

Collaboration Across Disciplines
in a Private Practice Healthcare Setting

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Dedication

This dissertation is dedicated to my late grandmother Amanda Safirstein, who taught me that it is never too late to pursue one's dream. Because society did not allow young women in her day to become lawyers, when she finally fulfilled her lifelong passion by graduating from law school she was 73 years old.

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Abstract

The most vulnerable patients often seek help from multiple providers of healthcare, yet time constraints and hierarchies can act as barriers to collaboration between practitioners; this lack of collaboration can lead to substandard care. Using Social Constructionist principles, this inquiry sought to introduce a new idea for collaboration across disciplines to a large integrative healthcare practice. Using grounded theory and participatory action research methodology, a case-discussion pilot meeting with practitioners of primary care medicine, psychotherapy and complementary and alternative medicine was held. This led to the formation of a small collaborative group of practitioners of psychotherapy, acupuncture, naturopathic medicine and nutrition. Themes of safety and connection between practitioners emerged as being important to the likelihood of effective collaboration between them.

Chapter One: Setting the Stage

As a psychotherapist who still thoroughly enjoys working with clients after twenty years in practice, I value immensely the relationships that I form with them. I am also deeply appreciative of the collaborative discussions I have had with other psychotherapists. And I am in equal measures frustrated by the difficulty I have encountered sometimes having even a single conversation with a co-treating professional from another discipline. Prior to this inquiry I was aware of the hierarchical system that can pose a barrier to collaboration between physicians and other healthcare professionals. I also understood that some medical approaches do not include critical conversations between experts and the subjects of their expertise. But I was curious about what could happen if they did? What if practitioners from more disparate backgrounds than counselors and social workers engaged in conversations about their approaches to shared cases in healthcare? What could they create together? How could such exchanges take place? These questions formed the basis of this inquiry.

The Problem

Collaboration across disciplines becomes more difficult when patients seek treatment from different providers of healthcare outside of a hospital setting, where there are fewer opportunities for professional interactions. Yet for these complex patients, who often suffer from both physical and mental illnesses, and may experience exacerbating socioeconomic challenges, a collaborative approach could be most beneficial to their treatment. Though there is no universal definition of a complex patient in healthcare, the term is generally used to indicate a patient who suffers from multiple or chronic medical

conditions, including chronic pain, that are bothersome to the patient and difficult to manage or cure for the provider treating him or her. Mental illnesses such as depression or anxiety, and socioeconomic factors such as racism or poverty, which can limit access to quality healthcare, only exacerbate the complexity (Loeb, Binswanger, Candrian & Bayliss, 2015).

Communication between providers of mental and physical healthcare could help examine the interplay between these factors, and provide a strong, holistic approach to treatment. Yet it appears that my experience of difficulty with such communication is not unique to the United States. In a study that examined the problems faced by general practitioners in Nordic countries who worked with complex patients with multiple healthcare providers, the authors concluded that a lack of communication between providers hindered the quality of care, and wasted resources by causing unnecessary or repetitive tests (Sonergaard, 2016, p. 124).

There are situations in which communication failures between treating practitioners could actually become dangerous for patients of multiple providers. One review of the usage of Complementary and Alternative Medicine in Western society warned about the potential problems inherent in combining non-traditional supplements or herbal remedies with prescription medications (Spence, 2004, p.117).

These examples illustrate the importance of collaboration across disciplines in treating patients with complex issues. An examination of the possible places where collaborative conversations could take place is a first step in opening doors to collaborative care outside of hospital settings.

Opportunities for Collaboration

The focus of this inquiry is collaboration between practitioners from different disciplines. In this category, primary care medicine and mental health treatment are particularly well suited for collaborative conversations.

Behavioral health and primary care medicine.

Primary care medicine has been called the de facto mental health system for the United States, in that primary care providers manage as much as 80% of patients with psychological disorders (Miller, Mendenhall, and Malik 2009). Today's primary care physician or nurse practitioner is expected to diagnose and treat myriad illnesses as they present, from infancy to old age. No one provider, no matter how intelligent, intuitive or educated could offer expertise across such a vast range of issues and ages. Therefore, in order to provide ethical care, primary care providers need to have relationships with practitioners from other disciplines, and to work collaboratively with them and their mutual patients. There is a movement in psychology that promotes the integration of behavioral healthcare into primary care settings, touting it as a means to deliver more cost-effective care by redirecting problems with health behaviors from physicians to psychologists. But integration is not synonymous with collaboration. Behavioral health appears to be a carefully chosen term, perhaps meant to indicate alignment with the medical model whilst avoiding the stigma of psychotherapy. In this paradigm, psychologists are called Behavioral Scientists, and are cautioned to take care when approaching physicians about adding their services to primary care practices:

Changing the behavior of the physician and the medical system is as

important as developing interventions to change the behavior of the patient seeking healthcare. Behavioral Scientists must learn to produce data that are persuasive to medical systems and these data may be different from what is persuasive to a Behavioral Scientist (Cummings, 2001, p.146).

I recognize the value in the integration of mental health counseling to primary care, as I believe that physical illness can impact and be impacted by emotional or social issues, and mental illness can impact and be impacted by physical issues. What I find disappointing about this model is that it seems to espouse obfuscation of the counseling aspect, and separation rather than collaboration between those who provide the physical and emotional aspects of healthcare.

Collaboration within the therapeutic relationship.

I conceive of psychotherapy as being co-created historically and locally through the relationship between the therapist and client, and I believe it is within the relational processes that the seat of transformation lies. Schore attempted to construct a name and location for this in his book *The Science of the Art of Psychotherapy*. He wrote, “Implicit right brain-to-right brain inter-subjective transactions lie at the core of the therapeutic relationship. They mediate....moments of meeting between patient and therapist” (2012 p.30). These moments of deep connection, where emotional intensity is palpable in the room can be transformative for both the therapist and client; they are made possible through their combined collaborative efforts. Besides being key to achieving change, I believe a collaborative relationship between a therapist and client is an important aspect of ethical care.

In his editorial for a journal dedicated to the topic of relational ethics in systemic therapy, Lerner posed the excellent questions, “What informs our ethical decision-making as therapists? Is it theory or is it a more natural and systemic process that evolves as a practitioner-based knowing” (2011, piii). For me it has involved both. As psychotherapists-in-training, we are taught important ethical guidelines in our respective disciplines. However, these theoretically based rules are not nearly enough to cover the myriad ethical dilemmas that occur in the relational processes of day-to-day psychotherapy. It is the difficult or confusing interactions with clients, and our reactions in navigating them that put those theoretical ideals to the test. Relational ethics suggests that “An individual's ethical landscape is inextricably linked to the relationships in which s/he exists, and ...the preservation of connectedness is a crucial component. Within this frame, ethical decisions are always interactional, operating within a consensual domain” (Shaw, 2011 p. 2). I have certainly found this to be the case; for example, years ago I worked with a schoolteacher on her desire to develop a stronger voice in her relationships. During the course of our work, her sister’s husband was arrested for possessing a large quantity of child pornography on his workplace computer. While he awaited sentencing, she reported that her family had offered their support, and planned to welcome him to their annual Christmas celebration as a show of support to her sister. As a practitioner with a specialty in trauma work with survivors of childhood sexual abuse, I found this acceptance appalling. I also considered whether this situation might be an opportunity to test the work we had accomplished towards her goal of being able to speak up when her relational needs were not being met. My relational ethics, developed through my experiences with clients tell me that while I have developed some expertise, I am not

an expert in being *them*. This means that we are a team, working together towards a shared goal. This does *not* mean however that I take a neutral stance to their issues; to claim so would be disingenuous. Our therapeutic relationship is unique in that I have experiences and opinions and biases, yet I do not have a personal stake in my clients' lives. This allows me to provide honest and direct feedback without feeling a need to convince them of anything. If they change jobs or have an affair or spend their money frivolously, it will not impact my life. But as I care about them, I will have opinions about such choices. In the case of the schoolteacher, I asked what her thoughts were about her brother-in-law's crime, given her career of helping children. I revealed my biases about his crime, along with my appreciation for her family's fierce loyalty towards her sister. Over the course of several sessions, we discovered that while my client was disgusted by her brother-in-law's choices, her primary goal was to bring the least amount of shame and disruption to her elderly parents, who were devastated by the publicity of the case. Because her parents had chosen to welcome her brother-in-law to Christmas dinner, she had chosen to follow their lead. We talked about ways that she could show support to her parents whilst keeping a distance from her brother-in-law, which felt like the right compromise to my client. In the process we gave careful attention and intention to the preservation of her connectedness to her family, as I did to my therapeutic connection to her.

I envision myself as a Sherpa for my clients; they have chosen to climb a mountain, and my job is to help carry the load and offer my experiences on the different trails. And as any client rarely lives in a vacuum, they sometimes choose to engage

family members to assist in the collaborative process. Using my experience, I point out paths that they might take or avoid as we make our way towards their goal. Because there is no “right” path that I can choose for them, I sometimes wonder if what I am suggesting will feel effective. To solve this quandary, I am always in dialogue with my clients to learn whether the treatment feels helpful to them, and that is an important part of the work. While I believe it is necessary to ask my clients if what we’re doing together is helpful, I do not believe that is sufficient for ethical care.

Collaboration with colleagues.

What counts as knowledge can change between and sometimes within even a single therapy session. For example, a client might “know” one week that he needs to change jobs, and then “discover” after engaging in dialogue with his therapist that he can find contentment in his current position. One way to understand this is to consider knowledge about a person as being co-created and de-constructed through the relational processes that occur between therapists and clients. As these relational processes take place between people, they are subject to and limited by their individual and collective histories and customs. Therefore, every discipline that produces psychotherapists, which include psychology, social work, counseling and marriage and family therapy requires that new practitioners participate in a minimum number of supervision hours as part of the requirements for licensure in the United States (NASW, AMHCA, APA, AMFT.) Supervision is a kind of collaboration with a more experienced clinician, where reflectivity is taught and students are supported and mentored as they gain clinical competency. Once clinicians achieve licensure, they typically choose to continue the process, which is known in my field as consultation. Consultation with trusted colleagues

is a kind of collaboration, with those who are removed from the case and willing to offer honest feedback to the treating psychotherapist. It provides an opportunity to catch something that the embedded therapist is not seeing, either about herself, her client or the therapeutic relationship.

Unlike most other forms of healthcare, psychotherapy is not comprised of measured techniques or maneuvers with predicted outcomes, performed on patients. A treatment plan emerges out of all of the previous relational processes that the therapist has experienced; for example in her own family of origin, in her marriage, between her and her previous and current clients, and between her and the client for whom the plan is conceived. This leaves considerable routes open for creating both successful outcomes and for resounding failures; experienced clinicians learn to anticipate which routes are more likely to be successful. In my experience, I have not learned this by merely observing my clients' reactions to treatment, or soliciting their feedback. Because human beings are so unique, what has worked well for one client cannot necessarily be transferred to another, even if their issues have appeared to be similar. What *has* tended to form reliable patterns has been my own behavior and reactivity within the relational processes that take place in my office. By focusing my attention on those patterns, the most salient routes to helping my clients have typically been revealed. In the example with the schoolteacher, I could feel my heart begin to race when I thought about her family's invitation to her convicted brother-in-law. As a younger clinician, had I discussed the case in a consultation group, I would likely have ignored that sensation, and been unaware of my stance as I pontificated to my peers about the importance of my "helping" my client stand up to her parents. The group might have brought to my

attention the tone of my voice and rapidity of my speech, perhaps asking me what personal connection I might be experiencing to the topic. These relational experiences could have slowed my thinking to a place where I could consider whether my plan was better for myself, or for my client. That would have allowed me to ask my colleagues what their previous experiences had taught them when they had felt such intense reactions. Now that I am a seasoned clinician, I am able to catch more of such reactions as they occur in sessions, but I cannot see all of them. Collaboration through consultation provides extra lenses to help me see and consider the relational processes that escape my grasp.

The goal of collaboration need not be agreement, but simply exploration of different ideas. As such it may require a tolerance for dissonance, or at least a different view of dissonance. Because there is no right way to do therapy, there is often disagreement during consultation, not only about the most effective course of treatment, but also about what is happening in the relational processes between therapist and client. Those who are not prepared for dialogue that includes dissent sometimes find the process of consultation threatening or uncomfortable. But those who view dissonance as necessary for exploration of processes that lack clarity come to welcome it. The level of dissonance in consultation groups is limited to an extent by the amount of homogeneity in the training and theoretical approaches of its members. I have for many years been a member of a monthly consultative group, which offers the opportunity for dissonance in a safe atmosphere. This consultative group has challenged and supported its members in providing excellent care in some very complex cases. In the process, it has made me a better therapist, and I believe, a more reflective person. However, I also recognize that

because the members of this group come from similar socioeconomic backgrounds, are the same gender and approximate age, and have been similarly trained, any dissonance between us is infrequent. Therefore, the knowledge that is generated from the consultative process may not be as heterogeneous as it could be.

Collaboration across disciplines.

Collaboration with a provider from a *different* discipline could offer another viewpoint about the person, the illness, or some circumstance I am not aware of, or able to glean on my own. It could also offer information about me as the provider of care.

John-Steiner (2000) observed:

Collaboration offers partners an opportunity to transcend their individuality and to overcome the limitations of habit, and of biological and temporal constraints. The unity in diversity of complementary relationships is further strengthened when partners create an amplification of individual vision and purpose (p. 57).

By collaborating with trusted colleagues from different disciplines, I can gain unique perspectives about my clients and also about myself, and the ways in which I work.

Collaboration across disciplines also offers information about relationships, which can be invaluable in mental health treatment. The importance of relationship will be discussed later in this chapter; here I will briefly describe its use in psychotherapy as it relates to collaboration across disciplines.

Most presenting issues in psychotherapy are informed in some way by the relationships in a client's life, and those in turn are impacted by the presenting issues. For example a man who seeks treatment for alcohol dependence may also want relief from

his marital distress. The drinking makes his wife turn away when he longs for connection with her, and the rejection and resultant loneliness fuel the drinking behavior. Even if someone seeks treatment to *find* a romantic relationship, information about what happens in her non-romantic relational experiences can be useful in helping her achieve her goal. For example if someone recoils when others attempt to make connections, or responds only to objectifying overtures, those patterns would provide valuable information. However such information might not be readily available; in the paradigm of individual therapy, to formulate a treatment plan, a therapist has only his understanding of interacting with his client, and the client's *reports* of other relationships to draw from. But if that client is also working with another provider (be it in couples therapy or with a different modality), that other provider can share *his* experience of interacting with the mutual client, in addition to his thoughts about the client's symptoms. And he can share what his discipline teaches about their interactions. The therapist can, in turn, share his impressions and concerns with the other provider, whose picture of the client is likewise limited by the paradigm of his profession. Through collaborative dialogue between providers, an exponentially more comprehensive sense of the client can be gleaned. This puts both providers in a position to notice strengths the client may possess but not always display, and symptoms that might be cause for alarm. It also allows co-treating practitioners to support each other as they construct a more comprehensive treatment plan.

A primary care provider who has known a patient for years is in an advantageous position to notice changes—in appearance, or cognition or emotional affect--- which could be invaluable in recognizing subtle symptoms. However these busy providers are

bound by their schedules, which typically allow only 15-30 minutes for an office exam, which may happen only annually. Psychotherapy sessions typically last between 45-60 minutes, and can occur on a continuum from more than weekly to sporadically, often over the course of years. This affords the therapist an opportunity to get to know someone gradually, and to gain a sense of the relationship systems in which they live and work. It provides a less-hurried space for the exploration of patterns of behavior that no other healthcare specialty allows, and even in the case of physical illness, time to develop a narrative of how that illness is experienced. Psychotherapists can expose other healthcare providers to this concept of the narratives of illness, thus in turn helping more patients access this important component of healthcare. Kleinman wrote about the importance of patients, families and practitioners coming together to interpret the meaning of illness as an accepted part of any treatment (1988). Similarly, in her book *Narrative Medicine*, Charon wrote:

A scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying. Along with their growing scientific expertise, doctors need the expertise to listen to their patients, to understand as best they can the ordeals of illness, to honor the meanings of their patients' narratives of illness, and to be moved by what they behold so that they can act on their patients' behalf" (2006, p.3).

Having explained my rationale for the inclusion of collaboration across disciplines in healthcare practice, I would like to pause and illustrate its importance by presenting some

client stories that unfolded as I was conducting the research for this dissertation. I find that individual narratives bring theoretical ideas to life, making them more accessible, as they offer opportunities for personal connection, even to people one has never met.

The Danger of a Single Lens.

In the summer of 2014, I received an email from John, a 49 year-old man whose wife of 25 years had left him two years prior, and married his best friend. I offered him an initial appointment, deciding before I'd even met him that his diagnosis would most likely include complicated grief. His physician, who had known him for years, suggested he seek psychotherapy to address his depression. His adult children, who'd grown tired of his anger and despondency, had also urged him to seek counseling. His neurologist, who had helped him manage a seizure disorder for three decades, had recently prescribed antidepressants. They'd given him some relief initially, but increasing doses had failed to contain his rage and despair.

He had been put on administrative leave from the job he'd held and enjoyed since graduating from college, and his reputation as a pleasant and fair leader was dismantled in the process. The most significant people in John's life had come to see him as an irritable and depressed man, who was unable to move past the loss of his marriage.

John arrived at my office and began to tackle the requisite paperwork, which typically takes no more than 15 minutes to complete. Thirty minutes later when he still hadn't finalized it, I expected that he was writing a tome about the loss of his marriage. To my surprise, when he finally handed it to me, I saw that he'd written very little. During our first session, John was animated and engaged, but had difficulty completing sentences. I was somehow able to infer what he meant, getting confirmation by his non-

verbal communication. However, our interaction felt strange to me. I asked for permission to contact his other providers, and told him I'd let him know if another appointment was appropriate, given the importance of talking in psychotherapy.

Speaking with John's neurologist proved extremely difficult, as he only made himself available during very brief windows of time. When we did finally connect, and I shared concerns about John's limited ability to engage in conversation, he said that it was a symptom of depression and anger. I explained that I had not seen this symptom in my years of experience treating people with similar losses. He expressed disdain for my profession, and also for psychiatrists who believed that they alone were capable of prescribing psychotropic medications. While he acknowledged that John's difficulty forming complete sentences was a relatively new symptom, he insisted that it had improved under the increased doses of antidepressants. I inquired whether he'd ordered any tests to rule out other, more serious possible causes, and he dismissed this idea as unnecessary. He had no questions for me, and abruptly ended our brief conversation.

John's physician was more eager to talk about his perplexing symptoms. In reviewing his notes from John's last visit five months prior, he said that he'd also noticed changes in John's ability to communicate. Regrettably he'd forgotten to follow up with John, and was glad for the opportunity to do so now. He agreed to contact the neurologist to ask for additional testing, and to let me know the results when they were available. John returned for a second visit, thankful for the collaboration, and eager to uncover what might be behind his symptoms. He pantomimed curious moments when he was still working, where he'd been unable to recognize faces of colleagues. He'd also reported episodes of road rage so intense that they frightened him. He talked in fragments about

his wife, recognizing in retrospect that the marriage hadn't been happy for him, and I realized that he was not grieving the loss of the marriage. He expressed gratitude for the time off from work, which had allowed him to reconnect with old friends and his children, as well as deep confusion about what he could have done to result in his being put on administrative leave from work.

John did not show for his next two appointments. I left messages inquiring about his condition, and he responded with fragmented, confusing emails, which he signed using terms of endearment inappropriate to our relationship.

When he returned a month later, he reported with relief that he'd received confirmation via phone that his MRI had not revealed any tumors or strokes. He told me that he was scheduled to meet with his neurologist to review the results in two weeks. I encouraged him to bring his children so that they could help him remember and interpret the results. He cried, stating that he'd secretly feared for some time that he might have Alzheimer's, and I gently agreed that we might need to prepare for that possibility. Knowing that I was crossing the boundaries of my training and licensure, I did a bit of research online, plugging John's symptoms into a search engine. I rationalized that it couldn't hurt to educate myself, and that it might provide some helpful information to the other providers, who seemed to be more pressed for time than I was. I found several articles about a specific type of dementia that seemed to fit what John was describing, and contacted his physician to share these details with him. He read about the dementia as we talked, and exclaimed with a combination of sadness and regret that this indeed did seem to describe John's symptoms. He wondered why neither he nor John's neurologist had considered this, and revealed that while the results of the MRI hadn't revealed any

masses or tumors, they had actually identified atrophy of John's brain in the very area described in the article, though this information had not been shared with John. The physician agreed to contact the neurologist again, and make the necessary referrals so that John could receive a formal diagnosis and receive whatever care might be available.

Seven months after his initial appointment with me, a neuropsychologist confirmed this very diagnosis. John had lost precious time to arrange for his financial and physical wellbeing, and to discuss his wishes with his children while they could still be somewhat easily conveyed. His loved ones lost months with him that could never be reclaimed. He lost the opportunity to retire with dignity and the expressed appreciation of his co-workers. If I had been unwilling to set aside the trauma lens, through which I do much of my work, I may not have considered alternative explanations for John's symptoms. If his primary care physician had not believed that a psychotherapist, a patient and a physician could co-create knowledge together, John may have run out of time to take control of his life and his health. If John's employer hadn't learned of his illness, he might not have received the disability income to which he was entitled. And had they not understood his behavior in another context, John's children might have been left with regret for the way that they'd interacted with him during the last years of his life.

Chet and Sally: A Narrow Perspective Hurts, Not Helps

Sally was 45 when her husband Chet, 48, suffered a traumatic brain injury. He was left mostly unable to speak, feed himself or care for his bathroom needs. He was wheelchair bound and could no longer participate in activities he'd previously enjoyed. Sally was his sole caretaker as money was tight, and she felt exhausted and trapped much

of the time. During a visit to Chet's primary care physician in the first year after the injury, Sally was shocked when the doctor launched into a lecture about the importance of sexual activity for patients such as Chet, and asked whether they were still having intercourse. Chet hung his head in response, and Sally was rendered speechless. Her shock turned to confusion when the doctor turned to her and suggested couples counseling. He explained that such counseling could help them resume their sexual relationship, apparently oblivious to the fact that his patient, who was sitting right in front of him, could hardly speak, and that Sally, overwhelmed and exhausted, might not be interested in participating in sexual activity with her husband.

Seeing him as the expert, Sally felt unable to express her disgust, confusion and anger to the doctor. She left the office in tears, questioning whether she was doing enough as Chet's wife to take care of him. It was only months later that Sally was able to recognize the inappropriateness of the doctor's suggestion, and his complete failure to understand the situation she and Chet were in. Sally recovered from that experience, but the opportunity for Chet's physician to learn from them about what life is like after such an event was lost. And that meant that his opportunity to help other families who might be stricken with life-altering illnesses was diminished as well. When physicians fail to learn from their patients, the impact is like dominoes falling.

Assuming that Chet's physician was only trying to remedy what he perceived to be a problem with Chet's overall health, one wonders how he failed to notice what was happening right in front of him. Where do physicians learn *not* to be curious about those who seek their services? I turn to my own academic training for a clue.

**My Professional Journey:
From Contempt to Collaboration
(or Philosophy is the Biography of the Philosopher.)**

Sarewitz wrote, "...the recognition that something is a problem demands a pre-existing framework of values and interests within which problems can be recognized" (2004, p. 386). The seeds of this research, and my identifying a lack of collaboration across disciplines in healthcare as a problem were probably sown years ago when I was an undergraduate student in the Biology Department at the University of Colorado, Boulder (known as CU). Like most universities, where there are strong barriers between disciplines, CU's departments indoctrinated students quickly to the accepted discourse of each discipline.

I cannot recall the exact moment I learned that the students and professors in the Biology Department were superior to our counterparts in the Psychology Department, but I did overhear, from early on, many conversations that were contemptuous of their soft science and their pitiful research. Though I laughed along with my classmates, I was holding a secret; I longed to study human behavior myself. Gergen has drawn back the curtain on the territoriality of higher education, which may be the first exposure healthcare practitioners have to a culture that does not value collaboration, writing:

There are also risks for roaming. Scholars who are curious about another discipline are often viewed as alien interlopers by the denizens of the discipline. Within their home disciplines the same scholars may be dismissed because their ideas are quirky or alien (2009, p.211).

As I progressed through my required coursework, it became increasingly difficult for me to conjure much interest in courses like Ecology or Chemistry. I had entered the discourse though, so there could be no psychology courses for me; I would have to find another way to explore my genuine interests.

In my third year, I fought for the right to devote my semester-long project to the study of human behavior. While my classmates were studying the behavior of fish and stray dogs, I was observing how students' participation in class related to where they chose to sit. I remember the professor's initial sarcasm and his attempts to dissuade me from this project, only to watch him do an about-face and read my paper to the class when it was finished. He even jokingly admonished that he would now be paying attention to where we all chose to sit during his lectures.

While this felt validating to me, I did not recognize at the time how limited I had become by adopting the single lens of biology. I continued to believe that as a student in that department of "real science," I was part of a more "elite" group of scholars and I missed opportunities for intellectual exploration by failing to take classes in other departments that interested me.

Ten years later, I enrolled in a graduate program where the hierarchy would be reversed, and psychologists placed at the top. At The University of Dayton, which turned out license-eligible mental health counselors, there was a powerful discourse that also went unnamed. The discursive practices of professors and students alike compared us to psychologists, alternately constructing us as inferior and superior. Though we'd be doing essentially the same job after licensure, psychologists would be paid more. The managed

care insurance companies, who determined reimbursement rates for our services, were most definitely participants in that discourse.

But as psychologists went to school longer than we did, and probably scored higher on their Graduate Record Examinations (an important measure for a graduate student), we accepted the anticipated discrepancy in income. This was balanced by our belief that they weren't as accomplished at relating to people, and so would likely find more success publishing esoteric articles than actually helping people. And though they would be called doctor, and they had exclusive rights to the word psychologist, we consoled ourselves with the notion that we would be the better clinicians. We embraced our own title of psychotherapist, and found a box for the Social Workers (bleeding hearts) and Marriage & Family Therapists (similar to us but too narrowly focused). In one class, we learned the *Diagnostic and Statistical Manual III-R*, (DSM) (American Psychiatric Association, 1980) which was the most current iteration of the diagnostic tool available for clinicians at the time. The dialogue in my head was, as always, about the need to 'get it right.' And diagnosis was the quintessential place for such a construct; surely doing it correctly was the first step towards effective care?

The dialogue in the classroom was partly based on the presumption that the DSM III-R *was* right, and that it could be taught by a professor to counseling students. And it was also based on a belief that while other disciplines offering similar services would use this same book, our lens was the one that could find the "right" diagnosis.

I could not see at the time that the discursive practices that had been so limiting of my ability to learn in undergraduate studies were even more restrictive in graduate school.

My coursework and internships set the stage for a very insular experience, and a belief that there was only one legitimate lens through which I should see my clients.

That class on the DSM made it clear that we were not in collaboration with our clients when it came to diagnosis; rather, our role was to see through any “tricks” they might use to obscure the “real” issues. And it was our professional gaze that would enable us to find that truth.

We formed some beliefs about physical health and medicine in graduate school as well. Namely, that the job of a physician was completely different from ours. With the exception of prescribing psychiatrists, we would have no reason to initiate contact with a physician. And they would never initiate contact with us; psychologists were fighting for legitimacy with them, and as we fell significantly below psychologists in the hierarchy, we could expect to be invisible to physicians.

Now, as a seasoned clinician, it seems preposterous to consider that there is no need for collaboration outside of our discipline, either because our clinical gaze is somehow sufficient to know *all* there is to know about human *being*, or because we as a culture of healthcare providers have agreed that healthcare should be dispensed from separated silos.

This phenomenon was certainly at play in the classrooms of graduate school, where we were deciding what we believed about mental health and mental illness. It was at play in the overarching undergraduate and graduate departments of Biology and Psychology, and it would remain with us as practicing professionals unless we actively decided to change it. By the time we made it out of the classroom to our internships, these beliefs were part of what we considered knowledge in our regimen of mental and

emotional and behavioral healthcare. And in my experience, they were reinforced regularly throughout my years working in community mental health.

As I gained experience and confidence in my clinical skills, I moved to a busy private practice. There were two psychiatrists on staff who were respectful of my work, and several psychologists who declared that I seemed more like one of them than a master's level clinician. I collaborated with providers from other disciplines in formal case-presentation meetings, informal conversations over lunch, or quick conversations in the kitchen. I joined a consultation group where we challenged each other and established a norm of co-creating and deconstructing new knowledge about human behavior with each meeting. I began to question the beliefs I'd subscribed to for many years that had reinforced the boundaries between my discipline and others, and recognized the value in offering clients a seat at the table where their own care was discussed, rather than leaving them out of such conversations. It was one early case in particular that opened my eyes to the idea that I could choose to collaborate *with* my clients, instead of collaborating *about* them.

Paula: Exploring the root of her pain

I'd been working with Paula for several months, and I didn't feel that I was helping her. Paula was a 35 year-old professional who'd sought treatment after the latest in a series of romantic breakups. As she saw the age 40 looming closer, she feared she would never marry or have a family of her own. She lived with her widowed mother, to whom she had always been very close. She had developed mysterious stomach pains and reported that her primary care physician had diagnosed her with Crohn's Disease, even though he admitted that she did not meet the criteria for such a label. She behaved as if

she had the disease, severely limiting the foods she ate according to color. She appeared quite underweight and fragile. Her stomach pains worsened with each breakup, and she underwent a series of increasingly intrusive tests to rule out other possible causes. None of these tests provided anything solid that could suggest a course of treatment. But I had a hunch that I might have an answer. I thought about ways to float my theory to Paula, which I hoped wouldn't seem dismissive of her suffering. I gently wondered aloud during a session if Paula's symptoms, while severe and painful, might possibly be related to her romantic difficulties, and fears about separating from her mother. This seemed to provide some movement in the therapy as we began to explore an alternative source of her pain, and I felt proud that my clinical skills had begun to help Paula. However my enthusiasm was short-lived; I was surprised and dismayed when not long after, Paula announced that she had scheduled exploratory surgery, which was, according to her physician, the last hope for uncovering the *real* source of her unexplained pain.

This recommendation was not unusual in my experience; many clients seem to prefer quick solutions to their unexplained health issues, placing the highest value on surgical interventions, and surgeons are often eager to comply (Ashton & Wray, 2013, p.81). Paula made it clear that she believed this was the best course of treatment, and she declined further exploration of her relationships as a possible source of her physical symptoms.

I pretended to accept Paula's surgery as a wise choice, and Paula tolerated my insistent curiosity about other possible alternative meanings of her pain. But we were no longer in dialogue, as I'd retreated to an internal dialogue of which Paula was unaware. Over the years I'd had several clients on whom similar exploratory surgery was

conducted, with disastrous results. Consequently, I had formed some strong opinions about this procedure, and the surgeons who practiced it.

I dug in, propelled by a wish to protect Paula, and my adherence to the lens through which I saw her symptoms. I asked for permission to consult with her primary care physician and surgeon prior to the procedure, hoping that I could convince them to postpone it and allow more time for my approach to treating her symptoms. Paula agreed and I faxed the signed releases and left messages for both professionals, but did not hear from them as the date for her surgery loomed closer. Recognizing my place in the medical hierarchy, I reasoned that Paula's physicians would not, in all likelihood, be interested in my input regarding their patient's treatment. Believing that I needed something to legitimize my opinion, I sought empirical research to support my theory. I found an article published in a respected journal about the unintended consequences of performing exploratory surgery in such cases. I shared it with Paula, and got her permission to fax copies to the other treating professionals. I followed up with two additional phone calls, but never talked to the physician or the surgeon.

Finally recognizing that Paula was not seeking my intervention on this matter, and as such I was now pushing my own agenda, I stopped trying to reach the other treating professionals. Paula underwent the exploratory surgery, where part of her intestine was removed. She reported that the tissue was not found to be damaged or diseased in any way, and to her great frustration, her stomach pains continued. My subsequent move out of state resulted in a termination of the therapeutic relationship, and I don't know what happened with Paula's treatment. However, I do wonder what might have been created if

Paula, her physician, surgeon and I could have engaged in dialogue as we explored *her* narrative of her pain. I see this as a missed opportunity for all of us.

The three case examples presented in this chapter highlight the dangers of conceptualizing cases from a narrow lens, and call attention to the possibilities for collaboration across disciplines to widen it. There remains significant variation in the ways that illness, health and care are conceptualized, both within and across disciplines. In order to navigate such a disparate landscape, we need an orienting principle from which to explore. Social Construction is well suited to the task; Chapter Two will explore its basic principles, and their application to the idea of collaboration across disciplines.

Chapter Two

Social Constructionist Theory

The term Social Construction itself was introduced in 1966 with the publication of Berger and Luckmann's influential book, *The Social Construction of Reality*, though several philosophers whose ideas were published decades before made significant contributions. Berger and Luckmann put forth the notion that human beings develop in part through interactions with their environments, both natural and human-created. As such there are as myriad ways for humans to 'become,' just as there are cultures and social contexts to shape them. Groups of people together produce a social environment, with its own behavioral, cultural and social standards. Institutions arise when people habitually act in ways that are reinforced by cultural institutions over the course of time, creating social order. Thus, institutions both have a history and are the products of history. In bringing these concepts to the topic of this inquiry, I examine some of the taken-for-granted beliefs of healthcare practitioners, and the institutions in which they train and work. In this chapter I will introduce ideas from some of the philosophers whose groundbreaking work contributed to the principles of Social Construction, using examples from my professional experience to illustrate ways that the theoretical ideas can be applied to the practice of healthcare.

Basic Principles of Social Construction

The basic principles of Social Construction, outlined below, can be applied to examine the creation of illness and disease, and the institutions created to name and treat them. This was referred to in the previous chapter as healthcare.

Examining Taken-for-Granted Assumptions

The first principle invites us to explore our taken-for-granted assumptions rather than accept them as truth. As human beings, we behave in habitual ways without always recognizing that we are doing so; we tend to then assign legitimacy to our actions simply because we have always acted in particular ways, without considering the consequences of those actions. Following is a story, told to me by a client, illustrating this concept. “I was visiting Harriet (who suffers from advanced dementia, and requires assistance to eat). We were in the cafeteria when I overheard the staff refer to the residents at her table as “The Feeds.” The supervisor said they should get The Feeds taken care of quickly, all within earshot of us. I was horrified by the use of this term, and asked them to stop. Even though they have dementia, the patients can still hear, and that is an awful way to talk about them. The supervisor told me that they had used the term for years, without ever considering how it might sound to the patients and their families. She apologized and said she would talk to the staff about it.”

From the first class we attend in professional school, we are indoctrinated into a system and taught a language that presents *ideas* about human beings as *facts*. And as we begin to work and interact with patients and other professionals, there is more that we take for granted, all of which becomes intrinsic to the ways that we practice. The result is that we can be guided by erroneous or arbitrary assumptions without noticing or questioning them. This is evident in something as simple as the typical length of time allotted for an office visit. Psychotherapists typically see clients for 50-minute sessions, without questioning the effectiveness or even the source of this decision; yet we are quick to criticize the 15-minute medication checks that psychiatrists typically provide. The

point here is not to determine whether or not these allotted times are correct, but to bring to our awareness the ways that we take them for granted. When we begin to question our habitual ways of behaving rather than accepting them as “correct,” we open the door to other ways of knowing and behaving. By bringing attention to taken for granted ways of interacting with healthcare providers from different disciplines, we can become curious rather than judgmental about how others construct knowledge in healthcare, opening the door to dialogue across disciplines.

Relational Processes and Realities

Our actions impact the environments and people with whom we interact. Instead of considering people as bounded individuals who possess some sort of inner entity that drives them and their behaviors, Social Construction considers the relational processes *between* people (and between people and their environments) as the space where we construct social practices. Buber wrote about the importance of making oneself fully present in relation to others:

Entering into relation is an act of the whole being: it is the act by which we constitute ourselves as human...man is able to enter in relation with other beings distant from, and opposed to him, for the ‘overcoming’ of distance does not mean simple unity, but the polar tension of distance and relation together (1988, p.12).

Relational processes occur in an on-going manner within local and historical contexts. Because they are fluid, they can open and close possibilities for change, constructing and deconstructing realities in the process, which can be called relational realities. Consider the relational processes between providers of psychotherapy and their

clients, and the relational realities that they have produced. In traditional psychoanalysis, a relational reality was constructed which put the therapist in a role of detached observer. This led to the creation of relational processes in which the therapist concealed all emotion, dispensing coolly to his patients what both accepted as knowledge about the patient's symptoms. Carl Rogers' work led to a different sort of relational reality in psychotherapy, where the therapist revealed his own emotional reactions to what the client was saying, displaying warmth and privileging the relational process over an answer or insight. In my sessions, I have recognized that revealing the impact of their stories on me as I listen to clients can act as a powerful agent of change. Yet paradoxically, psychotherapy maintains the most rigid rules among healthcare providers for what are considered healthy boundaries between clients and therapists. What this can mean is that we may enjoy deeply connective relational experiences we share in sessions, but I may not acknowledge a client if we happen to meet in public and he does not acknowledge me first.

The Ways We Use Language

So central is language to the human experience that neurosurgeon Paul Kalanithi considered it a crucial determining factor in choosing to move forward with neurosurgery to prolong a patient's life. If the regions of the brain considered responsible for producing and understanding language were damaged, he explained, "the patient becomes an isolate, something central to her humanity stolen forever." In these cases, Dr. Kalanithi refused life-preserving surgery, writing, "What kind of life exists without language?" (p. 109).

Mikhail Bakhtin (1979), a Russian philosopher, proposed that the words that people utter are embedded in the expressions, cultures and histories of the words spoken by others. As such, a dictionary cannot adequately capture the special meaning that a social context provides. He stated:

Neutral dictionary meanings of the words of a language ensure their common features and guarantee that all speakers of a given language will understand one another, but the use of words in live speech communication is always individual and contextual in nature (as quoted in McGee, 1986 p.88).

In reviewing the literature for this inquiry, I was impressed by the work of an early cross-disciplinary collaborator who will be profiled in the next chapter; I was equally astonished at the blatant anti-Semitism he revealed as he admonished new physicians to really *see* their patients:

...Abraham Cohen, of Salem Street approaches, and sits down to tell me the tale of his sufferings; the chances are ten to one that I shall look out of my eyes and see, *not* Abraham Cohen, but *a Jew*; not the sharp, clear outlines of this unique sufferer, but the vague, misty composite photograph of all the hundreds of Jews who in the past ten years have shuffled up to me with bent back and deprecating eyes, and taken their seats upon this same stool to tell their story. I see a Jew—a nervous, complaining, whimpering Jew,---with his beard upon his chest and the inevitable dirty black frock-coat flapping about his knees. I do not see *this*

man at all. I merge him in the hazy background of the average Jew”
(Cabot, 1909 p.4-5).

Societal norms in the U.S. would prevent a healthcare practitioner from using this language publicly, but reading it in retrospect offers an informative glimpse into what the practice of medicine and perhaps society in general was like in Boston at the turn of the last century.

This view of language invites us to consider it an important part of the process of relating to others. For providers of healthcare, the words chosen to communicate with patients could result in a range of responses, from alienation to connection. For example Patti, a client who engaged my services for marital counseling reported that she and her husband Ed had fired their previous counselor. During a session with her, Patti had described her adolescent years, when she had opted to stay at home most weekends with her recently widowed father, rather than attend parties and dances with peers. She reported that upon hearing that history, the previous therapist declared that her relationship with her father had been emotionally incestuous. This proclamation served to instantly transform a period of Patti’s life that she had remembered fondly into something shameful and repugnant to her. It prevented the formation of a therapeutic alliance between Patti, Ed and the couple’s therapist, and rendered the therapy office a place of danger rather than safety and healing. Healthcare providers who bring reflexivity to their choice of language are in the best position to build alliances with those who seek their services.

Lord Byron wrote, “I do believe, though I have found them not, that there may be

Words which are things” (1892). As children, we are not able to appreciate the difference between the names of things and the things themselves; as adults, we can grasp the concept and question the veracity of long-held beliefs. In his seminal work *Philosophical Investigations*, Wittgenstein developed a philosophy of human language that challenged taken-for-granted assumptions about its use, and demonstrated that it is much more complex than simply naming things so that we can talk about them. He coined the phrase “language-games” to refer to the myriad ways that people use language, which are in turn impacted by innumerable factors, such as cultural or familial norms. Adding to the complexity, he suggested that language-games do not simply involve words and the ways people respond with words, but also the activities that are woven into people’s lives. What might we learn, for example, about the Zulu people who used for the English phrase “far away,” “There, where someone cries out: O Mother I am lost” (as quoted in Buber 1947)? That choice of words might tell us about the value the Zulu people placed on familial or in particular, maternal relationships, or perhaps a safety-related custom of needing to remain in close proximity with others. In either case, the words seem to indicate a great deal more than a simple measurement of distance. The Yaghan word *Mamihlapinatapai*, which roughly translates in English to “a look shared by two people, each wishing that the other would initiate something that they both desire, but which neither wants to begin” could be interpreted as valuing the nuanced and intimate interactions that are possible between people. It could also indicate a cultural norm that included discomfort in feeling vulnerable, or giving voice to what people felt in relational experiences. The new idea that Wittgenstein brought is that language is not simply a

vehicle for delivering information; the way people put words together offers a unique opportunity to understand something about them and their milieus.

Wittgenstein suggested that we ask ourselves how we came to learn the meaning of a word, in what games, and from what sorts of examples. In so doing, we can begin to understand how we engage in language games, and how that colors our thoughts; for language doesn't describe a thing so much as it does our *perception* or experience of it.

He wrote:

The general form of propositions is: 'This is how things are.' That is the kind of proposition one repeats to oneself countless times. One thinks that one is tracing nature over and over again, and one is merely tracing round the frame through which we look at it. A picture held us captive. And we couldn't get outside it, for it lay in our language, and language seemed only to repeat it to us inexorably (1968, p.53).

Social Construction builds on the ideas of Bakhtin and Wittgenstein by suggesting that language, as social action, *creates* rather than describes what are held as truths by a people, whether a dyad, a community or an entire nation. The ways we use language, through talking, writing, daily activities and artistic expression are connected to thought and action. Therefore language, rather than being ignored or taken for granted, can be considered a valuable source of information for what happens between people. Social Constructionist theory, with its focus on language, offers a useful frame for considering the questions put forth in this inquiry about what might be possible if providers from different healthcare disciplines engaged in collaborative dialogue. Consider the words disease and illness, which at first glance could be considered rudimentary to the language

of healthcare; yet there is great flexibility in their meaning, according to who is saying them, when they are uttered or written, and to whom and what they are referring. When the language constructed in a particular time and place is used in an agreed upon manner, it gives rise to co-created realities that can have far-reaching consequences. Following are three very different definitions of the construct illness. A definition from the language-game of pharmaceutical companies, highlighting the economic possibilities that illness provides, “As the business literature shows, new clinical diagnoses are often welcomed primarily as opportunities for market growth ” (Scully, 2004, p. 651). As I read this, I thought of illness as a vehicle for possible wealth creation, which is considered valuable to businesses and researchers. Consider now a definition from the language-game of scientific research, creating an entity called disease, “A morbid entity ordinarily characterized by two or more of the following criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomic alterations” (The Freed Dictionary 2003). For me, this language evoked a sense of visible, recognizable cellular changes, devoid of the person in whom they occur. A definition from the language-game of an experienced physician, recognizing the possibilities that can emerge from a serious illness, “It is when one is ill that one has to decide how valuable life is, which relationships are most meaningful, and what terrors or comforts the end of life holds” (Charon, 2006, p.87). This language stirred in me a sense of urgency, but also of opportunity. And, a definition from the language-game of a patient, Eve Ensler, objecting to the ways that data place people into categories:

There is something so dull and brutal about data. Stage IVB cancer survivor, rape survivor. But I am not data and I don't want to be

dismissed and judged by categories or grades... What if our understanding of ourselves were based not on static labels or stages but on our actions and our ability and our willingness to transform ourselves? What if we embraced the messy, evolving, surprising, out- of- control happening that is life and reckoned with its proximity and relationship to death? What if, instead of being afraid of even talking about death, we saw our lives in some ways as preparation for it? What if we were taught to ponder it and reflect on it and talk about it and enter it and rehearse it and try it on? What if our lives were precious only up to a point? What if we held them loosely and understood that there were no guarantees? So that when you got sick you weren't a stage but in a process? And cancer, just like having your heart broken, or getting a new job, or going to school, were a teacher? (Ensler & Astudillo, 2013, p.88.)

As I read this passage, I imagined illness wielded first as a limiting label, and then captured and reassigned to the role of agent of change for possible transformation; still powerful but less dangerous. This passage could inform providers of healthcare that thoughtful employment of language may serve to circumvent the inadvertent yet painful marginalizing of patients through labels.

Dialogue

People can communicate in a variety of ways, through music, dance and other art forms, and by engaging in dialogue. There is no universal definition of dialogue, and it is often approached methodologically, with orchestrations for how people *should* talk.

Drawing from Bakhtin, we can consider that people are dialogical beings in that every word we utter is related to others who have also spoken those words. Social Construction proposes that dialogue is a particular kind of exchange, (either within oneself or between people) that is generative in nature. Some of the characteristics of this kind of dialogue include being tensional and ethical. The tension is between "...holding one's own ground while letting the other happen to them" (Stewart and Zediker, 2009, p.231). This can occur for example when polarities emerge as people engage with each other in expressing their multiple and sometimes discordant viewpoints. Recalling John's story, when I spoke with his neurologist, I certainly felt some strain as I attempted an approach that was assertive yet open to his alternate viewpoint of John's condition. Dialogue is an ethical practice in that it presumes that those who engage in it are held as equals, with an equivalent voice and the same rights and opportunities to influence and guide the conversation. That means that no set of values and beliefs is superior to another. Throughout this inquiry, when I use the term dialogue, I am referring to exchanges that are generative, tensional and ethical, where each participant attempts to understand the other before being understood. The hierarchy that exists in healthcare can make this aspect of dialogue difficult to maintain. Traditionally, the opinions of physicians are afforded the greatest credence, while those of other healthcare professionals (nurses, psychotherapists and CAM providers) are given less.

Every dialogical exchange unfolds within a particular context. As such, each can be "...enhanced or blocked by such features as the time available, exigencies of space, the presence or absence of an audience, role definitions, and cultural norms (Stewart and Zediker, 2009, p.230). I consider collaboration across disciplines in healthcare to be a

special kind of dialogue, with a specific goal of the co-creation of knowledge about the patient who is being discussed. Of course due to the influential features listed above, there is no way to guarantee that such an outcome will occur. Depending on the participants, time constraints, and the norms of the dominant discourse, the exchanges that unfold may be restrictive or generative in nature.

This definition of collaborative dialogue is prescriptive in that I propose it as an ideal way for providers of healthcare to interact. However, this creates a conundrum for those for whom it is prescribed, as it is difficult to create something when there are no clear steps for how to get there. As there are different norms and customs for each of the disciplines represented in this inquiry, constructing a unified prescription for collaborative dialogue would be particularly difficult. There are ideas that if enacted might *enhance* the process of collaborative dialogue, such as Anderson's tips (Appendix Three). Collaborative dialogue can also emerge when healthcare providers enter into dialogical conversations with those who seek their services.

Relating dialogically involves letting go of what we think we know to be true or good, and opening ourselves to disparate viewpoints. It requires us to invite another to speak, and to listen attentively; in so doing that provides space for people to co-construct new ideas and practices. Conversely, monologues involve the telling or selling of preconceived ideas, and as such, they convey a lack of interest or concern for others' opinions or ideas. Being able to recognize the difference between monological and dialogical interaction is a powerful resource for providers of healthcare. We can convey interest and empathy by attuning ourselves to those who seek our services; leaning in, tracking their facial expressions and body movements and adjusting ourselves

accordingly are behaviors that reflect attunement. If we ask questions only to confirm preconceived diagnoses or hypotheses, we may communicate disinterest, superiority, or perhaps subscribing to a schedule that is too busy to make conversation. One way to assist us in recognizing whether we are engaged in dialogue is to ask ourselves what we are doing with our talking. In the case of this inquiry, a provider might think she is communicating with a colleague. But if all parties involved don't agree about what is happening with the talking, that might change the relational reality. If this question had been posed for example to the physician and neurologist with whom I spoke about John's care, we might have expressed different ideas about what we were doing with our conversation. I would characterize one of them as dialogical and the other as combative; it would be interesting to learn how the other healthcare providers experienced them. What is important is for providers of healthcare to bring to their awareness whether the intention of their words matches the impact on those who receive them. For example if a speaker notices during a conversation that a listener is looking away, or tapping his foot, or has suddenly gone quiet, that speaker can make a shift by simply bringing curiosity to those behaviors. For example, he could say "I noticed that you stopped talking, and it appeared as though your foot started tapping when I said something just now. I would like to understand what is happening for you in this moment, because it seems that something between us has suddenly shifted." If a colleague said that to me, I imagine I would feel seen and heard and valued, which would create a sense of safety for repairing any mis-attunement that had taken place.

Hiding as dialogue.

There are occasions when patients fail to disclose pertinent health information to

their providers because they do not recognize its importance, and there are occasions when providers fail to disclose information that might be valuable to their patients because they simply do not think of it; these can be thought of as inadvertent omissions. It is also common for patients to purposely conceal health-related information from their providers, which can severely limit the effectiveness of the care they receive. An online survey of more than 3700 American patients reported that half admitted deceiving their physicians, usually about their drug and alcohol use, to avoid judgment or being lectured (Irwin, 2014). In a Canadian study of Complementary and Alternative Medicine (CAM) usage among complex patients, the authors found that patients who sought care from CAM providers were also likely to seek more help from conventional medicine for their symptoms than non-CAM users. However, fewer than 30% of those who utilized the services of CAM providers reported this to their traditional medical providers (Sirous, 2007, p. 78).

In a study of patients treated for eating disorders in The Netherlands and Belgium, the authors commented on the taken-for-granted response of many patients to their physician's inquiries about their eating behaviors, concluding: "...secrecy and concealment are common behaviors in people with eating disorders...they distort or withhold information...to appear as not having a problem" (Vandereycken and Van Humbeeck, 2008 p.113). Fear of judgment or abandonment, a desire to achieve a certain outcome, or simply not knowing how to initiate a difficult conversation could be explanations for purposely concealing health information; what patients choose to disclose to providers could also be indicative of the nature of their previous interactions. It is presumable that with a deeper connection and sense of trust between them, patients

would be more likely to disclose pertinent information to their providers, even if it felt uncomfortable doing so. In my practice I have worked with a few clients who, only after years in treatment, revealed information that invited them to feel ashamed, such as credit card debt, sexual dysfunction or substance abuse. These kinds of issues significantly contributed to their symptoms of depression or anxiety, yet they chose to navigate the treacherous waters alone. This has always saddened me, because I believe it is within these dark places shame inhabits that we *most* need to know we are worthy of support. But I also believe that it is my clients who should retain control of the pacing of treatment, and so I can create a space where I hope they will choose to invite me in to their experience, but I do not force the revelation. Even if I suspect there might be salient information they are not disclosing, I respect their right to keep it secret, and I express gratitude rather than disgust when they are ready to reveal it. Dialogue provides the tools for healthcare practitioners to meet those who seek their services where they are.

It is also not uncommon for providers to knowingly conceal information from their patients, based on their past relational experiences, or cultural norms and customs. In a study of patients diagnosed with terminal cancer, Shahidi found significant disparity with regard to how doctors disclosed information about prognosis, based on the cultural norms of the physicians and patients. For example in Iran, fewer than half of cancer patients were aware of their diagnosis, and of those, only one in six was informed when it had become metastatic. The author cited four primary reasons for withholding information; a physician belief that doing so would inflict emotional or psychological pain on the patient, patient reluctance to engage in informative conversations, physician avoidance of distressing conversations, and families' requests to conceal information

(2010). As I read these explanations, they all seemed to involve relational processes and the inherent terror that engaging in conversation about a cancer diagnosis brings to those who are faced with such news, and those who must deliver it. If providers have experienced previous patients' displays of emotion as overwhelming, future conversations are likely to be limited in an attempt to avoid such discomfort. Relational ethics become quite important in such instances, as healthcare providers balance their needs with those of their patients. For example, it is equally conceivable that a physician could usurp a patient's opportunity to make meaning of her illness by insisting that she "accept" it before she has had time to accept its presence in her body. There are other, less dire circumstances where healthcare professionals conceal information from those who seek their services.

Anecdotally, I have observed that many psychotherapists conceal their clients' diagnoses when they include personality disorders. People given these diagnoses have historically been viewed derisively by mental health disciplines as being characterologically disordered, meaning that they are difficult to work with, and not easily helped. As such there is a presumption that they will react poorly to the description of their illness. When clients discover their diagnoses from sources other than those who have bestowed them (because of avoidance on the part of the practitioner), that relational process alone can lead to client distress. Yet if diagnoses were descriptions of patient experiences, constructed through dialogue between client and practitioners, they might cease to exist as good or bad. Being in dialogue means being aware that what is omitted can be as powerful as what is said. Regardless of the circumstances, it seems to be an accepted practice that both providers and seekers of care withhold information from each

other, “Unfortunately, both patients and physicians are challenged by complicated communications; each group withholds, distorts, obfuscates, fabricates or lies about information that is crucial to the doctor-patient relationship and to effective treatment” (Palmieri and Stern, 2009, p. 163).

For physicians, the discourse of medicine includes a long history of “benignly intended deceit” as illustrated by this advice for physicians from Hippocrates:

Perform your medical duties calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and sincerity, turning his attention away from what is being done to him; sometimes reprove sharply and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition, for many patients through this course have taken a turn for the worse (as quoted in Palmieri & Stern 2009, p.165).

Internal dialogue.

Dialogue occurs between people, and also within individuals. Sometimes information is inferred when none is intended, based on the internal dialogue of an individual. For example when a provider of healthcare fails to respond to requests for information from another provider, they may communicate disinterest or disrespect, when in actuality they may simply be too busy or disorganized to reply. Based on our past relational experiences with people and institutions, with our surroundings and the environment, we develop an internal dialogue through which we narrate our lives, whether or not we are cognizant of it. This concept can be quite useful in the practice of psychotherapy. For example, many clients engage in a habitual pattern of negative self-

talk and then choose behaviors based on the perceived veracity of the thoughts. It is usually quite surprising to them to consider the possibility that such virulent language is not describing them so much as it is creating a version of them. There are other clients who were not exposed to the discourse of emotions as representations of inner experiences during the years that language acquisition typically occurs. Psychotherapy for these clients can feel painful, and may not be useful. If they are asked about their experience of something, they are usually bewildered by the question, or only able to provide a one-word answer. It can feel to their loved ones as if they are purposely withholding something, but it is often the case that there is simply no experience to report. A former client of mine, Rod taught me about this.

Rod's story: a forced confession.

Rod sought individual therapy at the behest of his wife, with whom he was also engaged in couples counseling. He was satisfied in the marriage, but Linda wanted more connection to Rod through daily conversations. Rod found such talk to be frivolous and unnecessary, and he struggled to come up with stories about his day that would meet Linda's needs. Rod saw himself as a hard-working, loyal husband who enjoyed being active with his wife, and he wished that could have been enough for her. Our therapy focused on the use of language to create the kind of connections that Linda was seeking, and Rod learned how to turn experiences at work into amusing stories. Whether he chose to share them was his prerogative, and he retained his preference for the role of listener, reporting that he rarely communicated those stories to Linda.

When their couples' therapist felt that her work with them had plateaued, she sent Rod and Linda to a renowned couples therapist for a three-hour session, to reinvigorate

the therapeutic process. Foucault wrote, “Power is tolerable only on condition that it masks a substantial part of itself” (1978, p.86). He proposed that the way we use power often happens outside of our awareness, and that happens frequently in the practice of well-meaning psychotherapists. In this case, the expert masked his powerful role by insisting that he was *helping* Rod to identify a hidden inner experience. Rod’s collaborative couples therapist phoned me after the session, which she had also attended, to tell me that it was successful, because Rod had finally expressed his core emotions. Rod had a different experience of that session. He reported that the expert had pursued him for two hours, insisting that he was hiding emotion inside, which needed to be let out in order to heal the marriage. Rod reported feeling violated by the experience, and admitted that he had manufactured an emotion in order to bring the session to a close. He reported that after his forced emotional confession, the professionals all appeared proud and satisfied with their work. But to his dismay, nobody seemed to notice his frustration, discomfort, and withdrawal from the process. And perhaps most disempowering, he was never asked what the experience was like for him. Using Social Constructionist terms to reflect on this case, I could say that the dominant discourse of the therapy team privileged emotional expression as the only legitimate means to communicate connection, and in the process, the therapists’ and Linda’s needs over Rod’s. They attempted to create a version of Rod as they believed he should be, rather than bring curiosity to his actual experience. I will revisit this case after exploring another aspect of Social Construction.

Discourse

Closely related to language is the principle of discourse. The term is used in Social Construction to refer to the systematic practices through which people produce the

objects or events they hold as important or valuable. Discourses can highlight different aspects of events, depending on how they are constructed and utilized. For example, in 2015, the director of the health center at Bryn Mawr College used a single arbitrary measure, derived from private health information to select students she labeled overweight for a special program. She sent emails only to them, inviting them to join a weight-loss program called The Fitness Owls; she later claimed that her intention was to deliver valuable information about the health risks of obesity. Those selected students received the invitation as fat-shaming, and using social media, demanded a public apology (Iverson, 2015). Sieved through one's previous experiences, this interchange could be seen in a variety of ways: as part of a discourse of intention, where explanations for behavior were demanded, as part of a discourse of power, where private health information was used without permission, or perhaps as part of a discourse of instantaneousness, where students immediately took to social media to seek justice for the insult they had endured.

Discourses are present throughout the healthcare system, and so embedded that they are hardly noticed; yet they are powerful forces. Take for example a current dominant discourse in the United States, heavily influenced by pharmaceutical companies, in which medication is the presumed first line of defense for everyday issues. Whether people are experiencing unpleasant sensations in their legs upon trying to sleep or feeling the effects of over-eating, there is a drug to address their discomfort. They want rapid relief, and believe that healthcare providers are there to prescribe it.

Of course in order to prescribe medication, a diagnosis must be made. The dominant discourse also includes creating and legitimizing diagnoses of what some might

consider healthy responses to life stressors, in effect *creating* illness or disease out of natural processes. During a recent meeting with a physician where I shared my ideas about the natural process of grieving, which I did not see as pathological or automatically requiring treatment, she enthusiastically nodded in agreement. Paradoxically, only moments afterwards, she described a patient as still grieving the sudden loss of her father only 30 days after his death. She explained that she had prescribed a “baby dose” of antidepressant medication to help her patient with the grief process, which she had only minutes earlier agreed should be given sufficient time to unfold. Social Construction would challenge this approach, “... we could examine the ways in which our own use (perhaps as patients) of the medical profession’s discourse of diagnosis serves to simultaneously maintain the authority of the medical profession and entrap us in stigmatizing and pathologizing descriptions” (McNamee & Hosking, 2012, p. 53).

In *Foucault, Health and Medicine* (1997) Fox wrote, “Discourses create *effects of truth* which are of themselves neither true nor false” (p.35). If practitioners brought to their awareness the dominant discourses of their disciplines, or of the culture of their workplaces, they could create space for other possible discourses. Considering knowledge to be a discourse rather than fact offers an opportunity for a shift:

As confidence in the medical profession erodes, and medical authority is increasingly challenged with lawsuits and alternative approaches to health (Starr 1982:379-419), descriptions of medical knowledge and interactions as “discourse” suggest an emphasis on professional practice as a distinctly *social* and conventional production, rather than as some sort of utilitarian

dispensation of unmediated, determinate wisdom and disinterested scientific truths (Kuipers, 1989, p.100).

The discourse of the American Psychiatric Association, which publishes the widely used Diagnostic and Statistical Manual (DSM) is a good example of a social and political production. The DSM V could be viewed as a representation of the disjointed committees of people, often at war with each other over funding and power, who have created it. The circumscribed committees are considered owners of the different parts that make up the manual. They do not communicate about the illnesses each creates, resulting in large areas of overlap, which they call co-morbidity; though it may be the result of errors in their approach, this term becomes another label for the *patient*. Utilizing the DSM V, the average hospitalized psychiatric patient would receive 15 different diagnoses, which is itself a statistical impossibility, if we follow the DSM V's own rules. Perhaps even more alarming is that when employing the manual during field trials, the very people who co-created it were not able to agree on diagnosing something as typically seen as Depression. In those trials, the Cohen's kappa scores, which range from 0 for none to 1.0 for perfect inter-rater agreement, were only .28 when the creators of the manual diagnosed this illness (Workshop given by Colin M. Ross, MD, 2016). The discourses of diagnosis and power, privileging the DSM, are reinforced by insurance companies, who require its use for payment of services. Providers of mental health treatment and those who seek their services inadvertently contribute to the institutionalization of these discourses, which could be interpreted as disempowering to all of them, when they accept or utilize insurance payments. Other providers have chosen to cut ties with insurance companies,

and work only with clients who can pay cash for their services; that practice creates its own discourse of money and power.

Another closely related discourse is that of shame. Though it has eased in recent generations, there remains a discourse of shame around mental illness and treatment. In particular, for both medicine and psychotherapy, there is a strong component of blame and shame in the discourse of addiction. I was able to learn about the powerful impact it has from another client, Melody.

Melody's story.

Melody had sought treatment to help deal with frustration, anger and sadness around her adult daughter Sequoia, who had lost custody of her three children due to substance abuse. Sequoia was considered the “black sheep” in the family, ostracized by her brother and father, and barely on speaking terms with my client. While I found myself disgusted by some of the stories Melody reported of her daughter's neglectful parenting, I was also aware that my client's constant criticism of Sequoia was not producing positive results for anyone in the family. Around the time that Sequoia and her ex-husband were headed to court over yet another conflict involving visitation, I happened to be reading the book *Rebirth of the Clinic* (Patton, 2010) for this dissertation. Chapter four described the Australian approach to the treatment of opiate addiction, methadone use; one paragraph in particular caught my attention:

Waldby argues that a reliance upon the medical model of treatment and care tends to negatively impact pregnant female clients (and by implication their children) by conceptualizing the fetus as the primary medical client and the drug-using mother at best as an incubator and at

worst an obstacle to the well-being of the fetus....Wherever the mother's interests and needs are seen as antithetical to those of her child and relegated to second place, her incentive to cooperate with services in the care of her child is diminished (Patton, 2010, p.72).

While reading this I thought about Sequoia, whom Melody seemed to see only as the neglectful mother of her grandchildren. Yet Sequoia had herself experienced childhood sexual trauma. I wondered if she had felt unworthy of care, and deserving of contempt once she had become pregnant. I expanded my notion of collaboration to include parents and their adult children, who, even if they had different ideas about how to get there, would most likely share a wish for future generations to be happy and healthy. I began to conceptualize a collaborative team that could include myself and my client Melody, her husband and her daughter and son, working together in opposition to the problem, instead of in opposition to each other.

I shared what I'd read with Melody, who was stunned and deeply moved. She began to shift away from anger, and towards collaboration with her daughter. She finally apologized for failing to protect Sequoia when she was a child, which she had longed to do for 20 years, but had not known how. This led to a thaw in their standoff, and my client's growing awareness of the things her daughter did well. Though skeptical at first, Sequoia tearfully accepted the apology and began to assume more responsibility for her own three children. Months later, Melody reported that Sequoia and her ex-husband were sharing custody of the children, and working together more successfully as co-parents.

Questioning Objectivity

Within the institution of science, techniques for research were developed based on the premise that objectivity is an attainable requirement for membership. The discipline of medicine in turn has a long history of seeking legitimacy through membership in the institution of science. Social Constructionists see a paradox here; human beings, who have values, experiences, biases and needs, carry out what we call scientific research. Because Social Construction suggests that we are shaped by the relational experiences we have throughout our lives, starting with caregivers and our surroundings, it is not possible to extricate ourselves from them. Therefore, objectivity in scientific research is not attainable. Our experiences help form the subjective lens through which we navigate the world; that subjectivity forms the beliefs we have agreed to refer to as prejudices or biases. Our biases have fluidity and can change or evolve over time; the preference in Social Construction is to bring awareness to them rather than to deny their existence. Within the institution of psychotherapy, there is agreement that objectivity is neither possible nor desirable. We are all part of multiple communities of meaning and we carry them with us, and bring them into the relational processes that comprise psychotherapy. It is incumbent on the therapist to be mindful of the many interactions that can impede meaning making and the process of change in her work with clients.

Power

Foucault's contributions to Social Construction are immense and varied. In Chapter One I referred to the disciplines of psychotherapy, primary care medicine and complementary and alternative medicine without defining the word discipline itself. In different books, Foucault (1975, 1982) explored the ways that power resides both within individuals and institutions, coming into existence when it is put into action. He wrote:

“‘Discipline’ may be identified neither with an institution nor with an apparatus; it is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a ‘physics’ or an ‘anatomy’ of power, a technology (1975, p. 215).

Though he was referring to prisons and other bureaucracies in this case, I believe that these words can also be applied to the different modalities of healthcare (which are, in their own right, bureaucracies), which are also referred to as disciplines. The healthcare professions were historically developed with a price for admission including the relinquishing of a degree of power by each individual, the imposition of social control by a handful, and a set of hierarchical relations amongst them. In these systems, power is omnipresent, and human beings are both the agents and products of it. Practitioners of these modalities co-create social norms and rules for acceptable behavior. These rules serve to solidify power differentials between members; once there are prescriptions for how people or things *should* be, judgments and consequences follow. In the process, innovation is often stifled or snuffed out altogether. Chapter Three describes what has historically happened when healthcare innovators have questioned the status quo within their disciplines. As described in Chapter One, disciplines also construct and reinforce beliefs amongst their members about their place in the hierarchy of multiple healthcare disciplines. Qualitative studies of communication in hospital settings have described communication between physicians and nurses as “fraught with tension, impacted by latent or manifest relations of power...” (Conn, Lingard, Reeves, Miller, Russel & Zwarenstein, 2009, p. 943). Additionally, because modern society has agreed that those

who wish to become providers of healthcare must pass requirements for licensure, these bureaucracies must interface with the governing bodies that oversee that process, and also police the bureaucracies themselves. Relational processes accompany all of the interactions that take place under these practices, and power differentials are inherent throughout. And all of this takes place before a patient seeks the services of a healthcare provider. Once patients enter the arena, the imbalance of power becomes more evident. Patients who are overwhelmed or terrified by the possible implications of symptoms seek help from practitioners who have information about them. In her foreword to Atkins' book *My Imaginary Illness, A Journey into Uncertainty and Prejudice in Medical Diagnosis*, physician and educator Bonnie Blair O'Connor wrote, "Many of us have also felt frightened, ignored, belittled, accused, dismissed, or deeply and painfully humiliated by healthcare professionals on whose knowledge, skills and mercy we have depended when we were sick" (O'Connor & Atkins, 2010, p.xii). But the relational processes that emerge between giver and receiver of treatment are fraught with possibilities for exploitation, disappointment, shame, blame, anger and resentment on *both* sides. Patients have only partial empowerment to locate care that is ethical, timely or effective for them; the skills of even the most highly recommended clinician are still subject to human limitations. On the other side, practitioners who are charged with locating and curing the internal source of patient symptoms presumably care deeply about their patients, carry a heavy sense of responsibility for their care, and perhaps just put out of reach the thought that they could be blamed or sued for any mistakes that they make along the way. The American Board of Internal Medicine commissioned a survey in which three out of four physicians reported a belief that their peers order unnecessary tests on a regular basis, in

order to satisfy their patients' requests, even when they don't believe the tests are warranted. One physician, a hospital vice president summed it up this way, "I think we're afraid of not being liked. We want to be the hero to the patient" (American Board of Internal Medicine, 2015.) Charon writes of the relational possibilities for physicians and patients around these shared experiences, "What power would devolve on our medical care if these two could take stock of one another's emotions and engage fully in their joint suffering" (2006, p.33). It is interesting to consider the role of power in defining the term medicine itself:

When professional prestige among medical practitioners in settings such as American teaching hospitals is measured by the most competent use of advanced often 'experimental' biotechnologies, when an esteemed Korean professor of medicine proudly documents his competence in terms of the three hundred patients he sees per day, when a young Peruvian physician has limited antibiotics and scarce resources and thus limits his two hundred patients per day to mention but one symptom, when a British trained Kenyan oncologist knows how to treat and cure most children on his Nairobi hospital pediatric oncology ward...but does not have the financial or institutional wherewithal to access the necessary chemotherapies, the brute facts of local practice and political economies defy any reified analysis of "biomedicine"(Good, 1995, p.461).

One might also consider the power differential between the patient and his illness.

In her chapter, “*Governing the Risky Self*,” Nettleton (1997) wrote that the increased use of the construct ‘risk’ in healthcare jargon serves as an attempt to gain control over disease and death, in the process confirming our faith in the power of medical science to provide cures which may not be forthcoming. Yet that same belief provides a sense of hope in the terrifying terrain of serious illness, which has also been linked to increased resiliency (Martz and Livneh, 2007). Foucault’s comparison of patient treatment in both the hospital and the clinic settings illustrates the role of power in disease:

In the hospital, the patient is the *subject* of his disease, that is he is a *case*; in the clinic, where one is dealing only with *examples*, the patient is the accident of his disease, the transitory object that it happens to have seized upon (1963, p.59).

Another relational process vulnerable to power differentials occurs after treatment recommendations are made, when the patient’s “health behaviors” come under scrutiny. Compliance is a common term used among healthcare professionals to describe the degree to which patients’ behaviors mirror their expectations. Ironically, it is not uncommon for providers to fail to live up to those very expectations in their own lives, particularly around dietary, exercise or relational habits. This sets up a clear position of power on the part of the provider, placing blame on the patient for “non-compliant” behaviors. Using the lens of Social Construction, right and wrong with regards to health behaviors do not exist independently as facts, but are instead created through these constructions of power. With a more equilateral approach, a provider of healthcare might instead seek to understand what gets in the way of a patient’s ability to follow treatment recommendations. And if suggestions are still not followed after such a conversation,

another about the value or legitimacy of the recommendations themselves could take place. The patient's behavior would be more indicative of the *relationship* between her and the provider than of some negative quality called non-compliance residing in her. Likewise, if providers saw themselves as neither superior nor inferior to practitioners of other modalities of care, they would most likely be more open to having collaborative conversations with them.

Pulling together these ideas, in the field of psychotherapy there is a taken-for-granted belief about a relational reality labeled resistance. Resistance is accepted as an observable characteristic, residing in the client, un-related to the therapist, which acts as a barrier to psychotherapy's effectiveness. (Not surprisingly, therapists believe that clients should not be resistant.) In a study that reviewed the literature on resistance, the authors created a new term, reactance which constructs a more negative view of the client:

Common to various theoretical definitions is an assumption that resistance is both a dispositional trait and an in-therapy state of oppositional, angry, irritable, and suspicious behaviors. Reactance is a special class of resistance that is manifest in oppositional and uncooperative behavior (Beutler, Moleiro & Talebi, 2002, p.207).

Out of that construct have come articles, books and workshops on how therapists might 'break through' client resistance in treatment. For example, the American Psychological Association recently sponsored a continuing education course by Clifton Mitchell, Ph.D. titled "*You Can't Make Me---Effective Techniques for Managing Highly Resistant Clients*" (retrieved from <http://www.continuinedcourses.net/active/courses/course036>,

2015). Workshops like these serve to ratify the legitimacy of this discourse, which was originally taught in professional schools to psychotherapists.

Rather than accepting resistance or reactance as an internal trait of a client, Social Construction would invite psychotherapists to consider the possibility that what we are labeling might not be located within the client, but instead in the relational *processes* of the therapy. If we consider what we are experiencing in this way, we can have very different conversations with our clients. The old view, with the therapist in the privileged position of power, holds the client as being a difficult person who is behaving badly. In this paradigm, a therapist might say to a client “ You continue to date your boyfriend when we’ve discussed how unhealthy it is for you. I can’t help you if you won’t help yourself.” This type of comment is likely to be experienced as scolding, which would most likely threaten the therapeutic alliance. If the *relational processes* were understood to be the source of the impasse, the therapist might say, “When I think about your being treated the way you’re describing by your boyfriend, I notice a tightening in my chest. I feel myself wanting to protect you, because I think you deserve to feel safe and respected.” By sharing an honest experience instead of blaming the patient, the power is shared; the therapist affords the client the opportunity to become the expert in her own life’s choices. And through this process, both can have a transformative experience

Knowledge

Intrinsically related to power is knowledge. Social Construction challenges the taken-for-granted belief that knowledge refers to the discovery of essential, observable facts. It proposes instead that people construct and deconstruct what counts as knowledge over time, as history and culture impress their influences. What counts as knowledge is

taught, practiced, reinforced, and organized at local and global levels, and healthcare professionals who dare to challenge accepted knowledge within their communities often face harsh penalties. In writing about the ubiquitous and unavoidable feature of power, Pasewark wrote, “In such impressive disguise, knowledge’s power is nearly absolute. If one resists knowledge, one is accused of resisting not power but truth” (as quoted in Cilliers, 2013, p.3).

Knowledge creation in medicine.

Foucault (1963) wrote about the history of Western medicine in *The Birth of the Clinic*, exposing the changing nature of what has counted as medical knowledge over centuries, and the hidden power structures behind it. He proposed the idea that medical knowledge is created locally by individuals and institutions, making it historical and cultural rather than factual. He suggested that over time a shift occurred whereby medical knowledge was no longer obtained by mathematical measurement as it had been, but instead by the opinion of the physician, which he labeled The Gaze; this translates roughly to a perception and a way of seeing. He wrote about its nature, which involves the patient as object, and the physician’s prior experiences:

It is directed upon that which is visible in the disease---but on the basis of the patient, who hides this visible element even as he shows it; consequently, in order to know, he must recognize, while already being in possession of the knowledge that will lend support to his recognition. And, as it moves forward, this gaze is really retreating, since it reaches the truth of the disease only by allowing it to win the struggle and to fulfill, in all its phenomena, its true nature (1975 p. 9).

In healthcare, The Gaze is the process through which disease and illness come into existence through a purported discovery on the part of the physician, privileging himself by creating a hierarchy rather than a partnership between physician and patient.

Currently, I believe that knowledge in medicine is constructed through an endless feedback loop between the patient, the healthcare provider and affiliated institutions, from medical training programs to pharmaceutical companies. Brown wrote:

The social construction of medical knowledge ... deals with ways of knowing that are based on the dominant biomedical framework, contemporary moral and ethical views, the socialization of medical providers...the professional and institutional practices of the healthcare system and the larger social structures of the society (1995, p.37).

Rita Charon is a physician and literary scholar who teaches medical students at Columbia University, and has written about the importance of listening to patients' narratives of their illnesses. Yet in teaching this skill to her students, she has written about the necessity of hiding certain aspects of relational being in the medical discourse, "The death knell of any innovation in medicine or medical education is for it to be labeled "touchy-feely" or "soft" (2006, p.156). To avoid this, she created a teaching tool called the Parallel Chart, which requires her students to write their reflections on their experiences treating patients, and then read aloud from them each week in groups. Though this tool provides the same elements of emotional exploration and connection as a support group, she notes that were it called that, it would signal weakness to students (and perhaps faculty), and therefore not be valued by either group. Though Charon extolls the virtues of psychotherapy and collaboration across disciplines, by disguising

the relational and supportive aspect of what the students are doing with Parallel Charts, I believe as a professor she is reinforcing the established discourse of hierarchy for both medicine and psychology in her influential role.

The discipline of psychiatry has historically created knowledge that it has later disavowed, over a relatively short period of time. For example, homosexuality was once considered a treatable mental illness, as was Asperger's; both have now been eliminated as diagnoses (American Psychiatric Association, 2013). Because psychotherapists must utilize the knowledge of psychiatry in order to diagnose those who seek their services, those changes impact this discipline as well. And still, most healthcare professions remain predicated on the belief that knowledge about disease and illness exists, waiting to be discovered by objective researchers and practitioners. Social Construction suggests instead that if practitioners were free to consider that what *looks* like disease could also be something else, whilst recognizing that their previous experiences influence their beliefs, they may better serve those who seek their care. Utilizing this lens might result in welcoming or even seeking the opinion of someone with another vantage point. This kind of discourse forms the foundation for the co-creation of knowledge across disciplines. If healthcare professionals believed that each discipline could offer *an* answer rather than *the* answer to treatment, the options for patients would be automatically expanded. Wittgenstein suggested a simple yet profound orientation towards the acquisition of knowledge, which has guided my work, "Suppose it were forbidden to say 'I know' and only allowed to say 'I believe I know?'" (1968, p.47e).

Knowledge creation in complementary and alternative medicine.

The social construction of knowledge in Complementary and Alternative Medicine (CAM) begins with a privilege for ancient traditions of healing. Ayurvedic medicine, originating in India, and Chinese medicine are the two oldest known medical systems, and their longevity is often cited as proof of effectiveness. Unlike traditional medicine or psychotherapy, here the first priority is not diagnosis, but symptom reduction. The focus is on the whole person, rather than their respective parts, and also on the relationship between the patient and the practitioner. Indeed it has been stated that “successful healing transforms the practitioner as well as the patient” (Goldstein, 1989, p.853). Social Construction suggests that *all* interactions can transform both the patient and the practitioner. The focus in CAM on *positive* outcomes leaves us with questions; who determines whether the outcome is positive or negative? What constitutes a positive outcome? What does it mean for both practitioner and patient if the outcome is not positive? CAM adds the construct of patient responsibility for good health. Coward (1989) points out the moral underpinnings inherent in use of this language. If to be well means achieving harmony within yourself and in your relationships, does a sick or weak body indicate that you have failed in some way? Coward believes that the CAM approach doesn’t allow for the possibility of random or unexplained illness, instead blaming the patient. She suggested that illness and goodness need not be mutually exclusive, “Virtue is still an issue connected with disease ... but the virtue is in the ability of the individual to fight it off” (1989 p.42).

Sontag (1977) wrote about the assignation of blame to patients battling cancer in the dominant discourse of CAM, “Cancer is commonly viewed as being caused by the

repression of emotion, afflicting those who are sexually repressed, inhibited, unspontaneous, incapable of expressing anger” (1977 p.21).

These beliefs have gained a foothold with many ‘enlightened’ people. The writer Marjorie Williams experienced the effects of the CAM discourse after her cancer diagnosis:

....That was a deeper anger than the irritation I felt at the people---some of them important figures in my life---who had memorably inappropriate reactions. I can’t count the times I’ve been asked what psychological affliction made me invite this cancer My favorite New Yorker cartoon, now taped above my desk, shows two ducks talking in a pond. One of them is telling the other: ‘Maybe you should ask yourself why you’re inviting all this duck hunting into your life right now’”(2005, p. 335).

My CAM colleagues say that because their disciplines have historically been ostracized by providers of medicine, they are frequently socialized to refrain from expressing what counts as knowledge in the company of providers practicing more traditional modalities. This can form a barrier to collaborative dialogue.

Knowledge creation in psychotherapy.

Knowledge in the field of psychotherapy is also constructed through interactions that are politically, socially, economically and technologically based. The different theoretical schools of thought that produce each type of clinician (Social Work,

Psychology, Counseling, Marriage & Family and Pastoral) have their own histories and rules for admission. Perhaps as a backlash to the power of pharmaceutical companies, in the last decade there has been growing momentum to shift the focus away from *symptoms as a means of diagnosing* mental illness, which artificially groups people together who may benefit from vastly different treatments. Instead, clinicians and now some in positions of power are placing more emphasis on bringing curiosity to contributing factors, such as childhood sexual abuse and addiction. In 2013, during a surprising break with the discourse of the psychiatric community, Dr. Tom Insel, the U.S. Director of the National Institute of Mental Health publicly denounced the psychiatric community for its failure to make significant strides in the diagnosis and treatment of mental illness in the last half-century. He created the Research Domain Criteria Project (RDoC) to revolutionize the ways that psychiatric disorders are understood, and end the overreliance on pharmaceutical drugs as the *de rigeur* treatment for mental illness (Casey, Craddock, Cuthbert, Hyman, Lee, & Ressler, 2013).

Acceptance is growing in the field for adoption of the language of traumatology, a term that was co-opted from the field of surgery, where it indicated the surgical repair of physical injury. Within the discipline of psychotherapy, it refers to the treatment of those who have experienced emotionally life-altering, negative events. My colleagues and I have long believed there is a connection between childhood trauma and the eventual diagnosis of personality disorder, which only serves to further marginalize patients. However if we adopt the language of Traumatology to describe this accepted phenomenon, we can then utilize technological advances to add legitimacy to our experiences in the field, by assigning meaning to brain scan images. This knowledge

serves the psychotherapist, as it grants admission to the medical discourse, which is far more powerful than that of psychology. And although nothing may have changed with regard to actual treatment options for these clients, there is an implicit suggestion that without having the images, psychotherapy cannot be effective, “The development of effective treatments is limited by gaps in knowledge about the underlying neurobiological mechanisms that mediate symptoms of trauma-related disorders like PTSD” (Bremner, 2006). Most psychotherapists would take offense to that statement; we don’t need to see the neural pathways of the brain in order to know how to respond to someone who is suffering from trauma-related disorders. It is ironic to consider that the very technology we psychotherapists have privileged in order to gain legitimacy in the eyes of the medical community has actually extended the hierarchy between us.

There is another viewpoint about knowledge in psychotherapy that does not require costly tests, or assigning of meaning. Instead, focus is on collaboration with the client to co-create knowledge about what brought them to treatment, and what could be helpful. Anderson has written extensively about this approach, called collaborative therapy, which does not require the abandonment of previous knowledge, but rather a willingness on the part of the therapist to *not* be the expert. It privileges heuristics and local knowledge (including language, customs, wisdom and values of a person, family and community) in addition to what a therapist might bring from her training or experience (2012). Regardless of the discipline we are trained in, or the silos between them, there are factors worth noting when we consider knowledge creation.

All psychotherapists, including mental health counselors, social workers, psychologists and marriage and family therapists are trained to consider the

psychological and social aspects of illness. Social Construction has historically been critical not only of the questions psychology has asked about human behavior, but also the methods it has adopted to investigate them, and the answers it has traditionally provided (Burr, 2003). Social Construction takes exception to the most basic assumption of traditional psychoanalysis, that each individual has a self that exists apart from others, and can be objectively and scientifically studied. It suggests that individual pathology cannot exist irrespective of an individual's family, community, economic situation, and cultural and historical contexts. Further, regarding psychotherapy, the traditional view of the individual seeking help puts the therapist in the role of expert who claims to have moral and political neutrality, which as discussed, is not reasonable. As previously discussed, the therapist too is connected to and a product of her own family and community relationships, and the economic, cultural and historical contexts in which she lives. And the arbitrary process of diagnosis in mental health treatment is fraught with the dangers of oppression, hierarchy, and judgment. All of this has led to some conflict between the two fields:

There is therefore something of a tension in the field around the extent to which social constructionist theory and research is able to generate its own theoretical and research programmes, as opposed to maintaining guerilla warfare upon mainstream psychology from the margins of the discipline (Burr, 2003, p.20).

Social Construction suggests that psychotherapy does not exist as an entity; it gains significance because of the relational processes between client and therapist that it enables. This viewpoint is now widely accepted among the psychotherapists with whom I

engage in dialogue. It expands the possibilities for what therapy can be, but it does not offer tactics or techniques to accomplish such a relationship. As a psychotherapist, I don't believe our profession needs to be at odds with Social Construction. Social Construction encourages us to consider the importance of relationships in every aspect of our lives; I cannot imagine any psychotherapist taking issue with that idea. By allowing for multiple viewpoints or truths, Social Construction frees us to appreciate differences, and to bring curiosity instead of judgment or fear to unfamiliar ideas; psychotherapy shares this value. Conversely, I do not think the concept of a self needs to be eradicated from Social Construction.

Therefore we can have a self-concept that arises out of interactions and relationships with others, and that is additionally constructed through self-reflection and internal dialogue. Instead of a right-wrong paradigm, Social Construction suggests one that recognizes and appreciates the value of divergent ways of thinking; therefore we need not choose between psychotherapy and Social Construction.

Pharmaceutical companies and knowledge creation.

Big Pharma is the derisive nickname given to the American pharmaceutical industry, indicating the significance of its powerful role in healthcare. The ability of the industry to create influential knowledge that serves itself has been facilitated by the explosion of television advertising; it has been estimated that companies spend more than twice as much annually on advertising to consumers as they do on research, more than \$3 billion in 2012 (Barker, 2011). Overall marketing expenditures in the U.S., estimated to range between \$27 billion and \$57 billion annually, are also aimed at influencing prescribing physicians (Ashton & Wray, 2013). The authors observed:

Physicians have long wanted to believe that their interactions with the pharmaceutical companies do not sway their prescribing behaviors....But over the past 15 years, research has proven otherwise. Drug company gifts and personal interactions with physicians do indeed increase the likelihood that the physician will write more prescriptions for the agent(s) being promoted (2013, p.38).

This creation of medicines to treat symptoms of illness has led to a phenomenon known as medicalization, whereby typical human experiences come to be known in medical terms as legitimized problems needing solutions. This appears to be a welcome practice for consumers, as Barker observed, “it is increasingly patients rather than physicians who are eager to classify their ‘physical distress’ and ‘uncomfortable body states’ as diseases” (2011, p.834). It would be interesting and perhaps possible to study the impact of marketing on medicalization, as the U.S. is one of only two countries (along with New Zealand) that allow direct-to-consumer advertising. There are other relational processes involving the pharmaceutical industry that influence the creation of illnesses and their treatments.

In the U.S., the Food and Drug Administration (FDA) is responsible for regulating pharmaceutical products and medical devices. Ashton and Wray wrote about the potential conflicts of interest inherent in this arrangement, “The (FDA) agency works under congressional oversight in the center of a nexus of patients, providers, industry, payers and other governmental agencies concerned with health care. These constituencies sometimes have very different priorities” (2013, p.28). The pharmaceutical industry spends more money than any other industry on lobbying to members of Congress in the

U.S. (Barker, 2011). Therefore it is reasonable to assume in the United States that pharmaceutical companies are key players in the discourse of disease and treatment, including the policy-makers who are responsible for regulating them.

The Body

On the one hand, a person has a body; on the other, depending on prevailing discourses, she *is* a body. As a psychotherapist, I understand that the body is material and the mind is a concept, and I subscribe to a discourse that views them as the co-authors of people's narratives of illness and health. A common discourse among psychotherapists who treat survivors of childhood sexual abuse suggests that the body provides information that can sometimes seem mysterious, as if it "holds" memories and thoughts—perhaps wisdom--that the "mind" may not be ready or able to confront. For example a woman with whom I had begun unpacking some traumatic childhood experiences reported to me that she had suddenly found it impossible to brush her back molars without setting off a gag reflex. This had never happened before in her life, and she was puzzled by its sudden onset. As we continued working within the safety and structure of the therapeutic relationship, the gag reflex disappeared. Upon reflection, my client reported a sense that her gagging was related to the fear she had experienced in revisiting such painful events, which dissipated as she experienced a sense of acceptance and support in our relational processes.

As discussed, Foucault proposed that in medicine, the body is constructed through the discourses and practices of the physician, thus creating a power differential with the patient (1963). More recently, Charon has suggested that physicians should consider the body a *proxy* for the self, and treat it with the utmost respect and dignity

(2006). Regardless of the approach, Social Construction suggests that practitioners of healthcare *examine* the discourses that inform their practice of constructing the bodies of those who seek their services, and this idea resonates strongly with me. My clients have taught me the importance of inviting into our work the information that our separate bodies offer as we talk. As a result, if my heart begins to race, or my breath becomes shallow during a conversation, I will bring this information to the dialogue, just as I inquire about any physical reactions that I notice in my clients during sessions.

Reflexivity

This very inquiry, which is based on the observations I made of what has happened historically when I have tried to collaborate across disciplines, could be considered a reflexive practice. Reflexivity involves recognizing a dilemma, observing one's reaction to it, and being willing to form and test hypotheses about that. Reflexive practice requires mindfulness, openness and a willingness to take risks; in Chapter One I discussed the risks and rewards of engaging in reflexive dialogue with colleagues through supervision groups. Schön has written about the importance of using reflexivity to attend to moments of strong emotional affect that emerge from certain relational interactions, as they can provide a wealth of information, and a roadmap to change (1983). Mezirow has suggested that transformations in learning come from our willingness to recognize the distortions we have about events and interactions, and to critique the very presuppositions on which our beliefs have been constructed (1990). As unsettling as it can be, Social Construction suggests that bringing reflexivity to one's practices opens the door to possibilities for improved outcomes, across relational processes both personal and professional. For example, if I thought reflexively about having bristled when my

husband asked me if I was wearing a new dress, I might recognize that I was feeling ashamed of my already burgeoning closet. That would create a space for me to explore my shopping habits, and to apologize to my husband for my tone. If I thought reflexively about my impatience with a client who had demonstrated difficulty accepting the bounds of our therapeutic relationship, I would try to identify what about that was frustrating to me. In the process I would also seek to understand how he experienced whatever it was we were examining in session. Then when we discussed his repeated attempts to persuade me to set aside boundaries that I felt were needed, I could bring curiosity instead of annoyance to his requests, opening a space for deeper connection between us.

Radical reflexivity.

Cunliffe suggests that ethical researchers must engage in critical examination of the ways that they themselves construct meaning, and make knowledge claims from the research they conduct. She includes the following elements in the construct she calls radical reflexivity,

- *Questioning our intellectual suppositions.
- * Recognizing research is a symmetrical and reflexive narrative, a number of participant stories which interconnect in some way.
- * Examining and exploring researcher/participant relationships and their impact on knowledge.
- * Acknowledging the constitutive nature of our research conversations.
- * Constructing ‘emerging practical theories’ rather than objective truths.

*Exposing the situated nature of accounts through narrative circularity.

*Focusing on life and research as a process of becoming rather than already established truth”(2003, p. 991).

These ideas resonated strongly with me, as I inhabited the dual roles of researcher and participant for this inquiry. Social Construction suggests that it is not enough to simply acknowledge the impossibility of objectivity in research; researchers have an ethical obligation to examine and bring to light the ways that *they* make sense of their research experiences.

Contemporary Social Construction

Brown suggests that there are three versions of Social Construction that could apply to medical sociology (1995, p. 35). The first and most rigid, which was developed in response to positivism, places no relevance on the existence of a medical condition. The second uses the deconstruction of language to show the changeable “realities” that make up what we consider to be knowledge in healthcare. The third adds the element of the researchers themselves, focusing not only on what they construct in the lab, but also on how they might personally and professionally benefit from their discoveries.

A more contemporary version of Social Construction suggests a “synthesis of symbolic interactionism and structuralist/political-economic approaches” (Brown, 1995 p.36). Simply put, this version proposes that we do not need to discard biomedicine altogether, but can hold it as important whilst also considering people’s individual experiences of their illness and the social, political and economic forces that surround it. This view allows us to consider the patient, their family, social stratification, treating

professionals, pharmaceutical companies, media, governments and institutions, as we ask questions about how a particular medical condition comes into existence. This account of Social Construction does not require us to believe that nothing exists as a fact; instead it focuses on the ways that we construct what we believe exists.

Complementarity

John-Steiner writes about the possibilities that emerge when scientists from different disciplines expand their reach by coming together and creating something bigger than the sum of its parts, which she calls complementarity. She cites as an example the interrelatedness of brain function and social relationships, “On the one hand, neurochemical action in the brain ...cannot be explained through social analysis; on the other hand, social interactive processes of symbol development ...cannot be explained through neurophysiology” (2000, p. 56). As healthcare providers, we can step in and out of professional discourses in order to collaborate with each other, and with our patients; they need not be considered oppositional, or mutually exclusive.

This chapter has illustrated the value that Social Constructionist principles bring to the construct of collaboration across disciplines in healthcare. To aid in planning this inquiry, I turned to the literature to learn from other practitioners who had similar interests, in the hopes that their experiences could inform my approach.

Chapter Three: Learning from Others (Review of Literature)

My experiences with the hierarchical system between physicians and other healthcare professionals were validated during the literature review of more than 150 articles, as the entrenched pattern was frequently mentioned among barriers to

collaboration across disciplines. But the value of a literature review is not merely in offering selected articles to shore up preconceived ideas. Reading scientific literature provides an opportunity to interpret the narratives of others who have had shared interests. In so doing, I felt connected to other practitioners across the boundaries of time and space, by learning what they considered to be problems, and how they decided what counted as knowledge in their particular healthcare milieus. As a result I felt less circumscribed, and saw myself as a link in the chain of past and future providers of healthcare, all with a common goal of alleviating suffering through collaborative practice. My exploration of literature also revealed a dearth of literature about collaboration across disciplines in private practice, revealing what I believe to be a gap in the research.

Identifying a Gap in the Research

Missing in the research literature was information about how collaboration might be facilitated across the disciplines of primary care, psychotherapy and complementary and alternative medicine in private practice settings, which is surprising considering its relevance. In Chapter One I discussed the significance of primary care medicine to mental health in the U.S. as the main source of psychotropic medication prescriptions, despite the fact that many primary care prescribers lack mental health training (Smith, 2012). With the passage of the Affordable Care Act in the U.S. in 2010, it is estimated that an additional 32 million people will seek care from primary care practices. There are similar reasons to consider the impact of complementary and alternative medicine (CAM) on primary care and mental health treatment. A study surveying the use of CAM in 15 countries reported that its use was substantial, (Harris, Cooper, Relton, & Thomas, 2012) and results from the U.S. National Health Interview Survey indicated that adults spent

more than \$33 billion on CAM expenses in 2007 (Nahin, Barnes, Stussman, & Bloom, 2009). Collaboration between providers of these modalities could enhance the quality of care they provide even on non-shared cases; as discussed earlier, understanding what counts as knowledge outside of one's own field of expertise provides a greater depth of information from which to draw treatment options.

Because I did not locate literature specific to collaborative practices between the three disciplines and setting chosen for this inquiry, I sought to learn how others have managed to collaborate in ways that I believed could have significance for what my colleagues and I were trying to do. With few exceptions, I selected research published in scholarly journals that was conducted by practicing healthcare professionals as opposed to academicians or researchers. As a clinician, I privilege ideas that can be translated to practice. I begin by introducing three early practitioners whose ideas, bold at the time and strikingly similar to those outlined in this inquiry, were initially rejected by their disciplines. I see them as forgotten pioneers, and respectfully share their wisdom with appreciation for the risks they took to improve the lives of those who sought their services.

Pioneers

T.S. Eliot wrote, "The historical sense involves a perception, not only of the pastness of the past, but of its presence" (1921). When I began this project, I felt isolated in my ideas about knowledge creation and collaboration across disciplines in healthcare, and anxious about sharing them with my new colleagues; however in reviewing the literature, I discovered that challenging the status quo at the risk of professional

alienation was hardly a new phenomenon. In 1896, the English physician Sir Clifford Allbutt, who invented the clinical thermometer, wrote an essay called *System of Medicine*. In it he included criticism about the prevailing use of language in medical philosophy, that held diagnoses to be truths. As a result his peers roundly attacked him and he defended himself as follows in a letter to the editors of a prominent journal:

Dr. S.W. MacIlwaine ... objects to my definition of a disease as 'a certain assemblage and succession of symptoms, normal and abnormal, recurring with fair uniformity,' because it does not include the causes of disease. It does not because it did not pretend and, I venture to think, ought not to pretend to do so. Your own note upon Dr. MacIlwaine's letter is conclusive-viz., that in this case a disease is not a disease until its causes are known. Thus, to use one of Dr. MacIlwaine's own instances, typhoid fever was not a disease until Eberth discovered its bacillus, and scarlet fever is not a disease even yet (Allbutt, 1912, p.1017).

Years later a young British epidemiologist, F.G. Crookshank read and was greatly influenced by the essay, and noted that, in medical school he had not been taught the difference between words, thoughts and things. He wrote about the fallacy of confusing the three:

...but it is a vulgar medical error to speak, write and ultimately to think, as if these diseases we name, these general references we symbolize, were single things with external existences. It is not to be thought that any educated medical man really believes a 'disease' to be a material thing,

although the phraseology in its current use lends colour to such supposition (Ogden, Richards, Malinowski, & Crookshank, 1938, p.342).

Crookshank wrote of the harsh punishments meted out to physicians in his era who dared to question the taken-for-granted beliefs about diseases being morbid entities,

They have been condemned as traffickers, not in the ‘concrete facts’ and indifferent reasoning proper to Medicine of the Twentieth Century, but in wordy nugae and in something contemptuously called Metaphysics. For only ‘mad doctors’ may in these scientific times dabble in Philosophy without loss of their reputation as practitioners” (p. 339).

Around the time of Allbutt and Crookshank, another maverick physician issued his own challenge, which also has relevancy to this current inquiry. A Boston physician named Richard Cabot wrote *Social Service and the Art of Healing* for the stated purpose of “ennobling” medicine, by challenging the existing hierarchy between physicians and social workers. He believed that teamwork between doctors and social workers was the key to providing effective medical care, and lamented their separation:

...division of labor is never an unmixed blessing and may easily become a curse unless energy and intelligence are devoted to the ways and means of attaining a close cooperation and interchange of ideas, methods and plans among the divided laborers. There is a distinction and an important one between the troubles of mind, of body, and of estate; but there is also a unity among them (Cabot, 1909, p.93).

After his death, Cabot was remembered this way by a renowned cardiologist:

In every generation there are restless souls who cannot be made to fit the common mold. A few of these are valuable in keeping their communities and professions in a ferment by their constant challenge to the existing order of man's thought and action ...(White, 1939).

In 1948, prominent hospital administrator Dr. Martin Cherkasky also recognized the value of collaboration across disciplines when he sent teams of physicians, nurses and social workers into the community in New York City to provide home care services, as part of a hospital outreach program dedicated to improving care and decreasing costs.

Tom Andersen was a beloved professor of Social Psychiatry in Norway whose willingness to question the taken-for-granted ways of doing psychotherapy led to important changes for the profession. Rather than viewing the psychotherapist as the expert who would use techniques on his patient, he saw the patient as the best resource for change, and believed that the therapist should strive to be *with* his client. Using Social Constructionist principles, he constructed a discourse of psychotherapy as a living system, where each member of the system (i.e. the therapist and client) shared his or her own version of reality, and sought to understand those of the other members, by demonstrating an open curiosity to their experiences. Within this discourse, the therapist does not use his own time-table to *impose* change on the client, but rather he recognizes that change will *emerge* from relational processes that are based in mutual respect. Dr. Andersen wrote:

Every living system is organized as an autonomous system, and only the system itself knows how and when it is ready to change its structure, or when it is ready to disintegrate and cease to exist. One part, whether a

group or a person, must bear in mind that the other part can only participate through one of the modes of relating that is already available in its repertory. If the relationship between the parts is “safe” enough, nonintrusive enough, interesting enough, the mutual exchanges that carry new ideas may trigger new modes of relating (1987, p.415).

For me, Andersen’s most influential contribution to my profession came out of his Reflecting Team model. The idea for this model evolved organically as Dr. Andersen was working with his team to mentor a student in family therapy. He had been considering ways to involve the families more directly when professionals were discussing them. At that time, a common method used in training of family therapists included the use of one-way mirrors. A student would interview a family about the problems that led them to seek therapy on one side, whilst a team of experienced professors watched and listened on the other. The team would discuss the process as it unfolded, and then periodically summon the student (away from the room with the family) to offer feedback. The family and the student were unable to see and hear the team. On this particular day, as the student struggled to incorporate the feedback he had received into a different way of engaging with the family, Dr. Andersen recognized an opportunity. Instead of discussing the student’s process *outside* of the family’s awareness, he invited the family and the student to hear what the team was saying about their interactions. He switched the mirror and microphone, and the family and the student watched and listened to the team talk about the family in a positive way. The family might have received feedback like this, “As I listened to you talk about your problem, I noticed how determined you all were to find a solution that could work. The strong connections to each other, and fierce loyalty you

display to your family is inspiring.” The family and the student liked and appreciated the ability to hear the team reflect on what they had witnessed, and the Reflecting Team model was born. I consider this model an example of dialogical and collaborative exchanges between the practitioners and the family being treated. While I have thoroughly enjoyed and embraced this model since I learned it in graduate school, it is not even the model or technique itself that has been so influential. Rather, it was Dr. Andersen’s reflective thinking and willingness to take a risk by stepping away from taken for granted ways of working with clients that inspired me. Additionally, his reflexive willingness to de-mystify the process of psychotherapy, by inviting the family to listen to the team’s discussion of their interpretation of the family’s interactions is quite inspiring to me. I believe it demonstrates a rare mix of humility and confidence in the process that are important to psychotherapy as a discipline. I have held Dr. Andersen’s beliefs and approaches as a sort of scaffolding for my own work, upon which I have added my own ideas about the process of psychotherapy.

Reading about the experiences of these pioneering practitioners as they shared their unorthodox ideas was both comforting and distressing. It was reassuring to learn that the very topic of this inquiry was described and discussed more than 100 years ago, and simultaneously disappointing that we as professionals are not further along in recognizing the value of practicing collaborative care. There are other pioneers who sought to improve collaboration between healthcare professionals by targeting their training and education.

Interprofessional Education (IPE)

By creating opportunities for them to co-actively learn across disciplines during their formal education, proponents of Interprofessional education (IPE) believe that students will be more likely to engage in collaborative practices as working professionals.

The origins of interprofessional education.

In the United States after World War II, when interdisciplinary teams of surgeons, physicians and nurses worked successfully to treat soldiers, a movement was begun to bring interdisciplinary healthcare to the public. This led to attempts to bring change to the educational practices of professional schools, in the hopes of starting interdisciplinary relationships earlier by combining training across disciplines. In a review of the history of IPE in the U.S., the authors identified the main culprits preventing implementation of such programs, “Attempts to promote such efforts seem to meet overwhelming barriers of disciplinary territoriality and systems inertia ... each new generation seems to have to repeat the experiences and frustrations of the past” (Baldwin, 2007, p.32).

An early class of IPE students.

The history of IPE in the US reflects the historical discourse of gender inequality, as reflected in the opinions of its students. In a study of attitudes from an entering class of American male and female medical students in 1978, the authors found that women supported IPE nearly twice as often as men. Among the arguments in *favor* of IPE were these from a female former nursing student, who was hopeful that IPE could solve a simmering problem:

The attitude of the typical nursing student is to regard medical students and doctors with increasing hostility and disdain. Nursing students are

taught their role and place and as lower members of the hierarchical system, come to resent those on top (Rezler and Giannini, 1981).

Following are some of the arguments *against* IPE from the male students.

*The doctor must analyze the patient's condition on a purely factual, scientific basis. The nurse must have enough scientific background to understand and comply with the doctor's orders. The psychological aspect of treating the patient in a hospital must be the responsibility of the nurse.

*Medical students are far more intelligent than other students in health related fields. Placing them in the same class would impede the progress of medical students.

*Arguments between nurses and doctors are common enough without nurses getting the background to back their arguments."

*IPE may lead to more interpersonal relations, and studies show that people think on a more rational level if they're not personal friends"

(Rezler & Giannini, p. 238-240).

At the time the study was conducted, women made up approximately 17% of enrolled medical students; the discourses of gender and power at that particular place and time in culture and history are evident in the students' quotations. Indeed as these answers were given during the first month of medical school, the authors concluded that existing biases were more likely to influence the outcome of the experiment than the actual program.

Other factors named as contributing to the failure of early IPE programs included a lack of role models who collaborated, professional turf-guarding, traditional professional

power dispositions, and administrative resistance to new forms of organization and education. The discourses of power in Academia, with its protected silos of disciplining likely played a role.

Interprofessional education today.

IPE programs today are more prevalent than they were 50 years ago, and are receiving more positive reviews from their students participants. In Canada, where the availability of IPE opportunities is now a requirement for accreditation of all the major health profession schools, they have been able to innovate when it comes to collaboration across disciplines. The Health Mentors program at the University of British Columbia pairs mentors who are dealing with a chronic health condition with students from various professional schools. They meet for two hours, six to nine times over a 16-month period, discussing topics that emerge from their own discussions and interests. Though it allows room for each group to talk about what feels relevant to them, the program is also highly structured, from recruitment of mentors to suggested topics and assignments. In this way, they are preparing students for dialogue, and early results of the program appeared quite promising:

Students gain an understanding of how each discipline views the diverse range of topics covered in the meetings, and how these compare with the mentor's views. Different perspectives allow rich interactive discussions that challenge students' assumptions. Building relationships over a long period of time promotes personal and professional growth, while cultivating mutual respect and an understanding of each other's roles and potential. It encourages the development of empathy and a deeper

understanding of lived experiences (Towle, Brown, Hofley, Kerston, Lyons, & Walsh, 2014, p.304-305.)

Time and research will tell whether this translates into increased collaboration across disciplines once these students graduate, and engage in professional practice. With a sense of the history of beliefs about collaboration across disciplines, and an idea for improving interdisciplinary communication, I draw attention to the problem of creating a commonly understood idea of what is called collaborative practice.

Attempting to Define Collaboration

As a construct, the focus of this inquiry, collaborative practice in healthcare is defined according to the individuals, their disciplines, and the social contexts within which they are embedded, among other factors. As a result, what feels like a collaborative conversation to one practitioner might quite reasonably feel like a *non-*collaborative series of platitudes to another. Loughlin wrote about the distinction between substance and slogans, “Definitions can only really be incompatible if they have substantive implications: the more semantically empty they are, the more they function like alternative slogans to promote a brand name...” (2008, p.936). Over the years that I have practiced psychotherapy, I have met practitioners who have advertised their practices as collaborative or integrative, whilst simultaneously declining to engage with me in dialogue about mutual patients. I have sometimes wondered if in healthcare, the words collaboration and integration are more slogans than descriptions of relational interactions between people.

A complex and common problem.

During this project, it became apparent that the participants had different ideas about what collaborative practices across disciplines look like. For example, a language-game refined in primary care medicine, where interactions between people are limited in duration, and solutions and economy of words are privileged, might produce the following definition: “making a referral to a provider from another modality.” A language -game refined in psychotherapy, where relational processes are the focus, and words are considered valuable sources of information about internal experiences might produce another: “engaging in generative, mutually reflexive dialogue about a shared case.” Consulting the literature, I discovered that defining collaboration differently is a common occurrence. This can lead to a relational problem when practitioners of healthcare consider themselves collaborative, whilst their colleagues and patients do not. In those cases, it could be argued that regardless of intention, collaborative care has not been received. Numerous articles have addressed this particular conundrum, and illustrated that it may be easier to describe what collaboration is *not* than to confine it using language (Blount, DeGiorolama, & Mariani, 2006; Blount, 2003; Miller, Mendenhall, & Malik, 2009). Following are some terms frequently mistaken for collaborative practice, which proved useful to the ongoing dialogue my colleagues and I had about what we were creating together.

What collaboration is not.

**Co-location:* Providers from different disciplines delivering care in the same location. This is more descriptive of where services are provided than how. Co-

location provides opportunity for referrals across disciplines, but does not guarantee it (Blount, 2003).

**Coordinated care:* Providers of different modalities practicing separately within their respective systems, while valuing and making referrals to other providers for different kinds of care. Contact if any is usually limited to the initial referral (Blount, 2003).

**Information sharing:* Providers of healthcare allowing access to each other's patient files, giving other practitioners an opportunity to read their notes asynchronously. This could also be accomplished through short non-generative monologues about treatment.

**Integrated care:* Providers of different modalities producing a unified care plan. Ongoing dialogue about shared cases may or may not occur past initial planning (Blount, 2003; Blount et al., 2007).

**Patient-centered care:* Providers of a single modality ensuring that patient values guide all clinical decisions by collaborating with them, but not necessarily collaborating with other providers about that care (Institute of Medicine, 2001).

**Care management:* A targeted program utilizing behavioral health practitioners (usually nurses) to address a specific disease, such as depression. May or may not involve collaboration with other treating professionals (Dobmeyer & Miller, 2014 p.314).

Lack of Collaboration in Hospitals

Given the shared goals and close proximity that hospital-based healthcare providers have to one another and to those who are entrusted to their care, one could reasonably expect for collaboration to occur spontaneously and frequently in that setting. But this has not historically been the case. As a result collaboration between physicians and nurses in hospital settings has been extensively researched. Failures in collaborative practice between physicians and other healthcare workers have been correlated to increased medical errors and readmission rates, and decreased satisfaction for both patients and providers (Garman, 2006). In Intensive Care Units of some hospitals, collaborative failures are considered among the leading causes of inadvertent harm (Rose, 2011).

The Australian handbook *Interprofessional Collaborative Practice* offers a metaphor for lack of collaboration that brings into focus the patient's experience:

Polite strangers are sharing a bus journey. The journey is the patient's journey through the healthcare system. The patient is driving the bus but is unsure of where she's going, and what the best route may be. Intermittently the polite strangers talk to her individually, but there is no overall agreement on the direction and the best route between passengers. There may be some limited agreement on the destination. The driver gets increasingly frustrated by the mixed and sometimes contradictory messages and directions received (Stone, 2009, p.2).

Forced Collaboration

Hospital administrators now recognize the financial benefits of collaborative

practices among treating professionals, and their correlation to decreased medical errors (Vogelsmeier, Scott-Cawiezell, Miller, & Griffith, 2010). As a result, programs designed to increase its likelihood have been developed and marketed as solutions to the problem. It remains to be seen and perhaps debated whether collaborative practices can be incentivized or imposed on unwilling participants. In his review of such programs, Bushe found that there is a difference between what is promised and what actually occurs in organizations that endeavor to legislate the practice of collaborative healthcare (2015). I included his findings because they are representative of my own experiences in other groups, where practice owners attempted to impose weekly meetings between clinicians to encourage collaborative dialogues. What actually transpired during those meetings were negative relational processes comprised of monological airings of office staff complaints against clinicians, building resentment rather than connection between us. Many members of that group practice eventually made excuses, or booked “emergency” clients during the scheduled meeting times to avoid them. Bushe’s results are reproduced below:

We talk about	We actually experience
Organizations in the abstract as systems, as “things”, subject to impersonal forces, for example, “drivers” of change	Organizations are conversations and what happens is influenced by who talks with whom, when and how
Independent, autonomous, rational	Far from being purely rational, people

individuals making choices and taking action	are emotional and often unconsciously driven by the anxieties aroused by organizational life
Wise, heroic leaders whose vision and acumen steer their organizations to success	That no one can control what everyone else is choosing and doing, and leaders often feel powerless to influence their organizations
Rational, analytical ways of making decisions, using big data and increasingly automated decision processes	Results emerging from the interplay of all the choices, intentions and strategies of all the stakeholders in both intended and unintended ways.
Generalizable tools and techniques of management and leadership in the belief that they will improve organization	Situations so uncertain and the local contingencies so important that any generic tools we have are of very limited value

Table 1: Ideal vs. Actual experiences of organizations attempting change. (Bushe, 2015, p.7)

Lessons from Forced Collaboration

Within hospitals, administrators often use incentives and/or disincentives to try to enforce collaboration across disciplines. The generally accepted belief is that the frequently changing protocols that mirror the fluid state of medical knowledge can be hard to follow for practitioners; yet patient safety requires their immediate adherence. While the idea behind these incentives or punishments may be sound, studies show that they don't necessarily lead to improved interprofessional relationships, which are considered integral to collaboration. Researchers believe that participant refusal, lack of support from people in key positions, and loss of momentum can contribute to gaps in collaboration in hospital teams (Henrickson, Battles, Marks & Lewin, 2005).

Collaboration Without Compensation

Outside of the hospital setting, even when practitioners recognize the value of collaboration, issues related to time, logistics and compensation can act as barriers.

Healthcare practitioners who choose to operate private individual or group practices create their own unique customs and norms regarding collaboration. Where there is no employer-driven edict, or financial incentive to collaborate, how likely are providers to make time for it? This question was asked as part of a study of Canadian Integrative Healthcare Clinics, designed to identify the key components of successful collaboration across disciplines. Following is one response to the question of value placed on collaboration in this setting that is reflective of the dominant discourse of financial compensation common in private practices:

We have a healthcare system that is not set up to compensate for preventive health [care] or practitioners' time when they are not actually seeing patients or treating patients. How do you compensate people for reading the file, reading what other people have written, sitting around talking about it for an hour? The hour that they take to discuss one patient, I could see presenting to a couple, to ten people in that time. They could be paid for it (Gaboury, Bujold, Boon, & Moher, 2009, p.710).

Healthcare practitioners create their own realities for their time, and use both professional and personal moral codes for what they consider to be ethical care. Reflexive thinking about the relative value of using an hour to engage in collaborative dialogue versus generating additional revenue could provide the space for new realities and discourses to emerge. If a practitioner accepts a discourse that measures productivity *only* in dollars earned, his taken-for-granted behaviors will be limited to those that generate income. He will not be likely to interact with colleagues during his workday, and will spend regimented amounts of time with patients, as determined by guidelines rather than

clinical judgment. If he adopts a discourse that values generative *experiences* as well as dollars earned, he is likely to seek generative exchanges, regardless of their remunerative value. This might result in his initiating collaborative conversations with colleagues during a stressful workday, or spending additional time with a patient for whom he does not have a billable diagnosis, but seems to need more relational connection.

Having examined the literature for information regarding the complexities inherent in defining and operationalizing collaborative practice, I returned to the literature for information from those who have claimed to do it successfully.

What Collaboration Is

In their publication *Framework for Action on Interprofessional Education and Collaborative Practice*, The World Health Organization defined collaboration as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (Robiner, Tumlin and Tompkins, 2013, p.). This language includes practitioners from different disciplines, and suggests that services are comprehensive *because* they include patients, their families and communities. However, it does not specify practitioners talking with *each other*, only with patients and their families and communities. Similarly, the framework calls for interprofessional education for the specific purpose of training future healthcare professionals to *value* collaboration across disciplines, but not specifically to engage in collaborative dialogue about mutual patients. *Collaborative Care* has been defined as:

...exceptional health care in which patients, family members, and other care team members are able to consistently co-create care that is

meaningful, high quality, efficient, safe, reliable, resilient, and exquisitely responsive to the hopes, needs, goals, and purposes of everyone involved” (Raboin, 2004, p.1).

This language is descriptive and evocative of a utopian world of healthcare that many people would find appealing. While Raboin (who is a researcher specializing in collaborative processes, but not a clinician herself) has used it to put forth ideas about collaborative care that are principled and laudable, I do not find them realistic. As a provider of healthcare, my experiences of the constraints of time are such that it can be difficult to be responsive to the hopes, needs, goals and purposes of everyone involved in healthcare *once*, let alone consistently. Additionally, there is the problem of *coordinating* the “hopes, needs, goals and purposes of *everyone* involved.” When would those items be identified and articulated, and what would happen when they were discovered to be in opposition to each other? Or is the assumption that what is hoped and needed, that what the goals are, are all somehow identical for all patients, families and members of a treatment team? There are realities that providers of healthcare face- constraints of time and resources, limitations of ability or sometimes desire to help in the way that a patient is seeking. By creating a definition so idealistic, I believe there is little chance that it could be achieved.

Spontaneous collaboration.

In their examination of a relationship-centered model between physicians and CAM providers, researchers found that colleagues were more likely to trust, cooperate and exchange knowledge with each other *when they placed a high value on collaborative*

relationships. In the same study that identified lack of remuneration as a barrier to collaboration for some, the researchers noted that for other physicians, collaboration was valued, *regardless of remuneration*, “[Spending time to exchange with a colleague about a patient] is enjoyable, it’s part of our communication, it’s interesting, so it’s not a problem. It’s part of our game” (Gaboury et al., p.712). The authors found that within the same practice, providers placed varying degrees of importance on collaboration across disciplines, despite their choosing to work in an integrative practice. As this setting was similar to my own, I was curious about what might make someone more or less likely to *want* to collaborate there.

Ingredients for collaboration.

Rather than limiting the construct of collaborative care by a single definition, some authors put forth “ingredients” for its construction. In their guide *Models of Collaboration*, the authors suggested six key ingredients for effective collaboration (Seaburn, Lorenz, Gunn, Gawinski, Mauksch, & Kelly, 1998). They include,

Common purpose presumes that all providers of healthcare consider as their overarching goal the effective management of patients’ concerns. The authors propose that having a common goal “keeps the group together until the task is completed or the product is made” (p.52). Unfortunately, this has not always been my experience, as the case studies attest. Discourses of power and territoriality, or the complexities of busy schedules often prevent the development of a common purpose.

Paradigm allows for different approaches to lead to collaboration as long as they are not mutually exclusive; a provider can hold a specific theory about treatment yet seek and respect another’s. However if a practitioner is not aware that it is precisely *from* a

paradigm that he works, as opposed to Truth, he is not likely to seek that other's point of view.

Communication includes language, pacing, form and content. The authors recognize that there are many barriers to collaborative communication, from the lack of common vernacular to norms around frequency of contact to scheduling difficulties and differences in what is considered important enough to share.

Location of service refers to the degree of geographical togetherness that providers from different disciplines create. The authors suggest that the "together model," which places offices in the same location encourages practitioners to set common goals.

Business Arrangement refers to the financial relationships that providers and those who seek their services create. Recognizing the discourses of power and hierarchy that often accompany conversations about money, the authors recommend careful consideration of business arrangements between providers from different disciplines who seek to practice collaboratively.

Relationships are named the most important ingredient in this model. The authors suggest that the level of collaboration across disciplines is a reflection of the relationship between providers. They also state that allowing sufficient time for relationships to mature builds trust, which results in greater work satisfaction for providers. As I discussed in the previous chapter, instead of understanding relationships as distinct entities, Social Construction focuses on relational *processes* between people, or between people and their surroundings as the place of potential healing.

The philosopher Martin Buber emphasized the importance of the relational processes that are possible when professionals truly meet their clients and patients as partners in healthcare, which requires a letting go of the certainty of pre-ordained theories and facts. He wrote:

Help without mutuality is presumptuous, it is an attempt to practice magic. The doctor or the psychotherapist who tries to dominate his patient stifles the growth of his blessing. As soon as the helper is touched by the desire, in however subtle a form, to dominate or to enjoy his patient, or to treat the latter's wish to be dominated or enjoyed by him as other than a wrong condition needing to be cured, the danger of falsification arises, besides which all quackery appears peripheral (1955 p. 95).

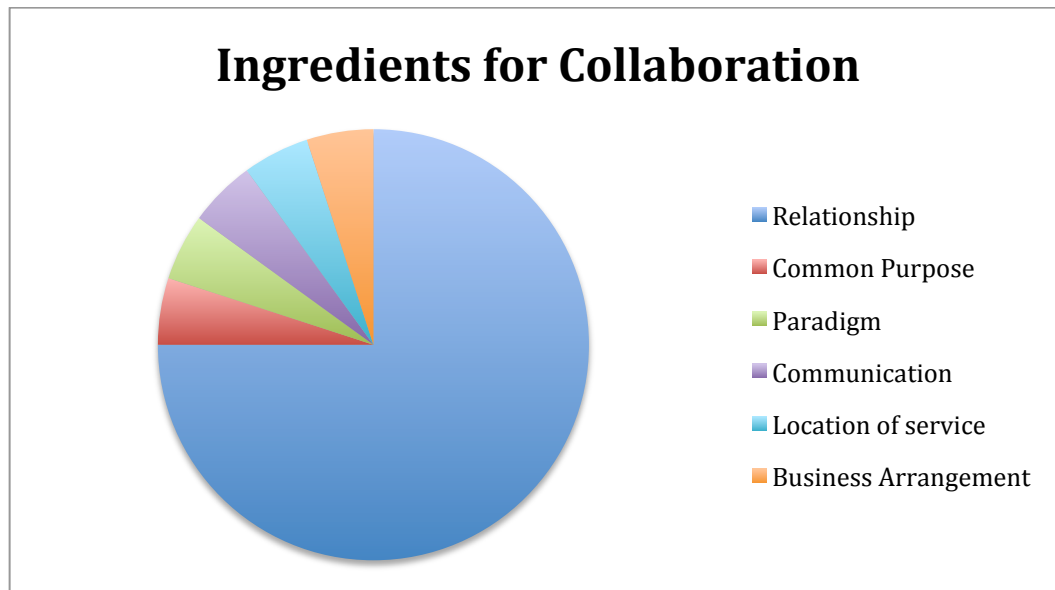


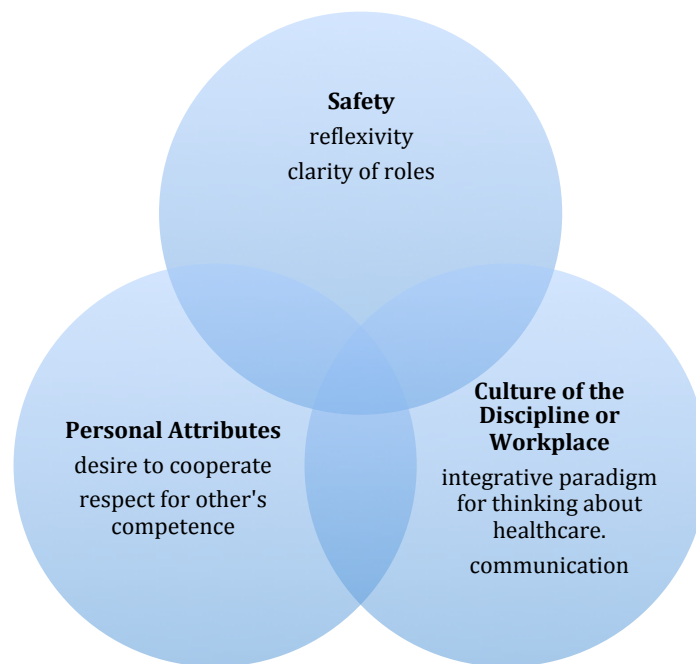
Figure 1: Representation of Seaburn et al.'s recipe for collaboration.

Seaburn et al.'s research can be appreciated through this lens. By asking providers about their early experiences with illness and treatment, the authors developed a questionnaire designed to increase reflexivity about the ways that providers had constructed their beliefs around illness. The authors proposed that earlier life events had influenced the degree to which healthcare professionals chose to practice collaboratively. The argument could be made that what the authors referred to as life *events* were themselves *relational processes*-----for example, experiences with loved ones who were ill, with the physicians who treated them, and with the family members who helped make meaning of them. Through this frame, this research invites us to consider that the likelihood of providers' developing collaborative relationships will to a degree be influenced by their historical experiences in relationships with illness, as it occurred in their loved ones and themselves. Building on this idea, I was curious about what the

literature held about other factors that might impact relational processes across disciplines, and render them more or less collaborative.

Factors affecting collaborative relationships.

A review of additional articles and books revealed the following factors as being important to collaborative relationships (Stutsky, Laschinger, & Spence, 2014). They can be organized into three subgroups, with a high degree of overlap:



Safety.

Collaboration between health-care providers involves professional risk-taking; practitioners chance embarrassment, judgment or rejection when they proffer opinions about diagnosis and treatment options. In a private practice, there is also financial risk; if one is not seen as competent, referrals from peers are not likely to be forthcoming. Referrals are a necessity for self-employed healthcare professionals.

Edmondson introduced the construct of team psychological safety, defined as “a shared belief that the team is safe for interpersonal risk taking” (1999, p.354). Some of the factors named as contributing to psychological safety included respect for each other’s abilities, believing each other has positive intentions, belief that one will not be rejected for expressing what one thinks, and having interest in each other. Edmonson proposed that safety is essential for healthcare teams to function, and I suggest that safety is also necessary (but not sufficient) for collaboration across disciplines to occur. A person might be more likely to offer their ideas about healthcare if they felt respected and safe in doing so, but feeling safe and respected alone would not necessarily lead to the creation of a collaborative relationship. Personal attributes might also play a role.

Personal attributes.

Gaboury et al. cited the constructs of professional maturity, intellectual curiosity, and awareness of one’s own limitations as being important to the level of collaboration achieved (2009). Social Construction challenges the conventional belief that individuals either possess (or do not possess) innate, internal characteristics such as awareness, maturity and curiosity. Instead, it invites us to consider that these behaviors occur within relational exchanges which are themselves embedded in particular historical, cultural and economic periods. It would be hard to find any practitioner who *always* behaved maturely, or *never* exhibited intellectual curiosity, across all situations. How then would practitioners learn to interact maturely, bring curiosity to others’ positions, and become aware of their own limitations during relational exchanges? To answer this question, I examined the literature regarding professional cultures of the different disciplines included in this inquiry.

Cultural aspects of the discipline and workplace.

Each of the disciplines included in this inquiry has its own culture, with norms for behavior and discourses and beliefs about knowledge creation. There is room for interpretation as to whether the culture of the disciplines is shaping neutral neophytes, or attracting predisposed practitioners-to-be. A team of researchers summarized the discourses of disciplines this way:

Each of the major disciplines — physicians, nurses, allied health providers, and health administrators—represent qualitatively distinct sets of goals and professional values, influencing not only current behavior but also who chooses these roles in the first place. Once a career is selected, the educational process further fortifies these differences, so that new professionals enter the workplace with fundamentally divergent perspectives on how care should be provided and how processes should be improved. (Garman, Leach, & Spector, 2006, p.829).

Psychotherapy.

Psychotherapists, who can be trained as Social Workers, Mental Health Counselors, Marriage and Family Therapists, or Psychologists are required to participate in reflexive practice, which privileges self-reflection and mindfulness especially as they apply to relationships. Psychotherapists are typically trained to be respectful of their clients' beliefs, which often include non-traditional discourses, such as those associated with CAM. However as the discipline of psychotherapy has sought to gain acceptance in the scientific realm, psychotherapists have placed increased value on brain imaging techniques. In doing so, they have effectively declared the brain as the location of psychological events. As a result, a discourse is emerging that privileges *the brain itself* over the relational processes that may influence and be influenced by it. By assigning meaning to functional magnetic resonance images (fMRI's) as proof of underlying emotional and mental processes, psychotherapists have essentially created a discourse that privileges the scientific community. This may serve to create distance from the CAM community, which has rejected this discourse.

Complementary and alternative medicine.

The myriad practitioners of CAM operate from a similar paradigm to each other, which is different than those associated with medicine and psychotherapy (Polich, Dole, and Kaptchuk, 2010). The focus of CAM, usually based in ancient practices, is on utilizing natural and minimally invasive techniques aimed at prevention and self-healing; yet the term Complementary and Alternative itself indicates that another modality is primary, and therefore preferable in some way (Patwardhan, Warude, Pushpangadan and Bhatt, 2005). I am curious as to why that term continues to be used *within the discipline*, as it reinforces this dichotomy. The dichotomy is further reinforced by the derisive attitude that conventional medicine has historically held for CAM approaches. These factors might contribute to a culture of isolation among CAM providers. As one said to me during her interview for this inquiry, “I would not likely talk about chakras in front of primary care providers or psychotherapists, for fear of being considered foolish.” A reviewer of the text *Essentials of Complementary and Alternative Medicine*, which was created to facilitate physician acceptance of CAM, admonished that the authors had inadvertently reinforced the very hierarchy that placed their discipline below medicine:

...an otherwise logical and well-conceived “decision tree” algorithm to help physicians evaluate when to use CAM stumbles on its first step. If the answer to the opening question---“Is an acceptable conventional therapy with good evidence available?”---is yes, then the decision tree’s recommendation is “No need to consider CAM.” The authors thus explicitly endorse a hierarchy in which first-rank priority is always accorded to conventional therapies.... This approach ignores the possible

existence of an equally desirable, more desirable or less risky CAM procedure.... reflects a bias that runs contrary to the goals of evidence-based medicine” (Redwood, 2000, page 292).

It is possible that the discourse of CAM providers serves to keep them at the very place in the medical hierarchy they wish to avoid, thus reinforcing that barrier to collaborative conversations with providers of other modalities of healthcare.

Medicine.

In the U.S., the dominant medical discourse privileges aggressive treatments, techniques and cures, and equates unsuccessful treatments with failure (Good, 1998; Charon, 2006; Ashton & Wray, 2013). As physicians can train for up to a decade under the mentorship of others before practicing autonomously, those relational processes most likely serve to reinforce the discourse status quo. In his ethnography of medical training, Atkinson, a British physician described a culture where swift decisiveness was valued, and “not knowing” resulted in immediate exclusion from the group. In this excerpt from a consultation where a surgeon was teaching students to palpate a patient’s neck, that discourse is evident,

Surgeon: “So here is this swelling in her neck, and there is no doubt about the state of this—no doubt about her thyroid state.”

Student: “There is a soft swelling---with soft edges---not nodules.

Surgeon: “I thought it was nodular myself.”

Student: “I couldn’t find any nodules.” She palpated the patient’s neck

once more. “No, I can’t find any nodules.” (Hesitantly)

Surgeon: “You’re hedging. Let’s get another opinion” (1997, p.169).

As discussed in previous chapters, the emphasis in medicine on what can be seen and measured as objective truth could make it even more difficult for those who have only experienced this discourse to practice reflexivity, or be curious about other ways of providing care, such as CAM and psychotherapy. Indeed, members of the medical community have frequently labeled some of the constructs central to CAM approaches to healthcare, such as energy or spirituality, as fringe or quackery, creating a “them” that is inferior (Redwood, 2000). I myself have frequently been told by practitioners of medicine that their skepticism about the efficacy of psychotherapy is due to a lack of scientific “evidence.” Even if some physicians managed to appreciate the approaches of CAM and psychotherapy, they might be reluctant to support them publicly among their peers. In a study that examined collaboration between biomedical and CAM providers, a physician reported, “If you do not [follow the College’s guidelines], then your license is on the line...” (Gaboury et al., 2009, p.711).

In summary, the dominant discourses of the modalities covered in this inquiry may serve as barriers to collaboration between them, essentially reinforcing the medical hierarchy in the process. Though there are individuals who may value multiple viewpoints in healthcare, the discourses of their disciplines may effectively silence them from publicly declaring their views. This chapter of the literature review has included research from the distant and recent past about other practitioners’ experiences with collaboration across disciplines in healthcare. That information, along with my own professional experiences as a psychotherapist in private practice for 20 years led me to

the following research questions.

*What would happen if co-located healthcare providers from different disciplines were introduced to the Reflecting Team model, and asked to utilize it to discuss a shared case?

*Would they voluntarily choose to participate in ongoing collaborative meetings, outside of the mandatory practice meetings, without being financially compensated for their time?

*If they did elect to meet regularly, would they adopt a relational, dialogical approach, or continue to use the monological method that had become customary?

Chapter Four: Methods

In the previous three chapters, using my experiences as a psychotherapist, the principles of Social Construction and a review of the literature, I examined many of the factors that could enhance or act as barriers to collaboration across disciplines in healthcare. In this chapter I will first discuss the more recent epistemological tradition of Evidence Based Medicine (EBM) and its impact on healthcare policy. From there I will propose a different healthcare epistemology, and then describe the research agenda for this inquiry. I will then explain the theoretical underpinnings of the selected approach, before describing in detail the methodology employed for this inquiry.

Historical Roots in Logical Positivism

The logical positivist movement of the 1920's, which introduced the dichotomy of objectivity and subjectivity to medical epistemology has been called the parent of Evidence Based Medicine (Loughlin, 2009). This philosophical theory about meaning privileged statistical analysis of experimental data over personal observations and judgment, thus narrowing the definition of what could be considered meaningful in science. It valued generalizable results over individual experiences, in effect discounting those that weren't readily replicable. It is understandable to me that the medical community would have found much about this philosophy appealing, for it offered the allure of certainty. Surely both patients and practitioners would welcome an epistemological tradition that promised the reduction of uncertainty; patients presumably want reassurance about their health, and practitioners want the confidence to provide it. However desirable it may be, in any generation, certainty of outcomes in healthcare is illusory, as Sarewitz suggested, "claims of scientific certainty say more about the state of scientific understanding at the time they are made than they do about the...natural phenomenon being claimed as knowledge, and ...certainty estimates may say more about the psychological state of those making them than they do about the subjects of the estimates" (2004, p.393). If we recognize that it is difficult for healthcare practitioners when they are unable to provide definitive treatments or cures, just as it is for those who seek them, we might alter the discourse of success and failure and evidence and certainty with regard to treatment options. From there the rigid adherence to approaches that promise objectivity from which treatment decisions can be made, thus obfuscating other perhaps equally valid approaches, might be lessened. Dutch researchers Slob and Staman

observed that different disciplines seem to construct their own “evidence cultures,” with norms for what is considered meaningful there (2012, p.19). As a result, what is considered a high standard in one discipline may not be achievable or even applicable to another. For example, educational research would hardly be considered ethical if it withheld knowledge-sharing from children assigned to a control group in order to see if they fared worse than those who received it. However regarding healthcare research, if the evidence culture of medicine valued *equally* specific and generalizable information, then physicians could consider scientific literature regarding a drug, whilst also assigning meaning to a single patient’s reaction or response to it.

A Phrase is Coined and Widely Accepted

While the doctrines underlying Evidence Based Medicine (EBM) have been around for many years, the term itself is relatively new. It is credited to Dr. Gordon Guyatt, who, as the recently hired director of a medical residency program in Canada in 1990 sought to improve the training there by introducing an approach he initially called “scientific medicine.” When members of the faculty reacted negatively to this term, inferring that what they had been practicing was being denigrated, he changed the term to “evidence-based medicine” (Ashton & Wray, 2013). For a few years the meaning of this term was more implicit than explicit, until Sackett’s definition of EBM, which has been widely quoted, but still leaves room for interpretation:

the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice (1996, p.71).

Using the phrase “best evidence” implies a hierarchy, which would by default include worse evidence or worst evidence. Indeed many prevailing epistemological approaches privilege information gathered from research literature, often produced by scientists who do not interact with patients, over that gleaned from patient history-taking, and clinical judgment (Ashton & Wray, 2013; Loughlin 2009). Another problem with EBM is its reliance on what is considered “systematic research.” Most medical communities recognize Randomized Control Trials (RCT’s) as the gold standard of research for ascertaining the effectiveness of new medications and medical devices (Ashton & Wray, 2013). In a Randomized Control Trial, neither the researcher nor the patient is aware of whether the latter is receiving the treatment or a placebo. This approach is thought to eliminate researcher bias, and to allow for the placebo effect, whereby patients report improved outcomes, which researchers attribute to a *belief* that they are being helped, rather than from a medication or device itself. What is inherent in every study is that each is conceived and funded by groups of human beings. These human beings are embedded within cultures and institutions and societies that all play a role in the identification or construction of the problems that are studied. For example, in the United States, it has been documented that RCT’s can be influenced or perhaps even directed by the self-interests of pharmaceutical companies, rather than by a dedicated scientist’s search for evidence. In her book *Side Effects*, journalist Allison Bass followed the connection between the pharmaceutical industry and corrupt prominent psychiatrists who, entrusted

to provide ethical, researched-based care to their patients, instead took enormous amounts of money to fabricate research data about the antidepressant Paxil (2008). As a reporter for the Boston Globe, Bass had covered the severe professional backlash that scientist/practitioner Dr. Martin Teicher was subjected to when in 1990 he published a journal article about increased suicidal thoughts, based on his patients' experiences with the popular antidepressant Prozac, questioning its safety. I attended a workshop of his 25 years later on another topic, and he was still visibly shaken as he described that attack on his professional integrity, during which he was also ostracized by many of his colleagues. In a chapter titled "The Subversion of Evidence," Ashton and Wray described the results of a U.S. federal investigation made public in 2010 into GlaxoSmithKline's sales practices of the anti-diabetes drug Avandia. The company had made a significant financial investment in the diabetes market, with nearly 26 million Americans affected, and more being diagnosed each year. Their drug had received approval from the FDA, despite early signs that it caused cardiac complications. (Their safety review focused more on liver toxicity than cardiac events.) When diabetes expert and professor Dr. John Buse began to publicly discuss the increased cardiac risks associated with his patients who took the drug, the pharmaceutical company contacted his university department chairperson and threatened a lawsuit. The authors stated, "Dr. Buse ultimately signed a 'clarification' letter composed by GSK in which he agreed not to discuss the issue in public, and he wrote a personal letter to GSK asking that they 'call off the dogs'" (2013 p.60). Within this paradigm in these two cases, the reports of patients and clinical judgment of treating physicians were considered less reliable and therefore less *meaningful* than the results of the RCT's about the drugs. Yet later research suggested

that patient reports and clinical judgment were *more* reliable in those cases, and the FDA later issued warnings about the dangers of cardiac events associated with Avandia, and also about increased suicide risks associated with antidepressant use in adolescents (Retrieved from <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109352.htm>). This is not to suggest that RCT's aren't useful in testing the efficacy of drugs, and I do not suggest that they be discarded as a standard for pharmaceutical companies who wish to bring new drugs to market. What I am suggesting is that they not be taken as Truth, but instead as *one* piece of information from which healthcare providers can make treatment recommendations.

Even when research provides potentially helpful information, there is the problem of the busy practitioner's ability to embrace, read and digest the scientific literature, and to translate it into practice that will be helpful to his or her patients. The onus for this has traditionally been placed on the practitioner, but Loughlin has suggested that it is perhaps researchers who should consider the needs of the practitioner when disseminating information about their work (2008). In my own field, I have often wondered how it is that researchers identify problems to be researched. It is common for me to receive requests (through my professional affiliations) to participate in psychological research that feels completely unconnected to anything I would consider useful to my work with clients. The most recent, from a professor of psychology at a college in New York was a study proclaiming that practitioners of mental healthcare experience something they called "associative stigma." I was asked to complete a questionnaire with such questions as "Have you been told in social situations that the work you do is useless?" I found

myself wishing that he had chosen instead to ask what practitioners in the field considered problematic, and then constructed his research agenda from those results.

These problems notwithstanding, in America, the Affordable Care Act signed into law by President Obama in 2010 created a research institute, funded through a levy on healthcare insurers, to provide more of the gold standard RCT's to support EBM (Ashton & Wray, 2013). This institute will produce guidelines for healthcare practitioners to follow; rather than take these guidelines as the objective, reliable Truth from which we must operate, Loughlin suggested, "The rather obvious social fact that guidelines are drawn up by persons, and often ones far removed from the work contexts they increasingly regulate, is an embarrassment champions of this approach choose to ignore" (2008, p.666). In the U.S., it does not appear that EBM is losing many proponents at this time, with a preponderance of research articles currently utilizing the term. It does have a scientific ring, and this seems to be highly valued in the discourse of medicine and psychotherapy. Perhaps it provides a kind of authority for healthcare providers, the institutions that train them and the patients who seek their services. As a model reflecting present day beliefs about what counts as knowledge in medicine, it may one day, to future generations, seem like little more than a platitude reflecting our naiveté. Any medicine that claims to be evidence based is bound to become obsolete, because knowledge about disease, illness and health must constantly be de-constructed and re-constructed as new evidence becomes available. Perhaps healthcare practitioners of the future will recognize that "What Counts As Evidence To These Scientists In This Moment in History Based Medicine" was not as catchy a phrase. Nonetheless, the term has been widely used not just in medical epistemology, but also by politicians and

industries around the globe, who wish to use science to back a position they have already taken.

EBM and policy

Politicians and government agencies utilize something called “evidenced based research” to determine or perhaps ratify policy decisions around healthcare. At times the logic of these decisions is difficult to understand. For example in the U.S., while the FDA provides oversight of the approval of drugs and medical devices, there is currently *no* government oversight for surgical procedures. Often, research on new techniques is not initiated until years after the surgeries have been performed. Ashton and Wray described the culture of American surgery, “....the evidential bar a surgical innovation must meet before it is used in routine clinical practice is much lower than pre-market requirements for prescription drugs and biologics” (2013, p.83). Describing what they labeled the “Operate First, Evidence Later Paradigm,” the authors reported that when policymakers attempted to mandate research on the comparative effectiveness of spinal surgery to alleviate lower back pain, (per the newly passed comparative effectiveness research laws) the powerful lobby of spinal surgeons threatened to resign from the ranks of Medicare physicians. This would have left millions of Americans without professional surgical care. Not surprisingly, Congress essentially dismantled the federal agency that was attempting to enforce the legislation, and did not require the comparative effectiveness research (p.81).

Conversely, Eye Movement Desensitization and Reprocessing (EMDR) is a *non-invasive* psychotherapeutic technique introduced in the U.S. in 1990, researched in 24 RCT’s (Shapiro, 2014) and utilized around the world in the treatment of Post Traumatic

Stress Disorder (PTSD.) Nonetheless, for years Congress refused to approve its use in treating veterans covered by the military insurance program known as Tricare. This lack of approval essentially overrode the clinical wisdom of treating clinicians, depriving veterans from receiving the widely accepted gold standard of care for the injuries they sustained while serving their country. The International Association of EMDR clinicians lobbied Congress for five years regarding this matter, long after every major American insurance company had recognized and recommended EMDR as the treatment of choice for people suffering with PTSD. Finally in 2010, some 20 years after its introduction, Congress approved the use of EMDR for veterans covered by Tricare insurance (Retrieved from <http://www.emdria.org/?page=155>). Depending on one's lens, these political decisions could be seen in a variety of ways. It is possible that within the American medical hierarchy, surgeons have more clout than psychotherapists. Perhaps physicians are simply better lobbyists, or more politically savvy than therapists. It is possible that members of Congress did not wish to recognize a connection between serving in the military and developing Post Traumatic Stress Disorder. Regardless of the reasons, in both cases, policy-makers could have found "evidence" to back the decisions they were making.

In their study of the practices of evidence-based policy-makers in the Netherlands, Slob and Staman found many problems with utilizing scientific evidence as proof in the process of political decision-making. The authors recognized that as people, scientists often have competing interests and values, which lead them to the discovery of different facts, and make it impossible to produce a "single, cohesive and unambiguous 'scientific viewpoint'" (2012 p.12). Scientists also have different ideas about how and

when to disclose what they consider reality. These factors set the stage for policy-makers to select advantageous evidence, and ignore that which does not serve their needs. The authors observed, “Politicians now know that they can shop around science until they find something that best supports their position” (p.13).

The authors recognized that the world is sufficiently rich and complex and replete with data, so that there might be an excess of facts. As a possible solution, they proposed that policy-makers adopt an evidence-*informed* epistemology, where differing social values and convictions are openly explored and debated, instead of squashed through the use of what is considered scientific evidence.

Towards a New Epistemology

Combining the recommendations of these authors with my clinical experience, I suggest an epistemology of *discernment*, whereby providers of healthcare value the development of skills to evaluate research for themselves, and to decide its validity and place among other kinds of data. Clinical research would be one of many equally legitimate sources of information from which to make healthcare treatment decisions. By rejecting the hierarchy and dichotomy of logical positivism, practitioners could choose to give whatever weight to their intuition, patient interactions, patient values, patient reports and history, clinical experience, professional judgment, and applicability of relevant research they believed would best serve the needs of the individual patient in front of them, at a particular moment in time. Regarding collaboration across disciplines, this epistemological approach suggests that because each discipline’s bank of knowledge is limited, any individual practitioner’s knowledge is incomplete. Therefore, checking beliefs against the knowledge of other healthcare providers about mutual patients who

have made meaning from their own discoveries in different disciplines, could increase the chances of being able to provide more comprehensive care to patients. With the epistemological approach discussed, I turn to other ideas that influenced the methodology of this inquiry.

The philosophical ideas of Martin Buber greatly influenced my thinking, and factored in my methodological choices. Buber wrote about the spaces between people as being the locus of meaning in life. In *I and Thou*, he suggested that there are different ways for human beings to engage with the world. One is to see others and our surroundings as objects, or “It,” which puts us in the position of detached observers who analyze or classify them as objects. Another is to fully engage with others as if they *were* the world, whether human or inanimate object (1937). In this way we can create meaningful relations that ultimately lead to transformation, which occurs when we come to see *every* other as we do ourselves, with a sense of connection and responsibility for the world. These ideas resonated with me as I considered the spaces that my colleagues and I inhabited in our group practice. I wanted to know them in a more meaningful way than I could in our brief hallway interactions, and I wanted to understand what happened in the spaces between us when we talked about patient care. As I began to consider an agenda for this project, I thought about how I might weave these ideas together with my beliefs about collaboration across disciplines in a way that might bring something new to the existing research.

Formulating a Research Agenda

Chapter three illustrated that many researchers have examined the issue of teamwork in healthcare, supported by management as a means to an end of achieving

decreased errors and improved patient outcomes in hospital settings. I am more interested in the relational processes that occur in private practice settings, between practitioners and also between them and their patients, where interactions are not mandated or rewarded by outsiders. I view *these* exchanges as a significant source of information about how norms and customs evolve regarding collaborative dialogue in this healthcare setting, where so many patients receive care. I am also interested in learning about how practitioners come to value multiple viewpoints, given the restrictive lenses that most of them are exposed to in their professional training. My overarching goal is to extend this knowledge so that practitioners who wish to engage in collaborative dialogue across disciplines will have new ideas that may increase their likelihood. In my own field, there is a precedent for the generation of knowledge through the observation of relational processes.

One of the treatment options that has been most transformational in my professional practice is EFT (Emotionally Focused Couples Therapy.) This innovation emerged when practitioners brought curiosity to what seemed to be working in the field. Dr. Sue Johnson created EFT after spending hours with colleagues watching videos of their sessions with couples, to identify the transformative relational moments as they unfolded (M. Kaupp, personal communication, Nov. 2015). Their work led to the creation of a protocol for identifying negative relational patterns, and opening space for more positive interactions to emerge between couples. This approach influenced my methodology for this research agenda.

The Agenda Takes Shape

I hoped that by interviewing each practitioner about his or her decision to join a multidisciplinary group, some themes might emerge that could extend knowledge about this preference. I had no hypotheses or preconceived notions of what they might be, and was open to whatever they shared about this determination. Given that each had made this choice, I was curious about what would happen if these practitioners were exposed to the Social Constructionist ideas of relational dialogue, and given the opportunity to employ them to discuss a shared case. Would they value the experience enough to elect to continue such discussions? Would patterns or themes emerge that might assist others who wished to interact this way? By situating this inquiry in the practice I had recently joined, I also hoped to interact in the more dialogical way with my colleagues that I preferred, which I had not found possible given the current customs and norms of the group.

Adding the patient's voice.

I also considered the patient's voice to be an important component of a collaborative healthcare process, and wanted to know how patients might be incorporated into meetings in a private practice setting, where knowledge was created about illnesses and treatments. I hoped to expand this research agenda by including a patient in one or more collaborative meetings, and then interviewing the providers and the patient to understand how they experienced the process. In so doing, I hoped that I might contribute ideas for others in private practice settings who wanted to include patients in the dialogical and relational collaborative process. Outside of any contributions to research, I also wanted to create a framework for such collaborative, multidisciplinary conversations where I worked so that I could enjoy participating in them, and bring any relevant

knowledge that emerged to my work with clients. With my research agenda clarified, I began to construct an approach that would help bring it to fruition.

Grounded Theory

I drew from the concepts of grounded theory to help shape this inquiry, and will explain those that were used whilst describing the overall approach. Grounded theory emerged from a belief that social or relational processes are a source from which people construct meaning in their lives. Social processes have “structures, implied or explicit codes of conduct, and procedures that circumscribe how interactions unfold, and shape the meaning that comes from them (Starks, & Trinidad, 2007, p.1374). I considered the pre-existing meetings in the practice where I worked to be a kind of social process, with norms that had been established over a decade. I was interested to learn what meaning might be constructed from a different social process between the same people.

Challenging the positivist notion that hypotheses must be deduced and tested from existing theories, grounded theory presumes that qualitative analysis of data can actually *generate* theory (Charmaz, 2006). Using this method, data are constructed and analyzed as they are collected, allowing hunches and potential ideas to be followed as they unfold. By interviewing each participant individually at the outset of the inquiry, I could use the experiences of my colleagues as data to help shape the group portion of the research. For that portion, I hoped that we might engage in a *different* kind of social process than the existing monological conversations I’d experienced during group meetings; one that was more dialogical and collaborative. My goal was to observe what happened when participants were introduced to a new, dialogical way of talking together about shared

cases. Meaning would be determined in part by my interpretation of the data, and also by participants' feedback and interpretation of the process. As data were collected and analyzed, ideas for future meetings could be tried, and theories about them constructed and discussed.

Typical grounded theory approaches utilize theoretical sampling, whereby a small number of participants begin a study, and additional participants are added until the data can fully support the constructs that make up the theory (Starks & Trinidad, 2007, p. 1375). Due to the unique nature of this setting, the pilot meeting would involve the largest number of participants, and then based on the data collected there, the configuration of future meetings would be determined. Gerund coding would be used to analyze the data.

A gerund is a noun made from a verb that implies action; and because social *interactions* are the focus of grounded theory approaches, this type of coding is quite useful. For example, if a meeting were described as "a pointless waste of time," that would produce a static picture of an event, offering little information about the co-actions of its participants. But if it were described as "person one repeating himself, person two changing the subject, person three interrupting," that would paint an interactive picture of the same meeting. I expected that gerund coding would provide data about the relational processes that took place at the pilot meeting, which could be generative for developing a theory about such practices. As a participant-researcher, it also offered me an opportunity to understand the processes I would most likely not recognize as they unfolded, and to analyze my own interactions in the meeting. With grounded theory providing some useful ideas for the inquiry, I would need to find a methodology that could accommodate the

large number of participants, and short duration of time allotted for the pilot meeting.

Participatory Action Research

Participatory Action Research (PAR) is a qualitative approach to a wide variety of problems, concerns and questions occurring in communities or organizations, through which a relational co-production of solutions is possible. While there is no unified or single formula for a PAR approach, according to McIntyre, there are underlying tenets common to most PAR projects:

- A collective commitment to investigate an issue or problem.
- A desire to engage in self and collective reflection to gain clarity about the issue under investigation.
- A joint decision to engage in individual and/or collective action that leads to a useful solution that benefits the people involved.
- The building of alliances between researchers and participants in the planning, implementation and dissemination of the research process. (2008, p.1)

These principles can serve to open communicative spaces, allowing a growing awareness of collective resources for change. In situations where a discourse of power obscures or marginalizes some perspectives, this approach is particularly helpful in giving them a voice. Originating in South America to assess needs in low-income countries, the utilization of PAR has increased steadily around the world, from urban teens in Baltimore wishing to improve the safety of their communities to communities

seeking solutions to neonatal health problems in rural Bolivia (Baum, MacDougall & Smith, 2006; McIntyre, A. 2008). Introducing PAR projects in these settings allowed an opportunity for people whose viewpoints ordinarily went unheard to explore and challenge existing knowledge and practices, creating novel practices that better served their needs.

In its purest sense, regardless of the topic or the setting, a PAR project would involve an equivalent partnership between researchers (those outside the organization being explored) and participants (*all* of those who live or work in the organization) throughout the research process. Operationally, that would involve discussion and consensus on the problem to be researched, the method for researching it, on the system for deciding what constitutes data, and on the dissemination and purpose for the information generated by the process. In organizations where a hierarchy exists, those in power would have to bequeath it or be excluded from the process (though of course as members of the organization they should be included.) Besides producing a logistical dilemma, such a PAR approach would involve a considerable investment of time and energy. Indeed PAR projects often span several years, and their champions have written about the frustrations and disappointments inherent in pursuing them (Bourke, 2009; McIntyre, 2008).

Impact of Location and Culture

For busy healthcare professionals like my colleagues, investing time in planning a PAR would have required immense dissatisfaction with the status quo. While some of them expressed frustration with parts of the standard meetings, they were not sufficiently

dissatisfied to attempt to change the existing structure. Bradbury wrote, “In effect, the power of those in control produces the knowledge about how to act, and gaining that knowledge about ‘acting normal’ reproduces this power structure (2008, p.554). I understood from the interviews that the founder who had sacrificed so much to form the group had established a dominant discourse of ownership. As a result, certain relational processes were distorted by this power relationship; for example, though opinions were welcomed with regard to certain group practices, the leadership team alone determined outcomes. There was also another factor that made rigid adherence to PAR protocols difficult. As the newest member of the group, having made a considerable financial investment to re-locate my psychotherapy practice there, I felt that I would have had a great deal to lose if the project were not well-received. While I was passionate about this topic, and interested in exploring collaborative spaces with my colleagues, I was mindful that I could inadvertently offend them if I communicated that I thought they were doing things “wrong” through this inquiry. I most certainly did not want the leadership team to perceive me as coming in to try to subvert the local customs and practices, which they’d spent more than a decade building. Consequently, after engaging in preliminary conversations with them about ideas for this inquiry, it was decided that a modified PAR would best fit the needs of the team, the practice, the participants and myself as a researcher/participant. The modifications are contrasted with more rigid adherence to PAR conditions:

Typical PAR	This Modified PAR
Purpose generated by all participants.	Purpose generated by researcher/participant.
Methods decided by consensus of participants.	Methods for pilot meeting decided by researcher.
Meaning of data determined by participants.	Meaning of data determined by both.
Dissemination of data determined by participants	Dissemination of data determined by leadership.
Professional narratives collected by researcher/participant were kept private at the request of participants	

Research Design

The modified PAR and grounded theory design involved multiple sources of data intended to construct meaning about collaboration across disciplines, from observations of the relational processes that took place between providers from different healthcare disciplines. Data collection took place during 20 interviews, one recorded pilot meeting, five recorded small group meetings and three non-recorded leadership team meetings, during which field notes were taken, between March 2014 and March 2016.

The Setting

This study was conducted in a large integrative healthcare practice, which included 21 practitioners trained in three disciplines: primary care, psychotherapy and complementary and alternative medicine (CAM.) The primary care practice, which

shared expenses for overhead, was comprised of five Advanced Practice Registered Nurses (ARNP's.)¹ The nurse practitioners generated the majority of referrals to the other providers, but providers also referred to each other and to the primary care practice. Those other providers, of psychotherapy and CAM, were all self-employed, and responsible for their own expenses and practice management. The practitioners were co-located under one roof, and paid rent according to their office size; the building was a rambling historic mansion. The large number of practitioners was necessary to cover the considerable expenses generated by the size and age of the building. The leadership team was comprised of the practice founder, a business manager and a marketing manager. The leadership team was responsible for the maintenance of the building, and the hiring and training of the nursing assistants and front desk staff, who greeted patients for the entire practice. The team set the agendas for meetings and marketing materials. They maintained final authority over who was invited to join or leave the group, though opinions were sought from all practitioners.

The practice held quarterly dinner meetings to discuss matters such as adding new members or ideas for generating business; these typically lasted over two hours and were considered mandatory. The monthly clinical meetings were held over the lunch hour, where healthcare topics were discussed, though it was not uncommon for marketing ideas or logistical issues to be deliberated there as well. Attendance at these meetings was encouraged but not mandatory. As a result, they were less well attended due to practitioners' schedules; coordination of schedules was complicated by the nature of the modalities of care. Psychotherapy sessions typically timed predictably on the hour, but

¹ To illustrate the size of the practice, the nurses provided more than 10,000 office visits in 2014.

the time most other providers spent with their patients varied unpredictably. Because of this, monthly meetings rarely started on time, and often became disjointed when providers arrived late. Busy schedules and a privilege of patient care over meetings had contributed to some providers opting out of attending clinical meetings altogether. Other than the monthly and quarterly meetings, the group operated as separate individual practices, without much interaction between practitioners. It was not uncommon for me to go months without seeing my colleagues, or to pass them only as we greeted our clients in the waiting room. For the pilot meeting, I was given permission to take over a single clinical meeting in June 2014.

My Place in the Setting

Before officially joining the group, I had sub-leased office space there for nearly two years while I transitioned my existing practice from another town. Within the second year of that sub-lease, I had invited the four other psychotherapists in the practice to form a consultation group, and they had responded enthusiastically. I had gotten to know them quite well by the time this inquiry was conceived. I was also able to meet many of the other providers during lunch breaks, or in passing during those two years, and I found them all friendly and welcoming. At the time I approached the practice founder to discuss this inquiry, I had attended one monthly clinical meeting, having just been made a member of the group. During that meeting, a format was utilized whereby each provider described how his or her modality would treat a named disease. The providers did not interact with each other.

The Founder and Practice History

In order to understand an institution adequately, one must have an understanding

of the historical process in which it was produced. The practice was started in the year 2000 by a well-known and respected ARNP. Her journey in healthcare was rich and diverse, influencing her to want to create such a healing community. After graduating from college as a nurse, she spent two years working at a small hospital on a Native American reservation in Oklahoma. While there she observed the hospital's janitor, who was in his culture a Medicine Man, cure a patient of a virulent flesh-eating infection for which conventional medicine had been ineffective. She learned from the wisdom of the local people, and came to appreciate that knowledge about healing could be co-created in ways that were not familiar to her. From there she returned east to explore an interest in cardiac nursing, earning a Master's degree and developing expertise in this specialty. After spending several years running a cardiac surgical department, she wanted a change of pace and moved to a mobile medical unit in rural Maine. It served migrant workers who harvested blueberries and cranberries, and she appreciated the opportunity to assist an underserved group of people. Realizing that she liked working with a variety of patients rather than those needing a single type of care, she earned her certificate in family practice, along with her ARNP, which allowed her to prescribe medication. She worked for several years at a hospital-owned primary care practice, and it was there that she became aware of patient interest in CAM approaches. Though she found herself feeling concerned when they reported taking large doses of vitamins or supplements, as she feared this could be harmful, she also recognized that she herself had little to offer about those alternative treatments. Realizing that one person couldn't possibly develop expertise in so many modalities of healthcare, she began to envision a team of dedicated, patient-centered professionals who could offer different types of treatment, and would

also be willing to work together for the good of the practice. When the hospital that owned the family practice set an edict that providers had to see 40 patients per day, she made the decision to leave and make her dream a reality.

The original practice group included eight providers: two ARNP's, one RN, two nutritionists, a polarity specialist, an acupuncturist, and a psychotherapist. Yoga and tai chi teachers also offered classes in the building. For the first several years, the founder worked 16-hour days with few vacations, taking on the administrative, personnel and financial burdens in addition to providing patient care. (She once recorded all of the barriers she faced in trying to open the practice, and the list filled 12 pages.)

Over the years the practice grew, with some providers leaving of their own accord and others being asked to leave. The move to the new building in 2007 brought growth, with its challenges and rewards.

The Providers

All of the providers were experienced, having worked in settings from hospitals to group practices to community health organizations prior to joining. They ranged in age from 29 to 70 at the outset of the study. They shared a belief in the validity of multiple viewpoints in healthcare, which was known in the practice as an “integrative approach.” Some were highly educated and others had taken certificate courses to learn their modalities of care. They were at different stages of their careers; some were only a few years into their professions, and others near retirement. They had different demands on their time; some had young children/teens at home and others were not parents, or had grown children. All were self-employed and as such, had no paid vacations or sick leave or employer-funded pension. They were responsible for their own health insurance and

retirement savings. They earned money only when they saw patients, and attendance at meetings took time away from that. Providers kept their own schedules; some worked part time, some full time, a few offered evening and weekend appointments. When providers were in the building, they worked in their offices with clients, however collaborative albeit brief conversations did sometimes take place during chance meetings in the kitchen. There were no shared medical records, and no access to each other's patient charts. It was not uncommon for multiple providers to work with the same patient without being aware of it. There were no multidisciplinary treatment plans, and no triage team.

Disciplines

The practice included three disciplines and associated modalities of treatment.

Primary Care Medicine: Concerns primarily the biological, chemical and physical aspects of the clinical practice of medicine. This was practiced by the ARNP's and one Doctor of Osteopathy (DO.)

Complementary and Alternative Medicines (CAM): Includes five categories:

- (1) Alternative Medical Systems: (Ayurveda, traditional Chinese medicine)
- (2) Mind–Body Interventions: (meditation, prayer, craniosacral);
- (3) Biologically Based Therapies: (nutrition, herbs, vitamins, supplements)
- (4) Manipulative and Body-Based methods: (chiropractic, massage)
- (5) Energy Therapies: biofield therapies (reiki, qi gong), or bioelectromagnetic-based therapies (blue light treatment, electroacupuncture). (Caldwell, Karen L., Winek, Jon L.,

Becvar, Dorothy S., 2006.)

Each of the five categories was represented in this practice, including: Acupuncture, Ayurveda, nutrition, naturopathic medicine, chiropractic care, massage therapy, Reiki (a healing technique based on energy and touch), Bowen work (a hands-on technique using gentle pressure, believed to “reset” the body to heal itself) and intuitive healing (which utilizes the intuition of the practitioner to help patients understand what is at the root of their illness.)

Psychotherapy: Concerns primarily the psychological, social and emotional aspects of health and illness. This was practiced by three clinical mental health counselors, one marriage and family therapist, one social worker and one psychiatric nurse practitioner.

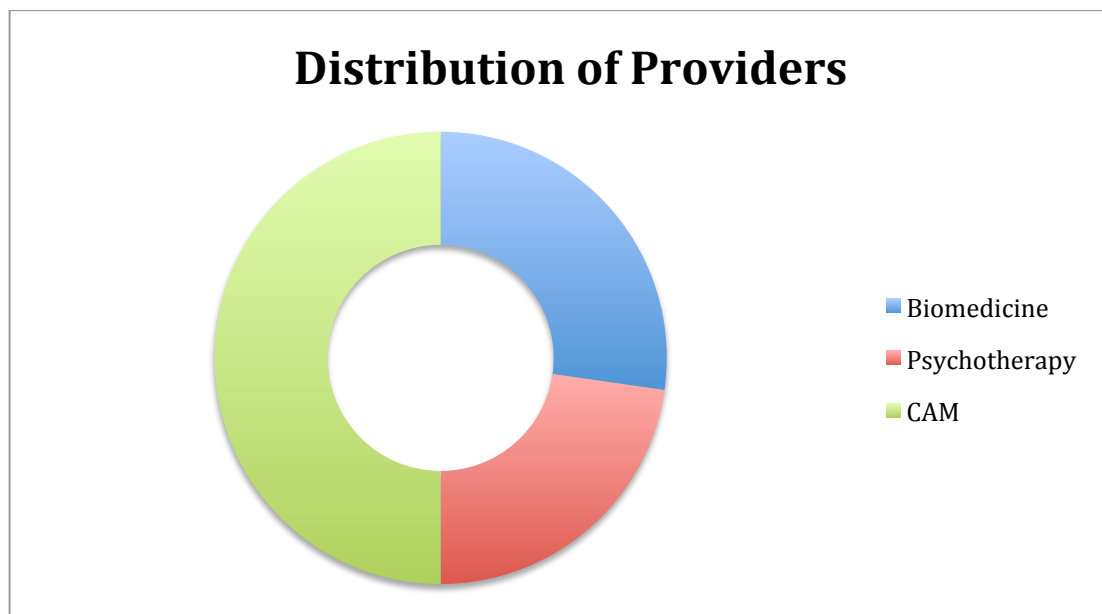


Table 1: Distribution of providers by discipline

Recruitment

The idea for the project was introduced during a quarterly meeting in March of 2014, where all 22 members of the practice (including myself) were in attendance, and the leadership team expressed its full support. The members were invited to participate in individual interviews, followed by a pilot meeting. The stated purpose was to learn about collaboration across disciplines in a private practice setting. Informed consent forms were distributed and signed. All 21 practice members were contacted individually, and invited to participate in a semi-structured interview. Only one did not acknowledge the invitation.

Overview

I facilitated a one-hour pilot meeting with 15 other participants. The meeting was recorded and transcribed. Data from that meeting was utilized to shape the format of future meetings. Data were analyzed and submitted to participants for their input. Initial results were shared with the Leadership Team first, and the entire group at a quarterly meeting. Participants were invited to listen to recordings and read corresponding transcripts, and to decide collectively through dialogic processes what the data meant to the group nearly two years after the pilot meeting.

Inclusion Criteria

Every member of the group practice was invited to participate in the inquiry.

Exclusion Criteria

One member who chose not to participate was not included in the individual interviews or the meetings. Five members did not attend the pilot meeting. Only five members (other than myself) attended the subsequent meetings.

Key Terms

Patient: One who seeks healthcare services from providers of Primary Care Medicine, Naturopathic Medicine or Chiropractic Medicine.

Client: One who seeks healthcare services from providers of psychotherapy, acupuncture, energy workers, massage therapy, hypnotherapy, nutrition.

Psychotherapy: Talk therapy provided by licensed psychologists, mental health counselors, social workers or marriage and family therapists.

ARNP: Advanced Practice Registered Nurse. Requires a master's or doctorate degree and in the state of NH, includes ability to prescribe medications without the supervision of a physician.

DO: Doctor of Osteopathy. Requires a medical degree and includes a whole-person, preventive approach to healthcare.

The Interviews

The 20 interviews were semi-structured using open-ended questions so that participants could direct the conversation where they wanted it to go; depending on that direction, different follow-up questions were asked. The structure of the interviews included beginning with these three questions: “What was the journey that led you to your profession?” “What drew you to the integrative practice at the particular time you joined?” “Describe some of your experiences with collaboration across disciplines?”

The purpose of the interviews was to build a rapport with each provider, listen to their professional narratives, and get a sense of their ideas about collaboration across disciplines. By learning about the experiences that led to their career choices, and demonstrating my genuine interest in their journeys, I expected that the spaces between us would be diminished. By hearing about their histories with collaborative conversations, I formulated ideas about what might work in our group dialogue, and what should be avoided. All of these things collectively were utilized to develop plans for the pilot meeting.

The Pilot Meeting Plan

During the interviews, I reminded my colleagues that they would be invited next to participate in a pilot meeting where we would engage in collaborative dialogue about a shared case. Although attendance at clinical meetings could be sparse, I considered how I might manage the logistics of engaging a potential group of 21 providers in a collaborative discussion. To accomplish this, I chose a ‘case consultation’ approach, where a mutual patient’s care would be discussed by five practitioners who were all simultaneously working with the patient, but had not previously talked to each other about his care. (Details of the case will be given below.) As this would invite only some practitioners to the discussion, I needed to find a way to include my colleagues who were not working with that patient or his family. I recognized that while they might believe they had little to contribute about a patient they had never met, I saw a benefit to their distance from the case. As presented in Chapter One’s discussion of consultation groups, that detachment could provide some perspective for those who *were* directly treating the

patient. I believed that the different viewpoints of those discussing patient treatment and those simultaneously hearing that discussion would be beneficial, as they could offer a different experience of the same event.

To invite and facilitate participation, I elected to use Andersen's (1987) reflecting team model. I had experienced the reflecting team process as a graduate student, and found it extremely valuable in introducing me to the ideas of dialogic interactions. Learning to alternate between talking and listening can be difficult, and it can help to have a structure that aids this process. For example it is common to formulate our answers, or ruminate about the exchanges that have just taken place while we believe that we are listening. Sometimes when we believe we are talking dialogically, we are using language intended to *convince* another of the veracity of our position, which is quite monologic. If we can become aware of our internal dialogue, and reflective about what is happening for us in these exchanges, we can learn to listen and talk in more inviting ways. The reflecting team model facilitates this by requiring us to wait for what can feel like an unnatural amount of time before voicing any opinions. The format involves two groups; one engages in dialogue while the other listens quietly, without interrupting or interacting in any way. When the first group has finished, the listening group then reflects through dialogic exchanges *about their experiences listening*, while the first group listens quietly to them. The listening group is not critiquing or challenging the *content* of the dialogue, but instead commenting on what the *process* felt like to witness. By listening in turn to the reflecting group, the first group is offered new viewpoints about their dialogical process, which can provide a vehicle for self-reflection or change or perhaps

verification of their customs and practices. Afterwards, the two groups come together to discuss the process, which can lead to deeper and more transformative discussions.

Based on my experiences in the clinical meeting I had attended, and the information that my colleagues had shared in the individual interviews, it appeared that the local custom of the group was for each practitioner to take turns explaining the virtues of his or her modality when they met together. I experienced this as a series of monologues, with little curiosity shown to each participant's discipline or way of working. I thought that the clinical meetings might be stuck in traditional ways of doing things, and could possibly benefit from some new ideas. I also had another reason for choosing the reflecting team model. I wanted to convey the Social Constructionist principles of inviting others to dialogue, and valuing multiple viewpoints in an organic way rather than a lecture. I thought that the shifting between listening and talking that the model provided could naturally illustrate the differences between monological and dialogical discussions. I hoped that once those unfamiliar with Social Constructionist principles experienced that difference, they would choose to engage in the kind of collaboration I thought was possible for the group. I also thought that by listening to the reflections of the team, a process of *self*-reflection might begin for the treating practitioners. By utilizing the reflecting team model, I also believed we would have an opportunity to witness the co-creation of knowledge across healthcare disciplines in real-time.

Correspondingly, I understood that there were inherent risks to the introduction of the reflecting team model, because different experiences of the same event can also be invisible or disturbing to participants. Andersen (1987) wrote of three ways that different

experiences of the same event tend to be expressed and received. In the first, the difference in experience is expressed in a way that's too small to be noticed. In the second, it is offered in a balanced way that's appreciable enough to be noticed, yet not so intense that it cannot be digested. In the third, the difference is so immense, or forcefully expressed that it is too unsettling to be of any value to participants. These ideas resonated strongly with me, and I wanted to make every effort to ensure that my colleagues could appreciate and digest whatever ideas were offered.

But because we would be discussing my client, there was more at stake than just losing the value of the feedback of the reflecting team if the approach were unsuccessful. If the feedback were so insignificant that nobody noticed it, my client would not be helped, and the group would not see any value in this process. If the feedback were overpowering or offensive in some way, my client would not be helped and my colleagues would most likely dismiss both the ideas I was trying to put forth and me as their author. With all of these potential problems, the pressure I experienced in the planning of the pilot meeting was considerable; I prepared for it with the potential risks and benefits keenly in mind.

The Case

The importance of safety in teams, outlined in Chapter Three played heavily in my choice of a case for the pilot meeting. I chose one that was new to the group practice, to allow room for exploration of treatment without the risk of any provider feeling that he or she hadn't been successful, in the presence of peers. The case involved a client of mine, a who was also working with four other providers in the practice. When I proposed that all of her son's healthcare providers could collaborate about his treatment, she was

eager for this to take place, and grateful for the opportunity. My client was a mother seeking parenting support for her 10 year-old son, whose acting-out behavior at school and at home had become unmanageable. He was taking several medications prescribed by a psychiatrist who was not part of the integrative practice, and she was hoping to wean him off of them and find a more holistic way of treating his behavior. I had just begun working with her, and I had not met the child at the time of the initial meeting. The co-treating providers had each met the child once, and seen him interacting with his mother. Of the four other providers, two were from primary care, and two from CAM. (Each was unaware of the other's involvement prior to the meeting.)

Preparation for the Pilot Meeting

Because I was not offered additional time during meetings when the entire group was gathered, I prepared participants for the pilot meeting primarily through email. After individual interviews were conducted and the reflecting teams approach chosen, I divided the participants into a Treating Team and a Reflecting Team.

Steps for preparation of the pilot meeting.

*An email was sent to 16 colleagues explaining the reflecting team process and the roles of the teams (Appendix One.) Of the four other colleagues who were part of the Treating Team, I sought out and spoke to three in person. The fourth provider worked only one day per week, and our disparate schedules precluded my speaking to him face-to-face, so I invited him via email; I did not attempt to contact him via phone.

*I sent two additional emails to the one provider with whom I did not speak, offering the invitation and sharing my ideas about the process.

*I invited the remaining 17 providers via email to form a reflecting team (Appendix Two)

*I created a handout based on Anderson's (2012) Tips for Dialogue, which I placed in everyone's mailbox (Appendix Three.)

*With the permission of my client, I forwarded to all of the treating team an email she had sent me about her son, who was their patient. (Appendix Four.)

*The practice manager sent a reminder email the day before the meeting to all 22 providers. (Appendix Five.)

*I enlisted a provider who had experience with the model to guide the Reflecting Team during the pilot meeting.

*The hour was structured as follows: Twenty minutes for a Treating Team conversation about the case, 20 minutes for the Reflecting Team to discuss what they'd heard, and 20 minutes for the group as a whole to process the experience.

*A member of the Leadership Team was recruited to keep track of time during the meeting.

After the Pilot Meeting

During the planning phase of this inquiry, I had intended to solicit feedback from all of the participants of the pilot meeting after it was held. However because of the way it unfolded, I chose to solicit feedback from only five members of the Reflecting Team. I did this because my experience was that the pilot meeting was not successful, and I felt that I understood many of the reasons for this. I reasoned that asking all of the participants to donate more of their time and energy to an inquiry that was not successful would have felt quite bothersome at that point. To discuss what felt at the time like a debacle, I selected representative members who had demonstrated their willingness to be

reflective and forthcoming. Based on those conversations, I amended my approach to this inquiry, which is reflected in the second meeting described below. I did not solicit written feedback from the participants of the pilot meeting because I believed I had sufficient information to move forward without it, and did not want to burden my colleagues with the request.

Approach to data collection and analysis.

The meeting had been recorded with everyone's permission using a digital recording device, and transcribed by me. The transcription was analyzed using gerund coding, for a specific reason. Collaboration is a relational process, and I wanted to capture that process as it unfolded during the meetings. Rather than providing static descriptions of "events," gerund coding focuses on actions. Using "speed and spontaneity" as has been recommended, I asked myself an initial question for each utterance in the transcript: What is happening here? I then worked quickly, and went with my strongest initial reaction to what I read. I then considered, what does it mean, and how does it relate to collaboration across disciplines (Charmaz, 2006)?

Of equal importance to the questions is reflexive consideration of how these questions were produced. I have described in great detail my path to becoming a psychotherapist, and the client interactions that have informed and shaped my passion for collaborative dialogue with other providers of healthcare. As previously mentioned, in the single clinical meeting I had attended prior to beginning this inquiry, I had experienced the discussion as a series of unrelated monologues about how each practitioner would treat a person with the healthcare issue being discussed. The overall feeling was one of informing others about each modality. In the many preceding years

that I had engaged in conversations with colleagues about shared cases, I had developed ideas about what we were doing, beneath the surface, with our words. For example there were times that it seemed we were seeking to justify our unsuccessful treatment choices, rather than talking about them with the openness that collaborative dialogue requires. My goal in framing the questions was to attempt to experience the meetings reflexively, in a different way than I felt possible as the researcher/participant. I thought that this approach might help facilitate more collaborative dialogue across disciplines than I had historically experienced. While there could be no objectivity in the way I listened to the recordings, I believed that the language-games of the three questions would put me in an optimal state of mind to experience the meeting with a bit of distance. I utilized gerund coding to separately analyze the conversations of both the Treating Team and the Reflecting Team from the pilot meeting. These results, along with my experience of, and feedback from five other participants of the pilot meeting served to alter the approach to subsequent meetings.

The Second Meeting: A Small Group

The purpose of the second meeting was to give my research questions another opportunity to be tested. It required me to step aside as the leader, and allow the participants as a group to choose the purpose, format, topics and facilitation of the meeting. These would be determined by a consensus, and the meetings would be held in addition to the monthly, pre-scheduled clinical meetings. Every colleague was invited via email to participate in a second collaborative meeting that would be held *in addition* to the clinical and quarterly meetings already in place (Appendix Seven.) When nobody accepted the invitation, I recruited two colleagues (in face-to-face conversations) who

had been part of the Reflecting Team, and expressed keen interest in the process, and one who had not attended the pilot meeting but had also expressed interest in collaborative dialogue to participate in another meeting where *they* would decide its purpose and format. They agreed, and in order to be considerate of their time, and to show my appreciation for their participation, I scheduled the second meeting during their lunch hour, on a day that I was not typically in the office. To be hospitable, I provided lunch for everyone as well. An email reminder was sent (Appendix Eight) and a member of the leadership team was invited to take notes. I started the meeting by asking my colleagues what they would like to do with a collaborative group, and the resulting dialogue formed the scaffolding for this small group. It was determined that another provider would present a case the following month. I sent a follow-up email to the participants, providing a template for a form based on their suggestions about ways we might collaborate with the busy Nurse Practitioners about shared cases (Appendices Eight and Nine.) The meeting was recorded and transcribed, and lunch was provided. Because this was a planning meeting and patient care was not discussed, gerund coding of the transcripts was not performed.

The Third Meeting

The group recruited another CAM provider who had been part of the Reflecting Team to join the third meeting, and the marketing manager did not return, as the group determined that note taking was unnecessary. During the third meeting I expressed interest in inviting a patient to join us occasionally as an “expert” on a healthcare topic. I sent an email invitation after the meeting confirming one of the CAM providers to lead

the next one, as the group had chosen to rotate leadership each month. (Appendix 10.)

The third meeting was audiotaped and transcribed, and lunch was provided. Because this was a planning meeting and patient care was not discussed, gerund coding of the transcripts was not performed.

The Fourth Meeting

The group recruited a sixth member, who had also been a part of the Reflecting Team. She was another CAM provider who had expressed interest in joining; the group considered itself complete at six members: three representing psychotherapy and three representing CAM. (This configuration of participants will be referred to as the small group to distinguish it hereafter from the larger pilot meeting.) The meeting was facilitated by a CAM provider who chose to present a case. After the fourth meeting, I sent an email to the small group members sharing an excerpt from the book *Narrative Medicine*, and making the case again for the inclusion of the patient's voice in our meetings (Appendix 12.) The fourth meeting was audiotaped and transcribed, and lunch was provided. The transcripts from this meeting were selected for gerund coding (Appendix 15) because all of the small group members were in attendance, and it was representative of the small group interactions. As data previously collected began to be repeated, no further meetings were recorded, though field notes were kept. Lunch was not provided for 18 months after the fourth meeting.

The Subsequent Meetings

The small group unanimously chose to continue meeting on a monthly basis for 18 months after data collection had ceased, with leadership alternating among members. To help facilitate cohesion within the group, I continued to send emails reinforcing the collaborative conversations that took place during the meetings. (Appendices 13,14.)

Questionnaires

A questionnaire was given to each group member (Appendix 16) after the sixth meeting, summarizing the analysis of data and requesting feedback about members' experiences.

Results Are Shared with Leadership

After the questionnaires were returned, I met with the leadership team to review the data analysis, and share my field notes. (Appendix 17.) The meetings were not recorded, but field notes were taken. Based on the data, I introduced the basic principles of Appreciative Inquiry as they apply to organizational change. Per the request of the team, I shared the results with the entire group at the next mandatory meeting. I had one final follow-up meeting with the leadership team to talk about possibilities for future expansion of the project.

The Recap Meeting

A recap meeting was held 21 months after the project had begun to generate summative evaluative feedback from the participants of the small group. Because the small group members communicated that they were not interested in listening to entire recordings of the previous meetings, I chose representative excerpts to share with

corresponding transcripts. Participants were asked three questions about the recordings:

“What was happening there?” “What did it mean?” “How does it relate to collaboration?”

Lunch was provided, and the meeting was recorded and transcribed.

In total, I spent 46 hours collecting data, as reflected in Table 3.

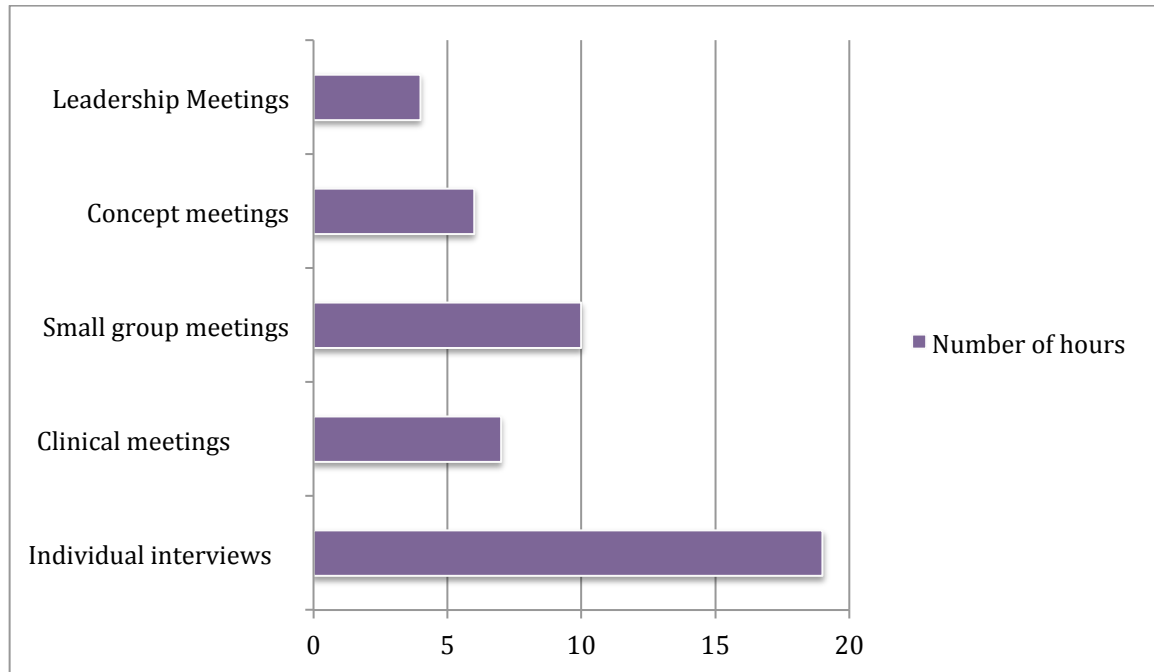


Table 3: Number of hours spent per activity.

Chapter Five: Results

This chapter describes the results of each of the steps undertaken in this inquiry, including the individual interviews, gerund coding of the pilot meeting, descriptions of three small group meetings and excerpts from the recap meeting. Most striking was the difference between the coding of Treating Team's and the Reflecting Team's conversation from the pilot meeting. Gerund coding of the fourth small group meeting produced similar results to the Reflecting Team's conversation during the pilot meeting. These trends will be illustrated below in excerpts from the transcripts, and discussed in the following chapter. Results from the questionnaires from the sixth small group meeting, my discussion with the leadership team in January of 2015 and discussion with the entire group practice at the quarterly meeting held in April of 2015 are also presented in this chapter. The results are merely presented here; they will be discussed in Chapter Six.

Results from Individual Interviews

I conducted 21 interviews with my colleagues between March of 2014 and February of 2015. The shortest interview lasted 30 minutes and the longest two hours; each participant determined the length of time spent on his or her interview. The results of the interviews were two-fold; I felt more connected to my colleagues when I understood what had led each to his or her chosen profession, because there were parallels to my own narrative in every story. Additionally, I perceived a common theme in the participants' appreciation for discussion of clinical issues in the monthly meetings, and a desire for less focus on business issues during those infrequent times that we were

all together. One participant stated that she had never considered collaborating about patient care, and 19 participants reported that they routinely collaborated with one or two practitioners of their own modality on complex or difficult cases. One participant stated that she purposely avoids collaborating until after meeting her clients in order to eliminate bias and form her own opinions about each case. All four psychotherapists reported attempting to collaborate across disciplines with practitioners of psychiatry and primary care medicine, with moderate success. The other participants, who practiced primary care medicine and CAM reported that while they valued the idea of collaboration across disciplines, they did not practice it regularly. They cited lack of compensation and lack of time or access as the primary reasons for this discrepancy. Following are short summaries of some of their professional narratives.

Professional Narratives: Primary Care Nursing

One of the most experienced ARNP's in the practice celebrated 50 years in nursing in 2015. Her story parallels the recent history of nursing in the US. She became enamored with the profession as a child, reading a series of books about a visiting nurse called Cherry Ames. She matriculated during a nursing shortage; as a result she attended classes during the day and worked the night shift with her classmates on a ward with 30 beds per floor, and only one supervising RN for the entire building. She observed a schism in the profession where some valued education and others practical skills, with advanced degrees eventually becoming a necessity. She was one of the first in New Hampshire to become trained in primary care medicine as a specialty, and for years fought physicians who objected to this change. She and her peers banded together and

won a lengthy court battle that allowed them to bill insurance companies, write prescriptions and provide care without being supervised by physicians.

Another colleague was one of the first ARNP's to study the practice of mindfulness with famed author ²Jon Kabat-Zinn. She incorporated meditation and other Buddhist teachings into her work as both a nurse and as a professor of nursing, at several universities in the northeast.

There were some commonalities among the nurses; all of them came to value alternative approaches to Biomedicine early in their careers. Four of the five had completed apprenticeships in herbal medicine; a fifth had lived in Nepal and come to admire and appreciate the approach to treating illnesses that she observed there. All of them had pursued advanced degrees later in life. Some of them had had children of their own, others had worked in Labor and Delivery departments of hospitals. They shared the experience of seeking to join the practice when the hospitals that had employed them mandated they provide care in a way that they did not find ethical. They appreciated the proximity to practitioners of other disciplines for the ease it provided in making referrals.

The nurse practitioners all reported that they collaborated with their patients and sometimes with the patient's families, and frequently talked to each other about difficult cases. However they tended to coordinate care with providers from other disciplines rather than collaborate with them; each of them cited time constraints as the main barrier to more interaction with colleagues from different disciplines.

² Jon Kabat-Zinn is a professor of medicine and the creator of the widely acclaimed mindfulness-based stress reduction program, which is utilized in a variety of settings to improve health.

Professional Narratives: CAM

All but one of the CAM providers reported being drawn to their professions because of personal experiences with illness----either their own or a loved one's---in which non-traditional treatment was successful where traditional medicine had failed. Two had been considered prodigies as children, able to intuit health issues in others, and to provide relief through energy work. Some took circuitous routes to their profession, others more direct. Two had spent years working in restaurants, several had worked in hospitals, and one had spent time as a dental hygienist before pursuing her medical degree. All of these practitioners shared a strong belief in the body's ability to heal itself, and in the importance of removing obstacles for optimal health. They expressed a belief that patients must first learn to be "in resonance" with their own bodies before collaborating with healthcare providers; teaching this was reported as a first order of business in treating patients.

The CAM providers reported frequent collaboration within their discipline, either through shared cases or consultation. One reported a belief that the human body shows something different to each modality of care, making each piece of information equally important in treating the person as a whole; however she reported only infrequent collaboration across disciplines. All reported receiving very few referrals for their services from other disciplines historically, and concern about their work being negatively perceived by traditional medical approaches. They reported being drawn to the integrative practice in large part because of the proximity to referrals.

Professional Narratives: Psychotherapy

All of the psychotherapists shared a childhood interest in examining relationships and experiences, and a wish to understand their own families as part of the appeal of the profession. All were proponents of mindfulness-based stress reduction, and strong advocates for exercise and healthy nutrition in their own lives and those of their clients. Expressed also was a shared interest in learning about the neuroscience of emotions and behavior, and in considering the wider system in which their individual clients lived and worked. Two pursued psychotherapy as second careers more than a decade after completing undergraduate degrees, and two started graduate school immediately after. One endured a serious childhood illness, unexplained to her at the time, which inspired her to want to help children as an adult. Another found a passion in Reiki, which she combined with psychotherapy and hypnotherapy to provide a unique treatment option for her clients.

All of the psychotherapists joined the integrative practice out of a desire to offer more holistic options to their clients. The psychotherapists all reported collaborating early and frequently in their careers with providers within their discipline, as well as frequent collaborative interactions with providers who prescribed psychotropic medication for their clients. They stated having very infrequent contact with providers of medicine or CAM prior to joining the integrative practice.

Table 2 illustrates the similarities and differences in their approaches to healthcare that my colleagues expressed during the individual interviews. In listening to their narratives, I assigned meaning to my colleagues' experiences as indication of their

openness to other ways of knowing in healthcare besides their own. Many of them were familiar with the vulnerability that comes with ill health, or with being seen as “lower on the hierarchy” by practitioners from other disciplines. I believed that talking with me about their professional experiences with might have prepared them in some way to engage in the reflective practices that emerge from reflecting teams. Given these impressions, I reasoned that they would respond positively to the reflecting team model, and to Social Constructionist ideas about dialogical conversations.

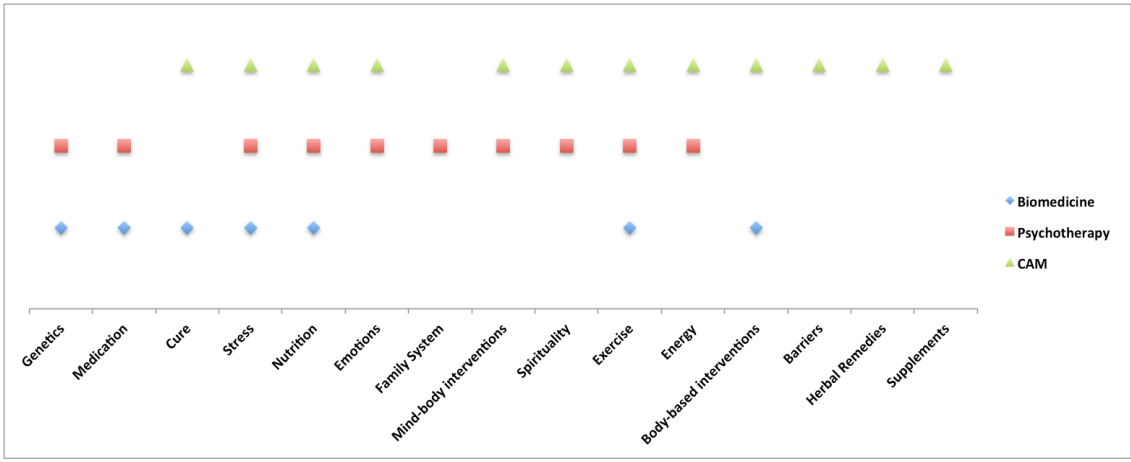


Table 2: Similarities and Differences to Healthcare, by Discipline

Results of Meetings

Five meetings were recorded and transcribed for this inquiry. The pilot meeting was attended by 16 participants, as follows: Five from primary care, three from psychotherapy, and eight from CAM.

Pilot Meeting Results

During the pilot meeting, because we only had one hour, I expected that the four co-treating providers who along with me would make up the Treating Team, and the remaining participants who would make up the Reflecting Team would arrive on time. However only one other person, who was also a member of the Treating Team, did so. I began to discuss our mutual client with her, and about ten minutes later, two other members of the Treating Team arrived and joined the conversation. Four of us discussed the case while eleven Reflecting Team members listened. The final member of the Treating Team arrived 25 minutes late, just as we had wrapped up our discussion of the case, and the Reflecting Team was beginning their conversation. We discovered that because that Treating Team member had not read any of his emails, and I had not spoken to him directly about the pilot meeting, he was aware of the meeting but not his anticipated participation in it. When this disruptive exchange took place, I felt frustrated. I was disappointed with the way the Treating Team conversation had gone, I was annoyed with the provider who had arrived so late, I was disappointed in myself for not contacting him directly, and I was concerned that the pilot meeting would be seen as a failure by my colleagues. As a result, I was not fully present to engage in dialogue about my client, or to really take in what the Reflecting Team had to say.

I gerund coded the transcripts of the Treating Team, and interpreted the actions as following a pattern of exchanges, which continued throughout the 20-minute discussion. Social Construction recognizes that utterances in conversations are informed by previous interactions as well as by what is happening in the process between participants as it unfolds. This is evident in the following raw data from the transcript. The first two excerpts were coded as *pushing an agenda*, which is illustrated below.

X1: “And something else that I wanted to share, and you have a handout for this, you may be aware of this; it was new to me. It’s a different way to look at Spectrum disorders. This doctor suggests you take a web approach where you and look at everything from their nutrition to their energy to their history, did they always have illnesses, that kind of thing, there’s a whole lot of things to look at. She finds that if you address their symptoms this way, the least intrusive way, you can sometimes get real changes. And so what I’d like to do is just hear your experiences with him, I know we’ve talked briefly and I thought you were incredibly insightful. And then what approach you would take going forward, hear how you would go forward.”

This excerpt was uttered at the start of the meeting, and included a reference to a diagnosis as well as a treatment plan before the case was even discussed. The plan was endorsed as if the diagnosis were indeed a fact, and then a solicitation was made of the other person’s thoughts. Because that was offered using the phrase “... what *I’d* like to do is just hear *your* experiences with him ...” it seemed not an invitation to dialogue, but rather a sort of hierarchical demand. And as it is occurred after the “selling” of the

treatment plan, it felt to me like a solicitation of corroboration, which I interpreted as pushing an agenda.

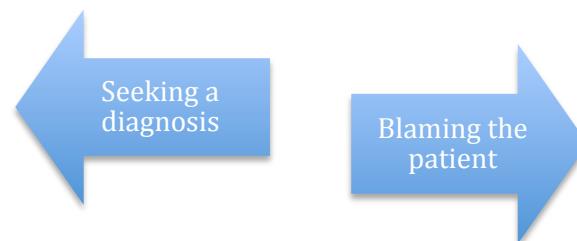
X2: “I’m sorry I haven’t seen him since March. He came to the clinic the first and fourth time I saw him, and twice and then Mom brought him to 2 sessions. He responded really well, children love (her modality) because in line with this handout, it’s about the brain. We’re really addressing the brain and helping that sense of being overwhelmed and challenged, and letting things calm. He responded really well but I think unfortunately, unbeknownst to me, um she was expecting a cure, and so she hasn’t been back. But she was really excited. I brought a handout about a child who was really helped, and his mother did this testimony for our (her modality) work journal, because it’s about calming and allowing and helping the child cope, and it can really change a child’s life. And that’s what it’s about, helping them manage. And so I think moving forward, as much as he responded well to the (her modality), if she was good with him...”

This response began with an explanation of the provider’s interaction with the patient. Perhaps in response to the tone of the first speaker, it provided “evidence” about the efficacy of her discipline’s treatments. It also included a sentence assigning meaning to the mother’s decision to stop treatment, before returning to the positive outcomes of her modality of treatment. Because of the emphasis on her particular modality, it was also coded as pushing an agenda. The second gerund coding was *Blaming the Patient*, as indicated in this excerpt from the raw data, which followed the above utterance:

X3: “You know I find it interesting that you said the mother gave up on it. He saw _____ and then he saw me. So I think there’s a piece where the mother needs

to get into a groove, and see that what's working and that's where I think you can work with her. Because I saw and I think 'what's going on with this kid?' because we don't even know him here. We've had three visits, he's seen three providers.³ So it's really hard to get continuity, consistency of care, and then _____ is seeing him so you know we did a neurotransmitter test on him to try to get some more specifics. She wants a magic pill."

Building on the meaning assigned to the mother's actions in the prior utterance, this excerpt expanded on her intentions. Here I interpreted the speaker as laying responsibility with the mother for the failure of consistency of care. This was coded as blaming the patient though technically, it was blaming the patient's mother. These ways of talking contributed to a disjointed conversation that appeared to be a series of unrelated monologues rather than a dialogue, as represented below:



The Reflecting Team then engaged in conversation about what they had heard while listening to the Treating Team discuss the case. Following is an excerpt from the raw data:

X4: "I thought it was interesting listening to each of you talk; it sounded like

³ During the discussion it was determined that it had been the scheduling desk, not the mother who had set three appointments with different providers rather than one.

you were all talking about somebody different. I didn't get any kind of um cohesive-you all were all looking at him through different eyes, and different experiences, so I think that might lead to---a different experience in collaborating ...”

For me, this excerpt illustrates the power of the reflecting team model in that it highlights the process rather than the content of the action. Here I interpreted the speaker as being careful not to criticize when she paused before saying that a lack of cohesion can lead to a “different experience in collaborating.” I coded this utterance as *reflecting one's experience*. Another member of the Reflecting Team offered a possible solution to the disjointed process:

X4: But what I started to think about was when I worked at _____, we had something called a ‘wrap-around’ meeting. Where the practitioners would all get together with the parent and the child and be able to, again, appropriately with the child there, and then the child would leave at some point, and it would be more of an adult discussion. And this would, you know, put everyone on more of the same page to be able to be right in the same room at the same time.”

I interpreted this utterance as *suggesting a solution* for the process of discussing cases that would be inclusive of the patient and the family. I coded it as seeking solutions.

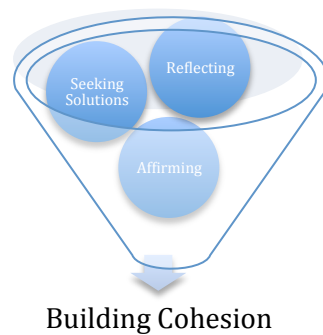
Another member of the Reflecting Team commented:

X5: And in this case, how helpful would that be!

I interpreted this utterance as *affirming support* of the idea that had just been put forth.

The utterances of Reflecting Team members as a whole (Appendix Six) made the process

feel dialogical rather than monological to me, as each directly mentioned or affirmed or posed questions about the previous utterance. This led to an overall sense of the process as building cohesion among the team members, as illustrated by the following figure:



When the entire group came together for the last 15 minutes of the pilot meeting, I attempted to initiate a discussion about the overall process of the reflecting teams approach. Following is an excerpt from the raw data of that conversation, which included three members of the Treating Team and one member of the Reflecting Team.

X1: “So what do we think about how we want, if we bring this out from this case a little further, how we want to collaborate as a team? What can we take from this?”

This was coded as *soliciting reactions prematurely* (before participants had been given an opportunity to digest it.)

X5: “I’m sorry for interrupting, I feel like I’ve had a call made, I talked to the mom for a long time, and I haven’t seen the patient yet. Is she back with the first husband?”

This was coded as *taking the conversation on a tangent*.

X6: “No. Could I also just say one more thing? I think as an integrative

practice, as we are we're a little bit sitting ducks for people who want to want us to cure in a completely different manner. For example, I had a woman come in with a wheelchair, had 2 cardiac surgeries, was on dialysis, and wanted to get off everything and get on herbs. She heard I was an herbalist. And I was like 'you are so out of my scope of care. I can give you some herbs to help you, you know cardio-tonic or whatever but I am not' and I wheeled her right out of the house. I couldn't deal with it (Laughter.) That's extreme but I'm just saying that sometimes we are sitting ducks. Like nurse practitioners are sitting ducks for narcotics seekers. They think that we're all so chummy and we'll slip it to them any time because we're so friendly but you know so in fact we're more hard-lined because of that. So you know I just think with the integrative, it's sometimes a neon sign. But I'm not faulting this wonderful mother for trying something different. I'm just saying that there's a splitting that she's doing or a splitting of consciousness of getting off all those meds and trying to recreate my child I think we're sitting ducks for that a little bit."

The first few sentences were coded as *pushing an agenda* (that vilified patients.) The last two sentences were coded as *blaming the patient* (while ostensibly complimenting her.)

X3: "And the other thing that comes to mind is "Where's the Dad?"

This utterance was coded as *shaming the patient*. When these exchanges, which were presented here exactly as they were spoken during the meeting, were examined, I noticed that each utterance did not reference or build upon the previous utterances, but instead introduced a new topic. As such they were interpreted as monological

rather than dialogical processes.

Feedback from the pilot meeting

In conversations with five of the participants of the pilot meeting, nearly all expressed confusion about the Reflecting Team model. One participant, who had been familiar with it prior to the meeting, said that she had learned it over the course of several months, and had needed that amount of time to fully understand its process and function. She suggested that people would have benefitted from gradual exposure to it, and more experiential time to try it. One participant stated that she did not routinely read emails, and would have appreciated a phone call to explain the proceedings. Another participant said that she routinely came late to meetings, and would have appreciated a written summary of the case we were discussing to help orient her when she had arrived. Two participants of the Reflecting Team revealed that they had historically felt anxious or intimidated in the group meetings, and had felt more confident speaking up in the pilot meeting because of the structure of the reflecting team model. There was universal agreement that a smaller group would be more practical for collaborative conversations. Based on this feedback, I was determined to try another collaborative meeting, this time with participants deciding the agenda.

The Second Meeting

After introducing the basic principles of Social Construction that I believed to be applicable to the process, which included valuing multiple viewpoints over a single truth, dialogical rather than monological conversations and the importance of connection, I still had an agenda for the group. I asked the participants if they would consider inviting a patient to join the group in the role of “expert” about a specific healthcare topic, and one

person strongly objected. She expressed concern that doing so would essentially result in that patient's *becoming* his or her diagnosis, and she did not want the group to contribute to this, as she deemed unhealthy. The group listened to both arguments, and decided to put aside that question for a future discussion. Members formed some unified ideas about how they wanted to proceed. They wanted to keep the group small, to allow flexibility for case discussions or other topics, and to rotate leadership of the meetings. A date was set for a third meeting, and it was decided that another member of the Reflecting Team would be recruited to join the small group.

The Third Meeting

The third meeting included three psychotherapists and two CAM practitioners. A psychotherapist presented a case, choosing also to provide a written summary of it to help facilitate the group's understanding. She requested feedback and ideas for treatment, and received support from the group.

The Fourth Meeting

For the fourth meeting, another CAM provider was invited to join the group. Members universally decided to close the small group at this point, and not invite or allow additional members. A CAM provider presented a case, and received support and ideas for treatment. The dialogue here was also coded as *affirming* and *seeking solutions*. Appendix 19 includes excerpts from that meeting, which illustrate those patterns.

Feedback from the Small Group Participants

A summary of findings (Appendix 16) was constructed and sent to the small group members after the sixth meeting. This method was selected in response to members explaining that their busy schedules and interest in the project did not permit time to

engage in open-ended or unstructured reflection about the process. They were asked whether the summary was representative of their experiences in the group, and were invited to provide additional feedback (Appendix 17.) Below are some excerpts:

“The biggest take away for me was the numerous lenses through which each person can see an individual or a symptom.”

“The group offers fresh perspectives on difficult cases; a place to get feedback on how to handle certain aspects of practice such as getting triggered by patients, or not making progress.”

Help with Difficult Conversations

Over the months that the small group met, there were many examples of collaborative dialogues that produced meaningful change for patients; following is one of them. During the fourth small group meeting, which was recorded and transcribed, a CAM provider presented a case about a patient who had been diagnosed with cancer, and had refused traditional medical treatments. The patient’s appearance had drastically changed since their last appointment, and the provider felt sad and uncomfortable in her presence, believing that the patient’s prognosis was grim. The group members inquired about the training the provider’s discipline had offered around death and dying, and she reported that it had been largely ignored. The group encouraged the provider to bring reflexivity to her discomfort and members shared ways that they had dealt with their own feelings around patient mortality. Over the next several months, the provider reported that she had confronted her own fears about death and as a result, had had poignant and productive conversations with her patient around the process of dying. She reported that this had led the patient to have long overdue conversations with her family members, for

which the patient and her family were deeply grateful. Charon wrote about the possibilities that emerge from shared suffering between practitioner and patient, “Such mutual recognition, transcending parallel suffering, would enable them both to reflect on their common journey and, by virtue of being together on it, would lessen one another’s suffering” (2008, p.33). This was certainly the case for our group member and her patient.

Conversations with the Leadership Team

I met with the leadership team in January of 2015 to provide the results of the inquiry (Appendix 18). They asked if I thought the group might be looking to alter the way the clinical meetings were structured, and I answered affirmatively. The leadership team asked me to share the results of the inquiry at the next quarterly meeting.

At that meeting, I explained that during the individual interviews, I had discovered that the group was comprised of intelligent and thoughtful practitioners whose stories were fascinating, and worth sharing. The group noted with surprise that not only were they unaware of each other’s professional narratives, they were also unaware of the founder’s story, or how the practice came to fruition. Nobody asked her to share it then, and no further discussion of professional narratives took place. The Leadership Team facilitated a discussion about the definitions of collaboration, integration and coordination of care that emerged from this inquiry. They sought to create a unified definition of integrated care for the group practice as part of a mission statement, and to learn from providers what they might like to change about the clinical meetings. Several providers stated that they appreciated time in the clinical meetings to talk about cases or healthcare topics, and did not want to use the time for business concerns. One person (who was not a member of

the small group) stated that the reason she had joined the practice was to be able to participate in the clinical meetings, and that she had grown frustrated that time was taken there to discuss business rather than clinical issues. Three providers from the small group spoke positively about their experiences there, and expressed a wish to bring something similar to the larger group. The leadership team shared their experiences from the preceding decade, when other practitioners had suggested different ways of structuring the meetings, all of which had ultimately failed due to lack of interest on the part of the group. The leadership team stressed the importance to the overall practice of the marketing materials that emerged from the business discussions. One person (who was not a member of the small group) stated that as the meetings were held on her day off, they would have to provide value, and she did not consider marketing discussions worth the drive. A lively discussion ensued about the relative importance of producing marketing brochures during meetings versus engaging in discussions about patient care or practitioner experiences. A compromise was reached and for the next six months, clinical meetings were more geared towards clinical content chosen by participants. At the end of that time, content of the meetings resumed in equal measure to marketing ideas, and attendance dropped by an average of five people per month.

Valuation of the Project

Following are the values that were reported by members of the small group, based on field notes of discussions and questionnaires completed by participants:

- * “It made me listen better, and be more thoughtful before speaking.”
- “It deepened my understanding of other disciplines.”
- “It allowed everyone to have a voice, lessening intimidation.”

- “It made me less judgmental of others’ viewpoints.”
- “It broadened my perspective on what can be considered healing.”
- “It improved my language skills.”
- “It offered the opportunity to see through other lenses than my own.”
- “It allowed my thinking to expand beyond my own theoretical training.”
- “It caused me to refocus on being humble with my patients.”
- “It improved my understanding of the patient’s perspective.”
- “It showed me that I was not collaborative before, but I am now.”

Results of the Recap Meeting

One member of the small group was unable to attend. The remaining members discussed what the process had been like. They commented that there was a distinct difference between the small group meetings and the clinical meetings, expressing a clear preference for the small group (Appendix 19.) One member commented that prior to the small group, she had felt intimidated in the larger group meetings, but now felt able to speak freely there. She added that while she did not understand the reflecting team model in the pilot meeting, she had come to appreciate it greatly after it was utilized in some small group meetings, as it enabled her to listen better and consider her words more thoughtfully. Another member commented that she had developed an awareness that collaborative dialogue could occur anywhere, citing a powerful discussion she had recently experienced with a colleague during a social event. She had grown to appreciate such experiences more as a result of this inquiry, and stated that she now made an effort to “hold onto those moments.” The group answered the questions as follows,

“What is happening here?”- The group described the Treating Team in the pilot meeting as having a disjointed monological conversation, and the small group as having dialogical conversations. One member commented that it might be due to intentionality; she believed that because the clinical meetings were mandatory, there was no intention on participants to collaborate. As the small group meetings were voluntary, she felt that indicated an *intention* to collaborate.

“What does it mean?”- The small group did not feel that they could assign meaning to the pilot meeting result, other than to say that it captured a moment in time where practitioners were not in “flow” with each other. They described the excerpts of the small group meetings as having “flow,” and determined that while one could set the stage for it by bringing an open mind and inviting others to share, flow could not be guaranteed to occur. One member commented: “Flow is a thing you can capture, but cannot create.”

“What are the implications for collaboration?”- One member commented that we were using the word collaboration only because I had introduced it, but that he believed what was happening in the small group was *connection*. He stated that for a variety of reasons (which he did not know) the large group lacked connection, but the small group had it. And as a result, he felt that collaboration between us was automatic: “You don’t even have to think about it because if you’re connected, you see the person at the same level and you want to help them. There’s a unity to it.”

The rest of the group enthusiastically concurred with this idea.

Awareness Across the Organization

Gradual but significant changes occurred in the relational processes of colleagues who did not participate, or participated only minimally in this inquiry, as a result of the discourse of collaboration that emerged from it. Examples include a member of the small collaborative group's request to facilitate a conversation about sleep disorders using the Reflecting Team model at a clinical meeting, which was well-received by participants. A practitioner of CAM who did not join the small group was co-treating a client of mine, who I didn't feel successful in helping. I initiated contact with her and we had two productive conversations about the case, which gave me new ideas about how I might move forward. Afterwards, I received the following correspondence from her:

"I really enjoyed these two collaborative talks. I feel good we have a plan. I also feel genuinely enriched and validated as a practitioner. Thanks for reaching out on this case."

A psychotherapist who was part of the Reflecting Team, but elected not to join the small group expressed surprise at what she discovered as a result of this inquiry. She reported that beforehand, she had considered herself to be highly collaborative, though she had never actually engaged in any conversations with co-treating providers. Since the initial meeting, she stated that she regularly engages in collaborative dialogues across disciplines, which she believes has enhanced not only the care that she gives, but also her experience of giving it.

Chapter Six: Discussion

In this chapter, I turn inward to examine how I made the claims reported in the previous chapter as results, and constructed meaning from them to create a theory about collaboration across disciplines in this private practice setting. I do not propose here that these ideas are generalizable to all providers of healthcare who are interested in collaboration across disciplines; the nature of relational processes is such that interactions are inextricably linked to previous interactions, and influenced by local customs and practices. My hope is that by bringing reflexivity to the discrete interactions described in this inquiry, I might offer some insight as to how certain individual and collective actions invited particular responses. In so doing, those healthcare providers for whom these ideas resonate might find something of value that can be added to their work.

Radical Reflexivity

I began this inquiry with a firm philosophical commitment to collaborative relationships and dialogical practices across disciplines in healthcare. I saw these processes as good and right, not just for patient care but also for provider growth and satisfaction. By default this created a sense of “wrongness” for providers of healthcare who chose to practice differently, (or perhaps who practiced differently on the days that I attempted to engage them in dialogue.) I constructed realities to explain their disinterest in collaborating as I had wished them to, but I was essentially relegating them to one of two categories: arrogant or ignorant. In so doing, I created a “single lens” view of them, which was not only limiting, but diametrically opposed to the values I hold dear.

When I attended my first clinical meeting with my new colleagues, along with my ideas about collaborative dialogue I brought with me the linguistic practices of my profession. That is to say that I privileged reflexivity and emotional connectivity over interactions that were purely cognitive. As the meeting unfolded I suspected that the dominant discourse of the group served a singular purpose: to sell the benefits of each provider's modality to the leadership team. I had inferred that because we were members of an integrative practice, we would all *want* to engage in more generative dialogue, as opposed to monologues about what we could achieve with our respective treatments. I sought to make sense of this paradox, because I liked my colleagues, and had not found interactions with them to be competitive or hierarchical. I suspected that the group's linguistic practices had emerged in part because of a lack of exposure to collaborative dialogical practices. Though the purpose of this inquiry was to *observe* what happened in the group when a new way of talking together was introduced, I hoped that my colleagues would choose to adopt these new linguistic practices moving forward. And so the foundation of what I am claiming here as knowledge is based on the historical interactions that I have had over the years as a psychotherapist, which privilege reflexivity and dialogical collaboration over recitations of clinical facts in conversation, and on a supposition that my colleagues, who had chosen to locate their practices in an integrative setting, were predisposed to valuing multiple viewpoints over singular truths in healthcare.

The interviews.

Part of what drew me to my profession, which still keeps me deeply engaged after so many years is my interest in people's stories. I find them endlessly fascinating, and I

consider myself privileged to be invited in to people's lives--- to hear about their interactions with others, with jobs, or hobbies or travel or technology that I will most likely never experience myself. I was just as interested in learning about the stories of my colleagues. I did not envision the interviews as some sort of window into their lives that would allow me to discover "truths" about collaboration for this inquiry. Instead I wanted to know my colleagues in a different way than I felt able within the current structure and realities of our practice, and to learn about the experiences that brought them to the integrative practice. Institutions have rules that are conveyed through social practice, and I had gathered during my interactions with colleagues that their lives were very busy, with much that competed for their time. I empathized with this as I too had found it difficult over the years to juggle the demands of my young family with those of my work. From these experiences, a relational reality emerged that left me wary of requesting too much of my colleagues' time for this inquiry, lest participation become burdensome to them. Happily, when the practice founder offered her support for this inquiry, I saw that as tacit permission to ask my colleagues for enough time to tell me their stories.

Language is the medium that allows participants to have a voice in the research process, and to reflect on their experiences. Through the course of the interviews, participants of this inquiry were given the opportunity to share with me their experiences, in whatever detail they chose to provide. Perhaps the closeness of the one-on-one semi-structured approach created space for the stories to unfold as intimately as they did. I recognized the many places where the participants' stories interlinked, and I lamented that these beautiful places of connection were not shared in the group as a whole. I suggested this idea to the leadership team, however the norms and customs of the group

did not allow for it to happen. I continue to wonder how we would all have been impacted if the narratives *had* been shared publicly. My guess is that any “single lens” viewpoints would have evaporated in the process.

While I was careful to use language that invited participants’ narratives to unfold, around the question most closely connected to the heart of this inquiry I was not as prudent. During the interviews, I asked my colleagues to tell me about their collaborative experiences, but in retrospect I see that language as restrictive. By using the word collaborative without defining it, I may have communicated that I was looking for something formal, or official, or I may have inadvertently suggested that they *should* have had a number of *some* kind of experiences. These kinds of expectations would most likely diminish the possibilities for a dialogical exchange. For example, I frequently engage in collaborative conversations in the car to or from work, or sometimes during brief encounters with other therapists. If someone had asked me about my experiences with collaboration, I might have felt that those brief exchanges didn’t count, despite their being quite meaningful to me. Had I asked them instead to tell me about some of the more significant conversations they had had with other providers about patients, this may have felt like a more open invitation. I may have learned about how and why and where it was that my colleagues had co-created knowledge that was meaningful to them, which is another way of learning about collaborative experiences.

The pilot meeting treating team.

Because conversations are relational processes, an individual participant cannot be held solely responsible for the direction or outcome of a communication event.

However as a researcher/participant, I do think it is worthwhile to explore my role in the outcome of the Treating Team's conversation during the pilot meeting. While I do not believe that I alone prevented a more collaborative dialogue from emerging between us, I do believe some of my actions contributed to the monological outcome. After revisiting the gerund coding from that conversation, and listening again to the recording of it, I heard myself pushing an agenda. In retrospect, I had pre-diagnosed my client's son, based on her descriptions and the few conversations I had had with his therapist. I was clearly looking for my colleagues to ratify my diagnosis, as I made four attempts within 20 minutes to steer the conversation there. However my experience of the meeting, and my memory of it afterwards was that I had had *no* agenda, and been only open and accessible with my colleagues.

There were other factors that could have acted as barriers to a more dialogical conversation between the Treating Team members in that pilot meeting. At the time, I had seen my client five times, spending nearly five hours with her. Two other members of the Treating Team had only seen the patient once, for 15 minutes each, and one had seen him twice for a silent energy procedure. Though they had received advanced notice about the case, they did not recall much about the unremarkable encounters they had had with the boy, and therefore relied largely on their sparse notes to formulate and provide opinions about his symptoms. It is possible that the disparity in time spent with the clients created a sort of unfair advantage for me, which would have been anathema to the establishment of safety within the Treating Team. My decision to share my client's urgent email request for help most likely contributed to a felt sense of pressure for them. Add to this the audience of colleagues listening to the conversation, and the burden to

come up with an “answer” for this patient must have felt even greater. And there was yet another factor involved. When one member of the Treating Team arrived very late and unprepared, making jokes and disrupting the proceedings, I had felt disrespected, and I am quite sure that my colleagues sensed my annoyance.

Had I relied solely on my memory of the pilot meeting for this inquiry, I might have believed that my colleagues on the Treating Team were the cause of the disappointing results of our conversation. However in listening to the playback afterwards, I was able to recognize my role in what transpired. Though it was cringe-inducing, spending hours transcribing it allowed me to confront the assumptions and biases that I could recognize in myself. I wonder what might have emerged had I made different choices as a member of the Treating Team? Had I abandoned expectations for diagnosing my client’s son during the meeting, acknowledged the widely varying amounts of time that each modality provided with clients, asked how it felt to be discussing a case in front of an audience, and remained calm and neutral when my colleague arrived late, there might have been a more relaxed and benign atmosphere. This in turn could have felt like more of an invitation to dialogue.

The pilot meeting reflecting team.

Despite the lack of a reliable reality for how the Reflecting Team would interact, they *were* able to engage in collaborative dialogue during the pilot meeting. The members, who did not typically share cases, and practiced modalities as disparate as chiropractic, nutrition and psychotherapy, incorporated each other’s ideas into their own suggestions. They affirmed each other as they talked, resulting in co-created knowledge about not only the patient, but also the ways that the group could improve its approach to

future patients who might also seek care from multiple providers within the practice. One reason for this could have been that as members assigned to the Reflecting Team, they were essentially placed in the role of evaluators, which may have felt empowering.

Giving them the opportunity to participate in the co-active process of deciding which practices were meaningful seemed to energize and bond the Reflecting Team. In listening to the recording, I noticed that their voices gained liveliness as they talked about what was possible for the entire group, and for those who sought their services in the future. It was disappointing that this conversation was never continued or revisited in the ongoing meetings of the larger group, effectively silencing their ideas after the pilot meeting.

Additional lessons.

There were additional details that I missed in the planning or execution of the pilot, which could have contributed to the outcome in a particular way. Participants in this research study mentioned a felt sense of safety as being important to their willingness to take professional risks in relational processes like case discussions, and this was also mentioned in the literature as an important factor. Below are additional ideas that might be considered when safety within groups is deemed important.

Relational realities.

Relational processes are imbued with historical events, and over time patterns emerge as people coordinate their activities. I assumed that because the participants had worked together in a co-located practice for several years, it would be easy for them to adapt to a new way of relating. However it takes time for new patterns to form reliable realities about what can be expected. What my colleagues taught me was that without a reliable reality for how we would engage in dialogue about a shared case while our

colleagues listened in, it might not have felt safe to adopt a stance of not knowing. Yet it was only from that stance that new knowledge about the patient could have been co-created by the group. And there was something else that I missed; though *I* labeled us the Treating Team, that name did not *make* us one. Without time and space to affirm each other in what each was contributing to the case, we could not be a unified group. Had a reliable reality been established where participants felt *valued* instead of evaluated for their contributions, more collaborative and less defensive exchanges might have emerged.

Pacing.

Proper pacing keeps participants engaged and committed to the process. Researchers often spend entire days just introducing participants to the theoretical concepts of their projects and PAR. I gave a five-minute introduction to PAR and the inquiry, and then provided only written communication to participants. In retrospect, I see that the pace of the pilot meeting was far too rapid. I struggled to find the balance between keeping the participants engaged, and being cognizant of the many demands on their time. I believe now that my concerns about wasting their time impeded my ability to recognize the complexities of what I was proposing to them. Had I asked the leadership team for more time, I could have introduced my ideas for the reflecting team model over several meetings. This might have led to a pilot meeting in which all of the participants felt comfortable and prepared for the process. Had this been the case, I wonder whether the leadership team might have also invited more discussion about the processes of *their* meetings.

Resources.

Material resources can be used to help facilitate relational processes within groups. This inquiry introduced a new way of talking to participants through emails and handouts, but there is a big difference between reading about something new and watching it unfold in real time. If I had shown video clips of a reflecting team in action rather than just describing it in handouts, it might have been more instructive and also inviting to participants. This could have resulted in a more confidence in the process, and a more dialogical discussion for the Treating Team. Having identified and explored possible factors contributing to the outcomes of the pilot meeting, I turn to the small groups meetings that followed.

The Small Group Forms Bonds

All of the subsequent meetings were co-created by the participants, based on the sharing of ideas, values and past experiences. I found myself more relaxed in these meetings, and I enjoyed them immensely. Each month, a different provider acted as leader, choosing the topics for discussion and methods for discussing them. This led to a deepening sense of connection between the members, which yielded positive actions for us and also for our patients. (Appendix 17.) During the 18 months that the group met, the number of referrals across disciplines increased dramatically, and conversations between members *outside* of the group increased as well. However, the strengthening of the “us” of the small group led to the assignation of “them” for the larger group meetings. Thus emerged the separation that Gergen has warned of, “When any cluster of people---great or small---becomes bonded, there is a simultaneous creation of an outsider. To sustain the specialness of the group, those outside will necessarily be ‘less than great’ or ‘second

rate” (2009, p.318). It is interesting to consider how a subgroup of people might avoid inadvertently creating such a divide. We might have considered what kind of reputation we were creating for ourselves within the larger practice, and periodically shared some of our “breakthroughs” in collaborative care, inviting others to engage in dialogue about them. Evidence of the disappointment the small group members felt for the large clinical meetings began to appear, and was reinforced through subtle jokes and more overt comments during small group meetings.

Distance from the larger group.

The clinical meetings, facilitated by the practice founder, continued to be held monthly and were not included in this inquiry, however participants of the small group attended both. Within a short period of time, members of the small group began to bond around the antipathy they felt for the larger group meetings. Discussing this during the recap meeting, nearly two years after the pilot meeting, some participants’ comments revealed that the distance between the meetings had remained intact for them. It was not particular *members* of the group who were held in disdain, but rather the *process* itself, as exemplified in the following excerpts. Further excerpts are included in Appendix 19.

X2- “And then in terms of the group it’s just like been, it was a nice alternate version of collaboration. I mean sort of the bigger group that doesn’t collaborate so much, it felt like more real collaboration here.”

X1- “I think that’s how our general meetings are. Everybody kind of has their, it’s like the political thing: “Tell me about the economy; I am strong on you know, okay?” You just, we all have our agenda. ‘We’re integrative!’ (said mockingly),

but there's no listening to what that person said and what was actually asked.

That's why I can't stand those meetings."

Another small group member also experienced the clinical meetings as not feeling collaborative, but this was not negative or frustrating to him, as he explained:

X3: "Well that's certainly not collaborative. In terms of what we're talking about, it's really sad. What really fascinates me is there seems to be effort from everyone to fix it, but it's not being fixed. I don't know what it is. I don't know. My honest experience is, maybe my other needs are in the hierarchy...But my experience is just, I like to hang out with people. They're often positive. I find a way to talk to someone and that makes me happy, somehow."

This small group member assigned meaning to the clinical meetings not solely as a place to collaborate, but as an opportunity to spend time with colleagues, with no agenda or expectations. Through his lens, the clinical meetings became a source of happiness rather than disappointment.

In reflecting on those comments, I was reminded of a conversation I'd had after the pilot meeting with Dr. Paul Uhlig, whose innovative work resulted in the formation of a collaborative approach to hospital rounding in a New Hampshire hospital (2002). Upon hearing my ideas for the creation of a smaller, self-selected collaborative group for this inquiry, he was adamant about the importance of including *every* practitioner in the process, in order to avoid the formation of "us" and "them" subgroups within the practice. An animated discussion ensued about the differences between hospital-based providers and those in private practice, and the unlikelihood of *every* practitioner *choosing* to add another unpaid meeting to his or her busy schedule.

At the time of that discussion, I saw the choices as a clear dichotomy but in retrospect, I can see that there were more options than simply 100% participation, or distancing between the groups. For example, by encouraging the one small group member who enjoyed both kinds of meetings to further explore his experiences with us, we might have learned to value the differences. I see this now as a missed opportunity to include the larger group in what we were co-creating. Though the leadership team was not initially supportive of the new ideas put forth, had the small group brought the vitality for what we were doing to them in a manner that also expressed appreciation for the larger group processes, perhaps they would have been more amenable. This illuminated for me the importance of considering organizational practices in planning such an inquiry.

Organizational Change

In conceiving this inquiry, I neglected to fully grasp the significance of its location within the existing organizational realities of a group practice, including the established dominant discourses, taken for granted practices, rituals, traditions and power structure. The leadership team did not invite me to help facilitate change, nor did they express any interest in cultivating it; they *allowed* me to utilize the practice to explore a long-held interest in understanding collaborative dialogue across disciplines. However the introduction of new ideas into existing realities carries the potential for transformation. In retrospect, I should have made a more considered and in-depth proposal to the leadership team about my goals, and the possible ramifications for the overall group. Reflecting now on the founder's comments about the unsuccessful attempts at change that had occurred in the practice over the years, I wonder if those

events had become reliable realities for the practice owner? If previous group members had repeatedly failed to follow through with new ideas that they themselves had put forth, it would make sense for her to expect that in future attempts at change. I wish that I had brought more curiosity to her previous experiences with change events, so that I could have understood more about the relational processes that had created them. It is possible that Appreciative Inquiry could have provided a framework for the current practice members to have markedly different results than the previous ones.

Appreciative Inquiry

Appreciative Inquiry (AI) is an approach to the process of organizational change that emphasizes the value of its strengths and assets as opposed to a focus on its problems. Using AI, members are invited to come together to explore the organization's core strengths and values, and to uncover what it is that makes their work meaningful. From there, they can begin to talk about their dreams for what they want the organization to become. As their goals are discussed, they develop a shared vision for the organization, and then collectively work to achieve it. Had we utilized the ideas of AI, my colleagues and I would have uncovered much that was positive about our organization, and meaningful to members. There were more possibilities for us as an organization; I had heard about some future oriented ideas for our group during the individual interviews, and the Reflecting Team had had a spontaneous conversation about ways to improve patient care during the pilot meeting. These expressions of ownership for a larger organization can be thought of as authoring.

Authorship and Authoring

Authorship describes the process through which managers use dialogical practices to construct a shared sense of the organization for those whom they manage. By inviting others to participate in organizational processes, managers create a sense of belonging, and a shared sense of responsibility and ownership for the organization as a whole.

Leaders who configure people as the authors of their own work seek to recognize and promote opportunities for them to add value, by soliciting their input on matters that will impact them. Authoring occurs when group members themselves purposely reorient to this way of perceiving the organization and their agency within it, and begin to pursue practices that reflect their investment in it. In so doing, a sense of belonging and trust in the organization is fostered, along with a desire to constructively contribute to the creation and achievement of its overall goals.

In the case of this inquiry, had the leadership team been aware of the possibilities that authorship provides, they might have invited the group to participate in a series of dialogues about the ideas put forth by the Reflecting Team in the pilot meeting. Specifically, the Reflecting Team had talked about the creation of a triage role to welcome new patients, and help them navigate the myriad possibilities for care within our integrative practice. They had also wondered about the possibilities for collaboration that might emerge from a shared records system. Had group members felt some agency and ownership in exploring and implementing these new ideas, they may have illustrated that authoring by collectively pursuing the creation of a triage team and record-sharing system. These events might have served to shift the reliable realities that had influenced the leadership team to conclude that new practices were not sustainable, and construct

new ones in their place that were more open and positive. A reflexive process that illuminated the assumptions on the part of the leadership team and the group members would have been necessary to make such things possible; authorship requires reflexivity as a productive, generative group process.

Reflexivity in Groups

As discussed earlier, bringing introspection to what one does and why one does it requires an examination of daily practices, and meaning attribution, which can result in greater work satisfaction for an individual. Organizational reflexivity refers to the ways that an organization turns its gaze inward to examine the interactional practices of its members, in order to increase its range of options for collective action. It is an active, public, dialogical social process that creates a collective ability to question the assumptions on which organizational processes are based. Organizational reflexivity is particularly suited to promoting the mutual development of both individual and collective ownership of practices (Gorli et al., 2015). However it does not come easily, as it requires a tolerance on the part of leadership teams for disruption of conventional practices and consolidated habits. It also requires a shift in orientation; when management teams participate in reflexive dialogue with group members, they *facilitate* rather than control meaning making, and the resulting creation and maintenance of organizational procedures and practices. That could be perceived as a loss of power rather than an opportunity to share responsibility, which might feel threatening to a management team.

Even with the most thoughtful preparation, and carefully planned invitation to dialogue, it is possible that organizational reflexivity will be perceived as more of a

liability than an opportunity. However this inquiry has illustrated that attention to detail, careful use of language and proper pacing can lay the groundwork for a more welcomed invitation to organizational dialogue.

A Theory Emerges

Based on my analysis of the data, the following themes emerged as being important to the creation of collaborative dialogue across disciplines in this private practice. Participants reported that when they felt a sense of safety, they were more likely to engage in reflexive and generative dialogue. Over time, these relational processes contributed to something participants termed “connection.” When participants felt connected to each other, collaborative conversations emerged organically. These were characterized by questions designed to elicit rather than provide information and respectful appreciation of dissonant views. During collaborative conversations, new ideas were generated and explored, and new knowledge was co-created in the process. Conversely, when participants experienced a lack of safety, they were more likely to withdraw from relational processes by withholding their thoughts, questions and opinions. Safety could be threatened by a single interaction between two participants characterized as sounding angry, or an unfamiliar relational process that felt evaluative rather than valuing. Participants concluded that without safety and relational connectivity, conversations that take place across disciplines in healthcare are more likely to be co-located and monological than collaborative and dialogical. Conversely, where there is connection, collaborative dialogue can emerge anywhere or anytime; it does not require formal pronouncements, or predetermined scheduling.

Having discussed this inquiry and the ideas it generated, I will broaden the discussion by examining other ways that collaboration across disciplines in healthcare might be accomplished.

Chapter Seven: Future Research and Technology Assisted Collaboration

As discussed in Chapter Three, there is a plethora of research on collaboration in healthcare. Many studies have focused on organizational processes within hospitals, with an overarching goal of decreasing medical errors through teamwork. While I appreciate the importance of these organizational questions, as a psychotherapist in private practice, I am more interested in the relational processes that form the foundation of collaborative relationships. In particular, I am curious about what can be built around the micro-level interactions of dialogue.

Dialogue

Anderson has written about dialogue as both a means and an end to forming connections:

It is a way of being in language and relationship with others. In its fullest sense, dialogue is a particular kind of conversation in which participants engage with each other in a process of understanding, a process of learning how the other makes sense of something and the meaning it has to them. Through this process new understandings and meanings begin to emerge in the space between people. (2002, p. 279.)

This inquiry has highlighted the importance of bringing awareness to how we engage others in dialogue, and the responses that our actions invite, as well as the way that we respond to the actions of others. I have learned that sometimes the barely perceptible and often over-looked ways that we behave can nullify what we intend as inviting actions, and our perceptions of ourselves as we engage relationally can be quite distorted. The experience of listening to the recording of the pilot meeting highlighted for me the disparity possible between how we think we are engaging others and how they perceive us during the same interactions. I see the generative possibilities that could emerge from recording professional discussions, and playing them back for all participants who wish to evaluate their dialogical skills. I do believe that self-knowledge surrounding one's patterns when engaged in relational processes such as dialogue could lead to new ideas about what counts as collaboration in healthcare.

Markers for dialogue.

This inquiry illustrated that there are markers that can help us recognize when we have fallen out of dialogue. When we find ourselves trying to convince another person of something, or when we are forming our responses as they are talking, or defending our positions or blaming others for our failures, we are no longer engaged in dialogue. That need not be disastrous however; if we recognize that we have gone off course, we can simply apologize and bring ourselves back to the space of listening, and seeking to learn how the other has come to understand his or her experience. For example, during the first and second small group meetings, I found myself trying to convince the other group members to adopt my idea to periodically extend invitations to patients as “experts” of whatever topic we were discussing. When I recognized what I was doing, I changed

course, and really listened to their objections. By making this adjustment, I learned how some CAM providers understood the role that patients' *talking* about illness played in symptom amplification, and the meaning they assigned to it. For them, the talking created an entity that would exist for the patient, which would make treatment more difficult; I had never considered this possibility. Though I did not assign the same meaning to the role of talking about illness, I appreciated their process and conclusion. I accepted that the group had chosen to adopt their stance, and I did not revisit the question of patient involvement in the small group.

Invitations to dialogue.

It has been said that if the Golden Rule requires us to treat others as *we* would like to be treated, the Platinum Rule requires that we treat others as *they* would like to be treated. This is a useful concept when considering how to invite others to engage in dialogue. I did not know, because I did not ask, how the participants of this inquiry would prefer to be contacted. As a result, I made assumptions that in one case, turned out to be erroneous. During the pilot meeting, I was hurt and offended that a key member of the Treating Team had arrived so late, and behaved in a disruptive manner. However in retrospect, I was able to recognize that I had used only one method to contact him about the proceedings, and that happened to be the very method that he did not typically utilize. I contacted him afterwards to apologize for my role, and he acknowledged his role in being unprepared for the pilot meeting. Since that conversation, he has been more responsive to email communication from the entire group.

Dialogue between researchers and practitioners.

A few years ago, I participated in a fascinating series of lectures given by neuroscientists at The University of New England, created specifically for psychotherapists who wanted to learn more about the brain. Specializing in trauma work, the therapists were interested in learning about the connections between damage caused by early childhood trauma, and the symptoms we were seeing in our practices. The scientists, who had spent long days in laboratories working with rats, reported their enthusiasm at being asked to present their research to such an enthusiastic and appreciative audience. What surprised me most about the experience was the lack of information that each discipline had about the other's work. For example, one scientist remarked that a particular symptom could not possibly be treated effectively, and in unison the therapists disabused him of this mistaken belief, as it was something that we had all treated successfully on a regular basis. When a neurosurgery student reported the difficulty she was having extracting historical information from a brain-injured patient as if it were solely a result of the injury, we encouraged her to consider that patient's experience. The patient was a young woman, confined to an assisted living facility with elderly dementia patients following a horrific snowmobiling accident. We believed that she might be experiencing sadness, loss and bewilderment at having lost so much so quickly, and that an empathic approach that acknowledged this might yield more information for the student. The student was astonished by our collective viewpoint, and a rich discussion evolved as a result. Conversely, when one of the scientists, an expert on pain suggested that there were pain pathways between the brain and the body, but there was also a part of pain related to how much it *bothered* a person that was a significant

predictor of the overall pain experience, I found myself looking at paper cuts quite differently! Dialogue between researchers and practitioners can yield powerful results. The relational processes of talking about typical, or frustrating, or confusing issues with interested people from different professional cultures often illuminates things that were previously unseen. From there, narratives that frame problems in different, researchable ways are able to emerge. The combination of practitioners in the field identifying problems, and interested researchers applying their “best practices” to examine them and seek solutions, might produce evidence more useful to both than either could produce alone. Conversely, scientists who share what they consider problems with practitioners from the same discipline could have productive dialogues about them. Academic research institutions are the perfect location to build such partnerships. The creation of a format whereby a series of conversations could be held between university departments and local professionals in the corresponding fields would be a good place to start. Regarding this inquiry, I would be interested to learn the viewpoints of researchers in a Communications Department about healthcare providers who have struggled, as I have, to collaborate across disciplines.

Practice-Based Evidence

While healthcare professionals might value something called “evidence based practice,” as discussed in Chapter Four, such a name is misleading, for what counts as evidence will differ according to the many variables that influence it. I propose instead that researchers consider studying “practice-based evidence.” Below are some ideas of how this might happen.

A longitudinal study of interprofessional education (IPE)

Historical research of IPE programs has focused on surveys of students as they progress through their programs. However I believe this research only examines part of the relative effectiveness of IPE; because the intention of IPE is to increase the likelihood of collaboration across disciplines *after* graduation, I am curious about what happens to students in the decades after they become licensed healthcare professionals. I would be interested in reading a longitudinal study that followed students for five to ten years into their professional lives. Researchers who embed themselves in the local cultures of the work places that the IPE graduates create for themselves, and engage in a series of dialogues about their cross-discipline collaborative practices are likely to get a richer sense of these practices than those who use surveys alone. Borrowing from the traditions of RCT's, if researchers also embedded themselves in the same way with cohorts of the same year who received training from more traditional programs, that might act as a "control" group. A comparison could then be made of the relative frequency of collaborative dialogical interactions across disciplines between the two groups.

Bringing this approach to collaboration across disciplines, I would be quite interested to learn what other researchers might identify as salient in private practice-based healthcare providers who already practice collaboratively. By recording practitioners engaged in collaborative dialogue, and then reviewing and coding the videos with participants, both might be able to identify steps that feel so natural to practitioners as to remain out of their awareness as the dialogue takes place.

While my interests in collaboration across disciplines are primarily concerned with relational processes, I do believe that advances in technology offer other opportunities for collaboration across disciplines.

Utilizing Technology to Facilitate Collaboration

There are many ways that technology can provide opportunities to enhance collaboration in healthcare; of course, advances in technology also have the potential to diminish collaboration--- between patients and providers, and between providers from different disciplines. The realities that emerge will depend on relationships—between designers of the technology and those it serves, between the technology itself and those who interact with it, and between those who hold the power of the information it provides, and those who will be affected by its use and dissemination. Following are some ideas about how Social Construction can guide the use of technology to improve collaboration in healthcare.

Electronic medical records (EMR).

In the United States by the year 2014, all public and private sector healthcare practitioners were mandated to provide digital record keeping (EMR) for their patients. EMR provides the potential for a unified record instead of the previously fragmented information that occurred when multiple providers worked with the same patients. With paper records, healthcare providers relied on hand-written notes in files, or conversations to coordinate care. Most EMR programs provide space for practitioners from different disciplines to leave notes for each other, allowing for asynchronous collaboration. However those spaces are created by programmers rather than healthcare practitioners, and as a result often restrict more than invite dialogue between them. A study of the impact of EMR on collaboration in Emergency Room physicians found that technology could simply bring new problems rather than solve old ones, depending on how it was utilized (Feufel, 2010). It is likely that a one-size-fits-all approach to EMR in healthcare

practices will not be successful in facilitating collaborative dialogue. However if an Appreciative Inquiry approach were used at local levels to examine how established practices might be enhanced through the use of EMR, and those programs were customized accordingly, relational processes between providers of healthcare could be enhanced. With regards to the practice where this inquiry was located, if EMR were available across disciplines, I would choose not to read the medical records of other practitioners unless specifically directed to do so by my clients. As discussed previously, I believe that my clients should retain control of their health information, and reveal to me only what they are ready to disclose. However if I *were* instructed to gather information about my clients from other disciplines, while it would be more convenient to do so through EMR than scheduling a conversation with another busy practitioner, I would still favor the latter, as I value direct conversation over asynchronous collaboration.

Technology and collaboration with patients.

Technology is currently used to include the patient's voice at all levels, from the formulation of public policy to the individual practices of healthcare providers. Examples of its use at each level are offered below as a means to facilitate relational processes.

Technology and patient involvement at the macro-level.

In the United States, the Food and Drug Administration (FDA) is currently planning to regulate the Homeopathic Remedy industry, which includes vitamins, supplements and food products. Before creating guidelines, they held public hearings in Washington, D.C. to elicit feedback from consumers. Technology allowed the FDA to solicit more broad public comment through the use of online forums to help determine

whether and how regulation could be helpful to consumers. At the very least, this invitation to public dialogue alluded to a sense of participation for those who will be impacted by any new regulations. However, as there is no authoring regarding what is *done* with the feedback that was gathered, the impact of the forums may be limited to an allusion of inclusion (United States Government, Food & Drug Administration, 2015).

Technology and patient involvement at the meso-level.

Many hospitals seek patient feedback about their experiences via online questionnaires, with stated goals of improving the quality of care (QI). However, what happens to that feedback is often unclear:

Previous research has shown that QI based on patient experience has not been made a priority in many hospitals, and only a few of these have adequate systems for coordinating the collection of such data, assessing its importance and implications and acting on the results in a systematic way (Wiig et al., 2013).

Social Construction would suggest that merely offering patients a questionnaire does not create an invitation to dialogue. If hospitals invited patients to participate in forums---either online or in person---that were attended by people in positions of power who privileged authorship, a space could be created where the co-creation of ideas to improve patient experiences could emerge.

Technology and patient involvement at the micro-level.

At the micro-level, which is arguably the heart of healthcare, is the relationship between provider and patient. Technology is currently being used to gather and

disseminate patients' reviews of their relational experiences with practitioners. Websites that provide public appraisals of physicians and other healthcare providers are gaining in popularity with consumers of that care, and it appears that they count. A recent study in the U.S. reported that a favorable review posted online was second only to a word-of-mouth referral as a reason for selecting a particular provider (Hanauer, Zheng, Singer, Gebremariam, & Davis, 2014). The potential impact of such reviews on relationships between seekers and providers of healthcare is significant. Providers who fail to create open invitations to dialogue with their patients about the care they provide may be surprised to learn about patient experiences in online forums. I have known psychiatrists who were blindsided and professionally wounded by online reviews of their work. However, if those reviews were considered invitations to dialogue by patients, they could provide opportunities for practitioners to bring reflexivity to their taken-for-granted customs. As discussed earlier, this would create a space for meaningful change to occur in the actions that patients did not experience as helpful. If the reviews were dismissed as punitive or retaliatory strikes by disgruntled patients, that opportunity would be lost. In the final analysis, what meaning will be attached to online reviews of healthcare practitioners may remain with the reader but regardless, there is a relational process between the review itself and the reader.

Crowdsourcing

Crowdsourcing provides a powerful opportunity for the creation of communities centered around patient experiences of particular diseases and treatments. Through the use of technology, large numbers of people working collectively can have a significant impact on public health issues. This is a particularly powerful tool for those who are

located in remote locations, or disenfranchised in some way. But crowdsourcing only provides an opportunity, not a guarantee; the key lies in the ownership and management of the information generated by the sites. Questions about how sites are monitored or edited, what institutions they are associated with, whether information produced is sold to outside vendors, and whether financial gain is associated could easily shift the potential from help to harm for those who participate. Additionally, the rapidly changing and immediate nature of internet-based communication make it difficult for reliable realities to be established. Crowdsourcing sites that are co-created by users with firm guidelines around acceptable customs and practices might have more of a chance of establishing safe and reliable experiences for them to immerse themselves in a rich communal experience.

Access to Information

The vast amount of information readily available via the Internet has changed the practice and delivery of healthcare, eliminating the privileged position of “keepers of the knowledge” that healthcare practitioners have traditionally held. More than ever before, patients (whether armed with information, misinformation or pharmaceutical company propaganda) come to healthcare appointments with specific ideas and intentions about their care. And they are less afraid to ask for it. As users of healthcare services become more aware of available treatments, they are able to explore different avenues in the pursuit of health. This change can serve to create more of a partnership between providers and seekers of care. Healthcare practitioners who feel threatened by knowledgeable patients, or insist on occupying the role of expert are not likely to fare well in this age of technology-enhanced patient education. A willingness to “not know”

as much as our patients about topics that are particularly relevant to them, and less so to us allows us to create a space for that partnership to emerge.

Telemedicine as Collaboration

Technological advances have provided access to behavioral and medical healthcare to people who are geographically isolated, and to those who feel ashamed or unsafe revealing their issues to practitioners in person. Telemedicine, which uses two-way video, email and other wireless tools to connect providers to patients, is growing in acceptance and usage. In my own profession, I am aware that some clients who experience problems regarding sexuality find this modality their only option for treatment, and they are immensely grateful for its development. For patients who have felt isolated by shame or geography, telemedicine offers a means of connection to others, and a sense of hope. But the technology itself is only the delivery system; practitioners who do not have the benefit of face-to-face energy have to work harder to convey their care and concern in a two-dimensional paradigm. There is another issue unique to telemedicine, which I myself have experienced. I have conducted online sessions at the request of clients who have moved or spent significant amounts of time away from my practice location. In each of them I noticed a tendency to want to multi-task whilst I was listening to clients; I could see on the screen their view of me, which allowed me to look at paperwork or check my phone without their knowing. These are things I would never consider doing in a face-to-face session, but because I tend to engage in other tasks while I am using my computer, it seemed to be an automatic response during the online sessions.

By considering the basic principles of Social Construction when utilizing technology, providers of healthcare give themselves a blueprint for keeping in mind the importance of relational connections, regardless of the system that delivers them.

Limitations

The limitations to this study included:

Research Design: Data were collected through only three types of interactions: one-on-one interviews, small group meetings of five or six people, and a single large group meeting of 19 people. There are many collaborative “hallway” conversations between subgroups of providers that take place on a daily basis which were not included in this research. Additionally, I was not aware of any financial, logistical or political issues that could have contributed to the content or tone of some of the meetings I observed.

Sample: Only Concept Members were invited to participate in this study. These providers have self-selected to practice in a multidisciplinary, integrative setting. As such, they may not be representative of other practitioners of Primary Care, psychotherapy, or CAM in private practice settings.

Assumptions

I assumed that the relational processes that contribute to collaborative practice in healthcare would be observable.

Protection of Participants and Client Stories

Participants of this inquiry signed consent forms and agreed to be recorded (Appendix 19.) To protect their anonymity, they were referred to during analysis and discussion only according to their discipline rather than their particular modality. Client

stories were highly altered so as to render them unrecognizable. Where possible, (with current clients), permission was sought and granted to include their stories.

Epilogue

During the interview portion of the inquiry, I experienced a pronounced shift in the way I thought of my colleagues. I had previously judged some of them based on the narrow perspective of a few comments they had made (or failed to make) in clinical meetings, and without realizing it, decided that we would most likely not have much to talk about. Once I listened to their professional narratives however, I developed a deep appreciation for their work, and *sought* ways to connect with them. This led to many moments of joining, and my increased satisfaction and gratitude for being a member of this group practice. By interviewing the practice founder, I developed an understanding of the complexities of building and maintaining a successful integrative practice, which I had never entertained before the inquiry. In the past I might have considered some of her decisions through a critical lens, where now I am appreciative of the difficulties of trying to meet the needs of such a large and diverse group of healthcare practitioners, whilst maintaining her own successful practice. Another unexpected outcome was the recognition that I had privileged my professional modality over that of some of my colleagues, particularly the CAM approaches that I did not fully understand prior to this inquiry. I now work closely with those providers, often seeking their advice, and I place great value on what they can offer my clients. As a result I assume that there are other modalities about which I'm currently ignorant, that could also be quite helpful to my clients. I believe that this has made me more open to approaches that are different from

mine, and less certain that my ideas are “correct.” That doesn’t mean that I lack confidence in my abilities to help those who seek my services; on the contrary, as a result of this inquiry, I am confident that I have *an* idea of what will be helpful rather than *the* idea. I am less quick to ascribe physical symptoms to underlying psychological issues, or to assign blame to clients for their “poor health behaviors.” I am more careful with the language I use with them, so that I communicate support and not criticism. Through both the pilot meeting and the process of writing this dissertation, I have become aware that I frequently explain things to others as if they have been with me in my head all along, and privy to my thoughts. There have been countless times since my advisor pointed this out to me that I have written passages with little connective information to guide the reader. As a result I have deduced that awareness and insight are not sufficient to change habitual behaviors and the corresponding relational processes that are impacted by them. It takes mindfulness and presence and a desire to connect with others to change deeply engrained patterns. This applies to collaborative practice across disciplines as well; it is easy to slip into patterns of bounded work in healthcare; intention and energy are required in addition to insight for this to change.

I believe that when a person’s psychosocial experiences play a role in their illness, addressing them can be helpful, and I believe that bad things can also happen randomly. I also recognize that “randomly” could simply be a construct that I am employing for something that I have not yet learned, but could be important to understand. Another unexpected outcome of this inquiry was the dissipation of the frustration I used to feel with other practitioners who chose not to collaborate with me on shared cases. This still happens, sometimes within my own group practice, but I no longer experience it as

distressing. I have come to believe that people have different ideas about how to utilize their professional time, or how to provide care to their patients, and my ideas are simply my ideas, not the “right way.” I continue to reach out to other providers on shared cases, but I do so only once if the interest is not reciprocated. I recently offered to speak to the couples’ therapist of a new individual client of mine, in order to coordinate care. My client expressed gratitude at the offer, but wanted to know first what the extra charge would be. I was dumbfounded and also pleased at her question; in all my years of practice, no client had asked it before. It was gratifying to hear that she recognized the value in what I was offering, and her question made me feel appreciated for including collaboration in my treatment plans. She was even more grateful that there was no extra charge for that service!

I am most appreciative of my colleagues, with whom I was able to participate in a monthly collaborative process that stimulated, challenged and supported my work with clients for 18 months. When the group decided that the time commitment for the group was no longer achievable with their changing schedules, I accepted the decision to end it with gratitude for what we had accomplished together.

Since the initial meeting two years ago, collaboration across disciplines has increased between the practitioners who participated in the inquiry: a psychotherapist has teamed with a nutritionist and a nurse practitioner to form a collaborative approach to binge eating disorder, and another psychotherapist has collaborated with a naturopath to team-treat trauma survivors. A nurse practitioner has initiated dialogue with other practitioners about the impact of long-term patients’ aging and failing health on them as providers. I have been asked by three different CAM providers to create a primer on setting

boundaries with patients, which they said they recognized as important and applicable to their work from the conversations of the collaborative group. Another said to me near the end of this journey: “I’m so glad you’re earning your PhD, because we are all learning so much from the process.” I can’t think of higher praise than that.

Appendices

Appendix One: General invitation to initial collaborative meeting.

Dear Colleagues,

_____ has graciously allowed me to use our June clinical meeting to introduce you to the techniques that will be used in my research. At the meeting, we'll be using them to open a dialogue about how we at WLHC want to collaborate on cases. We are in a unique position to be able to co-create a protocol for professionals to use across multiple disciplines in the field of healthcare.

One of the main strengths of WLHC, as I see it, is the multiple perspectives we can bring to any issue. We'll bring them to this issue as well. As this is a process, *the purpose of the meeting isn't to form a consensus*, but to open a dialogue where the multiple perspectives can be heard. Following are some guidelines to ensure that this can happen.

Focus on the task at hand: We have a shared responsibility to safeguard the professional context of what we're working on at the time.

1. Appreciation: We invite and appreciate each other's perspective.
2. Openness: We are open to being questioned and not agreed with.
3. Reflections are offers: The reflecting team's questions, hypotheses and ideas are options.

We'll be divided into two groups. The Treating Team will talk about a new shared case, and use it to brainstorm ideas about how we want to collaborate in the future. This team is charged with coming up with questions that open new opportunities, and highlight what might be missing from current practices. Examples of this are "What's the worst that could happen if.....?" "What would happen if we gave up the notion that.....?"

The Reflective Team will silently observe the creative team, noting their reactions as they actively listened. They will then enter into dialogue with each other, sharing their observations. They will not interact with the creative team at this point, but instead generate ideas together based on their experiences as appreciative listeners. (At this point, the Treating Team becomes a reflective team.)

We'll then come together as a group to share our experience of this practice. Jen will be taking notes, and can reflect our ideas back to us, which we can use to generate ideas in the future.

As we will have a lot to cover in an hour, the meeting will start promptly at noon. If you need to be late, please come in quietly and sit with your team. You can begin to participate as you see a natural opening.

Appendix Two: Reflecting Team Correspondence.

Dear Colleagues,

Welcome to the Reflecting Team! This vantage point offers a great opportunity to view the discussion of the Treating Team from a different perspective, which can lead to the discovery of new ideas and options.

While they're talking about the case, you're encouraged to actively listen, and notice any thoughts or ideas that come to you. You might have some thoughts about the content of their conversation, and also about the *process*. This could generate some ideas about how we might want to collaborate here at WLHC moving forward. The Treating Team will have their conversation for ~25-30 minutes, and then your team will begin a dialogue.

With this approach, you talk with your team about your observations rather than directly to the Treating Team. You'll have ~ 10-15 minutes for this conversation, which will take place as the Treating Team listens quietly. Of course, it works best to approach any ideas from an appreciative rather than a critical perspective. For example, you might say something like "That's interesting, it makes me think....." when expressing an opposing viewpoint.

We'll then come together as a group to process the experience. Jen will take notes and keep track of the ideas that are generated.

Because we have a lot to cover the meeting will start promptly at noon. The Treating Team will sit by the smaller table at the window. If you have to come in late, please sit with your team and just jump in when an opportunity presents itself.

Please feel free to reach out before the meeting if you have any questions or concerns. And again, I am truly appreciative of your support for this project, and eagerly look forward to your feedback.

Cheers,
Naomi

Appendix Three: Tips for Dialogue adapted from Harlene Anderson, Ph.D.

- Collaboration requires inviting, learning about and respecting the other person's perspective
- Differences are critical to dialogue.
- Dialogue requires openness to being questioned, and not agreed with by the other.
- If you find yourself trying to convince the other to agree, you are not in dialogue with yourself or the other.
- Dialogue requires time for inner and outer talk and reflections.
- Pauses and silences are therefore important to dialogue.

Appendix Four: Correspondence from my client shared with Treating Team prior to meeting.

Hi Naomi,

I'm having a hard time and not sure what to do. Tommy is off of all medication. I have seen some good things such as running and playing. Happiness I haven't seen for a while. I feel like he is able to talk about things when he is in a good place on some occasions. But there have been some tough things the school and myself have been dealing with as well. He had an incident on the bus, yelling and screaming at the bus driver. Telling her to turn off the radio. The station was inappropriate and she wasn't supposed to be listening to it anyway. Telling her she should be fired. All from the back of the bus while she is driving. The next day he is asked to sit in the front and he refused. At school he is acting erratic. Running through the halls, yelling, hiding in lockers, having a really hard time calming down. He spent most of the day in the principal's office today and was only at school for 4 hours because of an early morning appt. At home today he got his homework done with no problem but a couple days ago he was tapping the floor repeatedly and moving his body in circles. It took quite awhile until he could settle down to really focus. Still a ton of defiance. I am constantly counting down to get him to do what he needs to do. It is working for the most part but he is extremely angry when he isn't extremely happy or excited. It's one extreme to another.

I'm just really scared. Maybe the medication was helping with some things but the amount of side affects we were seeing were really troubling. But what I'm seeing now is also troubling. I'm afraid to send him to school. He seems ok at home for the most part, though tonight was a tough night.

Any advice would be appreciated. I really feel like we are going to need a lot more support this month and not sure where to turn.

Appendix Five: Reminder email from office manager

Hello Everyone - a quick reminder that there is a meeting today at noon ;)

Naomi will be presenting so please be on time, starting at noon sharp.

If you're late - please enter quietly and sit with your group.

Best Regards,

B.G.

Appendix Six: Excerpts from the Reflecting Team during the pilot meeting

X5: Yeah, and it wasn't like weekly or anything, it might have even been monthly. But I think it helped tremendously in helping everyone working together. And even being able to say I saw something here. Obviously the dialogue changes because the parent is there and then the child. Or you have it also without them. Just a couple of different combinations and ideas.

X4: And then maybe there would be more of a clear treatment plan. Even if it's still a discussion is it OCD or is it Asperger's, whatever it is at least there would be some more clarity around what his roles are, what mom's roles are. And then maybe that would cut down on, I heard a lot of assumptions based on pieces of information, which we all naturally do because we don't have 4 hours with every client to get all the information. But I wonder if that would help minimize assumptions and that there would be more clarity. Because I don't know if mom is jumping from provider to provider or if she's trying to follow or trying to get a sense of different things to try to decide what to do, or if she's avoiding the acceptance of a diagnosis or if she just doesn't want to say no to anything that has the potential to help her son, so she's trying a little bit of everything. Um and so the idea that maybe there could be like a wraparound meeting, or even one person to help decide information I don't know if that would help.

X5: Yeah but I think a treatment plan would be good to have. Because it didn't seem like there was how many weeks do you recommend for Bowen, and mom could you do this? And how many sessions with Ranan? Or for acupuncture? Or whatever might be included with that. So that way, gee mom it's best you could at least give hypnotherapy 3 to 5 visits or something else because that way you see if it really does work. I believe that things can work in conjunction with others. I know that at times you don't want to do both acupuncture and bowen in the same week or day I get that. And I understand that sometimes it's hard to like wait 5 weeks to see if just one thing works. But if there was a treatment plan, I think she would be, I don't know this person, I'll just speak for myself, a little bit more less scared of okay, I know what.....

X7: I think that's a good way to put it.

X4: I think that's something we've talked about over the years. It's always something I'd envisioned here is the idea of a triage or point person like you said, someone who could put all the information together, and present it well. And that person would keep in contact with all the providers, so it isn't just if you see someone in the halls or I thought this, I thought this,. You'd actually have someone collaborating and coordinating. I think that would be helpful in this case. And all cases.

X8: Yeah that's what I'd written down, in terms of communication between us, I know sometimes when I see a client from another massage therapist sometimes I don't want to see the notes at all, because I want the information I get to be pure. So I don't know if

maybe there's a place where maybe we could have like note space? Where notes would all go up in one sort of space, and whether we want to access that from the other providers to see what they have to say or wait until after someone would see this patient or client, because you know like I said I like to keep my information pure so I know it's just my observation and then prepare afterwards all that sort of stuff other people might need . Because it is very obviously you know this weird setup to have input from you know other people and so there's gotta I really like the idea of having that one person who could compile the information, review it, summarize it, and then send communication out to the patient or parents. Could be a whole new job title?

Appendix Seven: Correspondence after pilot meeting.

Dear Colleagues,

I have spoken to most of you individually, and have also gotten some helpful feedback from the pilot collaborative-case meeting held in June. I'm reaching out now to share my observations, and to invite you to participate in another collaborative experience.

We are a large, unique and diverse group of providers with decades of experience and talent between us. Regardless of our training, we came to WLHC because we share a vision of the kind of integrative care we want to provide. Amy's vision to bring together viewpoints from multiple disciplines could allow for the creation of something new that is irreducible to the components of just one. Yet our size and schedules can make it difficult to come together and tap into these many perspectives that we are lucky enough to have here, under one roof.

Based on these factors, I am hopeful that you will be interested in forming a collaborative patient consultation group. This voluntary group could meet regularly or periodically, and be comprised of whoever chooses to attend each meeting. Whatever form it takes, it will provide an opportunity to look through different lenses at our more complex patient cases, and to ask questions, share wisdom and in the process, allow space and time for us to get to know each other and the work we do at a deeper level.

The hope is that we will eventually invite patients to join us, and benefit from their perspectives as well.

Please let me know if you're interested in attending the first meeting, which is scheduled for Friday, August 29th from 12:00-1:30pm.

Thank you for your time and support for this project!

Naomi

Appendix Eight: Correspondence before second meeting

Hello Everyone,

I'm looking forward to our first meeting of the Collaborative Patient Consultation Group (unless we decide to call it something else:)

We are scheduled to meet this Friday, 8/29 from 12:00-1:30 in the conf. room. A healthy and delicious lunch will be served; please let me know if you have any allergies or strong dislikes.

The purpose of this meeting will be to lay the groundwork for what we want this group to become. Please give some thoughts as to what would make it meaningful for you to participate in such a group.

Looking forward to building something special with you all!

Naomi

ps: With everyone's permission, I would like to again record this meeting for my dissertation research.

Appendix Nine: Correspondence after second meeting

Hey Guys,

Attached is a copy of an idea I have for increasing the likelihood of collaboration. I thought we could complete these for each mutual client we have with primary care, and give it to them for inclusion in the medical records. Please let me know your thoughts, and if you would make any changes or additions. I've spoken to J about programing in some way to cross-reference and identify mutual clients now that they're moving to EMR; perhaps our colleagues will want to share info back to us in the future.

Cheers,

Naomi

Appendix Ten: Collaborative Treatment Summary

Collaborative Treatment Summary

Date: _____ Provider _____

Client Name _____ Date of Birth _____Strengths: _____

_____Current
Stressors _____

_____Obstacles Overcome/ Pertinent History:

_____Goals for Psychotherapy Treatment:

_____Links to Physical Health/ Request to reaffirm recommendations:

Would like to discuss with you now: _____

Will let you know if future collaboration needed: _____

Would like to arrange team meeting: _____

Client Signature

Appendix 11: Correspondence after third meeting

Hello Fellow Collaborators,

Thank you all for a great meeting! Our next meeting is scheduled for Friday, 10/24 from 12-1:00 pm in the conference room again. A healthy lunch will be served with cheese-free, gluten-free and meat-free options:) Hopefully everyone can attend.

I'd like to invite M or C to present a case and run the meeting. Some things to consider are: Why are you presenting this case? What are you looking for from the group? How can we best provide what you're looking for?

Thank you for your interest in this research project, and for your thoughtful and intelligent participation. Listening to the recordings and transcribing them offers me an opportunity to revisit the experience, and I am amazed at the wisdom, insight and caring that emerge so clearly.

Cheers,

Naomi

Appendix 12: Correspondence after fourth meeting

Hello Fellow Collaborators,

I'm reading *Narrative Medicine* by Rita Charon, which is a beautiful book that describes what I think we're trying to accomplish with this group. She defines narrative medicine as "medicine practiced with the narrative competence to recognize, absorb, interpret and be moved by the stories of illness." She talks about physicians borrowing from therapists and vs versa, learning to bear witness to their patients' stories of pain or illness rather than simply trying to *do* something. I was thinking of the gentle and respectful way that M listened to the patient she presented, and also of the same way that S opened the door to her patient's *experience* of her illness. I'm guessing it was a real relief to both of your patients to have someone really listen to them, without judging. I know that we did not agree as a group about the wisdom of inviting a patient to join us, but the more I read, the more drawn I am to the idea. I do believe they have much to teach us about their experiences with illness, and I like the notion of them as "expert" and me as "learner." I hope you'll consider this idea over the next few weeks. C will be presenting in January, maybe we could consider at that meeting whether we'd like to try this in February? Our next mtg is scheduled for Friday, Jan 24 from 12-1 in M's office. In the meantime, hope everyone has a wonderful Thanksgiving!

Cheers, Naomi

Appendix 13: Correspondence after the fifth meeting

I want to thank all of you for your participation in my research, and to welcome M to the collaborative group! I should have enough data after today's meeting, and plan to spend the winter reading and writing, and thinking about how it will all fit together and become a dissertation.

Though this group came about because of your generous willingness to participate, I am hopeful that we will decide to continue learning together. Today's meeting was incredibly thought-provoking and poignant, and an example for me of what is possible when folks from different disciplines come together to co-create knowledge.

I especially appreciated M's willingness to present such a complex case, and to share her doubts as a practitioner trying so hard to help someone seeking her services. I'm guessing that we've all felt ineffectual as providers, and so could relate quite strongly to the experience that she was brave enough to name. What's also nice is that there is room for us to bring curiosity to how we've made decisions regarding patients/clients; by allowing dissonance around how we approach cases, new ideas can emerge. And I know that I am still thinking about my beliefs around dying & bereavement, "shoulds," and how I "help" my clients, so thank you M!

Can you let me know if you're interested in continuing to meet monthly and if so, if you'd like to set the remaining dates as 11/21 & 12/19, or if you'd prefer to wait until next year? We can also talk about making it a pot-luck for the future or just BYO.

Thank you again; it's truly a pleasure to work with such amazing and dedicated professionals.

Cheers,
Naomi

Appendix 14: Correspondence After Meeting Six

Hello February Collaborators,

Thanks to C for presenting an interesting case that once again sparked thoughtful conversation about the ways we engage with those who seek our services, and how we are both transformed by the process. Here's a quote from Rita Charon's wonderful book "Narrative Medicine"

"The healing process begins when patients tell of symptoms or even fears of illness--first to themselves, then to loved ones, and finally to health professionals. That illness and suffering must be told is becoming clear.....the powerful narratives of illness....reveal how illness comes to one's body, ones' loved ones and one's self."

Kudos to C for helping her client tell her story, and hopefully find herself again in the process, regardless of what is happening in her body.

I'm wondering how we should proceed with February's meeting, as it doesn't look like there's a week where everyone can attend. Since this is O's month, perhaps he'd like to make the call? We could have almost everyone there I think if we met on Friday 2/13 (oooh!) Why doesn't everyone weigh in and the O can decide if we go ahead or wait til March.

Also, it looks like there will be an opportunity to talk with the Concept members as a whole on Wednesday about whether we might want to change the way we currently collaborate in meetings.

Stay warm!

Naomi

Appendix 15: Excerpts from Fourth Small Group Meeting

Reflecting X5: So I guess what-why I'm bringing it up for is I haven't dealt with a lot of people sort of in the close to dying stage. And she has hope. Like she has hope but like she's alive, right? So like the process is about her being alive? And I'm not her oncologist, I'm not her primary care. I'm the person that she trusts and keeps coming back to, even though inside of me I'm like 'I've never really been able to help you much, like, like I feel like a failure in that regard. Like I feel like maybe if I thought something like six years ago, you would be better,' right? So like I'm sort of taking on more than I'm, obviously I've been feeling guilty like something's not clean and clear boundary wise in there? Um and then like, you know like I kind of avoided it, and if certain like, you know like that letter, I should have called her and I'm sort of like every day you know dreading calling her. Like to talk about it ..."

Bringing curiosity X6: Mmm hmm. Does she want to live?

Engaging X5: She does. She really does, I mean she's like, I mean the fact that she like absolutely sort of like adamantly denies the fact that it seems to everybody else that she's dying is interesting.

Seeking solution X6: Has anybody ever brought in her family, like a family member? With her into an appointment?

Responding X5: Not with me, I don't know about the other folks.

Supporting X6: Cause there's something to be said for, and I mean, maybe it's, I mean the fact you're one of the sole practitioners, I guess it falls on you. Unless the primary care will do it, you know "bring a family member in..."

Reflecting X5: The primary care apparently spent two hours with her, talking. I mean that's pretty amazing... You know what it's funny, I have hardly talked to her about emotions. She's so like, New Hampshire rugged. Sort of. But I think it's great, like I think it's the place to go now. The other stuff is not...I don't care what she eats or puts in her body. Like now I realize that she, like when I was first a practitioner, when I was first out of school, I would be like so by the book like, "you gotta do this, and you gotta take this, and the book says do this" and now like, I don't care. I wanna, like I realize, "oh yeah, I should go there with her."

Affirming X2: Yeah, you're following her.

Connecting X5: Mmm hmm

- Reflecting* X1: I have a, like maybe a ‘cousin’ kind of a take to what you’re just saying. I found myself saying when you said “I said to her “there’s a physical body and a spiritual body” I found myself saying “and an emotional body.”
- Connecting* X5: Uhh haa
- Reflecting* X1: And um, it starts to, I started to feel like it feels like her self now has been broken down to ‘she’s a spleen, she’s a supplement.”
- X5: Yeah
- Sharing* X1: And I’ll just share with you I recently lost one of my clients to brain cancer. And when she came she’d had the diagnosis and was fairly similar. She was gonna not do any treatment, she wanted to use natural treatments, she actually was a nutritionist. And um she was very angry, and um very angry and combative with her husband and her kids ... But I do want to share with you what happened at the end stages for her ... we just started to have a conversation. And I am really comfortable talking about death and dying, so I should preface it with that. That um we couldn’t do physical healing anymore, but we could maybe do some emotional healing ... And um what emerged from that was, she wanted to, it was her birthday I think the next week. And she had never in her whole life had a birthday party. And she wanted to have a birthday party. And so there was this softening and um they had a birthday party in her room and I think maybe she died the next week. So I, you know, I’ll just kind of offer that, that I see there is an emotional piece.

Reflecting X5: Hmmm. I think it's so right, and I think what I really take from that is like I've followed her lead, and that's not the right, I think I've missed the mark. Like she comes to me and says she wants to do supplements and things, and it's right it's all focused on the physical part, which is not relevant.

Affirming X1: Or, it's a part of her, but it's not *all* of her.

Affirming MF: Yeah it's like, that yeah

Appendix 16: Questionnaire sent to small group membersResearch Findings on Building Collaborative Groups in a
Multidisciplinary Private Practice

Please take a few moments to review these findings, and answer the questions at the bottom of the second page.

Collaboration in healthcare can be considered ‘rhizomatic;’ there are multiple perspectives from which to view any topic, and so learning has no beginning and no end.

As practitioners who represent multiple disciplines, we will never have all of the answers from any one lens. But by remaining curious and open to what our peers and those who seek our services are teaching us, we have the best shot at learning through collaboration.

Collaboration is not reimbursable or directly “monetizable.” To choose to collaborate requires a different view of ‘time well spent’ in healthcare than what is traditionally valued.

Collaboration must be prepared for; it doesn’t automatically happen, even when practitioners self-identify as ‘collaborative.’

Collaboration in healthcare presumes that there is no one single way (or one singular truth) to treating any particular symptom or illness or person.

Collaboration in healthcare does not recognize one approach or discipline as being superior to any other; instead, it presumes that each discipline has merits and limitations. This allows for mutual respect among practitioners and a horizontal rather than hierarchical organization in a group practice.

Collaboration involves vulnerability in front of colleagues, which requires a degree of safety. A tolerance for vulnerability allows for a stance of “not knowing,” from which curiosity and questions can emerge.

Safety is more likely to be built over time if groups of six or less meet regularly, and have the opportunity to build trust.

Trust is built not from adherence to one way of thinking, but from the *manner of approach* to dissonant thoughts: Instead of asking/demanding “Why didn’t you do it this way?” or “You should have thought about that,” curiosity is expressed as “I’m wondering what would have happened if you’d done it this way?” or “It reminds me of a time I saw it done another way.”

Collaboration across disciplines in healthcare requires a willingness to translate ideas, terms and techniques into language that everyone can understand.

Collaboration that includes the patient's voice will provide a more complex and personal picture of a topic than practitioner-only collaboration can.

Practitioners sometimes adopt a different tone in language and attitude in peer-only collaboration as opposed to patient-inclusive collaboration.

That choice of language can have a powerful impact on practitioners' perceptions of patients, illness and treatment.

Inviting a patient/client to participate in a collaborative group would require careful thought to selection and preparation, in order to ensure that the process is beneficial and not harmful.

1. Does this summary represent your experience of what knowledge was co-created in the collaborative group meetings?
2. In what ways will your participation in this group inform your work with those who seek your services?
2. What is the biggest take-away you've gotten from participating in the group?
3. What recommendations would you have for this group in the future?
4. What recommendations would you have for other multidiscipline practices that are looking to form collaborative groups?
5. Anything I should've asked, or that you'd like to add?

Appendix 17: Results of Inquiry shared with leadership

Primary care manages either directly or indirectly 80% of patients with psychological disorders. (Strosahl, 1997)

Historically, some of the biggest obstacles to collaboration in healthcare have been territorialism, hierarchies, and a belief that a single modality or discipline is the only or best way. (There is no evidence of any of this at WLHC.)

Collaboration is possible only when there is psychological safety within an organization. It requires a willingness to be vulnerable in front of colleagues; to come from a stance of “not-knowing.” (WLHC is safe.)

Trust is built not from adherence to one way of thinking, but instead from the manner of approach to dissonant thoughts. When curiosity is expressed instead of explanations demanded, differences of opinion about care, no matter how strongly felt, can be openly discussed. (This happens at WLHC.)

Collaboration can include the patient’s voice in a variety of ways. The patient as ‘expert’ can teach the provider about how disease is *experienced*; this is another term for ‘illness.’

Commonly used terms & their definitions:

Co-located: Behavioral health providers and primary care providers (e.g., physicians, nurse practitioners) delivering care in the same practice. Co-location is more of a description of where services are provided rather than a specific service; however, co-location maintains a referral process, which may begin as medical cases and are transferred to behavioral health (Blount, 2003).

Collaborative care: An overarching term describing ongoing relationships between clinicians (e.g., behavioral health and primary care) over time (Doherty, McDaniel & Baird, 1996). This is not a fixed model, but a larger construct consisting of various components which when combined create models of collaborative care (Craven & Bland, 2006; Peek, 2007).

Coordinated care: Behavioral health and PCPs practice separately within their respective systems. Information regarding mutual patients may be exchanged as-needed, and collaboration is limited outside of the initial referral (Blount, 2003). *This best describes my experience at WLHC*

Integrated care: Tightly integrated, on-site teamwork with unified care plan. Often connotes close organizational integration as well, perhaps involving social and other services (Blount, 2003; Blount et al., 2007).

Medical home: A single-site, regular source of care for individuals seeking a broad range of biomedical and behavioral health care services (Starfield & Shi, 2004).

Patient-centered care: “Care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (Institute of Medicine, 2001, p. 3).

Ideas for future collaborative opportunities:

1) Bring in the patient’s voice:

Create a “panel of experts” made up of patients: Prepare both patients and providers ahead of time for the process. Meet for dinner to socialize a bit, then break up into groups of 4-5, with providers learning from “experts”. After patients leave, one spokesperson from each group reports to the team about the experience.

2) Create more opportunities to discuss shared cases:

Coordinate lunch times with other providers; consider what a unified treatment plan might look like.

Set monthly small-group meetings to review all shared cases (progress, impediments, etc.)

On difficult cases, convene a “panel of support” to listen (can use reflective team or another model) and offer alternate viewpoints.

Add space on EMR for behavior health; allow psychotherapists to add notes and request support/reinforcement for concepts being covered in therapy.

3) Create more opportunities to get to know each other:

Break into pairs, share stories of our professional journeys/path to WLHC; introduce each other to the group as a whole.

Break into smaller groups, perhaps with representatives from each discipline during some of the regular meetings, present to the group as a whole what the collaborative approach or treatment plan would include.

Appendix 18: Results of Small Group Questionnaires

“Small group collaboration deepens my understanding of other disciplines, broadens my perspective on patients’ emotional, spiritual, and physical journey towards healing, and improves my language skills. These benefits combined make me a better practitioner. When the patient is included, I anticipate gaining empathy and understanding of a variety of conditions and the emotional experiences that patients are going through as they balance their responsibilities while they seek healing. I know there are many stories of courage; these inspire me and in these stories, I can see where the practitioner and patient meet at different levels.”

“The biggest take away for me (and I was only able to attend two meetings) was the shift towards feeling like I could just talk without feeling intimidated by a larger group size. I can see over time how trust, safety, and vulnerability emerge and how beneficial this could be as a practitioner and how it will benefit the patient.”

“The case I presented elicited a lot of really great feedback that improved my understanding of my client’s situation and created some solid solutions with which we are working. I wished I had recorded the collaboration session so that I could go back and listen, perhaps take notes, and create some structure and continuity to my plan of how to facilitate change with my client. I know I missed

some good suggestions. Also, listening to it again by myself would have been a different experience and could add in other ways.”

“I think providing practitioners with your Summary of Findings prior to their first meeting would help to understand collaboration, set the tone, and begin to create that respect, trust, and vulnerability piece that is so important.

You did a terrific, concise job describing what our process has looked like. The only idea that I have a differing opinion on is the idea of preparing for collaboration. While it is helpful to have times set and trust created, I have found some wonderful and useful collaboration opportunities 'on the fly'.

“I feel like we are far too comfortable looking out our own lenses when we are looking for patterns. The group is an excellent opportunity to see through other people’s glasses. A client can only benefit from a practitioner who is able to step back from their comfort zone and see a new landscape.”

“I can be very comfortable in the way that I address an issue. It has been valuable to hear different voices, not only for me, but for my patients.”

“I think it might be interesting to have a more free form approach. Case studies are useful but a theme (i.e. dealing with triggering people) might bring some stimulating discussion.”

“I would suggest that the components of the group have their egos in check. A collaboration can easily slip into a 'my idea is the right idea' with the wrong

people. It is not always natural to really listen and come from a place of only wanting to help and be of service.”

“The group offers fresh perspectives on difficult cases; a place to get feedback on how to handle certain aspects of practice such as getting triggered by patients, or not making progress. Insight into what my discipline has to offer those in other fields and vice versa. It’s fun to learn about other’s experiences and challenges and to share my own.”

“This was a very thorough summary. It also provided me with a great perspective of the value of collaboration.”

“I am very much looking forward to getting feedback/learning more about the perspectives of practitioners outside the mental health field. Their input often generates great conversations and allows my thinking to expand beyond the bounds of the theories that I was trained in. By this way, I can truly expand the systemic way that I think about my cases.”

“This is very much related to the answer that I gave to the second question. I believe interdisciplinary collaboration is very valuable yet it is so hard to coordinate. I wish there was a way to make this happen more frequently. One of

the takeaways that I am getting is that I am missing out on a lot when I do not collaborate with practitioners in different fields.”

“So far I very much like the format that we have within our group. I especially appreciate the case presentations. In short, I do not have any major suggestions other than keeping case presentations as a part of the process.”

“First and foremost make the time for the collaborative group. "Finding" is not the correct verb as it's almost nearly impossible to find a time for things like interdisciplinary collaboration. Second keep the group small and intimate. Maybe maximum six practitioners. Also clarifying the rules and expectations of the group is crucial for success. I believe you/we have a pretty good job setting them up at an early stage.”

“Thank you SO much for putting the group together. I really enjoy being a part of it and benefit from it tremendously.”

“Yes this summary represented the experience I had in the collaborative group meetings. “

“It also reminded me of what it was about collaboration that I loved and facilitated me to refocus on that goal.”

“My participation in this group has led me to refocus on being humble in my work with my clients. For me to remember that they are the best guide for what is best for them. “

“The biggest take away for me was the numerous lenses each person can see an individual or a symptom. The ability one can have to shift their lens with an open mind and curiosity toward the client and our own work. That it's ok to not have a clear direct line toward intervention all the time.”

“This group can continue to move forward as we continue to develop trust in each other and softening any defensiveness into curiosity. To continue to challenge ourselves by being creative such as bringing patients into the room to be a major participant at the table to their own care. “

“My suggestion would be to keep the group small, continue to have dialogue about the group agenda and outcomes. To create groups where there is trust can be challenging, however is essential to moving forward.”

Appendix 19: Excerpts from the Recap Meeting

X1: "I thought the experience and perceptions were interesting. Especially in the, you do tend to have the goggles on for seeing things exactly the way that you've always seen them. And it was refreshing for me to see, especially um a psychotherapeutic tint and lens on it. You know I think I play one on tv. I end up hearing a lot of everybody's thing but there's certainly isn't a lot of education there. I get leaned on heavily in that area so I enjoy the um, the idea of boundarying up. The idea of having a boundary; I kind of like that part."

X2: "Yeah I like that too. Like the um sort of support on the personal side of like how to manage stuff? Like the patient who was dying that one..."

X3: "Mmm hmm."

X2: "That was so helpful. But also just sort of like what you guys say about sort of the therapy speak of how you maintain with people? Which was just sort of a big relief sometimes because like oh, yeah, we deal with that all the time except we're not really trained with the processing of that part."

X3: "Mmm hmm It's interesting, I think a lot of fields would benefit so much from that work around how to have those healthy boundaries or how to maintain them, and how to respond to people's stuff they try to put on us. I actually went on a, um was invited to talk at a conference of lawyers because of my divorce work. And I decided to set aside all that and I decided to talk about self-care for lawyers. Because they're terrible um and talk about transference and

countertransference that happens for lawyers as well. Because people go to them at the highest distress levels, and they put so much on to them. And if they don't now that is also happening, they're reacting from that place. And they are not trained at all, at all! They, some of them looked at me like I had 2 heads. And then they talked to me afterwards. But even with other caring professions, that is not I think talked about at times. In the name of like focusing on what we do which is great, but you I know I think it's so helpful."

X1: "Mmm hmm I think it's interesting to think about lot of people in the therapy industry as it were are looking towards adding more holistic feel, more like EMDR, mind-body techniques. And all of these are adding it in. And those of us who are in that field, we could really benefit. Like I would love to have a seminar on transference, or what to do when, or therapy "light." How to maneuver out of that. I think that would be incredibly useful for acupuncturists and naturopaths, reiki masters. Everybody who is in a room with somebody who does not want to go to therapy, but does want you to be there. As a coach..."

They answered the question "What does this mean?" in the following exchanges:

Naomi: "So what do you think is the meaning?"

X2: Of what?

Naomi: "Of, if we were going to attach meaning to, "this is what's happening in the first meeting, this is what's happening in the fourth meeting." Is the meaning that sometimes with people you aren't going to get that flow? Or sometimes people may have some needs that they're not even aware of and that's going to

interrupt that flow? Or sometimes you can't get flow with certain people? I guess I'm looking for, so what does it mean?"

X1: "It means at that moment in time with those five people, those six people, all the conditions were perfect for flow. And if there was one other person in that group, it may not have happened. It's a thing that you can capture, but it's not a thing you can create. You can't force it."

Naomi: "So you think you can't create it, it's going to come or not come?"

X1: "I think you can you know, invite people who want to, who have the consciousness of it feels good. You can create the perfect environment for it but it doesn't mean it's going to be birthed. The possibilities are there."

X3: "Yeah."

Naomi: "So that's what I'm looking for. That's helpful. So maybe the best we can hope for is we can set up the opportunity, but there's no guarantee?"

X3: "Mmm hmm."

Naomi: "It's kind of magic though when it happens, right?"

X2: "Is it the intention of it though? I think the intention of the big group is to not go to that place. But the little group does. And I also think the self-selection of the small group is people are going to show up who are probably more likely to do that. So it's intentional rather than mandatory."

X1: "That's true."

Naomi: "So that would be me setting up the conditions so that it's intentional, it's a certain amount of people who are more comfortable dropping deeper, being

vulnerable, you know, not knowing? But maybe even in the best circumstances, it's not necessarily, depending on your day....."

As to the question "What are the implications for collaboration?" the group concluded as follows:

X1: "But there can be pieces of collaboration. We did that Pink Martini thing and I was sitting across from _____ and it was so amazing, we had so much connection, more than like the whole how many years that we've been here together. And that was super useful, like we understood where we both were with patients. We talked about a mutual patient it was on a, really like a heart to heart level. I feel like in this group you hold on to those moments. Like I had that _____ moment, and CAM2 and I have had those moments, and those things are amazing. And if lightning strikes and you can have five or six people in a room, how terrific. But the entire group to imagine that it would be a collaborative effort..."

Naomi: "So forced collaboration doesn't work? But I love the idea that if you keep your eyes open....."

X1: "To those moments, and then appreciate them. Because those moments are amazing."

X2: "They're great."

X3: "Maybe I just had an "aha" moment because we're talking about because this is your dissertation topic, right, collaboration? But what if what we're actually talking about is connection? Because I think bottom line what I heard, from just reflecting on this is you can't have collaboration or anything if you don't have

connection. And what we're talking about, what we have here is connection. Um a lot deeper than what we have in the large group for whatever the reasons are. So in effect what we're seeking maybe is meaningful connection. That leads to collaboration; that's the nature of it anyway. Because when you're connected, you collaborate. That's how we evolved as human beings. We can't survive on our own. So when you're really connected, you collaborate. That's the natural outcome of it. So maybe it's about how do we connect versus. Maybe it's not even about topics. Like there's a part of me..."

X2: "You're so right."

X1: "I really like that. I like the idea about the collaboration is a very natural side effect of connection."

X2: "YES!" (emphatically)

X1: "You don't even have to think about it because if you're connected, you see the person at the same level and you want to help them. There's a unity to it."

X3: "It's an emergent quality."

X2: "Yeah, yeah. You want to share."

X1: "That comes from the connection. Collaboration is maybe not exactly what, it's connection."

X3: "You don't shoot for that, you shoot for connection and that's what happens."

X1: "And that's just part of it."

X2: "And that's like, it's like about getting your personal needs met. Like your human connection needs, versus the other thing."

Naomi: "Exactly, because we do *all* long for connection."

Appendix 20 Consent Form to Participate in Research Study

With Naomi B Rather, LCMHC
Taos Institute/Tilburg University

You are being invited to participate in a study focused on the ways that healthcare providers from different disciplines enact collaboration with those who seek their services, and with each other in a primary care setting.

This inquiry is being made because there is very little existing research about how collaboration happens between providers in this setting, and very little that includes the patient in any setting.

As a member of an integrative practice with multiple disciplines represented, you are an expert on working together in an integrative, primary care setting. I am inviting you to co-create ideas to possibly enhance the way that we enact collaboration on cases that are not easily treated through a single lens or discipline.

Your participation will include one individual interview, during which I will take notes about your professional background, and interest in joining an integrative practice. You will also be invited to join a “brown bag” meeting that will involve dialogue with patients about their experiences being treated by multiple providers in our practice. Patients and providers will be prepped before the meetings with information about how to engage in positive dialogue. The meetings will be audiotaped, transcribed and coded. The tapes will only be available to myself and my supervisor, Harlene Anderson PhD.

Your part is entirely voluntary. Even if you choose to participate, you are free to withdraw at any time without any consequences or explanation. You’re free to ask questions or seek clarification at any time during any meeting or interview. You may also choose to decline to answer any questions with which you’re uncomfortable, or do not wish to answer.

It’s possible that this dissertation will be shared through published articles and presentations. However, your identity can be kept anonymous except for your professional affiliation.

There are always risks and benefits to participation in research. A possible benefit is an increased awareness of your colleagues and their disciplines, and an enhanced ability to work together. A possible risk in opening up to new ideas for collaborating with your patient or client present might be some discomfort.

Your signature below indicates that you understand the conditions of participating in this study, and that you have had an opportunity to have your questions answered by Naomi B. Rather, LCMHC.

Name

Date

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