

A Narrative of Interprofessional Group Development

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Abstract: Interprofessional education is a new movement that is being adopted more by educators in higher education. In other words, it has come to stay. This is the story of a collaboration across five disciplines at the University of Texas Rio Grande Valley to implement a Primary Care Behavioral Health certificate program that benefits both the students and the community of Rio Grande Valley. Tuckman and Jensen's (1977) model of group development frames this narrative, with its stages of Forming, Storming, Norming, Performing, and Adjourning.

Keywords: interprofessional education, primary care behavioral health, behavioral health consultant, group development

Introduction

Although the mental health crisis in the US has been recognized long ago, addressing this crisis has been neglected (Hogan & Goldman, 2021). Of the US population, approximately 13.6 million individuals have serious mental health problems (Schmit et al., 2018). Forty to fifty percent of them receive some inadequate treatment (Soeteman et al., 2014).

Not all individuals who need mental health services have access to them, or they may not seek mental health treatment. However, almost all individuals visit primary care physicians. Eighty percent of Americans visit primary care physicians on a yearly basis (Robinson & Reiter, 2016). Primary care is often the gateway to mental health treatment and has an essential role in the proper functioning of the healthcare system. Primary care physicians provide comprehensive and accessible care to patients. Therefore, any new models aiming to address this crisis and improve public health should focus on primary care (Robinson & Reiter, 2007).

Primary Care Behavioral Health (PCBH) is a model that addresses this need. It includes a team of professionals working together in a clinic/outpatient setting. The focus is on the primary care physician to address patients' health and the Behavioral Health Consultant (BHC) to address patients' mental health in a duration of 15 to 20 or 25 to 30 minutes, following up with other short visits if needed. PCBH manages population health and empowers primary care (Robinson & Reiter, 2007) by integrating mental health services into primary care, enabling the treatment of more individuals' mental health in a shorter time period (Robinson & Reiter, 2016). Research shows that PCBH increases patients' health and mental health, limits their primary care visits, and as a result, improves their quality of life (Robinson & Reiter, 2016). PCBH's goal is also to increase patient satisfaction, improve accessibility to care, and reduce the cost of healthcare. Simply put, it reforms the healthcare system (Robinson & Reiter, 2007), addresses health disparities in society, and promotes health equity.

In response to health inequality in the Rio Grande Valley (RGV), which comprises 1.3 million Latinx and is one of the most disadvantaged areas in the United States (Lazaretti et al., 2019;

Llamas et al., 2025), an educator at the University of Texas Rio Grande Valley (UTRGV) School of Medicine has pioneered the training of a new generation of BHC. He and his team submitted and were awarded the Health Resource Service Administration's Behavioral Health Workforce Education Training (BHWET) grant to strengthen and establish a PCBH-focused training pathway in partnership with the four mental health degree granting programs in clinical mental health counseling, social work, psychology, and rehabilitation counseling. The PCBH core team includes a director of special programs, a PCBH clinician lead, program coordinator, and program manager.

The groundwork for a PCBH-focused training pathway for mental health programs at UTRGV was established in 2018, three years before the BHWET application. In close partnership with the Department of Counseling, a pilot course on "Integrated Primary Care" was introduced in 2019. With positive feedback from students from this initial experiment, the educator requested the Department of Counseling to serve as the connectors and facilitators to build a process for a PCBH-focused training pathway. The story described below began when the disciplines started meeting and cooperating. I aim to elaborate on this story through Tuckman and Jensen's (1977) model of group development, with its stages of Forming, Storming, Norming, Performing, and Adjourning (Kirst-Ashman & Hull, 2016).

Forming

In this stage, group members start to become acquainted with each other and mostly rely on the leader. I received an email from our School of Social Work inviting faculty to be the School's representative of the PCBH certificate program. In the beginning, curiosity and exploring the opportunity was my only motivation to join the group. Many of our School's faculty attended the initial meetings; however, gradually, many withdrew and only two of us continued to attend the meetings and became representatives. The idea of the collaboration was so new that the initial group members did not know what to expect. In this phase, the leader of the PCBH certificate program and his group patiently explained the goal of the collaboration, facilitated, and encouraged members to know one another and become ready to work on the common goal of training BHCs and empowering and enabling students to learn a new approach to mental health to address the RGV community's needs. Although as UTRGV university faculty members we knew each other to some extent, working collectively was a novel idea and experience.

Almost a decade ago, when I started my appointment as an educator, I had been exploring interprofessional collaborations. I could see many potentials; during that period, however, the interdisciplinary work was a new concept—often colleagues from other departments were not open to examine it—especially with a newer educator. My old habit of knocking on all doors helped me move past the limitations of the time and find creative colleagues with whom I successfully collaborated. The nature of the collaboration this time was completely different than my prior experiences. Collaborating with a significant number of departments at the same time and pursuing the same goal did not seem feasible at first—I felt, and perhaps was, truly unaware of the magnitude of the task I was undertaking. The process of forming our group was gradual and somewhat perplexing, requiring many months of numerous meetings. Ultimately,

the group was formed with two faculty members drawing from each discipline. Initially, the Rehabilitation discipline only had one representative faculty and considerably later, a new member joined our group and tried to acquaint himself quickly. The group members steadily started to trust in the leader and his team to guide the group and also trust in their colleagues to work. At the end of this stage, we knew who the core group members were and with whom we needed to collaborate to make the team.

Storming

In this stage, the group members express themselves, and conflict could be a natural result of the group's interactions. In this group, group storming was rarely about group members' power struggles. It was mostly about struggling with the new concept of PCBH and understanding the new way of training our students together. It was hard to imagine having a class consisting of counseling, psychology, social work, and rehabilitation students and training them on the same subject. It was not just the class; they had to work together in the same clinic and provide services to individuals in direct collaboration with residents and physicians.

Each discipline's faculty has had specific trainings and instructions on teaching in the class environment, preparing the students for the internship/practicum and supervising them in congruent with their accreditation body's rules and regulations. For instance, in social work, the clinical supervisor often teaches students about an almost one-hour intake process and later the 30 to 45 minutes therapy or services. However, in the PCBH model, students learn that as a BHC, they need to spend 15 to 20 or 25 to 30 minutes with a patient after a primary care physician visit. Follow-up visits, focused primarily on response to previous behavioral interventions, are targeted visits that last up to 15 to 20 minutes. The clinical supervisors had to deal with their own internal conflict of accepting this new way of clinical work in primary care and training students to the competencies of a BHC. In this capacity, I did not have the role of a clinical supervisor and did not face pressure. Therefore, as an external voice, I could listen to their struggles, acknowledge their feelings and concerns, and humbly invite them to move slowly toward the PCBH path. The other shift includes a shift in language to mirror a primary care culture and practice context. For example, the switch in language from client to patient and from sessions to appointments or visits. We were assured that the changes were minimal. However, I felt it was not just a change of terms—the adaptation of primary care terminology appeared to result in a loss of our unique identity as mental health clinicians.

I, as an experienced practitioner, struggled with the concept of BHCs. On a personal level, I was comfortable with the way I was trained to address clients' mental health. However, my concern was not just about adhering to my comfort zone. I knew that PCBH was designed to address mild, and perhaps moderate, mental health problems, and clients with severe mental health disorders would still need to be treated by the community's mental health providers; however, I began thinking that if this model becomes widespread, it could be a step towards superseding independent mental health providers in the same way larger corporations replaced small businesses some decades ago. I was also aware that PCBH is built on the well-known and well-practiced Cognitive-Behavioral Therapy and similar therapy models, and I was well-versed in its effectiveness and practicality. Despite all the evidence, I have always allowed myself to have a

critical view and remind myself that popularity and effectiveness are not always complementary. What is right is not always popular and what is popular is not always right.

The thought occurs that if mental health clinicians work as BHCs, they are more likely to focus on Cognitive Behavioral Therapy, Solution-Focused Brief Therapy, and other brief interventions (Lee et al., 2025; Shepardson et al., 2016) and are less likely to practice other theories—Client-Centered Therapy, Feminist Therapy, and Psychoanalysis, among other notables. These are theories that have undergone evolution and rigor for many years and yet may be set aside by many practitioners in favor of a quicker style of intervention. Historically Watson and Skinner’s Behaviorism theory had been praised and admired as a quick intervention; but we faced their theory’s limitations as time went on (Kurt, 2022). We may witness a similar phenomenon again. I was not comfortable discussing my thoughts about the PCBH program with my colleagues who were perhaps in love with its effectiveness or quite possibly preferred not to question it. Sometimes, change is inevitable; but embracing change is different from surrendering to it. In therapy, often therapists encourage couples who are in love and seek pre-marriage therapy to look for their loved ones’ negative traits in order to make a sound decision. We may have to do the same with newer interventions.

Although the power struggle was not a serious issue, mainly due to the same professional status of the group members, sometimes it could create small discomfort. For instance, in one of the group meetings, I was not clear on my possible roles and expressed my thoughts freely and openly on the UTRGV School of Medicine PCBH program leader’s decision of excluding other disciplines in the process of grant writing; one of the colleagues from another department that had more power, instead of allowing the program leader to address it, directly stated: “Maybe this program is not for you.” Although another faculty from her department mediated and softened the statement, and I did not have any emotional reactions to the statement, whenever I had some difficulties and challenges during the process of collaboration, I remembered what I had heard in that meeting.

Even though all disciplines’ spokespersons were respected, they had different positions in the group. A couple that represented one of the disciplines had their own small sub-team and obviously supported one another. Their adjacency probably facilitated the process of their integration in the group. One discipline’s representatives had a closer relationship with the PCBH program leader and were in some capacity leaders themselves, mainly due to their initial collaboration in 2018. They were more familiar with the program and more assertive than other group members, which likely de-escalated possible conflict among the group members and facilitated the group’s cohesiveness.

Although group cohesiveness facilitates teamwork and contributes to achieving the group’s goals, it can hinder the expression of viewpoints and ideas unfamiliar to the cohesive group. I was part of the homogenous group in most meetings and discussions, and because of it I often hesitated to express views that could potentially run counter to that majority—it’s not a stretch to imagine I was the only one. In all likelihood, I probably wasn’t. But I felt I had to respect the homogeneity of the group, and I was alone with my thoughts.

Norming

In this stage, the group overcomes their conflicts, and the written and unwritten norms and rules of the group are transparent. They have a sense of collaboration and trust and are ready to work with one another. The group is closer together and focuses on achieving the goal. Bi-weekly meetings and group members' training on the PCBH certificate program, including roleplay, made our bonds stronger and prepared us for the task performance. We felt the closeness at this stage. A pleasant event was the marriage of a couple in the group, which as one of the group members stated "made us a family."

Our training encompassed the reading of numerous articles, the watching of some training videos, and the roleplaying of many scenarios as both patient and BHC. In our roleplays, I observed that all trainees played the role of an ideal patient and a BHC. Thinking that in real practice not all patients are agreeable and exercise when they are suggested, I played the role of a disagreeable patient—though I was unsure it was perceived well by my colleagues. Again, I experienced group homogeneity and how it could block creativity and uncommon views.

In some training sessions, I was not sure that I understood the goal of the program and the procedure. I was not sure if it was possible to have a multidisciplinary class. It seemed that for each two steps that I went ahead, I had to take one step back in terms of comprehending and mainly believing that the program actually worked and benefited our students and the community. The doubt perhaps affected my learning and comprehension of the program. We as core faculty were trained in teaching two specific courses for this certificate. The training and internship sites visits were supposed to be in person; however, due to the COVID-19 pandemic, they were mostly managed via Zoom.

Performing

This stage is the most important stage. Group members are focused, and they accomplish their tasks. Our group had many tasks to accomplish, such as modifying the traditional and accelerated graduate program's plans for each discipline, adjusting each discipline's internship/practicum plan with the PCBH clinic sites, submitting and presenting the two new courses to the university graduate program to approve the certificate program for all disciplines, advertising to recruit students for each department/school, preparing a flyer and a PowerPoint presentation, and presenting it to the graduate students in all four disciplines. The approved syllabi were designed in partnership with the PCBH lead team and the Department of Counseling. Four national experts in the PCBH model reviewed and approved the syllabi for high fidelity content and provided edits to readings and assignments. However, the team can revise as needed with feedback from initial few cohorts and implementation successes and failures.

After all these tasks, the criteria for admitting the students to the program needed to be designed and adjusted to each discipline. The students were encouraged to apply to this certificate program. Despite of all our endeavors to attract students, we enrolled only six students in the first year (2021–2022). The second year (2022–2023), we were more successful and recruited 16

students. However, the goal was to enroll 29 students per year. We realized that we needed to be more organized and advertise effectively and equally across the four disciplines. We recognized that introducing the program to the faculty of four disciplines was necessary and somehow more difficult. They did not have any prior knowledge of the program, and some were hesitant regarding its effectiveness, which needed to be addressed.

We as a group evaluated each student's application and decided whether they were qualified to be accepted into the program. Some non-citizen students applied to the program, others were non-residents of the RGV, and a few had some health and mental health problems that made them unsuitable candidates for the program. I recall a student who wrote in the required essay not about focusing on the PCBH goals and the training's impacts on her future career but rather elaborating on how she could use the \$10,000 award to pay her rent, buy her course books, and borrow less from her parents. This honest assertion created a dilemma for me whether to recommend her into the program.

Medical students and residents were trained by the UTRGV School of Medicine, and we were not responsible for preparing their course materials or supervising them. Working and coordinating all these tasks in a short period of time was often overwhelming; however, group collaboration made it bearable. During this process, the leader of the team was always calm and collected.

The BHWET was awarded \$1,920,000, and its structure stipulates 60 percent of the budget for students' stipends and 40 percent for administrative costs. The grant writers and the program leaders reported limited financial benefits, and thus far, there has been no benefit for the faculty of the four disciplines involved in the program. One of the faculty team members administrated and submitted a grant proposal to bring some funds in to support the core faculty of the PCBH program, but unfortunately, the grant proposal was denied.

Although the core faculty were not compensated monetarily, this program benefited our students a great deal. All accepted students are awarded \$10,000 for completing the PCBH certificate and all their books are paid for by the grant.

The same PCBH core faculty member from the Psychology Department was the first "star of the show" to teach the first class, which consisted of students from psychology, counseling, social work, and rehabilitation counseling programs. He listened to the students and adapted the course materials to their needs. He paved the path for other potential instructors of the PCBH courses.

Running the university clinic based on the PCBH model has been a new and often complicated task. The whole team needed to be trained, managed, and supervised. For instance, sometimes, the physicians asked for re-scheduling, or simply did not show up, and the same with our students. Troubleshooting and creatively solving the unexpected problems has been a part of the daily tasks of the team, along with ongoing monitoring and evaluation of the program. Every day we have been learning from our experiences on how to implement the program. Every day has started with a new challenge.

These tasks are at least visible; the team has to manage other tasks that are less visible, such as REDCap database building and the student surveys. We have the university's support on database buildings; however, the main responsibility is on the leader and his team.

Those who were responsible for clinical supervision, another faculty member from the psychology department and my colleague from our School of Social Work, had to learn experimentally, and see what worked and what did not. They felt more lost and confused, while simultaneously being responsible for managing the students' confusions. They had to put aside their habit of supervising students in the regular practicum and had to re-learn how to supervise the students in the PCBH clinics. We had bi-weekly meetings to address all preparatory questions and concerns, and often dealing with all the problems across the four disciplines was exhausting and overwhelming. In addition to work-related complications, sometimes the group members faced personal challenges. For instance, one time after a dental surgery, when I could barely talk, I had to arrange a meeting with the leaders and our school's program coordinators. Another time a group member's child was sick, and she informed the group members to excuse her—the other time, a member of the group had surgery, and her recovery process was long and so she could not be present in the meetings and the trainings for a while. As a group, only with patience and understanding could we manage the unexpected circumstances.

Each of us was creative in our departments to solve the unforeseen problems and to assist other members. We learned from one another's creativity and even missteps. In August 2022, the first cohort graduated, and since then, we have continued to enroll new cohorts. Our goal is to use all available UTRGV and RGV community resources to create an evidence-based, efficient, and sustainable PCBH program.

Group Roles

The main role of our group was the task-related role. Implementing the PCBH certificate program connected the group members together. However, the group members' maintenance roles were essential. Each member had a role of being information- and opinion-seekers and constantly tried to learn about the program and explore the group members' personal and professional opinions. We sometimes also had the simple role of following the leaders. I have learned from working in the higher education system that playing the role of the follower is often expected—although, to the contrary, we are encouraged to be critical thinkers.

Each person had her or his own unique place in the group and from time to time, had roles of elaborator, instructor, encourager, harmonizer, and listener to maintain and protect the group homogeneity. In our group, the non-functional roles of aggressor, blocker, or dominator were not evident. Furthermore, a faculty from the counseling department had the main role of group maintenance and would motivate group members, encourage them, and harmonize the group. I call her the group lubricant, as the group performed smoother in her presence.

Adjourning

The last stage of group development is adjourning. We are far away from imagining the adjourning. We have started a long journey and aim to cultivate a sustainable program. Although, it is comprehensible that along the way some members, due to their other obligations, may separate from this journey. Their pioneering contributions would be appreciated. They would leave their trace on the program's history.

Lessons Learned and Conclusion

This new wave of education is gearing more towards interprofessional education. We, in some ways, are pioneers of this new model of education, at least at RGV. When one decides to create a multidisciplinary program, financial support is the most essential element, and after that, administrative support is significant. If the deans and chairs of the disciplines did not cooperate, the process would become more challenging, and the rate of success would likely be low. In this program, the leader focused on building an alliance with one of the disciplines and this discipline facilitated the process of including the other disciplines. Although a financial reward is a reasonable motivation, it is not the only motive to pave a new way. In our program, the sense of creating a better future for our students and serving the RGV community were together a stronger drive than financial reward or compensation for the time and efforts. We learned that patience is key; the path is not easy, and one might face complicated challenges in every step. Focusing on the group's strengths and on what they can do rather than what they are not able to do and identifying a person as a motivator of the group—someone who almost everyone can relate and connect to—are significant factors. The motivator can loosen the strong ego of some group members and facilitate the process of collaboration. Accepting the challenges that arise and removing the barriers gradually—allowing members to express and disclose their lack of trust and confidence in the program, and their disappointments—are essential for activating their creativity. Again, patience allows the group members to gradually develop a sense of trust and cooperation and invest in the program far beyond the expectations. This was our experience; but each program is unique and might pursue different goals. Nonetheless, the human factor is vital in making a program successful.

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