how he'll tear the room apart **(Safety?)** and most likely they'll get a hold of me too. And I always, you know, believe that and take that as gold and really try to tiptoe around that situation.

P2: **Empathy and Safety.** I said every family that comes in is different with their own issues, with their uniqueness. Being a therapist, all they need is you to be present while doing that assessment for you to understand. As long as you have empathy and you're present there with them, you're patient with them that covers any family that walks in with their unique circumstances.

P3: I had some people that were experiencing a lot of psychosis and it's really hard to do an intake to get accurate information if someone is constantly in a whole nother world. So, understanding that but meeting the person where they are. So I had to learn kind of through that. You can't say to the person, Well, you know that's not true.

P4: I think, sometimes patients didn't want to talk about whatever, like the substance use disorder patients specifically, the ones that come in on overdose, unknown substance, white powder that they injected. And, then they want to act like everything's fine and nothing's up. And, I'm like, Okay, cool. If you don't want to talk about it, that's fine.

P6: Ask in a therapeutic way. And, the families don't understand, especially black families don't understand psychiatric admission or the process and what it all means.

P7:I think for me, a lot of the times it was a lot of empathy. For me, there were occasions where I had to fight off getting mad a lot of times because of who was coming in. Just as a back note to me, I was also a child welfare investigator before I became a therapist. So when I had the child beaters come in, I mean we're supposed to be being empathetic.

P8: **(After safety concern with patient hers and patient's safety)** I was like what is the point? This is what I did. But then I remember I actually like helping people help themselves. My ancestors paved the way and I did the positive self-talk and I was like this too shall pass.

P10: Those ones are really sad and you don't want to dishonor their emotions by saying like, "It gets better. I promise you, your brain will fill up and it will be easier when you're in your 20s and your 30s." Especially working with teens, you just know that their rational thought is not 100% online. So that's really hard because you're trying to validate.

~~**Safety concerns during assessment**~~

(Theme: Grappling with Safety Concerns during the Assessment)

-Physical safety is a personal concern, adapting to patient symptoms

-Safety needed for patient and different than expected

-Staff is an issue during assessment

Safety is a concern during assessment due to physical environment, patient symptoms and staff that think they are helping but not.

P1: And so it's just all about, you know, the safety situations where maybe nobody told me to sit directly by the door and always have that exit.

P2: You are there to gather information, so listening and finding the best way to make sure that the patient is safe, in case you have to send them out.

P3: (Member Check?)

P4: Then I realized he was there, I was like, Stay there, backing away, in a very directive voice. And, it was the patient that I was talking to and I don't normally do this. I don't know what in the world I was thinking about that day, but I was standing in the patient's door and I never do that because it's not safe, right?

P6: I learned, after doing several, like watch their nonverbal cues, because 19they might keep answering your questions and stuff, but getting amped up the whole time and 20you want to pay attention to that and not just make them escalate.

P7: (Member Check?)

P8: So Glitterman one day in session decided that he wanted to sprinkle his glitter during my assessment. And he wanted to gift me with his present. At first that made me want to quit. I was like why did I go get two master's degrees. **(Staff issue with safety)**Because what was challenging at times, was sometimes the staff may trigger a client. Or they themselves may put someone at risk when they were supposed to be stabilized, since they've come to the hospital for this. And so, that was something that I definitely had to deal with a lot, was dependent on who was the staff present in the room, or within close proximity.

P10: So really we're on our own except we have one security guard who sits in there with us. So until a patient is assessed in the crisis center and if they are deemed appropriate to be admitted, then we put them in to be medically cleared.

~~**Overwhelmed by the System**~~

(Theme: Feeling Overwhelmed by the System and Desiring Relief from Staff)

-Staff

-Thinking of additional tasks

Too many tasks required for an assessment. Underlying desire to have help.

P1: So, I'm going to need you to keep it moving. So, it feels like this. Crazy balancing act of, please manage your feelings and emotions in a crisis, so I can get everything else done that I need to get done, which is a million impossible things and move on to the next person. We've got to get back on some sort of insurance review platform and convey that to them all over again in hopes that somebody's going to pay for this.

P2: We are able to process, go back into the intake, go back into our office because we are three or four intake counselors in there, and you talk about what the patients said or what the family said.**(No relief from other duties but able to vent with other staff)**

P3: The way that the system is supposed to go, I don't know people running these systems and put them in place, they've never done intakes before or have done, because I feel like a lot of times the people that are higher up never really actually was hands on, on certain things. So you're telling me to do it this way, there's not enough time to do it this way.

P4: They were cutting people's shifts, that they would cut nursing. And, so then,what we were getting was not psychiatric nurses, but regular ED nurses. And, then they didn't want to do anything to help us.

P6: Maybe, probably a little overwhelming. Because I was by myself a lot and everything, that I had someone to holler at, and come help me, that also I could trust, that wasn't going to make it worse, orescalate anything. So that was huge. That was really helpful.

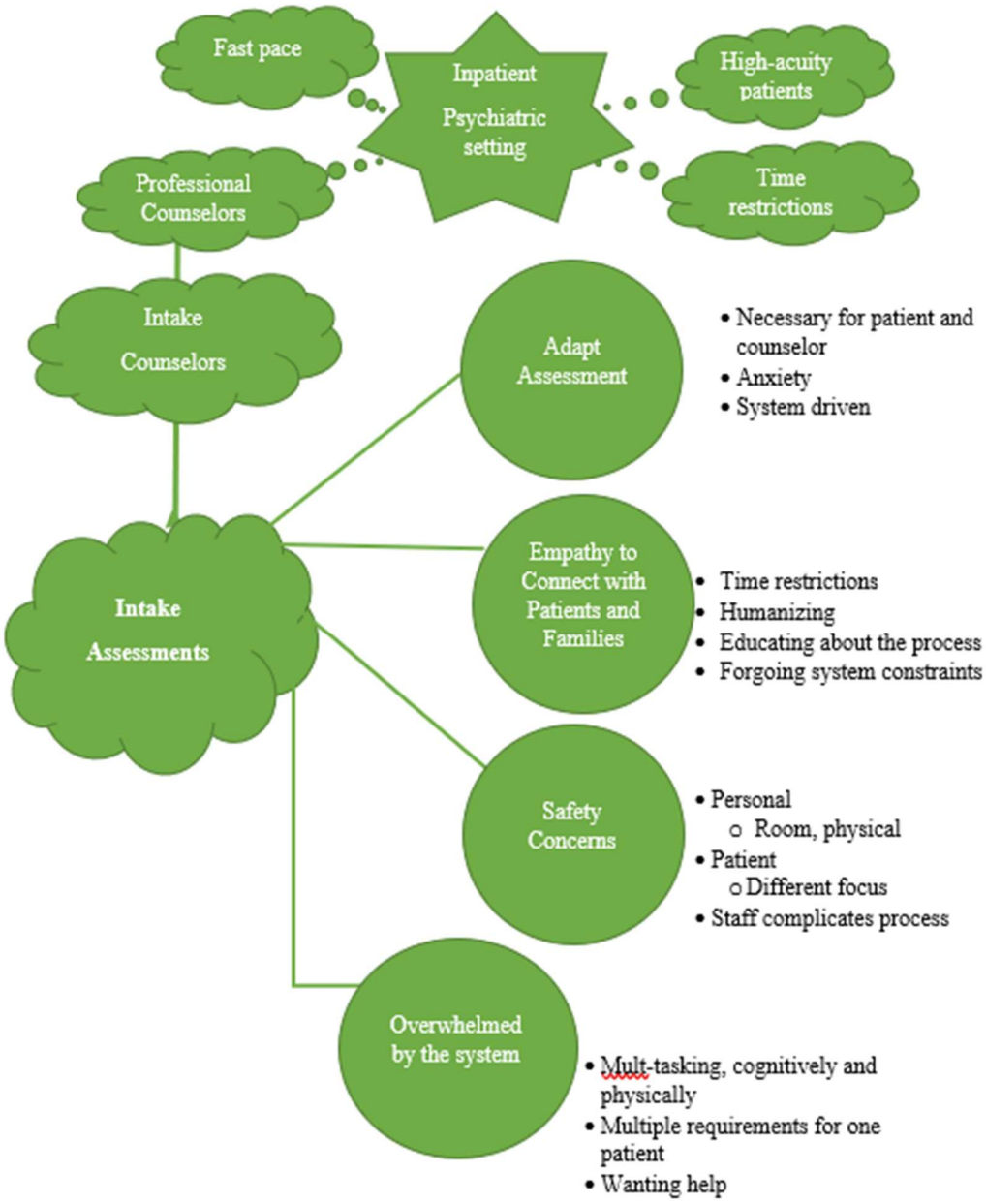
P7: So it became difficult, and so I think a lot of the nursing staff and such would be understanding and try and be a little more helpful sometimes when it got super busy.

P8: And I think where that burden was coming in at is, yeah, realizing there's some more things to do after the assessment. Okay, well, trying to find, let's say, a discounted pharmacy, if the client is indigent. And sometimes supervisory staff would not be available. So it was like, "Okay. I need to consult with my supervisor." And my clinical supervisor's not available, nor is the administrative supervisor.

P10: We have support staff in our crisis unit, just do all of the logistical things. Once we make a determination and write our assessment up, they get all of the transfer orders and communicate with the doctors and nurses and support the process.**(Deviates from the experience of others, healthy system)**

Appendix L

Manuscript 2 Theme Development



Appendix M

Member Checks Feedback

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Recap for Intake Counselor Study
3 messages

dysonn@oregonstate.edu <dysonn@oregonstate.edu> [redacted] Mon, Aug 2, 2021 at 9:21 AM

Hello,

Thanks again for working with me through the technical difficulties. I was able to retrieve the recording and transcribe it. Due to the technical issues, please review the transcript from the member checks and verify that the information is accurate. If you find themes to reflect your experience, with the additions from our recent meeting, please confirm this by email.

Regards,

Nineka Dyson

404.272.5488

---

dysonn@oregonstate.edu <dysonn@oregonstate.edu> [redacted] Mon, Aug 2, 2021 at 9:35 AM

Sorry the attachment didn't come through.

Nineka Dyson

404.272.5488

[Quoted text hidden]

P10_MC_Transc.docx
33K

[redacted] Mon, Aug 2, 2021 at 4:09 PM

To: "dysonn@oregonstate.edu" <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

Yes looks accurate!

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Confirmation of Themes

1 message

[redacted] Tue, Jul 27, 2021 at 10:56 AM

To: "Dyson, Nineka" <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

Dear Ms. Dyson,

Good morning. The themes are accurate.

Thank you for taking the time to complete this task.

Have a great day!

Sincerely,

[redacted]

[redacted] Mon, Aug 2, 2021 at 12:53 PM

To: dysonn@oregonstate.edu

[This email originated from outside of OSU. Use caution with links and attachments.]

I think you've done a fantastic job and appreciate you doing this! It has great potential to improve things for many people and systems.

Sent from my iPhone

> On Aug 2, 2021, at 11:06 AM, dysonn@oregonstate.edu wrote:
>
> [Quoted text hidden]

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Study Confirmation

1 message

[redacted] Wed, Aug 11, 2021 at 9:14 AM

To: Nineka Dyson <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

Good morning,

This email is to confirm that the themes of the study are accurate.

Thank you,

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Transcript Intake Counseling

1 message

[redacted] Fri, Jul 30, 2021 at 2:44 PM

To: Nineka Dyson <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

I agree with the themes of this transcript and intake counseling information. They completely match my experiences in this work! Thanks!

Sent from my iPhone

[redacted] Thu, Aug 19, 2021 at 11:33 AM
To: "dysonn@oregonstate.edu" <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

😊. Thanks. I skimmed. Like 474 says "bought", … it is " 'bout" like short for about. 😊. I'm sure you remember, but someone else might not.

I hope the study goes well.

[Quoted text hidden]

To: "dysonn@oregonstate.edu" <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

And fair enough on the themes. Sorry, I didn't see that file on the first pass.

[Quoted text hidden]

Wed, Aug 4, 2021 at 2:31 PM
To: "Dyson, Nineka" <dysonn@oregonstate.edu>

[This email originated from outside of OSU. Use caution with links and attachments.]

Hi Nineka,

I related to everything that was discussed in your research findings.

Appendix N

Peer Debriefing Note

Oregon State University

Dyson, Nineka <dysonn@oregonstate.edu>

Re: Feedback on Study
2 messages

Dyson, Nineka <dysonn@oregonstate.edu> Sun, Sep 5, 2021 at 4:05 PM
To: John Pryor <pryorjo@oregonstate.edu>

Thanks for the comments and feedback. Did you detect any bias in the results?

sent from mobile device

On Wed, Sep 1, 2021, 10:43 John Pryor <pryorjo@oregonstate.edu> wrote:

John Pryor, ABD, LPC, NCC
PhD Counseling/Counselor Education Candidate
College of Education
Oregon State University
OSU ID 933-284-752
p. (573) 280-1021
e. pryorjo@oregonstate.edu
Pronouns: he/him/his

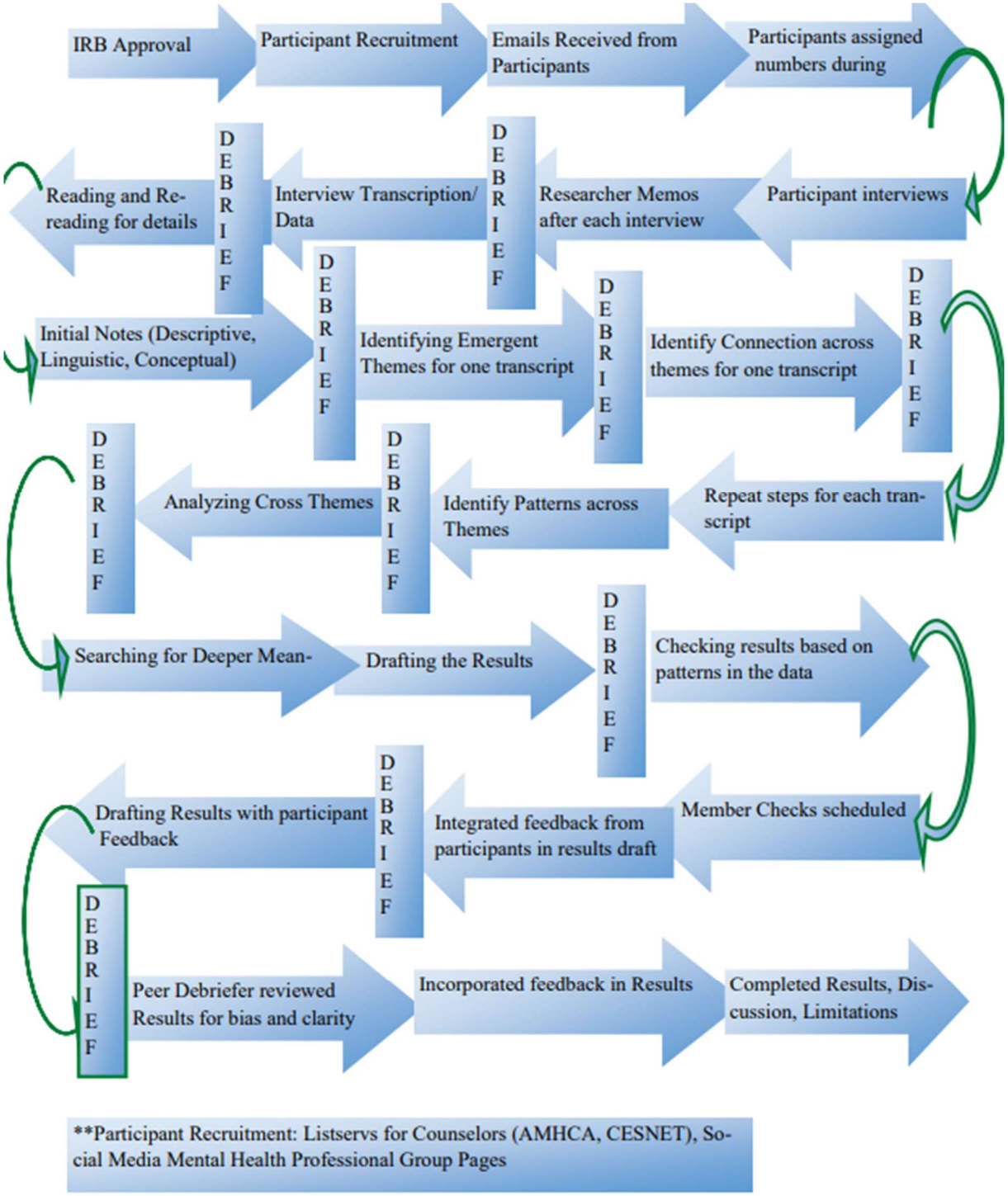
John Pryor <pryorjo@oregonstate.edu> Wed, Sep 8, 2021 at 9:50 AM
To: "Dyson, Nineka" <dysonn@oregonstate.edu>

Hey Nineka,
I have reviewed your findings and did not experience bias in your discussion of the themes and sub-themes. Your themes seem to be fully supported by the direct quotes from the transcripts and demonstrate the experience of what it is like to be an intake counselor.

Best,
John Pryor, ABD, LPC, NCC
PhD Counseling/Counselor Education Candidate
College of Education
Oregon State University
OSU ID 933-284-752
p. (573) 280-1021
e. pryorjo@oregonstate.edu
Pronouns: he/him/his
[Quoted text hidden]

Appendix O

Audit Trail



Appendix P

Researcher Positionality Statement

Reflexivity or self-reflection is an essential part of qualitative research. I began to reflect on potential biases, beliefs, and past experiences as I developed the studies. This self-reflection continued through all stages of the process from the birth of the topic, data collection and analysis, writing the results, and refining the results to write the manuscripts. Writing the manuscripts prompted me to engage in more intense reflection to ensure I was capturing the voice of the participants to the best of my abilities.

During the research process, self-reflection was essential to me personally and as a former intake counselor. Honestly, I wondered if my experience was similar to others within intake counseling, lending to a literature review on intake counseling. I accepted a position as an intake counselor to gain a different experience outside the scope of traditional therapy. The job was also available with a quick start date . Thus, based on my experience I assumed counselors that were intake counselors didn't like long-term therapy at the onset of this research.

Furthermore, I experienced challenges in my work as an intake counselor and later as the director of the department. The challenges required me to find ways to maintain working in the inpatient setting and minimize the impact of the job on my personal life. The job was hard for me as I often worked long hours and received calls overnight. This limited my interaction with family and friends. So, my biases starting the research were participants would have insecure attachment with friends and family.

In addition, other life experiences led staff to request my support in unsafe situations with patients. I came to the job with the clinical knowledge to assess patients and provide an accurate diagnosis. However, it was difficult to discern the spectrum of admission in my facility. My

colleagues viewed me as a team player which I initially thought would emerge in the data. However, as time went on and my role changed from colleague to supervisor, the other intake counselors viewed me as part of the system. The perception as me being part of the system was accurate and disheartening. The role of supervisor was hard to balance, as I knew the struggles of being on the front-lines in the department. Based on my experiences and biases, I began debriefing and reflexity at the start of the research process.

As I began the process, I journaled my thoughts and feelings with each phase. Even when deciding on this topic, I reflected on my experience and the importance of intake counselors to have a voice in professional counseling. Finally, I returned to therapy to reflect on the impact of my overall work experiences during this process. Therapy helped me to name my stuck points based on some of the disturbing experiences I had as an intake counselor. The most prominent feelings were sadness, anger, and after writing the results, a sense of peace.

The lack of research prompted an eagerness inside me to explore the experience of intake counselors. I hope to provide a glimpse into the world of an intake counselor and give this area of counseling a place in the body of scholarly knowledge. I recognize that my own experiences might lead to bias when analyzing the data. However, I have strived to convey the meanings of the participants' experiences correctly. Using participant quotes, member checks, peer-debriefing, and regular meetings with my major professor assisted with ensuring I interpreted the experience of the participants accurately.