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Timothy Albro
(Bradley Hospital, Riverside, RI),
Interdisciplinary Collaboration in a
Psychiatric Treatment Setting

ABSTRACT

This purpose of this exploratory, qualitative study was to explore interdisciplinary collaboration as experienced by clinicians in a psychiatric hospital setting, where collaboration is a routine part of mental health treatment. This study examined how individual practitioners brought their unique theoretical and personal perspectives to their work, and how interdisciplinary collaboration shaped their own clinical thinking and actions.

The subjects in this research were social workers, psychiatrists, and psychologists, working in clinical roles at Bradley Psychiatric Hospital for Children and Adolescents in Riverside, RI.; they were divided into two focus groups, each meeting for one and a half hours. Questions were raised about conflicts arising in group discussions, such as differences regarding theoretical orientations and treatment recommendations, and about collaboration leading to successful and/or unique clinical outcomes. Participants were asked whether training in collaboration was included in their professional education, and what recommendations they had for enhancing the utilization of collaboration in the future.

The key findings of this study were related to the positive contributions interdisciplinary collaboration in clinical treatment provided to these clinicians. The support the subjects received from team members across disciplines, in working with difficult clinical issues, was perceived as an important benefit of collaboration. In all cases where participants described conflict, or treatment complications, they also felt collaboration aided in addressing these issues. Another

benefit was the opportunity for learning new theoretical perspectives, and treatment approaches.

**Interdisciplinary Collaboration
in a Psychiatric Treatment Setting**

A project based upon an investigation at Bradley Hospital,
Riverside, Rhode Island, submitted in partial fulfillment of the
requirements for the degree of Master of Social Work.

Timothy Albro

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Northampton, Massachusetts 01063

2011

ACKNOWLEDGEMENTS

Thanks to all of my supportive and caring collaborators! Esther Urdang, PhD was most patient and insightful in facilitating this process as my thesis advisor. This thesis would not be what it is without her input, and I am very grateful to have had her as a guide.

Jeffrey Hunt, MD and Marilyn Sykulski, LICSW deserve thanks for signing on and supporting me in getting this research done at Bradley Hospital. I also thank Missy Tatum, who was instrumental in helping to set up the focus group meetings. Heather Thibodeau, LICSW, my supervisor, and all the rest of the SafeQuest team for keeping me grounded in the work by modeling a most wonderful collaborative experience.

Early experiences are ever important, and I thank Carol Boylan, MSS, LS my supervisor, and the acute care psychiatric team at Hahnemann Hospital in Philadelphia where I did my first Smith SSW internship for providing me with the first inklings of the idea for this project and contributing to my identity as a social worker.

My wife Laura Heffernan, PhD was amazing in being there with me while I got this thesis done! I love you and look forward to each and every one of our future collaborations.

My sister BA, her husband Jami, and their kids Adrienne and Julia, put a roof over my head Smith SSW summers and kept me going with constant inspiration and love.

To my parents Lillian and George, thanks for the love and support as I toiled away at this work. Kevin and Mary, you became parents half way through this project, new collaborators gained along the way are most welcome!

I wrote this thesis with the hope that everyone who participates in the mental health system will continue to seek equality, liberation, and ethical care for themselves and others.

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CHAPTER I

Introduction

This exploratory, qualitative study explored interdisciplinary collaboration as experienced by clinicians in a psychiatric hospital setting, where collaboration is a routine part of mental health treatment. This study examined how individual practitioners brought their unique theoretical and personal perspectives to their work, and how interdisciplinary collaboration shaped their own clinical thinking and actions.

In its history as a profession, social work has developed through interdisciplinary collaborations. Over the years, since psychiatric social workers took their positions in state and private institutions and agencies, there has been an increase in interdisciplinary work in the fields of medicine and mental health as well. Many clinical training programs have developed a multidisciplinary focus, bringing social work, psychology, or psychiatry together with such disciplines as law, business administration, and public policy. Studies in the humanities have also provided fruitful opportunity for borrowing concepts that have changed the theoretical base of social work, such as narrative therapy's development in relationship to critical theory and psychotherapy.

While the literature on interdisciplinary collaboration offers many ways of describing and valuing the structures and interactions of collaboration, this research focused on how interdisciplinary collaboration is experienced by practitioners. It is relevant to social work and its related fields, as it highlights both pitfalls and potentials of the collaborative process.

The subjects in this research were social workers, psychiatrists, and psychologists, working in clinical roles at Bradley Psychiatric Hospital for Children and Adolescents in Riverside, RI. The subjects were divided into two focus groups; each group was interviewed for one and a half hours. This study explored what it means for clinicians at Bradley Hospital to work together, how they work together, why they work together, and what they get out of working together.

Questions were raised about conflicts arising in group discussions, such as differences regarding theoretical orientations and treatment recommendations, and about collaboration leading to successful and/or unique clinical outcomes. Participants were asked whether training in collaboration was included in their professional education, and what recommendations they had for enhancing the utilization of collaboration in the future.

This study is grounded in my own experiences of interdisciplinary collaboration while a social work intern at Bradley Hospital and, formerly, in an adult inpatient acute care psychiatric unit. For a developing social worker, the clinicians from other disciplines in these settings such as psychiatry and psychology, and nursing and front-line staff to boot, played no small part in the social work identity I was beginning to form. I valued my experience of collaborations, as well as the social workers I had as role models.

In the chapter which follows, the literature relevant to interdisciplinary collaboration, its history, and utilization by the disciplines of social work, psychiatry and psychology is discussed. Chapter III describes the study's methodology, including the process of getting institutional approval, recruiting subjects, and procedures followed for the focus group interviews. In Chapter IV the findings of the research study are presented, and Chapter V offers a summation, considerations for future research, and implications for social work practice.

CHAPTER II

Literature Review

In social work practice, collaboration occurs on both macro and micro levels of practice, in the relationship of patients and clinicians, clinicians with other clinicians, clinicians with agencies and institutions, agencies with other agencies, and agencies with communities (Hornby & Atkins, 2000; Graham & Barter, 1999). In this qualitative study, the goal was to explore the experiences of mental health clinicians, specifically social workers, psychologists, and psychiatrists, in interdisciplinary collaboration in a psychiatric hospital setting where this type of collaboration is built into the structure of practice.

As the emphasis of this research is on mental health collaboration, this chapter begins with a look at the role of interdisciplinary collaborations in the early history of the development of psychiatric social work. This is followed by a discussion of definitions of interdisciplinary collaboration in the context of research and clinical work. Next, literature pertaining to practitioners' experiences of interdisciplinary collaboration in the field of clinical social work is discussed, and then specifically, collaboration in mental health treatment settings is presented..

As this study inquires about the role theoretical perspectives play in interdisciplinary collaboration, literature pertaining to recent and prominent theoretical clinical perspectives is reviewed. Finally, as this study uses the qualitative focus group research method, literature related to focus group research in clinical practice is presented.

History of Interdisciplinary Mental Health Practice

Albert Deutsch's (1937), *The Mentally Ill in America* describes the "beginnings of direct

collaboration between social workers and psychiatrists" in the late nineteenth century (p. 290). Deutsch describes psychiatrist Albert Meyer as pioneering a holistic view of psychiatric problems, which took into account, not just the individual being treated, but rather the "environment whence [he] sprang" (p. 286). Further, Meyer "conceived of the brain not only as an anatomical entity, but as man's social organ, acted upon and reacting to external social stimuli" (pp. 286-287). It is from this shift in perspective, that Meyer sought to gain as much knowledge of the social context of his patients as was possible. In 1904, when it became clear that physicians did not have the time to compile case histories, Meyer asked his wife to gather information from patients and make visits to their families and communities.

Out of a shift in theoretical stance by some in psychiatry, a need developed within the field from which psychiatric social work was fashioned. In addition, Deutsch (1937) describes forces within the discipline of social work working along parallel lines:

In the meantime, while this call for social service was developed from the inner needs of psychiatry, a simultaneous drive had been proceeding *from* the social work profession *toward* psychiatry. (Deutsch, 1937, p.287)

From its beginnings as a discipline, social work had been concerned with the social aspects of mental health treatment for patients of the late nineteenth century, such as readjustment and appropriate disposition after hospitalization, which were taken up by the After Care Movement. This led in 1906 to the installation of E. H. Horton, who would later be referred to as the first psychiatric social worker in New York City (Deutsch, 1937).

Ann Hartman's history of the Smith College School of Social Work, written for the school's 90th anniversary in 2008, highlights the integral and interdisciplinary nature of the school's role in the development of clinical social work practice. Social worker Mary Jarrett inaugurated training in psychiatric social work in a Boston psychiatric hospital with E. E.

Southard, a psychiatrist and leader in the Mental Hygiene Movement. Jarrett then turned to Smith College to establish a school for social work, devoted to integrating the new ideas being developed in the Mental Hygiene Movement, and to meeting the mental health needs of returning WWI veterans.

Deutsch describes Mental Hygiene in psychiatry as "a trend leading to the discovery and rediscovery of broad social factors hitherto obscured from the medical specialist engaged in treating the mentally ill on a mass basis" (Deutsch, 1937, p. 319). For social workers such as Jarrett and Mary E. Richmond (who Deutsch describes as "the leading exponent of social work theory of the day"), Mental Hygiene represented a way of integrating social and environmental factors with social work's increased focus on individual personality in social case work (p. 320).

In the book *American Therapy*, Jonathan Engel (2008) describes a similar interdisciplinary genesis of the two professions, with psychiatry taking cues from psychiatric social workers and adopting a more holistic approach to mental health, while psychiatric social workers became more focused on the dynamic process affecting the individual. Engel places emphasis on the developing role conflicts in the mental health clinic, as social workers and psychologists began to move into providing clinical treatment in the form of psychotherapy. Engel describes how initially psychology found its role developing, administering, and interpreting psychological tests, , but expanded its role to providing treatment after WWII, when the need for psychotherapists was great.

Engel describes the therapeutic practice of psychologists at the time as "rejecting psychiatry's increased reliance on analytic ideas and constructs and insisting on practicing a more hands-on pragmatic sort of therapy" (p.68). In Engel's view, tension between psychiatry and the "ancillary" disciplines of social work and psychology developed as each discipline became more

invested in having separate identities in an emerging market for mental health treatment. In this regard, Engel emphasizes forces outside of the disciplines such as managed care and the development of psychiatric medication as having influences on their development.

Although controversies arose between professions, such as the conflict between the medical model of mental health prevalent in psychiatry and the biopsychosocial model of social work (Nasser, 1995), also evident are the internal splits along theoretical lines within disciplines. These splits continue to have both positive and negative consequences. The splits within social work, psychiatry, and psychology have been productive in terms of adding innovations, and integrating these (Deutsch, 1937) with established views to provide the most helpful treatments. These differences have also sometimes promoted rivalries and interpersonal conflicts, which can impact patient care.

In my study, questions are designed to look at ways in which clinician's theoretical orientations and interdisciplinary collaboration are related in mental health treatment settings.

Collaboration

In an article framing collaboration as a "unifying method" of social work practice, Graham and Barter (1999) use the interdisciplinary literature to define collaboration as "a relational system in which two or more stakeholders pool together resources in order to meet objectives that neither could meet individually." Indeed, the literature, from applied disciplines such as organizational dynamics and nursing (Cadet, et al., 2011; Moulder, Staal, & Grant, 1988), as well as academic disciplines such as philosophy (Weick, 1986), meets Graham and Barter's (1999) criteria for this broad definition.

The literature describes collaboration as occurring on all levels of clinical practice. In addition, interdisciplinarity can be seen in the development of new practice approaches, such as

the integration of cultural studies in the literature of narrative practice (White, 2007) or the integration of cybernetics and social construction theory in family therapy practice (Hoffman, 1990). Hoffman marks this shift in her work as a move from a "strategic and instrumental" model to one that is more "collaborative and unconcealed" (p. 1). Further, Berg-Weger and Schnieder's (1998) research study on collaboration in social work education showed that 66% of accredited social work programs reported participation of the social work department in collaborations in research, education, and service.

In a unique form of collaboration, individuals integrate two disciplines into their own professional selves, such as social workers becoming lawyers, or visa versa. Many schools of social work now offer joint degree programs. In 2010, 47 out of 203 schools of social work offered a social work master's degree with a dual degree in law. The next most common pairing with social work was public health (32 schools) and public administration (24 schools). (Pace, 2011, p. 4)

Graham and Barter (1999) conclude that in social work "collaboration may be included among the most significant of all social work verbs, alongside to communicate, or to relate,"; these researchers see collaboration as a means of achieving a desired outcome, rather than a goal in itself. Most of the social work literature reviewed here supports this conclusion, emphasizing the centrality, ubiquity, and, in some practice settings, mandatory nature of collaboration.

This thesis explores the role of collaboration in a mental health setting where interdisciplinary collaboration is mandatory, related to the Hospital's family-centered approach in treating children and adolescents. This research examines how clinicians experience and utilize this process.

Interdisciplinary Collaboration in Clinical Practice

In a study focusing on developing a theoretical model for interdisciplinary collaboration, Laura Bronstein (2003) defines interdisciplinary collaboration as "an effective interpersonal process that facilitates the goals that cannot be reached when individual professionals act on their own (p. 299)." There has been a recent increase in research in interdisciplinary collaboration in clinical practice, spurred by increased pressures placed on clinical work in the wake of deinstitutionalization in mental health (Aviram, 1997), and the introduction of managed care (Cadet et al. 2011).

Within disciplines, a trend toward increased specialization of individual professionals is cited as a reason to develop models and practices for collaborative team approaches (Billups, 1987). A study by Zwarenstein and Reeves (2006) points to a lacunae in knowledge translation research, a.k.a. implementation research, where the dissemination of evidence based practice knowledge has been studied primarily within single disciplines. This has lacked the perspective of ways interdisciplinary collaboration could be a positive factor in enhancing effectiveness.

For the most part, recent research in collaboration is justified by the idea that as demands increase on individual professionals, interdisciplinary collaboration, as it is defined by Bronstein (2002), will allow for clinical practices that meet these increasingly complex needs. However, a critical review of the literature relating to interdisciplinary treatment teams in health related fields (Schofield & Amodeo, 1999), noted that managed care had caused a decrease in interdisciplinary collaborative practices, such as clinical team meetings. Agencies and institutions are being forced to jettison practices that they can't prove to be clinically viable. This approach focused on efficiency and efficacy of the treatment team model. Schofield and Amodeo noted that nearly all of the literature they surveyed did not put forward a cohesive model of interdisciplinary collaborative practices. In fact, although Schofield and Amodeo explored the

strengths and weaknesses of interdisciplinary teams, the literature reviewed was not consistent in the content and subject matter it addressed

Bronstein's (2003) recent work on interdisciplinary collaboration seeks to follow up on interdisciplinary collaboration with an empirical approach that would provide support for interdisciplinary collaboration as an evidence-based practice. Bronstein uses a review of multidisciplinary literature as a base to propose a working model for interdisciplinary collaboration, centered around five core components: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. In the model these core components are influenced by such factors as professional role, structural characteristics, personal characteristics, and history of collaboration.

Bronstein (2002) has also outlined the development of an instrument for measuring the extent of interdisciplinary collaboration dubbed the Index of Interdisciplinary Collaboration. The instrument is a questionnaire, which was administered to NASW member social workers, with questions grouped to indicate the five core components outlined in Bronstein's model. Bronstein found the measure to be a strong indicator of the extent of interdisciplinary collaboration as a whole, but only a moderate indicator of the presence of the five aspects of interdisciplinary collaboration outlined in the model.

Much of the work on interdisciplinary collaboration looks at collaboration in specific domains, such as social workers and lawyers working in a Chicago legal aid office (Smith, 1970). For this study Smith used open ended interview schedules and attitude scales to gather open ended information about the nature of collaboration, and quantifiable data about the perceptions of each discipline of itself and the other discipline. Interestingly, lawyers interviewed lawyers and a social worker interviewed the social worker to reduce researcher bias and increase subject

comfort. The authors concluded that lawyers generally held a lower view of social workers than social workers did of lawyers or of their own discipline.

The open ended data on the nature of collaboration showed that social workers were referred cases by lawyers, and that role conflict developed as social workers perceived that lawyers were not using this process appropriately. This study is limited by lack of control for variables, such as amount of time spent in collaboration, and begs further inquiry into the nature and quality of collaborative interactions. The sample is confined to one legal services organization, and is not necessarily generalizable to interdisciplinary collaboration in clinical practice.

Similarly, Abramson and Mizrahi's (1986; 1996; 2000; 2003) work on interdisciplinary collaboration focuses a specific area of interdisciplinary collaboration, that of social workers and physicians of internal medicine. They began this work in 1986, by describing the "strains" experienced in interdisciplinary collaboration between medical social workers and resident and internist physicians of internal medicine. In this review of the literature, they identified differing socialization and training experiences, ideological differences in treatment and role of practitioner, conceptualization and use of knowledge, role and rights of patients, valuation of teamwork, and perception of function of social work as contributing to strained collaboration between the two disciplines.

In 1996, Abramson and Mizrahi published a study, inaugurating a series of articles using qualitative data gathered from 54 social workers and 47 physicians, who worked collaboratively. The informants described positive and negative experiences of interdisciplinary collaboration, and selected factors involved in the success or failure of these collaborations from a precoded list. Data showed that in cases which were considered positive collaborations, three significant factors

were present: respect for colleagues, shared perceptions, and quality of communication. When negative collaborations were found, it was observed that differences in perspective were the most significant factor for social workers, and was tied for the most significant factor for physicians.

Abramson and Mizrahi (2000) published a later article using another piece of data collected from their first study in which the social workers were asked to select a case in which they collaborated with a physician; both the social worker and the physician were then interviewed to gather their perspective on the case. A high level of shared perspective was found in the discussions of the collaborations; when disagreement occurred, it was almost always because the social worker mentioned something that the physician omitted.

Abramson and Mizrahi (2003) returned to this data to study the typology they developed in coding the qualitative data. The social workers and physicians in the study were placed in one of three categories based on their collaborative stance: traditional, transitional, or transformational. These stances were coded based on the social worker or physicians views of psychosocial aspects of care, definition of social workers roles, communication, teamwork, and control of decision making. The researchers noted they found more traditional social workers and transformational physicians than had been expected.

The categorization was then used to search for significance in relation to data gathered in the interviews of the physician and social work pairs, with findings such as a high level of dissatisfaction with all types of collaboration in both traditional groups. The Abramson and Mizrahi (1996; 2000; 2003) studies were strong in that they generated both a rich description of the collaborations of these two disciplines and ways of quantifying the qualitative data they had collected to look at trends in the data set.

Couturier, Gagnon, Carrier and Etheridge (2008) argue that to the extent that the

literature on interdisciplinary collaboration (specifically in the health and "social care" disciplines), reduces interdisciplinary collaboration to its psychological aspects, there is an epistemological perspective that risks being lost. That is, interdisciplinary collaboration is a mode or a practice that produces a specific knowledge in practice, and this knowledge relates to the actual work of mental health treatment. Hence they describe interdisciplinary collaboration as a condition of the work, viewing this process as critical in producing new knowledge. In describing the hybridization that occurs in interdisciplinary collaborations, these theoreticians stated: "the encounter with difference provokes a transformation of self and other (p. 2)."

Couturier et al. (2008) emphasize as normative, the literature's general sense, that to solve the world's problems there is a need to work together, rather than break down each problem to be addressed by specialized experts. Indeed the literature reviewed here supports this point. Couturier et al. stress that the literature on interdisciplinary collaboration on the whole does not examine how collaboration can achieve this goal.

In this exploratory study, team members were asked to discuss their own subjective experiences about the collaborative process itself, citing factors which facilitated positive collaborative efforts, and those factors which may have led to conflict. Their views on the effect of collaboration on patient treatment are also examined.

Interdisciplinary Collaboration in Clinical Mental Health Practice

Interdisciplinary collaboration is practiced by all disciplines in the mental health field, at all of the levels previously reported. Collateral contacts are one way that interdisciplinary collaboration occurs. Gordon, Antshel, and Lewandowski (2010) studied "clinicians" in a child and adolescent psychiatry clinic, and found that clinicians spent twenty minutes in collateral contacts for every hour spent in direct clinical contact. Collateral contacts were considered "any

case related clinical activity outside of the standard therapy appointment," and as such included phone calls, school visits, meetings, and paperwork.

This study did not include data related to how much of the time spent in collateral work was interdisciplinary in nature; however the researchers correlated their findings to the disciplines and position of clinicians. They noted that MSW level social workers and trainees in psychology and psychiatry spent more time in collateral contacts than clinicians holding PhD or MD degrees. The study is limited in how generalizable this number may be to the larger population of mental health clinicians, but is surprisingly the only one providing numbers on time spent in clinical collaboration.

The psychiatric treatment team is typically a place where interdisciplinary collaboration occurs. These teams are mainly composed of psychiatrists, social workers, psychologists, nurses, and may include milieu therapists/staff, occupational therapists, and dietitians (Claiborne & Lawson, 1999). Interdisciplinary collaboration in psychiatric treatment teams has been studied for its effectiveness by Toseland, Palmer-Ganeles, and Chapman (1986) and Vinokur-Kaplan (1995).

Toseland et al. (1986) conducted individual interviews with 15 psychiatric treatment team leaders to develop a questionnaire which was then given to them and each of their team members. Respondents reported teams to be more effective in their treatment than individual clinicians were; in general they reported satisfaction with the functioning of their teams. Examining the roles of psychiatric team members, they found psychiatrists to be the most "influential" team members as ranked by clinicians, with social workers second. However, social workers had the most roles on the team, and were the most likely to have been "client advocates," "coordinators," "negotiators," "conflict diffusers," "socio-emotional leaders" and "task leaders."

This thesis explores ways in which the ongoing interdisciplinary team collaboration

effects the treatment provided, as perceived by team members. One method to clarify this point was by asking participants to comment on a specific case in which they thought treatment team collaboration found its way into treatment.

Vinokur-Kaplan's (1995) study used a model of small group effectiveness to evaluate 15 psychiatric treatment teams using quantitative data. The model focused on examining if the following three standards were met: 1) using the treatment plans the teams produced; 2) cohesion of teams defined as willingness to work together; and 3) individual well being, focusing on individual team members contributions, their well being, and their growth as clinicians.

Respondents reported moderately high scores for meeting standards, and for cohesion, with moderate to low scores for individual well being. The study included variables for examining enabling conditions, such as interdependence and interdisciplinary collaboration. Respondents reported a moderately high score for interdisciplinary collaboration.

This study used quantitative methods to study psychiatric team effectiveness by isolating variables and attempting to identify correlations between them. The use of qualitative methods in the present study has the potential of exploring in greater depth variables reported by Vinokur-Kaplan's (1995) study, as well as finding new factors that are part of the experience of interdisciplinary collaboration that could be operationalized for further study.

Theoretical Perspectives in Clinical Practice

As this study asked subjects to describe the theoretical perspectives that inform their practice, a brief classification of some major theoretical perspectives, is presented below.

The strength based perspective, traditionally part of social work practice, encourages clinicians to identify and use patients strengths to aid in recovery and empowerment (Saleeby, 2008). A critical response to the strengths based perspective in social work practice has been

presented by Morley (2003).

A family-centered approach in social work practice seeks to focus attention on the family in clinical treatment, and engage in collaboration with the family to foster growth and change (Hartman & Laird, 1983).

Psychodynamic practices include clinical approaches and theories loosely related to talk therapy as it was pioneered by Sigmund Freud (Mitchell & Black, 1995). Seven characteristics of psychodynamic practice identified by Blagys and Hilsenroth (as cited in McWilliams, 2004) include focus on affect, work with resistance, identification of patterns of behavior, emphasis on past experiences, focus on interpersonal experience, including the therapeutic relationship, and the exploration of intrapsychic experiences. Psychodynamic theory today, generally, also incorporates major concepts from Objects Relations Theory (e.g. the separation-individuation conflict), and Self Psychology (e.g. development of a self identity) (Urdang, 2008).

Cognitive Behavioral Therapy, pioneered by Beck (1976), stresses that thought patterns effect behaviors and emotions, and behaviors effect thought patterns and emotions in feedback loops. Cognitive Behavioral Therapy, influential in mental health treatment, is widely used today. This evidence-based practice, cites extensive empirical research to support claims of their effectiveness.

Attachment focused practices build on the theories of John Bowlby (1988) which focus on how our early relationships with caregivers affect the way we engage in relationships over time (Wallin, 2007). The key role played by attachment is also an underlying premise in Object Relations Theory.

Trauma informed treatment places emphasis on the role traumatic experiences play in the development of patient functioning, interpersonal relatedness, and the development of

psychopathologies (Solomon & Siegel, 2003). There is also a focus on resiliency and patient empowerment in developing trauma informed treatment approaches (Herman, 1997).

An eclectic approach, as described by Loewenberg (1984), allows for the clinician to select a lens for viewing a particular case based on the clinician's assessment of what theoretical or practice approach would best fit the needs of the situation. An integrative approach attempts to provide a similar level of flexibility, but focuses on the ways theory can be integrated into practice using all of the tools of clinical practice (Cooper & Lesser, 2008).

This thesis study initially asks clinicians which theories they use; and later explores ways in which these perspectives affect their interdisciplinary collaborative efforts.

Focus Group Methodology

A focus group is a guided small group discussion, which allows the researcher to "interview systematically and simultaneously several individuals" (Rubin & Babbie, 2010, p. 221). Focus groups are often used with a purposive sample, where participants are selected based on their relationship to the research inquiry.

Researchers often utilize focus groups to examine relatively new or unexplored issues or phenomenon, because it affords the advantage of participants bringing forth data that a researcher might not have anticipated. Additionally, participants can hear the responses of others, and have the opportunity to piggyback or brainstorm on others' responses. In addition, the process of group interaction can be observed by the researcher to provide more data.

Drawbacks to the use of focus groups include low external validity, as the sample is most often non-representative; there are also risks inherent in interviewing in a group. The latter includes lack of confidentiality, influencing participant responses due to risk of exposure, bias introduced by participants hearing the responses of others, and the risk of some members of the

group participating more than others, thus effectively skewing data.

The focus group methodology was chosen for this study for its use in effectively examining the relatively unexplored phenomenon of clinicians' perspectives on their own interdisciplinary collaboration. It was chosen over structured individual interviews because of the observation of group interaction that it offered the researcher, and the potential for new learning that it offered the participants in hearing the responses of others.

CHAPTER III

Methodology

Study Purpose

This qualitative, exploratory study examined interdisciplinary collaboration as it is experienced by clinicians in a psychiatric hospital setting, for whom interdisciplinary collaboration is a routine part of clinical mental health treatment. The study explored how individual practitioners bring their unique theoretical and personal perspectives to their work, and how interdisciplinary collaboration shapes their own thinking and actions in their clinical work.

Data for this study was collected by interviewing participants in two focus groups, which I led, in which social workers, psychologists, and psychiatrists participated. The time allotted for each focus group was 1 ½ hours . Focus groups were chosen as a research methodology, to enable participants to share their perspectives on interdisciplinary collaboration, and because it afforded the opportunity for spontaneous interaction and dialog among participants. It provided the opportunity for interdisciplinary collaboration to be subjectively described, as well as objectively observed by me.

Participants were asked to discuss cases or experiences in which conflicts arose in interdisciplinary collaboration, and to describe interdisciplinary collaboration leading to successful and/ or unique clinical outcomes. In addition, participants were asked whether training in collaboration was included in their professional education, and what recommendations they

had for enhancing interdisciplinary collaboration in the future.

A semi-structured interview guide covered these topics; this is in Appendix C.

Sample

The participants were recruited through a purposive snowball sample of convenience, and were social workers, psychiatrists, and psychologists working in clinical practice at Bradley Hospital, a children's psychiatric hospital in Riverside, Rhode Island, where I was completing a social work internship. In order to conduct research at Bradley, a hospital employee with approval to conduct research was required to act as the principal investigator for the study, and a departmental supervisor was required to approve the research proposal. Jeffrey Hunt, MD and Marilyn Sykulski, LICSW agreed to accept these responsibilities. They also helped facilitate the IRB process, and facilitated subject recruitment, and securing resources for the focus groups, such as a room, lunches, and video equipment.

IRB approval was granted on March 25, 2011. See Appendix A for approval letter.

Recruitment

Participants were recruited by using a Hospital IRB approved recruitment letter sent via email and in hardcopy (See Appendix D), a Hospital IRB approved flyer (see Appendix D), and by my announcements at clinical staff meetings. To send the email, a list of email addresses for eligible clinicians was obtained from the Human Resources department at the Hospital.

Dates and times for the focus groups were set, based on discussion with the social work department chair. Emails of the IRB approved recruitment letter were sent, using blind recipient addressing to eligible clinicians on the lists the human resources office provided. Emails were sent three weeks prior to the focus groups, and then twice weekly up to the last focus group.

Emails informed prospective participants of the purpose of this research, that it was for a Master's thesis and that a complimentary lunch would be provided. Human Resources was unable to provide a list of emails for Resident Physicians working in clinical fellowships; therefore, an email was sent to the Head Resident for distribution.

In addition, I made announcements and distributed fliers at a social work staff meeting and a monthly clinical staff meeting. Clinicians who worked directly with me in my clinical work were excluded from the study. However, they did receive the email announcement and hard copies of the flier for distribution to their peers, to facilitate a snowball sample.

Those clinicians who participated in the study responded to the emails, either by email or by calling me on my hospital phone line. Once participants responded with their interest and availability, they received an email with the location of the focus group and with the hospital IRB approved informed consent form to be signed and collected at the focus group. See Appendix B for the Consent form.

Sample Criteria

All social workers, psychiatrists, and psychologists working in a clinical role at this psychiatric hospital for children and adolescents were eligible to participate in this study. There were no criteria for age, gender, race, years of experience in the field or at the hospital, or degree held. The only exclusionary criteria were for clinicians who worked directly with me in clinical work.

The initial goal was to have between 6 and 8 members in each focus group. However, although there was much interest expressed among staff members in this subject, I was unable to recruit this number. Many potential subjects reported a desire to participate but were unable to, due to time constraints. Some clinicians offered their time outside of the focus groups to discuss

the topic, but this was not possible due to the research methodology chosen.

At the last minute, one participant transferred from the first to the second group, one person withdrew from the first group, and one participant withdrew from the second group. The first group had two members and the second group had four members. Although the anticipated number of participants had been higher, in the actual group encounters, the smaller number of participants allowed for greater individual participation, and more in-depth discussion of experiences. This observation is discussed further in the following chapter on Findings.

Description of Subjects

In the first group, there were two female members; both were social workers. The four members of the second group were all female; one was a psychiatrist, one was a social worker, and two were psychologists. Details about their background and experience are included in the Findings Chapter.

Data Collection

Prior to meeting with the focus groups, a written questionnaire and focus group guide were piloted with my clinical supervisor to give me an opportunity to become familiar with the Interview Guide.

Focus groups took place in a group room on the inpatient unit of the Hospital. They were conducted from 12pm to 1:30pm on Tuesday April 12th, 2011, and Thursday April 14th, 2011. I arrived twenty minutes prior to the start of the focus groups to arrange the room and set up audio and video recording devices. Once participants arrived, they were greeted and invited to help themselves to lunch, and to feel free to eat during the focus group. When all participants were present, informed consent was reviewed, signed, and collected from each participant.

Opportunity was given for asking questions about informed consent during review.

No referral sources were given, as the population participating (clinicians) and the basically non-stressful nature of the subject did not require providing resources.

Written Questionnaires (Appendix C) with brief educational and vocational background questions were distributed and participants were given time as needed to fill them out. Once all were finished, I started audio and visual recording. Participants were invited to share their written responses to the questions with each other as a way of introducing themselves.

Generally I went through the questions on the interview guide in order; participants typically each took a turn giving a response. Questions were not asked, if material had been covered in a previous part of the conversation; follow-up question were introduced, or sometimes participants were asked to add more on a topic.

At the end of the focus group the written questionnaires were collected. The April 14th focus group was abruptly ended by a fire alarm in the Hospital, and the final question about future considerations for interdisciplinary collaboration was not asked.

The focus groups were simultaneously digitally videotaped and audio cassette recorded to ensure continuity of recording as neither device was capable of recording continuously for the whole focus group. I changed recording mediums when needed. I made complete transcriptions from the digital video discs using audio cassette recordings for data missed when I changed digital video discs.

Data Analysis

Transcriptions of the focus groups were subject to content analysis. Video was reviewed and notes were taken by me to observe interaction among participants in the focus groups.

Participant's answers to questions from both focus groups were aggregated and reported.

Responses were compared and contrasted based on the theoretical perspective and discipline of the the participant who provided them. Data was used to examine areas outlined in the "Study Purpose", and to provide a basis for discussing theoretical considerations outlined in the Literature Review. Data also provided content for discussion of future research considerations. All results are reported in the findings chapter.

Limitations and Biases

I carried out this study on interdisciplinary collaboration as a 2nd year social work intern; this may reflect my bias in developing my own social work identity, working in an interdisciplinary field. My own experiences of interdisciplinary collaboration, in a mental health setting on a inpatient adult psych-med unit, and in an outpatient hospital based program for adolescents, may have influenced the questions and follow up questions that I asked. In reviewing the data, I attempted to be aware of and control for my own subjectivity.

The study was conducted at one psychiatric hospital for children and adolescents, and as such is limited in having its findings generalized to a larger population of interdisciplinary collaborators. Even as it sought to provide a basis for understanding interdisciplinary collaboration in this specific setting, it was also limited in this regard, as the sample was only six clinicians from the three mental health disciplines. All the participants were women, which may reflect the current trend of greater numbers of female clinicians, and declining number of male clinicians, in the mental health field; however male clinicians may have presented a different perspective. I did not include nursing or milieu therapists, which may have added another dimension of understanding.

The focus groups were composed of two social workers, in the first group, and one social worker, a psychiatrist, and two psychologists, in the second group. Excluding patients/consumers

from the sample leaves out another side of the interdisciplinary collaboration, certainly in questions regarding treatment outcomes.

The overall sample was biased toward social workers with one group being biased to psychologists. Not controlling the sample or asking participants for any demographic markers limits what the research might say about race or gender in interdisciplinary collaboration beyond what participants mentioned of their own accord in the focus groups.

IRB Requirements and Study Safeguards

Approval for research study was obtained from the Institutional Review Board at the Lifespan in Providence, RI, the Hospital group of which Bradley Hospital was a part. Hospital IRB informed consent was followed.

Data was collected only from clinicians in this study. The material discussed in the focus groups related only to the participant's clinical experiences, and details of any personally sensitive materials was not sought, and if spontaneously revealed, was not used in this published research. Research subjects did not divulge any identifying information related to any case material they discussed. Expectations for participants maintaining confidentiality were addressed at the beginning of the focus group.

Research subjects were told that they might experience minimal distress in discussion of a particularly difficult case or the circumstances of a difficult collaboration.

Referrals to join the study were taken confidentiality via email. Confidentiality and participant identity were preserved in that any data presented for use in print, publication, or public presentation has all identifying information concealed and demographic data separated from quotations.

Transcription of video and audio data was done privately by me, and participants received

coded numbers in transcriptions to conceal identity. My Smith College School for Social Work Thesis Advisor, Esther Urdang, Ph. D., had access to the data after identifying information was removed. Data transcriptions, videotapes, notes and consent forms will be kept separately and securely in my files for a period of three years as stipulated by federal guidelines after which time they will be destroyed or continued to be maintained securely.

Participation in this study was voluntary and participants could refuse to answer any question asked in the focus group. Participants were able to withdraw from the study at any point up to the end of the focus group, but due to the collective nature of the data collection method, any data collected prior to withdrawal, would not have been withdrawn from the collected data.

CHAPTER IV

Findings

Two focus groups were held for this study exploring the experiences of interdisciplinary collaboration of social workers, psychiatrists, and psychologists in a psychiatric hospital setting. All of the clinicians who participated were employees at Bradley Hospital in Riverside, Rhode Island, a facility for children and adolescents. Data collected from each focus group is combined in the report below, and illustrative excerpts from the responses of individual participants are included to highlight relevant points.

This chapter begins with the descriptive data about the participant's current position, background, experience, and theoretical orientation. This is followed by a discussion of the subjects' responses to the interview questions. Observations about the group process and interactions are included in the discussion.

Descriptive Data

The two focus groups comprised of six subjects, all female: three social workers, one psychiatrist, and two psychologists. The social workers held MSW degrees and two reported having LICSW status. One psychologist, held a PsyD and the other a MS and PhD in clinical psychology. The psychiatrist had an MD, and completed training in Child and Adult Psychiatry.

Five of the subjects had extensive experience prior to their employment at this Hospital, ranging from 11 years to 35 years. However, with one exception, their years of employment at the Hospital were not as extensive, ranging from less than a year to 8 years. The one subject who

reported no experience prior to work here, had been employed at this Hospital in multiple roles for 25 years, and as a social worker for 10 years. All participants were working in inpatient psychiatric care programs. One participant was working with families in the hospital and in the community.

Theoretical Orientation

In discussing theoretical approaches, the psychiatrist and the two psychologists reported utilizing a psycho-dynamic orientation, which included the bio-psycho-social perspective. While some referred to biopsychocial, trauma-based, relationship, humanistic, interpersonal and attachment theory, most respondents reported cognitive-behavioral, solution focused, family systems, and a problem-solving orientation. Several currently had an eclectic focus. One psychologist commented that most of her training was "in CBT with a relationship focus, at this point in my career I am pretty eclectic."

As noted in the Literature Review, interdisciplinary collaboration and theoretical perspective are related in a mental health treatment setting. The effect of theoretical orientations on the collaborative interactions of these subjects is discussed later in the chapter.

Responses to Interview Questions

6. Was training in collaboration included in your professional education? What was the nature of the collaboration taught? The subjects reported minimal formal course training in collaboration. Only one subject, a social worker, received training in collaboration in a course on group work, part of her MSW curriculum. Two subjects reported no training in collaboration at all, and those who had some exposure to this, experienced this in their internships and practice experiences. One psychologist attended a small practice seminar where collaboration was

discussed when relevant. The psychiatrist reported that in grand rounds, there were some thoughtful discussion of collaborations, such as in shared cases. One social worker was exposed to collaboration in her two field placements, where the work itself required collateral contacts.

7. Before coming to Bradley, did you have previous experiences of collaboration with other disciplines? How was this structured? Was it different from the hospital's model? The three social workers and the psychiatrist discussed previous interdisciplinary collaboration that included making collateral contacts, and all subjects described making collateral contacts in their present setting. The three social workers were unique in describing the collateral contacts as "aftercare" or "discharge planning."

The social workers expressed their conviction about the centrality of collaboration to social work practice; they stressed the importance of being flexible to meet agency requirements while doing essential clinical work. One social worker who had worked in a hospital Emergency Room, described her role as a "conduit" between the disciplines. In response to this statement, another social worker stated: "It was total collaboration. . . . you were connecting with everybody all the time. . . . social workers [are] by definition collaborators." She expressed the view that collaboration was a way for social workers to "prevail" in interdisciplinary mental health settings, as social workers were not at the "top of the heap."

The psychiatrist indicated that she felt there has been a continuity in collaboration from her past experience, in outpatient practice, when she hired a social worker to collaborate with. She finds her experiences in this hospital setting to be similar, where collaboration involves sharing treatment.

The psychologists and the psychiatrist described differences they found between previous interdisciplinary collaborations in outpatient practice and those in this psychiatric hospital

setting. In the present collaborative team, there is a more formal and efficient collaboration process versus previous experiences of an informal and at times a haphazard collaboration involving meeting in hallways, hurried phone calls between busy clinicians, or inconsistent attendance at meetings.

One social worker described how her experience of collaboration changed over her career:

In her earlier work, she described her professional self as being like "a bull in a china shop. . . impatient; I would say what I thought - maybe when my thoughts probably weren't the ones that needed to be expressed, [and were] naive." Now, "I tailor my own style and my own sense of where the case is going to what the bigger picture is; what other people's agendas are."

8. What are the major practice issues you find being raised by you or others in your present collaboration? Time constraints were felt by all the clinicians; this put a strain on the clinicians, and, paradoxically, also served as an impetus for increased interdisciplinary collaboration. The psychiatrist and the social workers noted that increased pressure from insurance companies negatively impacted treatment: i.e. pressure "to do things faster" or in fewer clinical hours.

Two social workers described being placed in the difficult position of being "the bearer of bad news" to families, because of insurance companies' restriction of treatment hours. The psychiatrist stated that "collaboration with insurance reviewers is the weakest link [in interdisciplinary collaboration.]"

All participants discussed how the time strains on clinicians impacted the ability of their treatment teams to function.

Several other practice issues were discussed:

Two social workers described having to work with other milieu staff to explain the processes and decisions of the interdisciplinary team.

The psychiatrist saw training of clinicians as an aspect of the interdisciplinary treatment team that suffered due to time pressures for team members. On a positive note, she gave an example of the interdisciplinary team sharing phone contacts made to families. This had a positive effect on her and the team members' therapeutic alliances with families.

A social worker, gave an example of difference in perspective leading to complications in treatment, when a family objected to another clinician's behavioral approach, feeling that they were being criticized. The family wrote to this social worker that

. . .the previous clinician always made us feel like we were good parents. That's the real issue right there. . . . the message they are getting [now] is: we're not good parents, so of course, well, they're resisting every intervention, every safety protocol because they feel it is an insult to their parenting skills.

So I email[ed] their clinician to say lets talk about this before we meet with the family - because I don't know if that clinician really understands that - and my message is going to be- we need to validate their parenting abilities, and to let them know that [their parenting skills] are not what [we] were addressing or questioning, but we do need to look [at] the child's aggressive behaviors, especially in the community outings and kind of approach it from there.

And we'll see - maybe the family will be able to cope with the behavioral interventions better or see that their child's aggressive behavior really is a major issue on how that's going to impact him. . . but I think if we can kind of see that message and attempt to work with the family in that [more positive] way.

The participating clinicians who worked on inpatient units described the psychodynamic process of patients "splitting" staff as placing stress on collaboration. However, the interdisciplinary treatment team was considered by the participants to be "supportive" in helping clinicians to manage these cases.

9. In what ways do you feel your theoretical perspective plays a part in your collaborative work? The subject of understanding how clinician's theoretical perspectives affected their collaborative work was not sufficiently explored to provide a comprehensive

picture. In part, this was due to the fact that in the second group this question was not asked directly by the researcher. The data presented here is from the responses to this direct question in the first group, and, in the second group, to indirect references made by participants in answering other questions. The overall comments, however, do suggest that theoretical perspectives are a relevant consideration, in need of further exploration.

One social worker stressed the need for team members being flexible in their theoretical approaches: "I don't cling to any theoretical model, I think it can be a too narrow a box for collaboration-- people should be able to see beyond their own specific [theoretical perspective]." As an example of being limited by a theory, she described a colleague who was wed to a Cognitive Behavioral approach, who failed to see the trauma aspect of a case. She used the interdisciplinary team to discuss the trauma perspective on the case, and she felt that doing so motivated this clinician to doing her own learning on trauma informed practice.

The following two examples illustrate the interpersonal/psychodynamic/attachment theoretical perspectives:

A psychologist described frontline staff on the inpatient unit as having the roles of "mom and dad," after which a social worker quipped "And we are the grandparents."

A social worker highlighted the grief families go through when learning of their child's developmental disorder.

One social worker stressed the idea that theoretical perspectives change and are subject to trends in the field of mental health; and that while we might fault someone who might not be in tune with a particular theoretical perspective, we may look back to find this was "over emphasized" at that time in the field.

10. There can be areas of conflict in collaboration, including differences regarding

theoretical orientations and treatment recommendations. Have you experienced any of these differences or other types of conflicts in your collaborative meetings? The focus of this discussion was on conflicts with front-line staff such as nurses and milieu therapists. Sometimes these conflicts led to additional conflicts within the team itself; two social workers and the psychiatrist discussed such conflict.

All reported that front-line staff has much more contact with patients than other members of the team; this was viewed as having both positive and negative aspects.

From a positive perspective, the data the front-line staff provided to the team was valuable. But this also led to conflicts stemming from the different view front-line staff had of patients. A social worker and the psychiatrist gave examples of how front-line staff and clinical staff can have different views of a patients' behaviors which are difficult to manage. One social worker discussed instances in which the front-line workers made an assumption of a family without having the whole perspective on the case. Another social worker discussed front-line staff having different ideas about medication decisions from those made by psychiatrists.

All participants reported using both the treatment team meetings and informal conversations to discuss these conflicts. The psychiatrist discussed how the treatment team, "talking as a group," could generate alternative ways of viewing a patients difficult behavior, utilizing concepts such as "attachment disorder or complex PTSD," which are more in line with the goals of a patients treatment.

The topic of the role in the interdisciplinary treatment team of front-line staff, such as milieu therapists and nurses, is an interesting one and is addressed further in the Discussion chapter.

One social worker described a conflictual situation between a psychologist and a

psychiatrist, who had differing opinions about a treatment issue; the psychiatrist's opinion was apparently given priority; this was seen as giving the medical staff priority in such a dispute.

11. Can you describe a clinical case in which interdisciplinary collaboration may have led to complications in the treatment process? The subject of how interdisciplinary collaboration may have led to complications in the treatment process was not sufficiently explored to provide a comprehensive picture. This question was not asked directly by the researcher. In the responses given in relation to other questions, it is noteworthy that no one stated that team conflict itself led to problems. Reports of conflict involved some tensions and disagreements between clinicians and front-line staff. Most of the expressed concerns, however, were related to sources external to the team itself, such as conflicts with another agency, and systemic conflicts within the Hospital.

One social worker described three clinical cases in which she collaborated with a family and an agency who had a conflictual relationship with each other. These cases were complicated because the social worker had to build and maintain alliances with both the families and the agencies.

Another social worker discussed a case in which the needs of a patient, as seen by her treatment team led by a psychologist, conflicted with the needs of another hospital program led by a psychiatrist. This illustrated how conflicting administrative needs can impact treatment.

12. Collaboration can provide support to clinicians, and opportunities to examine clinical issues from different perspectives. Have you experienced these or other benefits from your collaborative work? All participants felt they received support through their interdisciplinary collaboration, and expressed many positive feelings about this process.

One social worker described the advantage of being involved in a family meeting with many other disciplines. "You know what, I do that as much for me as I do for the patient, because I think that's support."

One psychologist and the psychiatrist discussed how inpatient interdisciplinary collaboration was a part of why they chose to do inpatient work, after doing outpatient treatment. They cited: support, getting the perspective of others, decrease in isolation, a hedge against worker burnout, and help finding patients support outside of the clinic. They felt this was especially so in the context of the greater difficulty and emotional burden of the inpatient cases they saw, in comparison to their former outpatient cases. The psychologist stated: "For me it's all the difference in the world---- I think the team has caused me to come to inpatient full time and leave outpatient, its just so valuable having that collaboration."

13. Can you describe a clinical case in which interdisciplinary collaboration led to a successful and/or unique outcome in the treatment? Five of the subjects discussed examples of how interdisciplinary collaboration led to successful and/or unique outcomes in treatment.

One psychologist and the psychiatrist described some creative treatments which resulted from interdisciplinary team discussions, applied to the longer term cases on the inpatient unit. Examples included: using yoga; and developing a distress tolerance exercise appropriate to a patient's emotional age.

Another psychologist described a case where the opinions of the team led to the psychologist providing a specific assessment of the patient directly to the family. This resulted in the outcome the team sought.

Two social workers described cases in which interdisciplinary collaboration led to overcoming administrative barriers which had prevented the patient from receiving treatment

recommended by the team.

14. What is the experience of being part of a collaborative process like for you? The broad question of how being part of a collaborative process was experienced, was not directly asked by the researcher, but was sufficiently explored in the discussions to give a comprehensive picture of the participants experiences.

The social workers described being at the center of the interdisciplinary collaborative process. One social worker stated "I was like the conduit- if you will- between the different systems" In examples that might be characterized as frenetic, emotionally draining, and time-consuming, social workers described interdisciplinary collaboration positively as an important and essential part of their identity as social workers in the Hospital, and in the treatment provided to patients.

A social worker related this story to illustrate both social work's role in the discharge process for patients, as well as the team input:

When the child is discharged from the hospital the hope is that all these disciplines. . . . connect so that the hope is that wherever the child ends up going, [will be] the appropriate setting for the child. . . and hopefully everything can be followed through and . . . a lot of times you have success stories.

When discussing the social worker's more autonomous role at Bradley Hospital one social worker stated: "Because we are social workers and good at collaboration we often don't just operate in that independent space; we do draw in other people."

All participants expressed essentially positive examples of successful interdisciplinary collaboration in treatment teams. The participants in the second group discussed how their teams attempt to share treatment; e.g. psychiatrists were expected to participate in the family therapy. In addition, both formal collateral contacts, and informal clinical conversations were ways in which

the burdens of providing treatment were shared.

15. Overall, do you think interdisciplinary collaboration is effective? If so, in what ways? All clinicians described the experience of interdisciplinary collaboration in their current roles as positive. Participants described the “richness” of treatment team discussions, with one participant stating that the treatment team experience was the “best [they] have ever seen.”

The range of perspectives gained by including milieu therapists and nurses in the treatment team process was discussed by all participants. One participant thought the collegiate atmosphere of the Hospital was an example set by Hospital leadership, which contributed to the effectiveness of interdisciplinary collaboration in this setting.

16. Do you have recommendations for improving interdisciplinary collaboration in settings like this? The question of improving interdisciplinary collaboration was not asked in the second group due to a complication with group being cut off by the fire alarm. The two subjects in the first group who responded did not actually make recommendations, but spoke of their present involvement in the process.

In the first group, one social worker suggested that having your own understanding of a case, not your own agenda, leads to improved collaboration.

The other social worker described fostering pragmatism with idealistic notions as putting social workers in the best position to be collaborators.

Group Process

Overall participation in the focus groups was enthusiastic and essentially positive. There were no overt indications as observed by the researcher that any of the participants experienced any discomfort during the focus groups. Participants in both focus groups did express the notion

that they may not have been the best members of the Hospital clinical staff to answer certain questions because of the type of program they worked in or the type of interdisciplinary collaboration they participated in. Participants were able to respond in these cases when encouraged that the researcher was seeking all experiences of interdisciplinary collaboration.

Although many of the researcher's questions were answered by the participants one at a time, there were instances of interactions among the group participants. As discussed in the Methodology chapter above, these interactions were a part of the focus group methodology. In one instance, when a psychologist discussed how collaboration in this setting was a balm to the isolation she experiences in outpatient work, the psychiatrist agreed.

In another example, a social worker described how the process of assessment was related to her experience of collaboration and then stated to the other members of the group, all of whom worked in another program: "But it's a different element than you...". The psychiatrist responded by saying that she disagreed, that in fact the role of assessment was a similar element and went into further detail on the idea. There were also numerous instances in which participants asked appropriate direct follow up questions of each other or simply built on a statement another participant had made.

A summation and discussion of the findings are presented in the Discussion Chapter which follows.

CHAPTER V

Discussion

This qualitative, exploratory study examined interdisciplinary collaboration as it is experienced by clinicians in a psychiatric hospital setting, where interdisciplinary collaboration is a routine part of clinical mental health treatment. The study explored how individual practitioners bring their unique theoretical and personal perspectives to this collaborative work, and how interdisciplinary collaboration shapes their own thinking and actions in their clinical work. The key findings of this study were related to the interdisciplinary sharing of clinical treatment and the support provided to clinicians in an interdisciplinary setting.

This chapter begins with a summary of these and other findings, followed by discussions of how the findings are related to the reviewed literature, the limitations of the study, and recommendations for future research. The chapter concludes with a discussion of the implications for the field of clinical social work.

Summary of Findings and Their Relation to the Reviewed Literature

Training in collaboration was not reported to be a significant part of clinician's educational background. The participants who described learning material in their clinical training related specifically to interdisciplinary collaboration were describing chance experiences, such as having a clinical practicum in an interdisciplinary setting. This is consistent with the literature, where Zwarenstein and Reeves (2006) found a need for interdisciplinary learning experiences in clinical education that would be built into the curriculum.

Participants' responses also supported the value of being exposed to a variety of

theoretical perspectives in interdisciplinary collaboration. Subjects felt that interdisciplinary collaboration provides an opportunity for learning new perspectives, even as it provides, and perhaps because it provides, opportunity for clinicians with different perspectives to clash. Clinical conflict was roundly described by participants as contributing to positive changes in treatment provided as well. In exploring the conflicts participants found in interdisciplinary collaboration, differences in perspective between clinical staff and, "front-line staff" who are nurses and milieu therapists, was discussed. This view that interdisciplinary collaboration leads to change was held in the literature by Couturier et al. (2008).

There were clear differences in the responses of the participants based on their discipline when they were asked to compare previous experiences of interdisciplinary collaboration compared to their current experience. This was most apparent in the reference to "aftercare planning" that was unique to the social workers responses. This was consistent with the literature in which roles in interdisciplinary collaborative teams are defined by the clinicians' disciplines (Toseland et al., 1986).

Interestingly, and perhaps both indicative of the family-focused model used at Bradley Hospital, all participants asserted that interdisciplinary collaboration extended to sharing of the treatment provided in the Hospital; the psychiatrist, for example, described how she shared family meetings with social workers. This was in contrast to most of the earlier settings the participants described. For the social workers, not having a role in providing therapeutic treatment in previous work, was contrasted with their experience at Bradley, where they had more of a therapeutic role.

One of the major practice issues participants outlined were time constraints endured due to shorter durations of treatment as mandated by insurance companies, as well as their own busy

schedules. Participants referred to the effects this had on treatment, as well as the functioning of the treatment team.

The current study found that in all cases where participants described conflict, complications, or practice issues in their interdisciplinary collaboration, they also described the support that this type of collaboration provided or the opportunity that interdisciplinary practices such as treatment team meetings provided for addressing these issues.

The study reviewed by Gordon et al. (2010) found that clinicians spent much more time making collateral contacts compared to time spent providing clinical treatment, and that this was greater when complications in the case were greater. Indeed the participants in this study included collateral contacts as a significant part of their interdisciplinary collaborative practices, but the support provided by collaborative treatment outweighed the time spent in collaboration. Time limitations were discussed as coming from outside forces such as insurance companies, and were not described as coming from the time commitments required for collaboration.

The interdisciplinary sharing of treatment found to be a part of the experience of interdisciplinary collaboration in this research may be an expression of Vinokur-Kaplan's (1995) "enabling condition" variable of "interdependence," but it is not a factor which Vinokur- Kaplan evaluates as being significant in contributing to the effectiveness of the treatment team. Additionally, this study's identification of support provided by interdisciplinary collaboration, expressed as working against the difficulties imposed by time constraints, is a new factor not addressed by Vinokur-Kaplan's study. The role of theoretical perspective of both individual clinicians and treatment settings is another factor identified here and not included in Vinokur-Kaplan's study.

While Abramson and Mizrahi's study (1996) was done on interdisciplinary collaboration

between physicians and social workers and not in a psychiatric setting, they found differences in perspective to be the most significant factor in negative collaborations. The present findings are from a setting where a major shared perspective on treatment, that is a family centered approach, is a part of the agency's mission. In addition, participants discussed the ways in which interdisciplinary collaboration is both aided by flexibility in other additional theoretical perspectives and can provide an avenue for clinician's learning about other theoretical approaches.

Limitations

The participants in this study are clinicians at the Bradley Hospital, a research and teaching hospital affiliated with Brown University. This psychiatric facility offers family-focused mental health care to infants, children, and adolescents, and is a unique setting because of the population it serves and its family-treatment approach. While this setting, with its institutional wide collaborative treatment approach was useful in providing rich material regarding interdisciplinary collaboration, this study may not be generalizable to other treatment settings that may have a different practice orientation, or may not have a strong institutional collaborative approach.

The small number of participants who attended the focus groups (2 in the first and 4 in the second), was far short of the goal of 6 to 8 participants in each group. Although a number of clinicians expressed interest in this research, many prospective participants reported that they were unable to attend due to time constraints or overlapping meetings. In several instances, clinicians offered their time outside of work to participate in the study, which was not implemented.

Two prospective participants canceled due to time constraints, and one did not give prior

notice. Due to scheduling problems, one clinician attended the second focus group after agreeing to attend the first, which contributed to the slight imbalance in group numbers. While the researcher had discussed with Hospital administrators appropriate times to schedule the study, the focus group model did not allow for balancing the busy schedules of clinicians in the same way scheduling individual interviews might have. Further, even with full numbers in each group the focus group model, both in general, and in this case, does not promote an externally valid sample as the participants are not necessarily representative of the field at large. It is also possible that these self selected participants may have had a positive bias towards collaboration, and that those who chose not to participate may have had a negative bias to this process.

The participants discussed nursing and milieu therapists, who were not included in this sample, but are important members of their interdisciplinary collaborations. Clinical staff were chosen for this study because of their direct role in providing individual and family therapy, as well as for their sharing the treatment role. However, the findings were limited by the exclusion of nursing and milieu therapists, who could have contributed to the discussion, including their perspective on the conflicts and practice issues. The study participants identified these front-line groups as having an important role in the overall treatment process.

Recommendations for Future Research

With this study finding that participants shared treatment across disciplines and that support was an important part of the experience of interdisciplinary collaboration, further research may be warranted to explore possible connections between these two factors. The literature describes support clinicians find within treatment teams (Vinokur-Kaplan, 1995), but does not address how sharing treatment practices might be supportive. Dyadic research interviews (Arskey, 1996) conducted with clinicians who are part of shared treatment (Abramson

& Mizrahi, 1996), or research focus groups comprised of clinicians who work together, could provide insights on the contributions of supportive conjoint treatment collaborations.

The literature notes the strains placed on interdisciplinary collaboration by changes in the field of mental health care (Schofield and Amodeo, 1999). This study contained the story of one clinician who chose to practice in the Hospital, instead of working solely as an outpatient provider, because of the support found in interdisciplinary collaboration. Future research with a larger sample of clinicians who have had experience in outpatient practice and in a more interdisciplinary collaborative setting, might produce interesting comparative data,

Further exploratory research could involve conducting individual interviews with clinicians in multiple settings to get a more representative sample. Research with individual participants, while not providing the same opportunity for group dialog, might allow for more freedom in response as participants may be less inhibited without co-workers present.

Where previous research has identified role conflicts or well defined roles as an integral part of the effectiveness of interdisciplinary collaboration (Abramson and Mizrahi, 1985), this study found role conflict to be minimal in this setting and ambiguities in role definition to be managed through group discussion. However, there were hints of some tensions between the clinicians and front-line staff. Future research could examine the perceptions and collaborative efforts of the front-line staff in the overall process.

This research focused on the perceptions of clinicians about their own interdisciplinary collaboration, and provided no data on how treatment is effected by interdisciplinary collaboration. Assessing the effectiveness of treatment outcomes on patients and their families, after case collaborative discussions would suggest further research. For example, a single case study methodology (Teall, 2000) could be applied to cases on the inpatient unit in which the

researcher can identify instances of specific interdisciplinary collaboration, and then gather data from clinicians and patients. This may be helpful in identifying the factors relating to interdisciplinary collaboration that effect the treatment and outcome.

Along a similar line, researcher observation of clinicians while in interdisciplinary practice and in treatment teams could be productive in providing a basis for follow up individual or focus group interviews with the clinicians exploring the phenomenon observed by the researcher.

Implications for Social Work Practice

All of the social workers who participated in this study described their role as central to collaboration and collaboration as central to their practice, whether it was interdisciplinary collaboration or collaboration with patients and their families. Coupled with the generally positive findings that interdisciplinary collaboration is a supportive and desirable attribute of practice for clinicians in this setting, an argument can be made for increasing the profile of interdisciplinary collaborative practice in social work education.

Cadet et al. (2011) have introduced an action research model that looks at social workers experiences in an interdisciplinary medical setting, suggesting that as collaboration becomes increasingly valued in clinical treatment settings, the value of social work practitioners for their ability to model collaborative practice should increase. This thesis has supported this notion, with social workers reinforcing the centrality of collaboration, with clinicians from other disciplines, and enhancing their their identity as social workers.

This study suggests that a potential exists for collaboration in a variety of practice settings, in addition to child psychiatric treatment facilities. Additionally, interdisciplinary collaboration, may be helpful in other interdisciplinary settings such as scientific or academic

endeavors involving disciplines not within the mental health field.

There are also interdisciplinary degree programs offering a social work degree in conjunction with another professional degree, such as law (Pace, 2011). These programs are designed to produce practitioners who are following new paths of practice integrating learning from both disciplines. This study also suggests that new theoretical learning can emerge from interdisciplinary collaboration.

References

- Abramson, J. J., & Mizrahi, T. T. (1986). Strategies for enhancing collaboration between social workers and physicians. *Social Work in Health Care*, 12(1), 1-21.
- Abramson, J., & Mizrahi, T. (1996). When social workers and physicians collaborate: positive and negative interdisciplinary experiences. *Social Work*, 41(3), 270-281.
- Abramson, J. S., & Mizrahi, T. T. (2003). Understanding collaboration between social workers and physicians: application of a typology. *Social Work in Health Care*, 37(2), 71-100.
- Arskey, H. (1996). Collecting data through joint interviews. *Social Research Update*, 15, 1-8.
- Aviram, U. (1997). Social work in mental health: trends and issues. *Social Work in Health Care*, 25(3), 1-9.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: New American Library.
- Berg-Weger, M. M., & Schneider, F. D. (1998). Interdisciplinary collaboration in social work education. *Journal of Social Work Education*, 34(1), 97-107.
- Billups, J. O. (1987). Interprofessional team process. *Theory Into Practice*, 26(2), 146-152.
- Bowlby, J. (1988). Developmental psychiatry comes of age. *American Journal of Psychiatry*, 145, 28-37.
- Bronstein, L. R. (2002). Index of interdisciplinary collaboration. *Social Work Research*, 26(2), 113-123.
- Bronstein, L. R. (2003). A model for interdisciplinary collaboration. *Social Work*, 48(3), 297-306.
- Cadet, T., Maramaldi, P., Sobran, A., Scheck, L., Cusato, N., & Daniels, A. Abstract: An Empirically Determined Taxonomy of Interdisciplinary Social Work (Society for Social Work and Research 15th Annual Conference: Emerging Horizons for Social Work Research). (2011). Retrieved May 20, 2011, from <http://sswr.confex.com/sswr/2011/webprogram/Paper14948.html>

- Claiborne, N., & Lawson, H. A. (2005). An Intervention Framework for Collaboration. *Families in Society*, 86(1), 93-103.
- Cooper, M., & Lesser, J. (2008) *Clinical Social Work Practice* (3rd Ed.). Boston: Pearson/Allyn and Bacon.
- Couturier, Y., Gagnon, D., Carrier, S., & Etheridge, F. (2008). The interdisciplinary condition of work in relational professions of the health and social care field: A theoretical standpoint. *Journal of Interprofessional Care*, 22(4), 341-351.
- Deutsch, A. (1938). *The Mentally Ill in America: A History of Their Care and Treatment from Colonial Times* (2nd ed.). Garden City, N. Y: Doubleday, Doran.
- Engel, J. (2008). *American Therapy: The Rise of Psychotherapy in the United States*. New York: Gotham Books.
- Gordon, M., Antshel, K. M., & Lewandowski, L. (2010). Economic grand rounds: the cost of collaboration: predictors of hours spent in collateral contacts. *Psychiatric Services (Washington, D.C.)*, 61(5), 440-442.
- Graham, J. R., & Barter, K. K. (1999). Collaboration: a social work practice method. *Families in Society: The Journal of Contemporary Social Services*, 80(1), 6-13.
- Hartman, A. (2008). Smith College School for Social Work History, 1918- 2008. *In Depth*. Retrieved from http://www.smith.edu/ssw/alumni/documents/InDepth_08_spring.pdf
- Hartman, A., & Laird, J. (1983). *Family-Centered Social Work Practice*. New York: Free Press.
- Herman, J. (1997). *Trauma and Recovery: The Aftermath of Violence--from Domestic Abuse to Political Terror* (14th ed.). Basic Books.
- Hoffman, L. (1990). Constructing realities: An art of lenses. *Family Process*, 29(1), 1-12.
- Hornby, S., & Atkins, J. (2000). *Collaborative Care: Interprofessional, Interagency, and Interpersonal* (2nd ed.). London: Blackwell Science.
- Loewenberg, F. M. (1984). Professional ideology, middle range theories and knowledge building for social work practice. *The British Journal of Social Work*, 14(4), 309-322.
- McWilliams, N. (2004). *Psychoanalytic Psychotherapy*. New York: Guilford Press.
- Mitchell, S., & Black, M. (1995). *Freud and Beyond: A History of Psychoanalytic Thought*. New York: BasicBooks.

- Mizrahi, T. T., & Abramson, J. S. (2000). Collaboration between social workers and physicians: perspectives on a shared case. *Social Work in Health Care*, 31(3), 1-24.
- Morley, C. (2003). Towards critical social work practice in mental health: a review. *Journal of Progressive Human Services*, 14(1), 61-84.
- Moulder, P.A., Staal, A.M., Grant, M. (1988). Making the interdisciplinary team approach work. *Rehabilitation Nursing*, 13(6), 338-9.
- Nasser, M. (1995). The Rise and Fall of Anti Psychiatry. *The Psychiatrist*, 19, 743-746.
- Pace, P. (2011). "Dual Degrees" Open New Opportunities. Retrieved May 26, 2011, from <http://www.socialworkers.org/pubs/news/2011/05/dual-degrees-social-work.asp>
- Rubin, A., & Babbie, E. R. (2009). *Essential Research Methods for Social Work* (2nd ed.). Brooks Cole.
- Saleebey, D. (2008). *Strengths Perspective in Social Work Practice, The* (5th ed.). Allyn & Bacon.
- Schofield, R., & Amodeo, M. (1999). Interdisciplinary teams in health care and human services settings: Are they effective?. *Health & Social Work*, 24(3), 210-219.
- Smith, A. (1970). The Social Worker in the Legal Aid Setting: A Study of Interprofessional Relationships. *The Social Service Review*, 44(2), 155-168.
- Solomon, M., & Siegel, D. (2003). Introduction. In Solomon, M., & Siegel, D. (Eds.), *Healing Trauma: Attachment, Mind, Body, Brain* (pp. xii-xxi). New York: W. W. Norton & Company.
- Teall, B. (2000). Using Solution-Oriented Interventions in an Ecological Frame: A Case Illustration. *Social Work in Education*, 22(1), 54-61.
- Toseland, R. W., Palmer-Ganeles, J., & Chapman, D. (1986). Teamwork in psychiatric settings. *Social Work*, 31(1), 46-52
- Urdang, E. (2008). *Human Behavior in the Social Environment: Interweaving the Inner and Outer Worlds* (2nd ed.). New York: Routledge.
- Vinokur-Kaplan, D. D. (1995). Treatment teams that work (and those that don't): an application of Hackman's Group Effectiveness Model to interdisciplinary teams in psychiatric hospitals. *The Journal of Applied Behavioral Science*, 31(3), 303-327.
- Wallin, D. (2007). *Attachment in Psychotherapy*. New York: Guilford Press.

Weick, A. A. (1986). The philosophical context of a health model of social work. *Social Casework*, 67(9), 551-559.

White, M. (2007). *Maps of Narrative Practice* (1st ed.). New York: W. W. Norton & Company.

Zwarenstein, M., & Reeves, S. (2006). Knowledge translation and interprofessional collaboration: Where the rubber of evidence-based care hits the road of teamwork. *The Journal of Continuing Education in the Health Professions*, 26(1), 46-54.

APPENDIX A

IRB Approval Letter

Office of Research Administration
Research Protection Office
Administrative Office for RIH and TMH IRBs

DATE: March 25, 2011

TO: Jeffrey Hunt, M.D.

Department of Psychiatry

Division of General Psychiatry

FROM: Patricia E. Houser, R.N., M.S.J

Director, Research Protection Office

SUBJECT: HUMAN SUBJECTS PROTECTION APPROVAL

FWA-00001230 IRB Registration #: 00004624

CMTT/PROJ: 4020-11

TITLE: Interdisciplinary Collaboration among clinicians in a psychiatric hospital setting

Your research project was reviewed and approved on 2/24/2011 . Requested IRB revisions were received and accepted on 3/24/2011. This research has been approved as meeting the standards for the protection of humans per 45CFR46/21CFR56 by the Rhode Island

Hospital's Institutional Review Board (IRB) This institution is in compliance with the ICH GCP as they correspond to the FDA/DHHS regulations. This review and approval are applicable for Rhode Island Hospital.

This notification CONSTITUTES AUTHORITY FOR ACTIVATION of this application

It is the responsibility of the principal investigator to ensure that the study is conducted as approved by the IRB. All protocol modifications/changes must be approved by the IRB before any changes are implemented except when necessary to eliminate immediate hazards to subjects.

If written informed consent is required for this study: The newly stamped consents are attached to this letter. Please review these informed consents to be sure you have received all the documents necessary to conduct this study. Please be sure all informed consents you submitted for approval, specimen banking forms and ads if applicable, are attached and stamped with the approval and expiration dates. These newly stamped informed consents and other documents are to be used immediately for this study and supersede any previously issued documents, if applicable.

You are required by Federal regulations and Hospital policy to immediately report any unanticipated problems, untoward effects or reactions, serious side effects and/or deaths of subjects involved and related to this project to the IRB through the Research Protection Office.

IRB approval for this project expires on 2/23/2012. If you wish to continue your research after this date you are required to submit a continuation report (CR) prior to expiration of approval. A reminder notice will be sent approximately 30 days before the continuation report is due. The CR must be reviewed by the IRB no later than the date of expiration in order for the study to be in compliance with federal regulations. Federal regulations do not allow for ANY grace period for renewal.

Please provide a termination report to the IRB when the research is completed and IRB approval may be terminated.

Patricia E. Houser, R.N., M.S.J

Director, Research Protection Office

APPENDIX B

Informed Consent Form

Affiliate	Rhode Island Hospital Bradley Hospital	The Miriam Hospital Newport Hospital
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Agreement to Participate in a Research Study And Authorization for Use and Disclosure of Information

Committee #

Name of Study Volunteer

INTERDISCIPLINARY COLLABORATION AMONG CLINICIANS IN A PSYCHIATRIC HOSPITAL SETTING

You are being asked to take part in a research study. All research studies carried out at Lifespan institutions are covered by rules of the Federal government as well as rules of the State and Lifespan. Under these rules, the researcher will first explain the study, and then he or she will ask you to participate. You will be asked to sign this agreement which states that the study has been explained, that your questions have been answered, and that you agree to participate.

The researcher will explain the purpose of the study. He or she will explain how the study will be carried out and what you will be expected to do. The researcher will also explain the possible risks and possible benefits of being in the study. You should ask the researcher any questions you have about any of these things before you decide whether you wish to take part in the study. This process is called informed consent.

This form also explains the research study. Please read the form and talk to the researcher about any questions you may have. Then, if you decide to be in the study, please sign and date this form in front of the person who explained the study to you. You will be given a copy of this form to keep.

1. Nature and Purpose of the Study

You are being asked to take part in a research project because you are a clinician on a

psychiatric team at Bradley Hospital. My name is Tim Albro and I am a second year MSW student at Smith College School for Social Work, and am interning at Bradley Hospital. Supervised by Dr. Jeffrey Hunt, I am conducting a research study exploring interdisciplinary collaboration as it is experienced by clinicians in a psychiatric hospital setting. As a clinician on a psychiatric team, I feel you are in a unique position to share your insights about collaboration, including ways in which collaboration may have led to successful and/or unique outcomes or led to conflicts arising in clinical work, such as differences regarding theoretical orientations and treatment recommendations. I would also like to know if training in collaboration was included in your professional education, and what your recommendations are for enhancing future collaboration.

This study is being conducted as my thesis for the Master of Social work degree at Smith College School for Social Work. Data from this study may be used in professional publications and presentations on this topic.

2. Explanation of Procedures

If you take part in this study, you will participate in one focus group with 6-8 participants, who are social workers, psychiatrists, and psychologists for the purpose of sharing experience and knowledge about your present and past experiences with interdisciplinary collaboration. The group will meet for one session lasting 1 hour and a half. You are eligible to participate if you are a clinician, engaged in direct patient care at Bradley Hospital.

In addition to the group discussion, you will be asked to fill in some brief forms regarding demographic information distributed at the beginning of the session. This data will include: name, current and previous clinical employment, length of time in current position, and educational background.

The focus group will be video recorded (audiotaped if videocamera is not available). I will also take notes during the session, which will be part of the data collected and analyzed. I will transcribe and analyze the data from the video, and all identifying information will be removed.

The videotapes (audiotapes) will be viewed (listened to) and transcribed by me. I will view (listen to) the tapes in private to protect your confidentiality. No one else will view the videos. Transcriptions of data collected will be seen by my thesis advisor only after identifying information has been removed.

Any data presented for use in print, publication, or public presentation will have all identifying information concealed and demographic data separated from quotations. Finally, all data, videotapes (audiotapes), notes and consent forms will be kept secure in my office for a period of three years as stipulated by federal guidelines after which time they can be destroyed or continued to be maintained securely.

Contact Information:

Timothy Albro
Bradley Hospital / Safequest Program
talbro@lifespan.org
phone 4014321125

Supervisor: Dr. Jeffrey Hunt
Bradley Hospital
jhunt@lifespan.org
phone 4014321000

3. Discomforts and Risks

Minimal risk from participation is anticipated. You may experience distress when reflecting on experiences of interdisciplinary collaboration that were particularly difficult. You may be uncomfortable expressing thoughts about this topic in front of others. You may also be concerned that others may discuss comments outside of the group. Expectations for confidentiality outside of the group format will be addressed with everyone at the start of the group.

4. Benefits

You may benefit from gaining further knowledge of the ways that interdisciplinary work can be an asset in your clinical role as well as considering roadblocks that come up in collaboration. This knowledge may enable you to think about ways to enrich your own interdisciplinary collaborations. The generation of new insight and theory from this study may be useful in the development of curriculum on interdisciplinary work in clinical education. You will not receive compensation for your participation in this study.

5. Alternative Therapies

N/A

6. Refusal/Withdrawal

You decide whether or not you want to be in the study. Participation is voluntary. Your decision to participate in this study will not be shared with your supervisor or affect your employment. You may refuse to answer any question asked in the focus group. You are able to withdraw from the study at any point up to the end of the focus group, but due to the collective nature of data collection, any data collected prior to your choosing to withdraw cannot be withdrawn from the data used in the study.

7. Medical Treatment/Payment in Case of Injury

N/A

8. Rights and Complaints

If you have any complaints about your taking part in this study, or would like more facts about the rules for research studies, or the rights of people who take part in research studies, you may contact Patricia E. Houser, in the Lifespan Office of Research Administration, at (401) 444-6246

9. Confidentiality

The researcher will keep all identifying information confidential, but there are limitations to confidentiality due to the fact that there are other members in the group hearing your comments. All participants will be asked to respect the confidentiality of one another by not discussing another's comments outside of the group.

SIGNATURE

I have read this informed consent and authorization form. ALL OF MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND I WANT TO TAKE PART IN THIS RESEARCH STUDY.

By signing below, I give my permission to participate in this research study and for the described uses and releases of information. *I also confirm that I have been now or previously given a copy of the Lifespan Privacy notice*

<p>This informed consent document expires on _____. DO NOT sign this document after this expiration date</p>
--

Signature of study volunteer/authorized representative* Date and Time when signed

I WAS PRESENT DURING THE CONSENT PROCESS AND SIGNING OF THIS AGREEMENT ABOVE BY THE STUDY VOLUNTEER OR AUTHORIZED REPRESENTATIVE

Signature of witness (required if consent is presented orally or at the request of the IRB) Date

I ASSURE THAT I HAVE FULLY EXPLAINED TO THE ABOVE STUDY

VOLUNTEER/AUTHORIZED REPRESENTATIVE, THE NATURE AND PURPOSE, PROCEDURES AND THE POSSIBLE RISK AND POTENTIAL BENEFITS OF THIS RESEARCH STUDY.

Signature of researcher or designate Date and Time when
signed

* If signed by agent other than study volunteer, please explain below.

Documentation that a copy of this Informed Consent was given to the research participant is a Federal requirement. Prior to making a copy of the signed and dated Informed Consent please check appropriate box(es) as applicable to indicate copy provided to:

Study Volunteer Medical Record Researcher Other (Specify)

APPENDIX C

Focus Group Materials

Interview Guide

Review, sign and collect Informed Consent Forms. Discuss Confidentiality.

Give each participant a brief background and demographic form to complete and hand in before group discussion.

EACH PARTICIPANT WILL BE ASKED TO INTRODUCE THEMSELVES TO THE GROUP AND ADDRESS THESE FOUR QUESTIONS:

1. What is your current position and discipline?
2. How long have you worked at Bradley, and how long have you been in this position?
3. How many years of clinical experience have you had before working at Bradley?
4. In what ways, if any, in addition to team meetings are you involved in collaboration with other disciplines?
5. Briefly describe your theoretical perspective.

THESE QUESTIONS WILL BE ADDRESSED TO THE GROUP FOR DISCUSSION

6. Was training in collaboration included in your professional education? What was the nature of the collaboration taught?
7. Before coming to Bradley, did you have previous experiences of collaboration with other disciplines?
How was this structured? Was it different from the Bradley model?
8. What are the major practice issues you find being raised by you or others in your present collaboration?
9. In what ways do you feel your theoretical perspective plays a part in your collaborative work?
10. There can be areas of conflict in collaboration, including differences regarding theoretical orientations and treatment recommendations. Have you experienced any of these differences or

other types of conflicts in your collaborative meetings?

11. Can you describe a clinical case in which interdisciplinary collaboration may have led to complications in the treatment process?

12. Collaboration can provide support to clinicians, and opportunities to examine clinical issues from different perspectives. Have you experienced these or other benefits from your collaborative work?

13. Can you describe a clinical case in which interdisciplinary collaboration led to a successful and/or unique outcome in the treatment?

14. What is the experience of being part of a collaborative process like for you?

15. Overall, do you think interdisciplinary collaboration is effective? If so, in what ways?

16. Do you have recommendations for improving interdisciplinary collaboration in settings like this?

Written Questionnaire

1. NAME:

2. DISCIPLINE:

3. WHAT DEGREES DO YOU HOLD- AND IN WHICH FIELDS?

4. WHAT IS YOUR CURRENT POSITION?

5. HOW LONG HAVE YOU BEEN EMPLOYED HERE?

6. HOW MANY YEARS OF CLINICAL EXPERIENCE HAVE YOU HAD BEFORE WORKING AT BRADLEY?

7. BRIEFLY STATE YOUR THEORETICAL PERSPECTIVE:

APPENDIX D

Recruitment Materials

Recruitment Letter Text

Hello,

I am a second year MSW student, interning at Bradley Hospital, and am doing research supervised by Dr. Jeffrey Hunt, exploring clinicians' experiences of interdisciplinary collaboration in a psychiatric setting. I am seeking psychiatrists, social workers, and psychologists who are currently working in a clinical capacity to participate in this study. This research is being conducted as my thesis for the Master of Social work degree at Smith College School for Social Work.

As a clinician contributing to a psychiatric team, I feel you are in a unique position to share your insights about interdisciplinary collaboration, as it both benefits and complicates clinical practice.

Participation in this study will entail a minimal time commitment of being in a single focus group, which will meet on April 12th or 14th at noon for one and a half hours. Lunch will be provided.

Please consider taking this opportunity to be a part of a small group discussion about this important and valuable part of the work we do at the hospital.

Please contact me by phone at 432-1125 or email at talbro@lifespan.org with your interest and availability.

Thank You,

Tim Albro

Recruitment Flyer

Rhode Island Hospital
IRB Approved

3/24/11

Expiration Date

2/23/12

calling all PSYCHIATRISTS, SOCIAL WORKERS
and PSYCHOLOGISTS

SHARE YOUR EXPERIENCES OF

INTERDISCIPLINARY COLLABORATION

In a single FOCUS GROUP research study

Psychiatrists, social workers, and psychologists who are currently working in a clinical capacity are invited to participate in a research study I am conducting for my MSW thesis at Smith College School for Social Work exploring clinicians' experiences of interdisciplinary collaboration in a psychiatric setting.

Participation in this study will entail a minimal time commitment of being in a single one and a half hour focus group scheduled for April 12th and April 14th at noon. Lunch will be provided.

Please contact Tim Albro with interest and availability by phone at 4321125 or email at talbro@lifespan.org. This research is being supervised at Bradley by Dr. Jeffrey Hunt.