INTERDISCIPLINARY COLLABORATION:
COUNSELLORS' PERCEPTIONS OF COLLABORATION
EXPERIENCES WITH PSYCHIATRISTS ON COMMUNITY
MENTAL HEALTH TEAMS

By

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ABSTRACT

The purpose of this study was to describe counsellors' perceptions of their collaboration experiences with psychiatrists working in the context of a community mental health team. Specifically, perceptions of facilitating and impeding factors that influence collaboration were identified. Interpretive description (Thorne, Kirkham, & McDonald-Emes, 1997), a qualitative methodology, was selected as the means of attaining descriptions of the collaboration process that would depict the commonalities among the participant sample while maintaining the unique experience of each individual.

Participants included four female and four male Caucasian counsellors between the ages of 38 and 57 who possessed either an M.A. or M.Ed. degree and were currently working in a mental health team. The counsellors engaged in open-ended interviews in which they read an orienting statement and responded to the following directive: Talk about some of the particular collaboration experiences you have had with psychiatrists.

Aspects of collaboration experiences fit into one of three general categories: 1) external-structural factors stemming from the work setting; 2) internal cognitive factors pertaining to counsellors' perceptions of psychiatrists and themselves; or 3) social-relational factors arising from communication styles and ways of interacting. The findings suggest that much of the quality of a collaborative interaction arises from the actual quality of the professional relationship. Findings are considered in relation to previous and future research, existing ethical codes, and counsellor training.
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Chapter I

Introduction

There is a growing recognition of and emphasis on the need for interdisciplinary collaboration and practice to occur between counsellors and psychiatrists. Interdisciplinary collaboration has been defined as:

"a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible" (Gray & Wood, 1991)

Several circumstances for counsellors to seek and engage in collaboration with psychiatrists exist. These circumstances include: 1) when a counsellor is seeing a client who has a mental illness, 2) when a counsellor is seeing a client who is concurrently being seen by a psychiatrist, and 3) when a counsellor and psychiatrist are part of a team in which each professional plays a role in the holistic treatment of clients. Collaborating with psychiatrists provides opportunities for sharing knowledge of a client from the perspective of each professional. It is also important that a counsellor be aware of any medication the psychiatrist may have prescribed to a client, and what effects this medication may have on the client. Furthermore, collaborating with one another is necessary to ensure that therapeutic goals are the same and that methods for working toward these goals do not conflict with one another.

Collaborating between counsellors and psychiatrists is an important component of effective care for clients, and competent collaboration is a reflection of sound ethical practice. However, the frequency of collaboration between these professionals is not as high as one might expect. A discussion among five experienced mental health professionals
revealed several comments that support the notion that collaboration may not be occurring as often as perhaps it could be (Paproski & Haverkamp, 2000). For example, a public health nurse and administrator with extensive experience in mental health agencies stated that, "The most difficult thing was to have a case conference or discussion with all the participants and players... including having the client in attendance, often because of difficulty in coordinating people's schedules" (Paproski & Haverkamp, 2000, p. 86). A psychiatrist stated that, "Until recently, there has been very little communication between me and the counsellors and psychologists with whom I work," and a registered psychologist mentioned that, "In the private sector there has been very little collaboration and sharing, and it is limited by the standards and codes under which we are operating" (p.86).

A number of factors influence the frequency and quality of collaboration, including geographic proximity to other professionals, specific working environments, available time, existing stereotypes among various professions, and personality factors (Paproski & Haverkamp, 2000). Counsellors who work on a team setting may have more opportunities to collaborate with other members of the team, including psychiatrists. However, as the factors listed above indicate, engaging in collaboration with other professionals is not happening as often as would be expected. Issues such as territoriality between professions, lack of knowledge about other professionals involved with clients, and lack of coordination and/or case management all influence the frequency – or lack of – collaborative practice. The mental health team in which I had my practicum experience did not have psychiatrists on site every day. When they were on site, they were generally booked solid with appointments throughout the day. This made it difficult for any extra discussions or queries about a client to take place. Perrin (1999) mentions similar barriers to collaboration such as
time pressures, poor communication, too few service providers, and inadequate training in collaborative practice.

While there is a wealth of literature on collaboration in health care settings, little or none exists that is specific to counsellors and psychiatrists. Of the existing literature, very little is based on research. There is no empirical data on counsellors' awareness of the term 'interdisciplinary collaboration,' what it means to collaborate, how often individuals engage in the process, or whether there are ways to improve upon one's ability to collaborate. It is hoped that the results of this study begin to fill in some of these gaps. This study focused on counsellors' experiences of collaborative practice with psychiatrists who work in the context of a mental health team setting. Specifically, factors that facilitated and impeded collaboration experiences were identified and explored. Because of the lack of research on collaboration between counsellors and psychiatrists, this study was a preliminary exploration of the area.
Chapter II

Literature Review

The following chapter is a review of the existing literature relating to interdisciplinary collaboration. As mentioned previously, there are little or no writings that specifically address collaboration between counsellors and psychiatrists. However, it is important to review the more general literature in order to become familiar with various aspects of interdisciplinary collaboration. Therefore the discussion will begin with a general description of the characteristics of collaborative practice in order to define and clarify the term for purposes of this study.

Characteristics of Collaborative Practice

Collaborative practice involves at least two professionals from different disciplines working together with a client to meet the assessed client-centred needs (Canadian Medical Association (CMA), Canadian Nurses Association (CNA), and Health Canada, 1996). In an ideal situation, collaborating professionals develop a shared vision, values, and philosophy that are focused on meeting therapeutic needs. Clear definitions and comprehension of roles and responsibilities by all who are involved are necessary in order for collaboration to be successful. Communication and respect for autonomous choices and decisions of each professional as well as the client are also crucial elements of good collaborative practice (CMA et al., 1996).

Harbaugh (1994) states that "helping professionals who work together with intention, mutual respect, and commitment, for the sake of a more adequate response to a human problem are working interprofessionally" (p. 19). Each profession maintains its distinctiveness, but working together allows different points of view to influence a more
holistic orientation. Interprofessional collaboration involves “purposeful sequences of change-oriented transactions between representatives of two or more professions who possess individual expertise, but who are functionally interdependent in their collaborative pursuit of commonly shared goals” (Billups, 1987).

The process of collaboration can occur in many forms including conferring, cooperating, consulting, and teamwork (Bope & Jost, 1994). These are defined by Bope and Jost (1994) as follows: Conferring refers to the informal sharing of observations, and this is most likely to occur in a team setting or casual conversation with another professional. Cooperating involves the sharing of knowledge and ideas. One professional might cooperate in referring a client to another professional on the other professional’s suggestion and, of course, the client’s consent. Consulting is more formal than conferring or cooperating in that one professional intentionally seeks another for an opinion. This opinion is likely to be more seriously considered by the person seeking advise. The various forms of collaboration all vary in quality, including duration, degree of intensity, disposition, and the amount of skill required from each professional (Specht, 1985). The duration of collaboration is simply the amount of time spent in an interaction. These interactions can vary in intensity from being light and superficial, to being more purposeful and in-depth. Feelings that range from extremely positive, to neutral, to extremely negative can characterize the disposition of an interaction. Finally, various professional tasks will require various professional and interpersonal skills. Each professional is presumably skilled in areas that are specific to his or her profession, as well as in their own unique interpersonal skills.
The ability or inability to directly deal with conflict is identified in the literature as a critical factor that determines how effective a collaborative process is (Abramson & Rosenthal, 1995; Casto & Julia, 1994). It is imperative that professionals be able to confront their differences of opinion, values, and beliefs in order to avoid a "groupthink" mentality that would be detrimental to the client. Conflict, when appropriately dealt with, has the possibility of contributing to the development of new ideas and effective action plans.

**Why is Collaboration Important?**

The current health care system is made up of a variety of professionals with their own unique skills, educational backgrounds, and areas of responsibility. When a client is being seen by several of these professionals there is the risk of receiving "segmented, uncoordinated and duplicated care" (CMA et al., 1996, p.7). Interprofessional collaboration is an avenue for combining areas of specialization that ultimately will result in outcomes that are far greater than those from individual efforts. Platt (1994) states that,

> With increased specialization, the person as client is divided up by body part, physiological system, by disease, and by intervention to be applied.....Some mechanism for getting the person back together conceptually is necessary, not only for humanistic reasons, but also because problems are not usually so divisible. (p. 8)

The multiple perspectives likely to be offered by different professionals ensure that decisions have greater potential to reflect a more informed and thorough vision (Abramson & Rosenthal, 1995).
In my practicum experience at a mental health team there were several forms and intensities of collaboration that occurred. Members of the team included social workers, counsellors, psychiatrists, nurses, physicians, and occupational therapists. The whole team would meet at the start of each day in order to discuss any relevant cases. New clients were initially seen and interviewed by all professionals who would be working with them. Some interactions were casual, such as meeting to discuss the case over coffee or lunch. Others were brief, as in asking a quick question in passing by one’s office. It was clear that by consulting and discussing cases with other professionals, there seemed to be a greater ability to solve problems beyond the scope of any one profession, as well as a more effective utilization of resources (Anglin et al., 1998).

The Case of Sam

One example from my practicum experience illustrates the greater potential to impact the overall outcomes of a client’s therapy when collaboration occurs among different professionals. It should be noted that the following is a composite case, and the name has been changed to protect the identity of any actual child who was seen by me at the mental health team. ‘Sam’ was an eight-year old boy who was referred to the mental health team by his school. Teachers reported that Sam was anxious, restless, and would cry for long periods for no apparent reason. It was also reported that he had problems with frustration tolerance and had difficulty staying on task unless the activity was very structured. The psychiatrist from the School Board noted that Sam had allegedly witnessed his step-father abusing his mother. Sam’s mother, with the aid of an interpreter as English was her second language, reported that Sam’s behavior at home was similar to that reported by the school and he had difficulty verbally expressing himself. Sam’s history was therefore provided by
his mother, an interpreter, a teacher, and a school counsellor. It should be noted that the interpreter also provided insight to the mother’s culture, and this contributed to a greater understanding of various emotional reactions that were presented at the intake meeting. A greater understanding of Sam’s background, school behavior, home behavior, and significant life events led to an organized and collaborative therapy plan. He was seen by me for play therapy sessions, he was seen by a psychiatrist for diagnosis and medication, and therapy at the mental health team was combined with scheduled team meetings which included his teacher, school counsellor, school psychiatrist, mental health team counsellor, mental health team psychiatrist, a social worker, Sam’s mother, and an interpreter. These meetings provided an opportunity to share what was happening in each area of Sam’s life, and to brainstorm ways of working toward therapeutic and educational goals. The results included an overall improvement in academic performance, better social skills, better ability to stay on task, and no further signs of anxiety. I do not believe these major improvements can be attributed to any one professional who was working with Sam. In my opinion, these improvements are the direct result of the collaborative efforts of many disciplines.

There are numerous benefits for the client, the professional, the profession, and society with the practice of interprofessional collaboration. The client and society benefit from the elimination of fragmented and duplicated services, the professional gains support and affiliation with other professionals, and the profession itself benefits from the clarification of professional boundaries (Julia & Thompson, 1994). Overall, interprofessional collaboration is more likely to result in a higher quality of service. For counsellors, providing a high quality of service for their clients is a necessary part of practice as they are called to ‘do no harm.’ Collaborating with other professionals has the
potential to enhance the quality of therapeutic outcomes. Therefore it follows that good collaborative practice is a reflection of sound ethical practice.

**Ethics**

The counselling profession is guided by a set of ethical codes used to govern appropriate conduct with clients. While there are no specific guidelines stating the importance and necessity of collaboration, the practice of collaboration is definitely implied in several of the ethical guidelines. The primary responsibility of counsellors is “to respect the integrity and promote the welfare of their clients” (Canadian Counselling Association, 1999; American Counselling Association, 1995). Promoting client welfare would necessarily involve collaborating and consulting with other appropriate professionals as well as the client him or herself in order to holistically address the client’s best interest. The complexities of an individual are somewhat like pieces of a puzzle that, when fitted together, make up the ‘big picture.’ These puzzle pieces represent many different aspects including physiology, emotions, environmental context, work, family, cognitions, beliefs, and social support system. Each aspect of an individual can in some way be linked to a professional who specializes in that particular area. A doctor is trained to identify and treat physical ailments, a counsellor is trained to work with emotions, cognitions and beliefs, and a social worker looks at the context and social support system. It is therefore crucial that each area of specialization is considered in the context of the whole picture in so much as is possible. Effective collaboration seems to be the most practical way of ‘putting the pieces together.’

As was stated previously, some ethical guidelines that relate to collaboration do exist. For example, the code of ethics put forth by the Canadian Counselling Association
(CCA) states that “counsellors may consult with other professionally competent persons about the client” (CCA, 1999). The code elaborates by noting that, if the identity of the client is to be revealed, then written consent from the client must be obtained. The American Counseling Association code of ethics gives guidelines for dealing with other agencies the client may be involved in:

Before sharing information, counselors make efforts to ensure that there are defined policies in other agencies serving the counselor’s clients that effectively protect the confidentiality of information.

(Article B6)

Therefore, counsellors are obligated to ensure that other agencies will protect a client’s confidentiality before they share information. It seems important that counsellors would also make a joint effort with the other agencies to operate in the client’s best interest in order to maintain the integrity and autonomy of the client throughout the counselling relationship.

The ethical codes of the counselling profession also give guidance in the area of confidentiality when it comes to collaborating and consulting with other professionals. For example, if a counsellor discovers that a client is concurrently in another form of counselling relationship, then it is up to the counsellor to discuss the issues related to continuing or to terminate the counselling relationship (CCA, 1999). Discussing these issues with the other helper(s) may be appropriate, but only with written consent from the client. Clients who are being served by other professionals may, in some cases, be a natural catalyst to the formation of collaborative relationships with those professionals. The American Counseling Association (1995) states the same guideline: “Counselors, with
client consent, inform the professional persons already involved and develop clear agreements to avoid confusion and conflict for the client” (Article A4).

While ethical codes exist in order to guide conduct within a profession, more general ethical principles underlie the formation of ethical codes. Ethical principles are more general and fundamental than codes and are the foundation upon which these codes are formed. Several of these principles, including nonmaleficence and beneficence, provide further rationale for the necessity of collaboration with other professionals (Kitchener, 1984). Nonmaleficence essentially means not causing harm to others. In other words, one of the strongest obligations is to ‘do no harm.’

Collaborating with other professionals may very well contribute to avoiding harm in that the counsellor gathers information and points of view from other sources in order to provide a more holistic treatment program for a client. The client is placed at risk if a counsellor were to knowingly ignore his or her limits and not obtain support from other specialized professionals (Paproski & Haverkamp, 2000). Beneficence involves doing good for others. Clients presumably have an expectation that they will benefit from their counselling sessions. It is crucial that one possess competence in order to provide a service that will, in fact, benefit the client. Again, collaboration may enhance the overall benefits for the client directly or indirectly from the team gaining insight from multiple points of view. Going back to the case of Sam, the psychiatrist provided a medical frame and prescribed medication to address symptoms of ADHD, the teacher provided an educational frame and made adjustments to Sam’s academic program, the mother and social worker provided a family history frame to provide context, the interpreter provided a cultural frame,
and the counsellor provided a therapeutic frame. All of these points of view had a direct benefit to the outcomes of our combined efforts.

**Advantages to Collaboration**

While there is little or no existing literature on collaborative practice that is specific to counsellors and psychiatrists, there is an abundance of health care and general literature that can be drawn on to identify some of the common issues, benefits, and concerns across disciplines. Of the existing literature, very little is based on rigorous qualitative or quantitative evidence. Most of the writing about collaborative practice is based on opinion and/or anecdotes. However, it is necessary to review what has been written about collaboration in general for the purpose of identifying some of the positive outcomes that have been identified with successful interprofessional collaboration.

When professionals collaborate there is wider ownership of the case process and the advantage of having several points of view due to differing areas of expertise focusing on a single case. This yields a better understanding of the client as a whole rather than an understanding based on one professional’s area of expertise (Abramson & Rosenthal, 1995). Furthermore, collaboration directly contributes to coordinated planning and treatment, the support of other provider group colleagues, greater recognition of the specific expertise and skills of other professionals, and avoidance of burnout (CMA et al., 1996).

The Canadian Medical Association, the Canadian Nursing Association and Health Canada (1996) combined their expertise in a project that addressed the challenges and opportunities arising from collaborative practice specific to caring for people living with HIV/AIDS. The authors identify several aspects of effective collaboration. It is assumed that these aspects are general enough to be applicable to other professionals who engage in
collaboration. Adapting the phrasing to address the collaboration of counsellors and psychiatrists, these aspects include:

1) Patient-centred [client-centred] care with a minimum of two care-givers from different disciplines [such as counselling and psychiatry] working together with the client to meet the assessed health care [therapy] needs.

2) Development of a shared or common vision, values, and philosophy focused on meeting health care [therapy] needs.

3) A clear definition and understanding of team member roles and responsibilities by all stakeholders.

4) A climate of respect, trust, mutual support, and shared decision-making.

5) Effective communication among all team members.

6) Empowerment of all team members.

7) Respect for autonomous professional judgement.

8) Respect for autonomous choices and decisions of the care recipient.

(CMA et al., 1996, p.1)

Further rationale for interdisciplinary collaboration comes from government and public recognition of a shared responsibility for health. With changes to professional and health system regulation come incentives for more integrated and efficient health services (Nurses Association of New Brunswick, 1995). Collaboration has the potential to increase the efficient use of health care resources as well as to strengthen interprofessional communication. Indeed, collaboration may be the answer to the way Canadian governments control costs while providing efficient quality care (CMA et al., 1996).

This study will focus primarily on the individual, social, professional and interprofessional aspects of collaboration between counsellors and psychiatrists who work
together in a team setting. In order to remain grounded in the realistic practice of collaboration, it is important to examine both the real barriers to collaboration as well as the perceived ones that exist. By knowing and recognizing what the barriers are it is assumed that a greater understanding of what is needed for effective collaboration to occur will ensue. The next section will focus on barriers to collaboration, and it should be noted that this literature review is based on general practices of collaboration and is not specific to counsellors and psychiatrists. However, a review of this literature was useful in the design of this study to explore the specific barriers to collaboration between counsellors and psychiatrists in a team setting.

**Barriers to Collaboration**

The various barriers to effective collaboration can be categorized as either external structural barriers or internal cognitive barriers. Those that are external in nature pertain to the structure of an interprofessional team such as the physical environment, geographic proximity of professionals involved on the team, and policies regarding how the team functions. Internal barriers originate within an individual as a result of one's beliefs, attitudes, role definitions, and stereotypes that are formed as a result of both personal and professional experience.

**External Structural Barriers.**

Professionals from different disciplines tend to have differing status in a team setting, creating an unequal balance of power and varying amounts of influence on decision-making (Abramson & Rosenthal, 1995). Abramson and Rosenthal (1995) state that "collaborators from various disciplines do not necessarily share the same values or terminologies and have been socialized to define their roles and the goals of service to
clients differently as well" (p.1483). A team setting may have a particular approach and/or 
value system that contributes to a view of certain professions having higher status in an 
organizational hierarchy. For example, in a team setting where a medical model is 
prominent, physicians and psychiatrists tend to be viewed as having higher status by other 
professionals.

Another significant external barrier to effective collaboration is a lack of education, 
knowledge and experience about the principles of interdisciplinary care. Each professional 
in a team may have differing ideas and perceptions of what ‘interdisciplinary collaboration’ 
might mean. Unless each is educated about the principles of collaboration and gains direct 
experience in communicating with professionals from other disciplines, there lies the 
potential to neglect seeking collaborative relationships simply because they have not been 
made aware of the potential benefits of such a process.

If team members do not work in a shared space, there are fewer opportunities for 
informal and frequent communications with those from other professions (Anglin, 1998). 
Whether or not team members work in a shared space, if there are poorly-run or non- 
existent team meetings, then effective collaboration is not likely to be happening. 
Caseloads may be heavy, and at times the only opportunity for collaborating with team 
members is during set meeting times. If no particular time is set aside for meetings, it is 
 easy to become consumed by one’s individual workload and difficult to find mutual times to 
meet with other professionals. If a meeting is poorly run and not all voices are given equal 
consideration there is the potential for communication breakdowns and misunderstandings 
among the various professionals involved. A poorly run meeting may indicate that team 
strategies, processes and objectives are not being reviewed (West, 1998).
Internal Cognitive Barriers.

Years of university training in a particular profession contribute to the internalization of the philosophical and value positions underlying a professional orientation (Mumford, 1983, cited in Wagner-Yates, 1992). Members of an interprofessional team will bring different values, beliefs, and professional frameworks due to having been educated specifically within their own profession. These differences become manifest in differing treatment goals, intervention methods, and communication styles (Wagner-Yates, 1992). Other internal barriers to collaboration include: a lack of interprofessional trust resulting in complicated power relations between professions (Anglin et al, 1998), a lack of professional role understanding and respect (West, 1998), and in some cases a lack of simple knowledge of the other’s profession.

Because the very nature of interdisciplinary collaboration involves a variety of different professions, stereotyped perceptions are likely to exist. Folkins et al. (1981) describe both cognitive and dynamic factors in explaining stereotypes and evaluative attitudes toward other professions. They state that recent research demonstrates that “merely grouping people leads to discriminatory perceptions and behavior” (p. 145). Stereotypes may be positive, negative, or neutral in nature. Folkins et al. (1981) write that “interdisciplinary interactions are heavily influenced by social stereotypes promoted in the culture and among professional groups; the social stereotypes that mental health disciplines harbor for each other may even help to “create” the behavior that confirms those stereotypes” (p. 141).

Any given profession’s training involves the acquisition of terminology that is specific to that profession. This allows precision when discussing a case or issue within a
particular profession, but may lend to difficulties in communicating across professions (Academic Health Center Task Force on Interdisciplinary Health Team Development, 1996). Vocabularies may be dissimilar, and those that are shared may have very different meanings for different professions. For example, the term ‘model’ will have one set of meanings for a psychologist and another for a mathematician (Derry et al., 1998). These differences result in an incomplete exchange of information among professionals (Academic Health Center Task Force on Interdisciplinary Health Team Development, 1996). Learning the language of each professional’s culture aids in the understanding of the rules for how communication should occur in each professional culture (Seaburn, 1996).

**Cognitive Processes of Collaboration**

The discussion will now shift focus to examine some of the underlying theories of collaboration in the hopes of shedding light on the cognitive processes that influence the effectiveness of interactions. These processes have been described by Derry et al. (1998) and consist of two theoretical frameworks: Situated cognition theory and groups as information-processing systems. Language and knowledge is developed in groups by a process of negotiation (Lave, 1991). Derry et al. (1998) state that “negotiation is necessary because different members bring to the group their own cognitive histories, and these unique perspectives cause members to understand and interpret work-related problems in significantly different ways” (p. 27). It is important that language and understanding are aligned among team members so as to avoid miscommunications in any case discussions. However, the desired outcome of interdisciplinary collaboration is not the assimilation of various perspectives by a dominant one, but rather one in which all perspectives have an influence.
Group information processing has been defined as “the degree to which information, ideas, or cognitive processes are shared, and are being shared, among group members and how this sharing of information affects both individual and group-level outcomes” (Hinsz et al., 1997, p.43). The sharing of information is influenced by several factors including status differences among professionals, and the extent to which a particular idea is held in common with other group members. Furthermore, the way new knowledge is interpreted by group members is influenced by prior knowledge. For example, classic information-processing models explain that at any given time, a portion of one’s long-term memory network is active and accessible. This active prior knowledge influences the filtering and understanding of new and incoming information. Therefore a potential cognitive barrier exists if individual understandings and definitions are not made explicit when members of different professions are discussing a case.

**Counsellors and Psychiatrists In Team Settings**

Counsellors and psychiatrists who work as part of a team must interact and work with each other in order to provide appropriate care for clients. Koeske et al. (1993) state that “it seems important that helpers trained in one mental health discipline feel that those trained in another possess attributes that facilitate good client care” (p. 45). One would assume that the perception of positive attributes in another professional would facilitate the likelihood of seeking collaboration with that professional. Conversely, a perception of a lack of attributes in another professional might hinder any potential advantageous collaborative efforts.

Each member of an interdisciplinary team comes from differing educational backgrounds with differing socialization experiences according to their profession. Along
with these differing experiences, each brings differing values, beliefs, and professional frameworks to the team (Wagner-Yates, 1992). These differences are likely to show up by way of differing treatment goals, intervention methods, and ideas or expectations about the team process.

The differences in training and socialization for counsellors and psychiatrists generally result in their subscribing to two different frameworks: the psycho-social model and the medical model. In general, counsellors are trained within a psycho-social model in that the client is viewed in the context of his or her environment and life situation. The client is encouraged to make his or her own choices, and the counsellor is trained to use the relationship as a tool in the therapeutic process. Psychiatrists are generally trained within a medical model that aims at using medical intervention to eliminate disease. The reality is that variations exist between individuals in both disciplines. Some counsellors may lie closer to the medical model end of the continuum, and some psychiatrists may lie closer to a psycho-social orientation. Depending on where professionals lie on this continuum, conflict and confusion may result from misunderstandings, stereotyped ideas, problems of communication, and interprofessional differences of expectations (Sherer, 1995).

A study was conducted by Sherer (1995) dealing with the division of work among three professions involved in the treatment of mental health patients: psychiatry, psychology, and social work. These professions’ domains are not clearly delineated other than psychiatry being the only profession among the three allowed to prescribe medication, and psychology being the only one among the three to administer psychological tests. The boundaries of these professional domains are unclear due to the fact that “psychiatrists, psychologists, and social workers share a common frame of reference and have access to
similar philosophies, sources of knowledge and techniques" (p. 448). The study sample consisted of 24 mental health teams in central Israel. Relationships and differences among respondents were analyzed according to profession, position, and gender. Questionnaires were used to look at differences among the professional groups. These questionnaires consisted of four parts: 1) demographic characteristics, 2) job characteristics such as methods used, types of problems dealt with, type of clients, techniques used, and cooperation with the community, 3) a job analysis questionnaire that addressed tasks performed by professionals, and 4) questions regarding role division among the professions in the organization.

The findings showed no differences among the three professions in terms of the amount of work, types of problems dealt with, and techniques used. Not surprisingly, the education, training, and positions held by the three different professions were found to be significantly different. However, these differences had only minor influences on actual job performance and the importance of the roles. The three professions did not demonstrate any role ambiguity and were clear about the roles they should perform as well as the roles of the other team members.

While Sherer's (1995) study looks at professions represented on a mental health team, the fact that team members were evaluated as individuals representing various professions prevents an evaluation of the contributions of various professions to teamwork or collaborative processes. Also, the study only addresses external structural factors such as education, training, function within the organization, and job position. Internal cognitive factors are not examined or addressed.
Summary

This chapter began by defining collaborative practice in order to provide a frame of reference on which the current inquiry is based. Examples of characteristics of good collaborative practice were provided so as to orient the reader to the perspective, ideals and possibilities of working collaboratively within an interdisciplinary team. It was argued that interprofessional collaboration results in a higher quality of service due to the elimination of fragmented or duplicated services and the support provided by multiple professionals. Existing ethical guidelines that pertain to counsellors collaborating with other professionals were presented, and it was pointed out that there are currently no explicit guidelines in this area. The literature relating to collaboration in general was explored as a means of identifying some of the commonalities across disciplines. One assumption of the researcher is that these common issues, benefits and concerns are applicable to the specific professional relationship of counsellors and psychiatrists. Another assumption is that there are also unique aspects of the counsellor–psychiatrist relationship that have not been formally investigated.

In summary, the professional experience of counsellors collaborating with psychiatrists has not been studied in the context of mental health teams. Existing literature focuses on external structural factors such as roles within a team, organizational structure of agencies, and educational backgrounds of professionals. Interpersonal factors and the actual working relationship have not been specifically explored. Therefore my intention in this study was to engage in a dialogue with counsellors that would create opportunities for them to tell their collaboration stories, positive and negative, in the context of their particular relationships with psychiatrists.
Purpose of the Study

As was previously mentioned, counsellors’ collaboration experiences with psychiatrists have not been studied in spite of the ethical importance of consulting with other professionals. The purpose of this study was to make explicit the collaborating experiences of counsellors and psychiatrists who work in a mental health team setting. As this study was a preliminary investigation into this topic, it seemed appropriate to utilize a qualitative methodology. Interpretive description, a methodology developed by the nursing discipline, was used to attain an understanding of the collaboration process (Thorne, Kirkham, & McDonald-Emes, 1997). This methodology utilizes a “critical analysis of the existing knowledge” to build an analytic framework for the research design (p. 173).

The current study looked specifically at counsellors’ collaboration experiences with psychiatrists. Internal and external factors pertaining to collaborative experiences were examined with the purpose of gaining further insight to the challenges and opportunities of interdisciplinary collaboration. The specific research question of the study was, “What are counsellors’ experiences in collaborating with psychiatrists?” It is hoped that the ensuing descriptions of collaboration experiences make a contribution to both the existing knowledge of interdisciplinary collaboration, and specifically to the collaboration experiences of counsellors with psychiatrists.
Chapter III

Method

This chapter will describe the design of this study, biases and assumptions of the researcher, a description of the participants, and the procedures that were involved in the research. The research procedures were approved by the Behavioural Research Ethics Board at the University of British Columbia (see Appendix A).

Design

The design of this study was qualitative in nature, using a method known as interpretive description (Thorne et al., 1997). This approach was chosen in order to develop knowledge about counsellors' experiences collaborating with psychiatrists, the purpose being to "reflect a respect for knowledge about aggregates in a manner that does not render the individual case invisible" (Thorne et al., 1997, p. 171).

Interpretive description is a methodology that allows the researcher to draw from existing qualitative methodologies and can create useful, practical, and theoretical knowledge (personal communication with Sally Thorne, May 31, 2001). It is based on the theoretical premise that, while experience is constructed and contextual, there are shared realities (Thorne et al., p. 171). Information is gathered using interviews and observations that consequently make up the research data. Analysis of the data is inductive in nature, and adjustments are made as new data emerges. Any modifications to the analysis are always made explicit and, before the analysis is finalized it is brought back to the participant for verification or modification.

One of the key differences between interpretive description and more traditional qualitative methodologies is that the process of analyzing the data involves reflecting on
what is becoming known as a whole as opposed to developing intricate coding systems and isolating small units for analysis. It is the overall impression that is brought back to the participant for verification or modification rather than impressions from an individual story (Krefting, 1991).

As is generally recommended for qualitative methods, a journal was kept throughout the research process (Krefting, 1991). This journal was used to record the researcher's thoughts, feelings, questions, ideas, and hypotheses generated by the interviews and reading of the literature. Journaling was also useful for identifying any particular biases and assumptions of the researcher, and these biases and assumptions are made explicit in the next section of this chapter.

In summary, the procedures that were utilized in this study followed those recommended by Thorne et al. (1997). These are as follows:

a) Field notes were made in order to record the context of data gathering sessions and to link the context to the phenomena of collaboration.

b) A reflective journal was kept to guide and document the interpretive process.

c) Field notes and the reflective journal were used as a form of traceable audit.

d) Beginning conceptualizations were brought back to participants for critical reflection.

e) Personal and professional biases were made explicit.

**Personal Assumptions / Biases**

The method of interpretive description requires that assumptions and biases that may influence the research process and product are made explicit (Thorne et al., 1997). What
follows is an examination of my assumptions related to this research. The following paragraphs were written prior to data collection.

One of my basic assumptions is that, while both counsellors and psychiatrists have ethical codes for their respective professions, the existence of ethical codes does not necessarily ensure ethical practice. I have a bias that effective collaboration with other professionals is a reflection of good ethical practice in that client welfare is likely to be promoted, but believe that collaboration does not occur as frequently as would be ideal. A second assumption that I hold is that most counsellors are not directly exposed to interdisciplinary collaboration as part of their education curriculum. What is learned either directly or indirectly about collaboration is a result of direct experience with other professionals.

The third assumption I have is that stereotypes exist in each profession about the other, and these stereotypes may sometimes negatively impact the quality and frequency of interactions with one another. If factors that facilitate and impede the process of collaboration were identified and made explicit, possibilities for overcoming barriers and finding new ways to effectively collaborate might be illuminated.

Finally, I believe that if interdisciplinary collaboration were addressed at an educational level where students learned from and about one another’s disciplines in classes designed specifically to address collaborative relationships, they might be better socialized into a work environment where such relationships are a necessity.

Throughout the data collection and analysis these assumptions and biases were kept in check by the researcher. This was accomplished by continually checking the transcripts themselves to insure that any developing ideas were based on what participants were saying.
and not on my interpretation of what was being said. Also, an effort was made to see through the participants' lenses in order to understand their own perspective. Listening to my own interview style while transcribing also aided my awareness of how my questioning could potentially lead to my own assumptions and biases manifesting in the data. This awareness allowed for a better controlling of how the interviews were conducted. Results of the data analysis contain quotes from the participants themselves as one means of demonstrating that the findings are grounded in the raw interview data. The follow-up interviews also served as a means for verification of the findings, and participants were encouraged to critique, disagree, modify, or refine any aspect of the description of counsellors' collaboration experiences with psychiatrists.

**Participants**

Participants consisted of counsellors who are currently working with psychiatrists on a mental health team. Originally, the inclusion criteria to participate required that counsellors have an M.A. or an M.Ed. in Counselling from an accredited institution. Furthermore, counsellors must have had a minimum of two years post-graduation clinical counselling experience. The rationale for these criteria was two-fold. First, possessing a Masters degree from an accredited institution presumably indicates a similar scope and quality of training experiences. Second, having a minimum of two years of clinical counselling experience post-graduation reflects the membership requirements for professional counselling associations. It is therefore inferred that one is considered to be a member of the counselling profession after having had at least two years of work experience. It is important to note that four out of eight counsellors interviewed met the educational criteria. Adjustments were made to these criteria upon learning that many
counsellors on mental health teams have a social work background or a clinical psychology background rather than counselling psychology. Because the actual role of the counsellor is generally the same across mental health teams, and in order to gain an accurate picture of collaboration experiences as a whole, adjusting the educational criteria seemed justified by the researcher.

**Description of Participants**

Due to the relatively small community of mental health teams in Greater Vancouver and in order to maintain anonymity of those who participated in this study, participants will be described as a whole instead of individual ‘thumbnail sketches’ of each individual. Each participant chose a pseudonym to be used when quoted or discussed in the study. The chosen names are as follows: Jean, Eric, Raoul, Jane, Phillip, Kate, Ray, and Margaret.

**Sex, age, and ethnicity.** Of the eight counsellors interviewed, four were female and four were male. The age range was 38 to 57 with a mean of 47.5. All counsellors described their ethnic background as Caucasian.

**Educational background and theoretical orientations.** As previously mentioned, the inclusion criteria were adjusted to accommodate the varying educational backgrounds of the therapists who work on mental health teams. While all eight participants held masters degrees, four participants had degrees in counselling psychology, two had degrees in social work, one had a degree in clinical psychology, and one had a degree in educational psychology. Described areas of degree specialization included clinical, adult, community, family, marital therapy, and men’s issues. The theoretical orientations that participants subscribed to were quite varied. All of the counsellors interviewed mentioned using several theoretical approaches when working with clients. These approaches include the following:

**Target population and work setting.** All of the participants work on provincially funded mental health teams. Five of the counsellors work with children, teens and families, and three primarily work with adults. The number of years of counselling experience post graduation ranged from 4 to 20 with a mean of 14.38. The amount of experience at the particular mental health team in which they were working ranged from 5 weeks (at the time of the preliminary interview) to 20 years with an average of 7.55 years.

**Procedures**

**Recruitment**

Participants were recruited by word of mouth and by letters to community mental health teams in Greater Vancouver and the Fraser Valley that described the study and the inclusion criteria to participate (see Appendix B). Those who had connections to additional counsellors qualified to participate in this study were asked to pass on a letter that invited that person to participate (see Appendix C). In each case, potential participants were asked to contact the researcher if they were interested in being a part of the study. Therefore, participants' identities were only learned if they chose to contact the researcher. Those who met the inclusion criteria and agreed to participate were interviewed by the researcher at the mental health team where they worked.

**Participant contact.** Twenty-six initial contact letters were sent out to mental health teams in Greater Vancouver and the Fraser Valley. Letters were also sent to practicum seminar instructors at the University of British Columbia to distribute to students in
counselling psychology who were doing a practicum at a mental health team. The students, in turn, were asked to pass on recruitment letters to anyone on the team who fit the criteria. The initial contact letter briefly described the research topic of collaboration, the criteria for participation, and the format of the study (i.e., interview).

Eight counsellors were scheduled for interviews, and four more individuals contacted the researcher by telephone. These four counsellors gave verbal permission to keep a record of their names and contact information if there was a need to conduct more interviews upon completion of the initial eight scheduled. Another mental health worker contacted the researcher via email and expressed disappointment in the strict inclusion criteria regarding the necessity for a Masters degree in counselling psychology, as there were three clinicians at that particular setting who wished to participate but did not meet the criteria. The researcher replied to this email, offering to record the names and phone numbers of the clinicians who were interested in participating in order to pass this information on to the research supervisor at the University of British Columbia who would, in turn, keep the names for other students who might be interested in researching interdisciplinary collaboration. There was no further contact with that particular individual.

When potential participants contacted the researcher by phone, any questions they may have had about the study were answered. These questions were primarily about the time commitment required by the study and the procedures used to maintain confidentiality. Several potential participants made comments about the topic itself, stating that they had not read anything specific about collaborating with psychiatrists in the literature. When interest in participating was expressed, the researcher asked questions about educational background and years of experience to determine whether they fit the inclusion criteria. An interview
time that was convenient for both the researcher and the participant was then set. Several additional demographic questions were asked during the initial telephone contact. These included questions relating to the counsellor’s age, year of graduation from a master’s program, area of focus and degree specialization, years of clinical counselling experience post graduation, type of work setting and client population, theoretical orientations, and professional organization affiliations or memberships. The reason for asking these questions was primarily to provide a description of some of the demographic characteristics of those who participated in the study.

Sample Selection

The initial proposal for this study stated that eight to twelve participants would be interviewed. Therefore, eight interviews were initially scheduled for the first participants who contacted the researcher and qualified for the study. Any additional counsellors who contacted the researcher were placed on a ‘stand-by’ list if they qualified to participate and agreed to have their name recorded if there was a need to conduct more interviews. While participants did discuss their range of experiences collaborating with psychiatrists, many believed that their positive stories would be unique to my study and provide a broader picture of the full spectrum of experiences. It should be noted that a few participants mentioned that other colleagues of theirs might describe their collaboration ‘quite differently’. As it was the hope of the researcher to gain a variation of experiences, both positive and negative, participants were encouraged to pass on a recruitment letter to these colleagues. Not a single colleague phoned about participating and so their story was not told. However, it is believed by the researcher that the range of experiences narrated by
participants do reflect aspects of the full spectrum, and the assumption is made that aspects of their stories would embrace aspects that might have been shared by their colleagues.

Interpretive description generally requires a maximum variation on themes that develop from the analysis. Participants can be sought on the basis of variations that arise as the study progresses. Because this study was a small preliminary investigation, selecting individuals on the basis of attributes was limited. However, those counsellors who contacted the researcher and chose to participate in the study did vary in areas the researcher was hoping to sample. For example, gender variation among participants was divided equally between male and female, and years of counselling experience also varied amongst participants.

The Interview

The aim of the interview was to obtain a description of counsellors’ experiences in collaborating with psychiatrists. Interviews took place in the office space of the participant at a time that was mutually convenient for both the participant and the researcher. All interviews were audio taped and then transcribed.

There were three main components to the interview: 1) establishing rapport and gathering any demographic information that had been missed in the initial telephone contact; 2) inquiring about the reasons for choosing to participate in this study in order to gain a sense of any motives and wishes on the part of the counsellor as to what they may hope for the results of this study; and 3) an open-ended portion whereby participants read an orienting statement and then described their experiences of collaborating with psychiatrists (see Appendix E).
Establishing rapport involved engaging in casual conversation about the work setting, the weather, participants' recollections of their own research for their degrees, and the immediate office surroundings. Any questions the participant may have had were answered prior to beginning the 'formal' component of the interview. Participants were then given two copies of the consent form (see Appendix D) to read and sign if in agreement with the procedures. One copy was given to the participant for his or her own records, and the researcher kept the other copy.

Participants were then asked about their reasons for participating in this study. The purpose of this question was two-fold: 1) to gain a sense of what each participant felt was important in discussing collaboration experiences; and 2) to gain insight to counsellors' perceptions and attitudes toward collaboration as these perceptions and attitudes would presumably pervade the narrations of collaborative experiences with psychiatrists. The orienting statement was then read aloud, and the tape recorder was turned on when the participant began talking about his or her collaboration experiences with psychiatrists. Throughout the interview, participants were often asked to elaborate on their stories or descriptions by asking questions such as, “What do you mean by _____?”; “Can you tell me more about _____?”; “Can you give me an example of _____?”; “What did _____ mean for you?”; “Is there anything else you would like to say/add about _____?” In order to avoid going off on tangents, participants were also sometimes asked how what they were saying or describing related to collaboration. This served as a way of keeping the focus on the collaborative process between counsellors and psychiatrists on mental health teams.

Other questions were asked throughout the interview if the counsellor was not bringing up certain aspects of collaboration on their own, and these included the following:
Asking about a collaborating situation that went well; asking about a collaboration experience that did not go well; asking about what helps the collaborating process and what gets in the way; and asking if there was anything in the counsellor's educational training that prepared him or her for collaborating with a psychiatrist. The final question was whether or not there was anything the participant wished to add. Some participants mentioned that they were certain they would think of something after the interview was over, in which case they were invited to contact the researcher by telephone or email if there was anything they wanted to add to what they had already talked about. No one did phone or email the researcher but there were some participants who, at the time of the follow-up interviews, commented on further reflection and thoughts they had had since the preliminary interviews.

Data Analysis

Interpretive description requires inductive analysis and avoids overly complex techniques such as intricate coding systems that may inhibit inductive reasoning (Thorne et al., 1997). As such, the researcher begins by asking general questions about the overall picture such as "What is happening here?" and "What am I learning about this?" rather than sorting, filing, and combining large quantities of small data units. This aids the researcher in maintaining a focus on the acquisition of an understanding of the research as a whole. Recommended analytic procedures are those that aid the researcher to synthesize, theorize, and recontextualize the data. Examples of such recommended procedures include Naturalistic Inquiry (Guba & Lincoln, 1985) and Phenomenological Inquiry (Giorgi, 1985). These approaches were used to guide the analysis of the interview data, and are detailed below.
Analysis began with the researcher 'immersing in the data' by listening to the recordings, transcribing each audio-taped interview, and reading the transcripts. After each interview, the researcher first listened to the recording and made any notes, thoughts, and ideas explicit in the journal. The interview was then transcribed, again recording any thoughts, ideas, or notes regarding participants' inflections and tones. Upon completion of the transcript, the audio-tape was listened to again while simultaneously reading the transcript in order to ensure that the transcription was accurate. This process was in keeping with the methodology of interpretive description that requires the researcher to become 'immersed in the data' and be familiarized with each individual case (Thorne et al., 1997). Furthermore, this process was conducive to gaining a general sense of each transcript as a whole and is the first step of data analysis described in the phenomenological method (Giorgi, 1985). Consultation with thesis committee members was sought out by the researcher for critical feedback on progress in making sense of the data.

The researcher then went through each transcript and 'chunked' the data into meaningful units of information that served as the basis for defining categories. This was accomplished in the following way: 1) The researcher read the transcript with the perspective of discriminating examples of contributors and barriers to interdisciplinary collaboration; 2) Whenever the researcher became aware of a change in meaning or aspect of collaboration being discussed by the participant, a data 'chunk' discrimination was made; 3) These data 'chunks' were 'interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry [was] carried out' (Guba & Lincoln, 1985, p. 345). In other words, the words within each 'chunk' told a story by themselves without the absolute necessity for a broader context. This process is also
described in the phenomenological approach that recommends going back over the transcripts “with the specific aim of discriminating ‘meaning units’ from within a psychological perspective and with a focus on the phenomenon being researched” (Giorgi, 1985, p.10).

The next step in the data analysis involved writing a critical paraphrase and key words in the margins beside each ‘chunk.’ This aided in the beginning process of general category formation. After paraphrases and key words were constructed for each meaning unit, the researcher looked at clusters of similarly labelled chunks to note any properties of categories that were emerging. Categories were defined using the method of constant comparison, which is detailed in the Naturalistic Inquiry approach described by Guba and Lincoln (1985). Common themes and trends were noted as they emerged, and the transcripts were constantly referred to in order to ensure that ideas and postulations were grounded in the actual research data as opposed to being formed by the researcher’s assumptions and biases. This process allowed for a production of “...a species of knowledge that will itself be applied back to individual cases” (Thorne et al., 1997, p. 175).

After the beginning conceptualizations of the research were generated, a final reading of the transcripts was done in order to search for anything that did not fit what had been described. This aided in refining the description of counsellors’ collaboration experiences with psychiatrists.

**Follow-up Interview**

As part of the validation procedures in this qualitative research, beginning conceptualizations were brought back to participants themselves for their consideration. The researcher summarized the findings and formed a preliminary description of the data set.
This summary included the following sections: Reasons for participation in the study, types of collaboration that occur with psychiatrists, reasons for collaborating, attributes and actions that facilitate the process of collaboration, attributes and actions that are barriers to collaboration, aspects of the work setting that either contribute to or get in the way of collaboration, and the researcher’s overall impressions from the interviews.

Participants were asked about the degree to which the summary did or did not reflect their own experience of collaborating with psychiatrists. The resulting feedback that either verified or contradicted the preliminary conceptualizations were then incorporated into the findings in order to strengthen the validity of the final research product (Thorne et al., 1997).

**Criteria for Judging Rigor**

The procedures utilized within the current study incorporated multiple criteria for judging rigor. Multiple sources of data were utilized including interviews, field notes and a reflective journal. The interviews provided a means for engaging in a dialogue with individuals who were directly involved with the experience of collaborating with psychiatrists. Field notes recorded the context of meetings with participants, and the reflective journal served to both document and guide the interpretive process within the research. Follow-up interviews allowed a vehicle for elaborating on the preliminary interview, clarifying current understandings, and determining the accuracy of the researcher’s beginning conceptualizations. These beginning conceptualizations represented the participants as a whole rather than each individual, allowing the researcher to be confident that the conceptualizations were “grounded in data and representative of shared realities rather than an artefact of design or researcher error” (Thorne et al., 1997, p.175).
As researcher, my job was to represent "multiple realities revealed by informants as adequately as possible (Krefting, 1990, p. 215). It was variation in experiences rather than repetition and sameness that was sought in this study, as it is uniqueness of the human situation that is emphasized in qualitative research (Krefting, 1990). The researcher purposely set out to interview participants who varied in age, gender, and years of clinical counselling experience in order to identify a range of collaboration experiences and perspectives.

**Summary**

Because this study was a preliminary investigation in an area that has not specifically been examined before, interpretive description was the method chosen by the researcher in order to attain an understanding of counsellors' perceptions of collaboration experiences with psychiatrists on mental health teams. The next chapter presents the findings constructed from the researcher's understanding of what participants shared and their input into that understanding.


Chapter IV

Findings

The central research question posed in this study was; “What are counsellors’ experiences in collaborating with psychiatrists on mental health teams?” Collaboration was defined for participants as: “a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible” (Gray & Wood, 1991).

The preliminary interviews with counsellors varied in length from 40 minutes to 70 minutes with an average of 56 minutes. In total, the research data was comprised of approximately 7 hours and 24 minutes of audio-taped interviews resulting in 124 pages (with an average of 364 words per page) of transcribed dialogue. The findings reported in this chapter are predominantly based on the data attained in the preliminary interview. The developing conceptualizations of counsellors’ collaboration experiences with psychiatrists were brought back to participants for verification, correction, or refinement. The follow-up interviews seemed to verify that the researcher had accurately described participants’ collaboration experiences, as they generally agreed with the preliminary description and interpretation. Details of the follow-up interviews will conclude this chapter. However, if any of the reported findings in this chapter were modified as a result of the follow-up interview it will be explicitly noted. For purposes of confidentiality, each participant chose a pseudonym to use in the description of the results. The names chosen were: Jean, Eric, Raoul, Jane, Phillip, Kate, Ray, and Margaret.

What follows is a description of what counsellors, as a group, shared in the preliminary interviews. This description will begin with an overview of the organizational
structures of the various team settings in order to give a general idea of the range of settings within community mental health. This will be followed by a description of the reasons that were given for participating in this study and an outline of actual activities that occur within collaboration. Domains in which counsellors collaborate with psychiatrists and goals of collaboration are then outlined, followed by descriptions of both positive and negative collaboration experiences. The chapter continues with descriptions of strategies used by participants that maximize the quality of psychiatric time, educational experiences relating to collaboration, assumptions and biases of participants, and general attitudes. This is followed by a description of the findings from the follow-up interviews.

**Organizational Structure of Mental Health Teams**

Before describing how participants saw their role within the organizational structure of the mental health team in which they worked, an overview of what kinds of professionals tend to make up a mental health team will be presented. In general, a mental health team is made up of professionals with diverse educational and experiential backgrounds:

- Psychiatrists have a medical degree, specialize in the use of psychopharmacological interventions, and have access to emergency and other hospital services;
- Psychiatric nurses play an important role in the supervision of clients’ medical treatments and tend to help other staff, clients and their families to understand a client’s diagnosis, prognosis, and the benefits and side effects of any medications being administered;
- The role of social workers overlaps with that of counsellors where they both are skilled in counselling and psychotherapy with individuals, groups, and families;
- There also tend to be activity therapists such as physical therapists, occupational therapists, and/or recreational therapists who are concerned with maintaining the physical and emotional health of clients through
engagement in activity. Teams will typically have a manager or leader who is either a psychiatrist, psychiatric nurse, or one of the non-medical human service workers.

In the current study, all participants described their roles on the team as the case manager and the person with prime responsibility for and to the clients. Whenever a new case came in to a team there was an intake process, and the client was assigned to a case manager. A psychiatrist was typically engaged initially for the preliminary meeting and assessment, and then may or may not have continued to see the client jointly with the therapist depending on the situation. There was a range in the number of psychiatrists on a team, and the amount of time they were on site ranged from three hours bi-weekly to full time. All participants made reference to team meetings that happened at each site. Some had team meetings every morning while others may have met as a full team only once every two weeks with smaller pods meeting weekly. The main purpose of these team meetings was to discuss cases, bring up concerns, and delegate new cases. Separate from the team meetings, counsellors and psychiatrists consulted both with one another and with the client in order to determine the general therapeutic direction to take and whether or not there was a need for medication.

The next section provides a description of the reasons counsellors gave for participating in this study in order to put a frame around the overt and covert intentions of the stories of collaboration experiences that were told.

**Reasons for Participation**

At the beginning of the preliminary interview, each participant was asked about reasons for taking part in this study. It was hoped that the answers to this question would give insight to motivations and what participants hoped to gain by participating. This, in
turn, would give the researcher a compass of sorts to find a general direction of inquiry that would guide the study. In other words, the answers to this question would give the researcher a sense of what each participant felt was important about this study. It is an assumption of the researcher that any underlying agenda or motivation of participants would shape the process and end product of the study.

Overall comments from participants were expressions of interest in the topic of collaboration, and intrigue about being able to be ‘in the other chair’ for a change in order to tell their stories. For example, Raoul stated that:

...I am eager to participate in this study because I think my particular story is one in which, um, I’ve had some very valuable relationships with psychiatrists....I guess, personally, what I would like to see happen is having the pleasure of telling this story....To think that anybody would specifically want to ask about an aspect of my work is just a very pleasant thing... and in fact, this public community mental health service should be extremely proud of the way we bring psychiatrists and therapists together. And we get very little audience for tooting our horns about anything, right? So I’m looking at this as a horn toot! (laughs)

Eric also identified with the topic of collaboration, stating that:

I don’t think we can work in isolation. It is very important to work in a multi-disciplinary type of approach. Psychiatrists, social workers, psychologists – they have different things to offer, so I think it’s important to look at how different professions and what you are doing – relationships between counsellors or therapists – how that works.
Most participants mentioned having had a range of experiences with psychiatrists, therefore fitting the criteria fairly well and desiring to make a contribution to research. One counsellor, Kate, was fairly new to the mental health team and expressed interest in the idea of how she is going about collaborating with psychiatrists, saying “I came completely open-ended as to what this collaborative process would look like, and so I have been just learning as I go and am fairly interested because I, myself, am working this out at the present moment.”

Margaret expressed that having more information about interdisciplinary collaboration would be useful to have for general inter-professional awareness:

I have this experience of a tendency for hierarchical issues to always raise their head around here. Because there’s such a range of professionals working, and uh, I just thought it seemed like a unique topic that I hadn’t read anything about. Within community mental health it is very common for a lot of people to be working with psychiatry, so it just seemed like more information would be useful not only for all of us working together, but useful for psychiatry – definitely – in terms of self-awareness around all professions.

In summary, counsellors chose to participate in this study primarily to tell their stories, to contribute to research in an area they felt was important to address, and to learn more about interdisciplinary collaboration. What follows is a description of counsellors’ collaboration experiences and factors that either contribute or are barriers to effective collaboration with psychiatrists.
Elements of Collaboration

This section will present findings that are more general and describe processes and activities that constitute collaboration. Following this will be sections that examine counsellors’ perceptions of contributors and barriers to collaborating with psychiatrists.

Goals of Collaboration with a Psychiatrist

The paramount goal of collaborating with psychiatrists or any other professional for that matter is to provide a service that will benefit the client. Means for achieving this goal include the provision of a forum to exchange information, share ideas, and weigh therapeutic options. Indeed, Phillip stated that the overall goal of collaboration is to provide a better quality of service to the client. One of the avenues for providing a better quality of service is simply keeping communication lines open regarding treatment and medication. Jean clarified about when she will seek out collaboration with a psychiatrist:

Often it is if the client is not doing well and oftentimes there’s medication concerns... I try to talk with [the psychiatrist] as soon as possible and inform them of what’s going on.... Client safety is a determining factor, definitely.

Margaret also talked about collaborating with the goal or intent of moving forward or past an impasse in the therapy:

...any families that we’re working with where we’re feeling particularly worried about or stuck with, and sort of feeling like we’re at an impasse or not feeling like we’re moving forward... we’ll often look to [the psychiatrist] to help us with it.

Jane talked about what she is looking for in a collaborative exchange with a psychiatrist, saying one of the goals is to “work towards some problem-solving and some ideas which
we, that’s what her job is, is to provide some different ideas from her training, her discipline – which might be different from ours.”

Overall, it was through the generating of ideas, clarification around prescriptions and diagnosis, clarification around what one’s role was in a client’s therapy, and seeking out others’ opinions that the ethical principal of beneficence – or ‘doing good’ – was directly applied in the context of benefiting the client.

Only one participant did not view client well-being as a goal of collaboration, feeling ‘well-being’ seemed to be too generous a term for the type of clientele served at a mental health team. This participant did say that the client’s overall functioning was certainly important, but most discussions were about medication management, symptomatology and treatment rather than a more holistic approach.

**Domains in Which Participants Collaborated with Psychiatrists**

It was mentioned unanimously by all participants that the essential purpose of collaborating with others was ultimately for the concern for and benefit of the client. Actual collaborative interactions either impacted the client overtly (i.e. discussing therapeutic options, medical reviews, exploring ideas directly related to client treatment), or had indirect benefits for the client (i.e. a good collaborative relationship in general, study groups, or educational programs provided a solid foundation on which to provide mental health care).

The various types of collaborative interactions described seemed to the researcher to be of two categories – formal and informal. The formal category included assessments, medication reviews, audits, team meetings, and planned consultation meetings. Informal types of collaboration mainly involved ‘catching’ the psychiatrists when they were free in order to update or query about a case, whether that was done by stopping by the
psychiatrist's office or talking with them in the file room. All participants made reference to the formal types of collaboration mentioned above. Interestingly, those participants with more years of experience working in a mental health team setting focused on the informal types of collaboration, saying this was where the essence of their working relationship came from that had a direct impact on client care. Those with less experience focused on the formal types of collaboration listed above. Raoul described the enrichment he gains from collaborating with psychiatrists on issues and concepts that may not necessarily have anything to do with a particular case. He detailed a conversation he had that related to planning for a joint presentation he and a psychiatrist were going to give to the team on the meaning of soul in psychotherapy. It was in that conversation that Raoul gained a significant revelation about his sense of self:

...THAT came from a collaboration with a psychiatrist I have to point out (laughs), and it's reflective of my practice and probably his and other people's as well. It enhanced and it enriched... it was inspired on the basis of ideas that had not a lot of direct case management connections (laughs). You know it was like 'let's do a talk on the soul and psychotherapy' and exploring that, and then becoming enriched as a therapist in the process of understanding.

Another domain of collaboration mentioned by several participants pertained to educational programs and study groups. A good example of educational collaboration that had an impact on client care comes from Kate:

...this was initiated by a psychiatrist and a case manager – the psychiatrist was reading a book... that’s relationship-focused, it’s very much an empathic kind of client-centred approach. It’s a systems model, and out of the interest the psychiatrist
had in reading this book, she shared it with the case manager who began to read the book as well, and then the two of them decided that they would offer a study group for the whole team for anybody that was interested... It's educational and it's beyond the hours that everybody is working and it’s been very well attended... in order to introduce that model in working particularly with clients who are classified as characterologically difficult.

Essentially, the domains in which counsellors collaborate with psychiatrists are ones that may or may not directly involve the client, but certainly impact the quality of care a client receives overall.

**Collaboration Activities**

The experiences of collaboration described by participants seemed to consist of several different activities. Exploring ideas or options together was one component of collaboration that was frequently mentioned by participants. Jane expressed an appreciation for the way a psychiatrist encouraged exploration:

... if we were feeling vulnerable about a case or unclear and say 'I don't know what I'm doing', she wouldn't jump right in and say 'you should be doing this, this, and this!'. It was really 'Oh, so why do you think this... ', like she made it more of a process about *us* as well and then work towards some problem solving and some ideas... which might be different from ours.

Giving and receiving feedback was also mentioned as an important component of collaborating. Eric talked about a challenging case that he shared with a psychiatrist where they were able to share personally and professionally with one another. The process of
sharing feedback with one another certainly illustrates the mutual egalitarian nature of their working relationship:

I was able to tell him what I thought he had done well as he was able to recognize what I had done well – and even to the point of saying ‘I don’t think I would have been able to do this, what you did.’ But my saying to him ‘you know, it was really good the way you did this or that with the family’....and to me, that’s true collaboration.

Some participants who described particularly strong collaborative relationships with certain individual psychiatrists mentioned they occasionally explored counter-transference issues in consultation sessions. Jane believes that a good rapport and environment of trust are crucial in order for this exploration to occur. Again, elements of mutuality and an egalitarian relationship seem paramount:

There’s a lot of looking at our own counter-transference. And you need to really have an environment of trust, I think, to really go into that work....With [the psychiatrist] it is very positive, very non-judgmental, always feel supported, your feelings normalized, not feeling ever put down...and with a mutual sort of degree of self-disclosure. So it’s a mutual thing and I think that’s quite distinctive where I would think that all of us would feel a comfort level in being able to talk about how we might be getting triggered. And then [the psychiatrist]... may bring a case where she might be looking for our input. So although that’s not her role there is that kind of regard that goes back and forth.
Collaboration Contributors and Barriers

Participants described an array of collaboration experiences that ranged from very negative to exceptionally positive. The negative experiences described by counsellors were situations that may have had the original intent of being collaborative but, due to various barriers, did not succeed. The positive stories were ones in which was a mutual, egalitarian approach and respect for what each professional brought to a case. Each professional – including the client – had a piece of the ‘puzzle’ to offer and contribute to the whole of a client’s therapeutic regime.

All collaboration stories contained facts, perceptions, and attitudes about the work setting, attributes and character traits of both psychiatrists and counsellors, and the actual interactive working relationship between themselves and psychiatrists. The next section will focus on aspects of the work setting that participants cited as having an impact on collaboration within their particular mental health team.

The Work Setting

There were several aspects of the work setting that were mentioned as contributing to an environment for collaboration to occur. This section begins by describing aspects of the work setting that facilitated collaboration, followed by those that were barriers to the process. An overview of these findings is outlined in Table 1.

Aspects of the work setting that facilitated collaboration.

Collaboration was facilitated by the accessibility of psychiatrists who worked in the team. The very fact that psychiatrists were on site at least part of the time made them somewhat more accessible due to the proximity of offices. Ray discussed this aspect as it related to his particular team:
Table 1

Collaboration: Domains, Contributions and Barriers of the Work Setting

<table>
<thead>
<tr>
<th>Domains</th>
<th>Contributions</th>
<th>Barriers</th>
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</thead>
<tbody>
<tr>
<td><strong>WORK SETTING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic proximity of office space</td>
<td></td>
<td>Lack of accessibility when off site</td>
</tr>
<tr>
<td>Morning team meetings</td>
<td></td>
<td>Not enough psychiatric time</td>
</tr>
<tr>
<td>Meeting in smaller pods</td>
<td></td>
<td>Heavy workload of psychiatrists</td>
</tr>
<tr>
<td>Accessibility of psychiatrists on site</td>
<td></td>
<td>Hierarchical</td>
</tr>
<tr>
<td>Adequate physical office space</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-hierarchical</td>
<td></td>
<td></td>
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...There's always time, a few times during the week where you could just book yourself in. So it's really easy and it's worked – there are some days that are too busy and you just know you really can't... and that’s rare that that ever is necessary so it works. And there are lots of safeguards for that because our supervisor encourages us if there's an emergency to interrupt our regular staff meetings and intake meetings and stuff. So really, the system has really made a lot of allowances for that so we can find time.

All but one participant mentioned the presence of psychiatrists in team meetings, this presence was said to facilitate the ability to brief them on any clinical concerns. Eric summed up his feelings about team meetings, saying “…having those meetings together has kept this team together.... I mean sometimes most meetings can be boring. But for some reason you feel that you are part of adults and kids and rehab – part of the whole.”

One participant, Phillip, related the psychological environment to the physical environment and ascertained that the personal dynamics had an impact on his view of the office space:

... The setting is positive in terms of [the work setting]. Like I say, the personal dynamics are positive here between people. It's interesting when I came to this building for my interview, I thought ‘Oh my god, what a dungeon – what a horrible place!’ But since I’ve been working here I’ve been quite fond of it strangely enough. I don’t know what that is – I think it's more of the personal atmosphere, you know. If you’re working in a nice building but you don’t feel comfortable with the people then – so I don’t know, it’s just a feeling a comfort that I have here and I guess it
kind of extends to the building. So the physical space is adequate, and the psychological space is good.

Margaret reflected on the value of meeting in smaller pods rather than strictly as a whole team for the emotional safety of being open with a smaller group of professionals. Rather than discussing every case with all team members, those professionals who may have been working with the same clients met regularly to share the work they were doing together. Margaret also mentioned that people seemed to be more open to sharing in a smaller group, stating: “that’s really important that we can be reflecting on who we are and what we’re bringing to the party!”

Several participants commented on a lack of hierarchy in their respective teams, and they strongly believed that this absence also allowed for truly collaborative relationships with other team members. Raoul ascertained that the hierarchy does not completely disappear because “the power of the prescription is significant, but you do not have to worship the psychiatrists – they don’t need it.” When there was a lack of an organizational hierarchy, each team member was considered a peer and could be approached and treated as such.

To summarize aspects of the work setting that enabled successful collaboration experiences, having psychiatrists on site at the teams for part of the time contributed to accessibility. Having meetings as a team and in smaller groups provided an environment that was supportive of collaborating and discussing with one another. Finally, eliminating or minimizing any hierarchical structure within an organization fostered a more collaborative climate in general.
Aspects of the work setting that were barriers to collaboration.

While there were aspects of the work setting that were said to contribute to the collaboration process, several aspects were also said to be barriers to effective collaboration between counsellors and psychiatrists. The most frequently mentioned barriers were not enough psychiatric time on site at the team, and the heavy workloads of both psychiatrists and counsellors contributed to rushed assessments and difficulty booking appointments.

Eric talked about the problem with accessibility, saying:

...we have to wait – there are three of us trying to set the appointments....There are very few cases that you don’t need psychiatric input, so that’s quite taxing and people have to wait for assessments....It’s frustrating, but not much you can do about it.

Phillip also expressed his frustration with the accessibility of psychiatrists, saying that an ongoing issue with psychiatrists in his particular mental health team was that they often changed when they would see people and how long they would see them for without communicating these changes to the rest of the team.

Lack of accessibility was also a contributing factor to a lack of communication or miscommunication. Jean talked about the difficulty in trying to track down a psychiatrist when they were not on site:

It can be a little bit of work trying to track them....I mean a lot of phoning around and I know one time I was trying to get a hold of one of our doctors who was at one of the other teams to get a written prescription as there was no other doctor here to do it....I was prepared to go over to the other team, pick up the prescription, and bring it back for my client to come and pick it up – And I phoned the team, left the
message, *nothing* all day. Well it turned out that she never even *got* the message because they, I guess, you know she was on a different floor or something and never even *checked* her messages.

Some participants referred to a tendency for hierarchical issues to exist within a team. A few admitted to feeding into a hierarchical dynamic in spite of a desire for an egalitarian structure. Margaret said:

> It seems to be an ongoing dynamic that *does* affect people's overall comfort level. Because we have people here from child-care counsellors to psychiatry that may be working with one family. So I think there are [professionals] that I know just from talking to them, that feel kind of discounted or have a hard time expressing their feelings with that kind of a style. And there is a sort of hierarchy.

In the follow-up interview, Kate brought up the issue of stress on the current mental health care system. She, too, spoke of large workloads and not enough hours of psychiatric time. This becomes even more noticeable when someone is away on holiday or sick leave because alternatives need to be found, which raises stress levels. When the psychiatric time available decreases, the workload of the counsellor increases.

In summary, barriers built by the actual structural organization of the team included a lack of access to psychiatrists due to the frequency they were on site, heavy workloads, miscommunications, and perceptions of a hierarchical structure. The next section will present the attributes and character traits of psychiatrists that were perceived by participants as having an impact, positive or negative, on collaboration. Of course the attributes and character traits mentioned by participants are merely *their* perceptions, but an assumption of
the researcher is that these perceptions will have impacted the actions and reactions of counsellors in a collaborative interaction.

**Perceived Attributes and Character Traits of Psychiatrists**

All participants reflected on qualities of psychiatrists with whom they had worked and interacted. The qualities identified were based on aspects of professional expertise and on personality attributes. The perceived psychiatrist attributes and strategies that were described by participants as having either a positive or negative impact on collaboration are depicted in Table 2. Participants unanimously emphasized personality over credentials as the main aspect they were looking for in a psychiatrist, although everyone did mention that professional expertise was also a determining factor for approaching a psychiatrist.

Perceived attributes and character traits of psychiatrists that contribute to collaboration. Investigative and diagnostic skills were said to be of particular importance for having contributed to collaborative relationships with counsellors. Raoul, in particular, focused on aspects of professional expertise and how they either enhanced or hindered his collaborations with various psychiatrists. He expressed his view of psychiatrists' contributions to both the professional relationship with counsellors and the therapeutic relationship with clients:

...the diagnosis is actually enlightening – so hints as to what direction to go in, a pre-screening decision about whether or not this person is a candidate for medication or not, perhaps even starting them on that medication if they are. If you get all of that in an hour and a half of spending time with somebody, it’s very productive....It’s amazing how their training actually [gives them] an investigative skill that we don’t get in counseling psych. And it is the one valuable thing from the medical model.
**Table 2**

**Psychiatrists: Attributes and Strategies that Impact Collaboration**

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<tr>
<th>Domains</th>
<th>Contributions</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>Expertise</td>
<td>Thorough, accurate assessment</td>
<td>Lack of respect</td>
</tr>
<tr>
<td>Listening skills</td>
<td>Approach counsellors for consulting</td>
<td>Self-centred</td>
</tr>
<tr>
<td>Approachable</td>
<td>Stay current in the field</td>
<td>Awkward presence</td>
</tr>
<tr>
<td>Calm disposition</td>
<td>Update counsellor</td>
<td>Sexist Attitude</td>
</tr>
<tr>
<td>Efficient</td>
<td>Focus on client well-being</td>
<td>Tense disposition</td>
</tr>
<tr>
<td>Client-centred</td>
<td></td>
<td>Arrogance/Elitism</td>
</tr>
<tr>
<td>Respectful</td>
<td>Brainstorming ideas</td>
<td>Lack of interpersonal skills</td>
</tr>
<tr>
<td>Candid / Open</td>
<td>Validate and normalize</td>
<td>Too predictable</td>
</tr>
<tr>
<td>Supportive</td>
<td>Acknowledge presence</td>
<td>Lack of knowledge</td>
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<table>
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<tr>
<th>Domains</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>ATTRIBUTES OF PSYCHIATRISTS</td>
<td></td>
</tr>
<tr>
<td>Expertise</td>
<td></td>
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<tr>
<td>Listening skills</td>
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<td>Approachable</td>
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<td>Calm disposition</td>
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<td>Supportive</td>
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<tr>
<td>Lack of respect</td>
<td>Not listening</td>
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<td>Self-centred</td>
<td>to feedback</td>
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<td>Awkward presence</td>
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<td>Sexist Attitude</td>
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<td>Too predictable</td>
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<td>Lack of knowledge</td>
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<tr>
<td>Lack of communication</td>
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But what’s nice here is that I then get launched with this medical model – gift if you will – of analysis with this client, perhaps some medication gifts thrown in there as well, and then they’re mine again... I get to unwrap the gifts and have all the fun I think.

He proudly described the incredible efficiency of one of his consulting psychiatrists:

[The psychiatrist] is ideal on two levels: One is she is probably mensa-level intelligence, so she can interview two people on her half-day here for an assessment, dictate two 5-page notes... which hold water even if I’m not sure about what she’s saying – a year later I’ll look at those notes and goddammit, she was right! So she’s right on the ball. She’s very flexible as to whether or not she prescribes medication – she doesn’t have a huge predictable bias. She will make three or four recommendations about phone calls that should be made to certain places and she’ll whip off three of them herself with terrifying efficiency.... You know I allow myself to be humbled and then to sort of hang on to her skirt tails and say ‘OK, let’s go’...

All participants mentioned areas of expertise that were particular to the profession of psychiatry such as medical knowledge and diagnostic skills. Because of the clientele served within mental health teams, such expertise is essential in order to aid the formation of therapeutic directions and treatment goals.

Participants also mentioned strategies utilized by psychiatrists that seemed to contribute to a more effective collaboration. Kate told of one psychiatrist making a conscious effort to move away from the ‘Doctor-Medical’ role toward a more holistic client well-being model:

... She may just try to put the focus back on the client being the expert in areas of choices that she might make around her own treatment and give her input into that,
and try to move the focus that she’s actually the expert on her own care.... At other times I see her also offer comments that build on the strength of the client, just on what she observes – either through what the client is sharing about what’s taken place in her week or things that I may share with her out of the sessions that we have one-to-one. The focus just shifts into more a well-being model and function.

The overall consensus of participants was that personality played a key role in any collaborative process. Attributes such as a calm disposition, an ability to communicate and empathize, actively listening to other ideas, and a client-centred focus were commonly mentioned by participants. Jane stated that:

... any basic counselling book you’ll read – I mean it’s the person. You know you can go in there with a billion degrees and whatnot, but if you can’t relate to people and they can’t connect with you in some way, you’re going to get nowhere.

Several participants mentioned that some psychiatrists were more open in talking about their own reactions and issues pertaining to a client or situation, and this led to a greater respect for those psychiatrists and a greater willingness of counsellors to also be open. Eric talked about what he liked about one particular psychiatrist he worked with:

... He stays current, and he talks about it. I mean the only thing I find with him is that sometimes he talks in medical terms that I don’t understand. But I can ask him and he can explain things so he’s approachable that way. The other thing I like about him is that he’s very candid about his limitations and his liabilities and also his experience, so he doesn’t boast, but he doesn’t put himself down either. And if he finds a situation uncomfortable or different or he thinks he’s mucked up he’s able to bring it up.... He’s very open and that makes a difference for me.
Kate, who was very new to the community mental health team, described her first experience collaborating with a psychiatrist there. This summarized the qualities of respect and rapport that she believed to be paramount in a truly collaborative relationship:

...from the outset the psychiatrist drew me into the interview by using it as an opportunity to review with the client in my presence their time together... and this client had had other case managers come and go but he had the same psychiatrist so they had quite a relationship established.....[The psychiatrist] made eye contact with me and with the client... we sat in a triangular formation and he made every effort to be inclusive. He introduced me to the client and then he asked the client’s permission if he could do this overview of their journey together, and he checked out quite often for input from the client.... He just basically helped to share the journey that they had been through and invited me into it. And I felt very comfortable, I felt very included, I felt very respected, and it was definitely a collaborative process.... [The psychiatrist] was very attuned to the holistic picture and gave me a starting point to begin working with the client.

Phillip summed up the essence of what attributes contributed to an ability to collaborate effectively, saying: “I think it boils down to basic human respect, you know? It’s like if you can just respect somebody else for who they are, their profession and so on and so forth, but more as people.”
Perceived attributes and character traits of psychiatrists that were barriers to collaboration.

There were a number of psychiatrist attributes that were cited by participants as definite barriers to any form of collaborative relationship. These were primarily counsellor perceptions of the personalities of psychiatrists, but there was also mention of qualities that were perceived to be lacking within psychiatrists’ areas of expertise. Opposite to utilizing professional expertise to enhance the quality of collaboration is the perception of rigidity in practice patterns. That is, some psychiatrists were described as having a tendency to give the same diagnosis or prescribe the same medication for nearly everyone they assess. Raoul gave an example of what he meant by this:

I once worked with a consulting psychiatrist where every assessment that she did, she saw the person as having a narcissistic personality disorder.....Some psychiatrists are very predictable in their practice patterns. Some won’t prescribe medication, some will tend to see things in a certain way. I will feel less drawn to consult with somebody whose opinion I don’t respect or whose opinion is limited. Raoul also talked about labeling clients and how he perceived some psychiatrists as seeming to put the label ahead of who the actual person is. He said,

I’ve had collaborations with psychiatrists who appear to take [a diagnostic label] at face value – they talk AS IF that IS, you know they talk as if their diagnostic work-up is primary and the client is secondary sometimes....So if I want a good collaboration from a psychiatrist they’re not going to have that habit...especially with assessments. Just ultimately labeling and not enhancing the power – empowering if you will – and having the client feel accepted and present as a person.
When discussing barriers to collaboration, participants continued to cite personality factors as outweighing credentials. For example, Margaret talked about a particular psychiatrist whom she believed to be a very good resource in terms of knowledge but with whom she deliberately did not consult with due to her perception that he had a tendency to lecture or talk down to her. Another participant talked about one psychiatrist who was 'exactly the same' as him, not providing any new or alternative ideas because of their similarities: "...he was totally non-medical and everything else so he didn't actually do anything. You know, if I wanted his opinion I'd ask my self....He was exactly the same, he didn't give me anything extra." Other barriers mentioned included such factors as miscommunication, lack of accessibility, airs of superiority, lack of trust, and lack of assertiveness.

Several comments alluded to what participants experienced as a condescending manner of some psychiatrists. For example, Phillip said: "I mean, I have run into some doctors unfortunately who I don't think have that respect – it's a very ivory tower kind of looking down their nose and 'well who are you?'" Margaret also referred to this perceived elitist or arrogant attitude of some psychiatrists. She described a scenario relating to when the team was interviewing psychiatrists for a consulting position. There was one particular psychiatrist who seemed to have that dimension of communication they were looking for as well as the qualifications. However, when he found out there was a probationary period that all new team members go through when first hired, he apparently took a great deal of offence to that. She went on to say:

It was a different aspect of who he was....I mean everyone else has to go through a period of probation and why should that be any different for psychiatrists? And so
he chose not to come... but this little situation just kind of revealed an element of
elitism I think – an arrogance that was a bit of a turn-off.

Ray spoke of his perception that some psychiatrists seemed rude and self-centred:

I’ve worked with some psychiatrists who were very rude and self-centred I guess.

Like really didn’t value anyone’s opinion and had lots of complaints from patients

too – that they weren’t being listened to or that they were given really odd feedback.

Ray also provided an example of one psychiatrist who he perceived to have a tendency to

describe frustration quite often: “He snaps at people sometimes and he does get frustrated.

He’s anxious so he’s not always comfortable – he just seems tense with patients and the

patients don’t always like him either.”

Another attribute mentioned by several participants as getting in the way of

collaboration was a perception of disrespect. Margaret mentioned a situation where she and

one of the psychiatrists were doing an assessment together and she perceived him as being

disrespectful of her and her professional role:

We were booking another appointment with the family, and I was going to be away

on vacation so I had said ‘Oh well, that’s not going to work for me because I won’t

be here that day.’ And with the family there he said ‘Oh it doesn’t matter, I’ll be

able to just carry on’... And I was shocked and thought that was quite disrespectful

and dismissive of me having a role that was equally important.

Another perceived aspect of psychiatrists that was said to be a barrier to

collaboration was ignoring a counsellor’s feedback. Ray discussed his frustration with

trying to share his professional opinions with a psychiatrist and feeling like his suggestions

and rationales were not being considered:
[Here is] a little scenario about discharging a patient he didn’t know very well and didn’t really have a grasp on her diagnosis and wanted to discharge her and she was still really quite sick and I wanted her kept in the hospital….I really had to get a whole bunch of people to tell him how – because he just wasn’t listening to what I had to say and that’s because when he went to see her she was sort of pulling it together for him, so I mean I could see his point of view….But I was providing a lot of evidence like chart evidence, past history, past diagnosis, all this stuff – other people’s observations.

A few participants mentioned their perception of some psychiatrists displaying sexist attitudes that subsequently impacted the quality of a collaborative relationship or lack thereof. For example, Ray noted:

The biggest theme I’ve noticed in the male psychiatrists – not valuing women at all, and making some pretty horrible sexist comments….I’ve done so much better than my co-workers, I think, at working with them because I’m a male. I think it’s made a huge difference. I think my co-workers use the same strategies, they just often are female and haven’t been heard. So not listening to patients, not being heard and having my opinion not valued or completely disregarded and not even in a sensitive way – that’s the bad end.

It should be noted that in the follow-up interviews, all participants were asked to comment on their beliefs about the role gender might play within professional relationships. Only two participants maintained that gender impacted the relationship. Others stated their assumptions about gender, but then said that their actual collaboration experience has transformed their assumptions. These participants cited personality rather than gender as
being the utmost important factor that affected the quality of their interactions with psychiatrists.

While some psychiatrists were perceived by participants as being extremely intelligent and as having a tremendous amount of expertise, there were those who were described as socially awkward with other people and this, too, had an impact on the overall quality of a collaborative relationship. Raoul spoke of a psychiatrist he had worked with in the past:

...He was quite strange - he was quite likeable, but he would get very intellectual and go off on sort of tangents. And while he was brilliant and quite an accurate assessor, he was an awkward presence in the sessions.

Margaret also drew attention to her perception that some psychiatrists seemed socially awkward:

You know psychiatry draws a lot of weird people... they're just kind of odd-balls.

And I sometimes wonder about – I believe in my profession in general... there are a lot of people drawn to this profession who have their own issues... People choose things for a reason. Um, but physicians are in a position of a lot of power and sometimes that combination isn’t the healthiest.

Jane perceived a lack of interpersonal skills in some psychiatrists:

My perception is she doesn’t have very good bedside manner, client skills. And so that just translates into the work in general. And I think there is a bit of arrogance in her in particular. So that’s just an impression – and we’ve had feedback from clients that they won’t go back to see her.
In summary, attributes and character traits of psychiatrists that were mentioned by participants as contributing to collaboration included: expertise specifically pertaining to the profession of psychiatry; basic counselling and interpersonal skills; approachability; sensitivity; rapport; and respect. The attributes and character traits of psychiatrists that were perceived by participants as getting in the way of collaboration included: an attitude of elitism; disrespect; a lack of listening and communication skills; an anxious disposition; comments with sexist undertones; and a socially awkward presence.

**Perceived Attributes and Character Traits of Counsellors**

Participants were asked about how they, themselves, impacted the quality of collaboration experiences with psychiatrists. Their descriptions included aspects of their own professional expertise as well as personality traits. Table 3 describes attributes and strategies of counsellors that participants perceived as either contributing to or getting in the way of collaboration. These attributes and traits will be presented next, followed by those attributes and traits that were described as impediments to the collaborative process.

**Counsellor attributes and character traits that contributed to collaboration.**

Participants discussed their own attributes and character traits that they believed made a contribution to the collaboration experience. They cited such attributes as being a good listener, empathizing with other points of view, showing respect and trust toward those psychiatrists with whom they shared very positive collaborative relationships, assertiveness and persistence. When Ray was asked about his attributes that impact collaboration, he said:

Well I think that is persistence and, of course, you have to be prepared obviously and have a good argument. I have some level of competence in order to be able to do that... and to make a good argument you have to see both sides and that's *their* side.
### Table 3

**Counsellors: Attributes and Strategies that Impact Collaboration**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Strategies</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>ATTRIBUTES OF</td>
<td></td>
<td>*Lack of confronting/</td>
</tr>
<tr>
<td>COUNSELLORS</td>
<td></td>
<td>Lack of assertiveness</td>
</tr>
<tr>
<td>Expertise</td>
<td>Establishing professional relationships</td>
<td>*Lack of respect</td>
</tr>
<tr>
<td>Reliability</td>
<td>Sharing input/point of view</td>
<td>*Preference to work alone</td>
</tr>
<tr>
<td>Persistence</td>
<td>Validate other point of view</td>
<td>*Gender</td>
</tr>
<tr>
<td>Listening skills</td>
<td>Initiates open sharing and feedback</td>
<td></td>
</tr>
<tr>
<td>Candid/Open</td>
<td>Initiating contact or leaving notes</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Updating psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Assertiveness</td>
<td>Questioning assumptions</td>
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</table>

* Mentioned in the follow-up interviews.
So actually you have to have some good empathetic listening. Like you have to be a
good listener and really see their point of view and validate that so they feel they’re
being heard....So I mean that really helps with that process I think with them – you
developing a relationship with them no matter...how difficult they seem to be.

Ray also mentioned that psychiatrists are often busy and do not have the time to think things
through, so he sees his job as helping them to see the whole picture in order to make the best
decision for the client.

Margaret discussed her ability and willingness to be open with putting her own
struggles on the table, and she attributed this openness to being older and having had plenty
of experience. She went on to say “I try to be...nonjudgmental when people are struggling
with a case, so I try and have that same kind of listening and openness and finding that place
of understanding that I try to have with my [clients].”

Other attributes considered beneficial to a collaborative relationship with
psychiatrists included expertise in counselling and psychotherapy, and a holistic approach to
mental health. Raoul talked about qualities that are particular to himself as a unique
individual:

...I come from a different place in my basic roots of education....I’m a very
intellectually interested person although I’m rootsy as well....I like to come with a
broad range of knowledge....If I’m appreciated by a consultant, or in any
relationship, a client who is a consultant after all, or a psychiatrist who is often in
consultation but had a rapport with me – they’ll be appreciating me for those
qualities that are my qualities...so they’ll like my intelligence perhaps, or my
reliability to get certain things done.
Curiosity is another attribute mentioned by participants that had a positive impact on collaborating with psychiatrists. Eric discussed his desire to “bounce off people that I respect what I maybe think a situation is or what the problem is, or what could be done, or what should be done.” He went on to say: “What I have done is reaching out, asking questions, asking for their opinion, consulting with them whenever I’m curious about something I don’t know – especially around medication, I talk to them.” Raoul also talked about asking questions in a way that contributed to the collaborative process:

I am the person most likely to stand up and say ‘the emperor has no clothes, can’t anybody see that?’ I’m a devil’s advocate… and I like to question the obvious assumptions. So in some ways, I can ask questions that help… I’ll ask questions that are not easy to answer – that I can’t necessarily answer – that I don’t think need an answer so much but they need to be asked. I like those a lot… I like to see people think on the spot or cannot be sure – I think those are contributions to the process.

The above mentioned qualities and traits described by participants helped to facilitate interactions with psychiatrists that were open, honest, and inquisitive and these interactions ultimately played a part in therapeutic outcomes for the clients. Once again, these qualities and traits included open communication, listening skills, respect, trust, persistence and curiosity.

Counsellor attributes and character traits that were barriers to collaboration.

Interestingly, participants did not spontaneously mention aspects of themselves that were a hindrance to collaborating with psychiatrists. During the follow-up interviews there were chuckles and expressions of surprise at this omission. This section is therefore
comprised of findings from the follow-up interviews as they pertained to attributes of counsellors that the participants reported to be barriers to a collaborative relationship.

Phillip reported that one aspect of himself that sometimes got in the way of collaboration was a lack of confronting a psychiatrist when he did not agree with an aspect of the working style in specific incidents with clients. He admitted that one can learn about how to address issues, but the theory and practice are often very different from one another. Ray also admitted to a lack of assertiveness with psychiatrists that has most likely impeded the development of a true collaborative relationship:

If there's going to be any impact when you're unhappy with the relationship, you're going to have to mention it to the psychiatrist. Willingness to be assertive is key - because of that position of power, people are often intimidated or don't think they'll listen to them anyway so they don't open up which lets them off the hook.

He went on to say that counsellors have a responsibility to speak up more.

Raoul described his predisposition to be a 'lone ranger.' He admitted to having many cases that he does not collaborate about due to a lack of personal need to process therapeutic issues. He also admitted to knowing there is the potential for certain things to be gained from collaboration that he chooses not to have, due to his tendency to work alone.

Some participants, when they were asked about what might be getting in the way of collaboration, raised the issue of gender as a possible barrier. Margaret elaborated on what she meant by 'gender issues,'

Historically, men have more entitlement than women. Doctors have more entitlement than anybody else. And so I think when you link those two factors you have a couple of heavy hitters right there. I think that most counsellors are women
so we’re a very female dominated profession, and we have a lot of comfort with each other and maybe not as much experience working with men where there are – there may be a little more intimidation on the part of the counsellor and lack of assertiveness and insecurity in working with men, period. And certainly where there are issues of power and authority. So I wonder about that. Often you might have a psychiatrist working in a predominantly female agency. And I think that a lot of us still also give the doctor a lot of room for – so how do we contribute to the problem?

I think that’s a really important omission, that it’s not all about them.

To summarize, a lack of assertiveness on the part of some counsellors, choosing not to collaborate, and possible gender issues were mentioned by participants as barriers to confronting a psychiatrist about controversial issues pertaining to client care.

**Qualities of the Interaction Between Counsellors and Psychiatrists**

The actual interactions that were described by participants contained themes of either mutual equality or of condescending inequality. The interaction is considered separately from attributes and character traits because of the two-way relational nature of an interaction. Attributes and character traits definitely impact this interaction, but aspects of the interaction, itself, reflect the outcome of combining these individual qualities. It is the outcome that will be described in this section. Table 4 outlines social-relational factors that either enhanced or impeded the collaborative relationships described by participants.

**Qualities of the interaction that reflect good collaboration.**

Participants unanimously agreed that when the consulting was two-way and both counsellor and psychiatrist actively sought one another out, there was a genuine experience of equality in the collaborative relationship. Kate shared about the two-way process of
Table 4

Interrelationships: Social-Relational Qualities that Impact Collaboration

<table>
<thead>
<tr>
<th>Domains</th>
<th>Contributions</th>
<th>Strategies</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapport</td>
<td>Giving and receiving feedback</td>
<td>Power Dynamics</td>
<td></td>
</tr>
<tr>
<td>Mutual Respect</td>
<td>Exploring ideas together</td>
<td>Lack of Mutual Respect</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>Mutual consulting</td>
<td>Lack of Rapport</td>
<td></td>
</tr>
<tr>
<td>Open Communication</td>
<td>Seeking one another out for collaboration</td>
<td>Lack of Trust</td>
<td></td>
</tr>
<tr>
<td>Complementary Roles</td>
<td>Mutual Self-Disclosure</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
seeking each other out to share thoughts, pose questions, or to reflect about a case in a very natural back-and-forth style. Jean stressed the importance of keeping the communication lines open at all times, whether by phone, notes, short conversations when they are both free, or formal consultation meetings. Margaret also discussed the mutual consulting that took place between herself and the psychiatrist:

We have been getting some training in a certain psychotherapeutic approach…and she’s taken that training, which there aren’t too many psychiatrists who will do that. And so she was sharing with me her experience of trying that technique, because I’ve been doing it for a while. She presented what issues were coming up for her within a context of the work, and asking me about what my experience had been like...

Jane talked about the ability for herself and the psychiatrist to be vulnerable with one another:

When you’re having supervision the whole point is to be talking about things that aren’t going well and where you might feel incompetent, or getting stuck with a client in a particular problem and you’re not able to shift it and you’re feeling hopeless or bad about that…. You want to feel like you know its going to be received as like everybody – every professional could have these issues, not just counsellors – psychiatrists would have them too, and she would relate to it from that point of view, like she might say ‘Oh I have a family that I wouldn’t know what I was doing’. So she can show us that as well – so she models that.

Jane also discussed the open communication that was mutually shared with a psychiatrist she worked with:
We can have disagreement around [a diagnosis], like she might say ‘oh it sounds like such-and-such’ and I might say ‘well no, I don’t get that sense’ – so we can definitely do the questioning of you know, I query about what might be going on for a family and we definitely can give our impressions…but we’re open enough to say ‘oh ya, you might be right.’ So I think the open-ness really helps….I think there’s respect for what we’ve been experiencing.

Raoul expressed his belief that having mutual trust with one another aided the entire collaboration process:

When it comes down to actually working with the clients, the fact that we have a very high level of trust, and what [the psychiatrist’s] level of trust has to be when she is finished [with the assessment], that she has a pretty good idea of what that client is going to get from me, because she is going to be out of touch if I don’t tell her.

That trust was developed not only through professional experience and respect for one another’s strengths, but also through a more informal rapport that developed within the professional setting. Raoul stated, “people like to be in relationships – moments of time spent with each other – that are enriching, and like to walk away from a situation feeling that that was good, that this was generally positive.” In the follow-up interview, Raoul continued to express the value he placed on the work relationship:

I think it’s really exciting and valuable to have another level that actually isn’t case-focused, that has to do with the general philosophy of treatment or new ideas that you’ve been exposed to because that’s a very valuable place to reflect with someone. It’s actually exciting to talk about aspects that have nothing to do with therapy – that comes back to enrich the relationship and, for that matter, also the clients’ benefit.
Phillip also discussed the ‘human element’ that contributed to his collaboration experiences with psychiatrists, saying: “a willingness to make those kinds of connections [on both our parts] shows respect, an equalitarian approach.” Ray nicely summed up what generally worked when collaborating with psychiatrists or any other professional on the team:

...Just treating each other with respect and being nurturing with each other like we do with our clients – when we’re that way with each other and our supervisors are like that, I think it just makes everything run so much better and the patients just win.

Qualities of the interaction that were perceived as barriers to collaboration.

There were several aspects of interactions with psychiatrists that were cited as getting in the way of collaboration. One of these barriers was a combination of a psychiatrist’s ‘professorial’ way of talking or lecturing and the counsellor’s unwillingness to listen to that, thus allowing the tone of the interaction to outweigh the actual content of what was being said. Margaret spoke of one such psychiatrist, providing an example of a way of interacting that was a barrier:

I think he’s got a lot of skills in terms of assessment and experience and family dynamics – I actually might want to talk with him about a case but my experience is that I end up getting lectured to. Or on and on and on and on and then its not about what I might be needing, it’s about what he has to tell me. And then I find myself resisting. I can just feel my wall going up, like there’s no room for me here? And I don’t operate very good, my listening isn’t very good or my hearing like that when I feel I’m being talked at…. That affects my ability to use his expertise and I think he
really has a lot of expertise... But I think its too bad because it means that there's someone there with some good expertise I think, and I don't tend to go to him.

Margaret goes on to say that at times she simply wants to be able to talk about what she is feeling with a particular case rather than have someone tell her what she needs to do.

Another quality of counsellor-psychiatrist interactions that was cited as a barrier to collaboration was a lack of rapport between the counsellor and psychiatrist that was partially the result of a lack of communication and a lack of inclusion. Kate told of a negative experience she had with a psychiatrist when she was fairly new to the team. She had been on her lunch break and returned to the office for a scheduled appointment, only to find that the client was already in session with the psychiatrist with the door closed:

So I was in the position at two minutes after one of having to knock on the door, and assuming I was supposed to be a part of this, and a little puzzled as to how could it have already taken place and I was only two minutes late....So I sat down, curious as to where we would go from there. I did not receive a welcome through expression or verbally....I just felt that I was very much marginalized, was not included....I was at no time included or encouraged.

Jean stressed the importance of collaborating prior to making suggestions to clients in order to share ideas and share any information the other professional may be lacking. She gave an example of a time when a psychiatrist had made a suggestion to a client that he had not previously discussed with her:

...He made some suggestions where I just kind of went 'oh god...no, no, please don't suggest that!'....and this was a parent who had a type of personality that was quite kind of obsessive in some ways - and once you plant an idea in this parent’s
head… they won't let go of it and sure enough I'm being badgered weekly…. It was just, I just sort of felt that that recommendation – I guess it would have been nice maybe if the doctor had maybe collaborated first instead, you know 'what do you think of this? Is this something we should suggest?'

Summarizing the qualities of interactions mentioned by participants, those that had a beneficial effect on collaborating included elements of mutual sharing, trust, honesty and rapport. Those qualities that were deemed to be barriers to the collaboration process included opposing elements such as mistrust, lack of rapport, and condescending tones that overpowered the content of an interaction.

**Counsellor Strategies that Maximized the Quality of Psychiatric Time**

Findings from interviews with participants indicated that counsellors who work in mental health teams seemed to have developed strategies to maximize the available time they had with psychiatrists and focused more on the quality of the time rather than the quantity. Strategies cited by participants included utilizing other resources when the particular psychiatrist they were using was not on site, applying knowledge gained from work with psychiatrists, and actively seeking out psychiatrists for brief, five-minute check-ins before a client session.

Jean talked about seeking out other psychiatrists for input, saying: “A lot of times I'll maybe try and grab one of the other psychiatrists that is here [to ask about] what I should do.” She also mentioned times when she strategically chose which psychiatrist she wanted to book for particular clients because she knew the different working styles and could ascertain who was likely to be the best fit for the client:
[One psychiatrist] is great for a situation where you want a fairly assertive approach because she’s not afraid of medication. She knows her stuff and she’s usually right on the money.... [The other psychiatrist] tends to be more cautious and he’s the one who will suggest the psych testing and all this first before he goes to medication. His strong suit is more sometimes in the family dynamics.

Eric also talked about figuring out which psychiatrists he worked best with, saying that he gave each psychiatrist a ‘try’ to see whether they fit with the families or with himself and the work he needed to do.

In the follow-up interview, Kate elaborated on her strategy of taking five minutes before a session to discuss the direction she and the psychiatrist will take with a client. Kate mentioned that when doing this she needs to have something clearly in mind such as presenting an observation or direction, ask for a response, and a feeling that they are on the same page. Ray alluded to his role of helping the psychiatrist to obtain all necessary information in order to make decisions relating to client care: “I think that sometimes they’re just busy and they don’t have time to think things through so that’s my job is to help them see the whole picture and make the best decision for the patient.” Other participants talked about communication systems they have developed with the psychiatrists, such as leaving notes for one another in order to keep the sharing of information current.

Raoul emphasized the efficiency of his collaborative relationship with one particular psychiatrist, and described the benefit of sitting in on assessments with the psychiatrist:

I consider an assessment by a psychiatrist to be a pretty formal thing, I want to let them do what they want to do because they’re responsible for a document and they’ve got a schedule, a regime, that they’re trying to get through. If I can
comfortably participate 30% of the time or 20% of the time in a meaningful way where it enhances their purpose from their view, and it also starts my process with the client perhaps – makes us in the same room and everybody’s involved a bit, I’m not a wall flower and all sorts of things like that – That can be very rewarding and it’s rich on every level, which is the ideal again that I think we’ve achieved in this particular case very well. It’s a lot of fun!

The ultimate strategy emphasized by all participants was working at establishing professional relationships with the psychiatrists. Phillip stated: “it’s just a process of getting used to them and finding out what their styles are.” Ray also mentioned that he has developed relationships along the way that he did not have initially. In talking about when he first arrived on the team, he said: “My opinion wasn’t valued as much, and [the psychiatrists] had to test to see if I had any common sense… So it took some time before I was valued as much as I thought I should be.” Kate knew that she needed to define her role when she first joined the team, and described her initial strategies:

I tend to just sit back and read situations, so I took stock of it. I just knew that as I developed more of a relationship in terms of knowing this person more – both the psychiatrist and also as I got to know the clients more and I had more to contribute that was pertinent to the situation that [the relationship] would likely change. And I think it has [changed].

Kate said that building relationships with psychiatrists happens gradually over time:

Some of that takes place within a room with the client present and some of that takes place quite casually whether its morning [meetings] or in the hallway. Or just
seeking that person out or they seeking me out...I’m just proactively trying to get to know these different personalities and different strengths.

In summary, a utilization of other resources, choosing the ‘right’ psychiatrist for a particular client, taking a few minutes before a session to check in with the psychiatrist, and ultimately being proactive in building professional relationships with psychiatrists were all strategies described by participants as maximizing the available time for collaboration.

Education

As previously mentioned, each participant was asked if they had had any educational training that helped prepare him or her for collaborating with other professionals. Most counsellors commented that there was nothing in their actual coursework that aided in collaboration, but some had their practicum experience on mental health teams or had experience in other professions that contributed to their ability to work successfully with psychiatrists. For example, Kate stated:

Uh, (laughing) probably the best education I had was my internship [in my previous profession] because I worked in so many different settings before I went into my Masters in counselling psychology. I don’t think I had any training (laughing) in my masters in counselling psychology along those lines. None!

Eric also mentioned learning about collaboration through past jobs, saying “…I’ve done other jobs and training before coming here... and I learned a hell of a lot there.... That is where I learned the true meaning of interdisciplinary work, because you had to do it.”

Jane believed that having a degree in her particular discipline has made a difference in the way she collaborates with psychiatrists because her training involved familiarization with the medical model:
...even from some of the counsellors here who maybe did their Masters in Social work and are doing the same job that I do, I think there is a difference in how some view the medical model *themselves* and that might create some tension in how the work, the collaboration goes because they are maybe from a farther perspective.

In terms of being prepared for collaborating with other professionals, some participants explicitly stated that the parameters of how to collaborate had not been laid out in any form of orientation when they first started working at their respective mental health teams. For example, Phillip stated:

...it’s not that comfortable for me because I don’t know what they want, because they haven’t – it’s interesting actually, I haven’t thought of that before – that’s something that hasn’t been discussed here with me specifically as sort of how to work with the psychiatrists. What’s your role, what’s their role – I’m just kind of learning as I go and asking my colleagues how they do it.

Basically, participants expressed that having some form of training at both an educational level and at a work setting orientation level would definitely benefit them and the other professionals with whom they collaborate.

**Psychiatrists’ Training**

Some participants made reference to the actual training psychiatrists received and expressed their perceptions of how their particular training might have impacted the way they interacted with professionals from other disciplines. Jane wondered about the relationship between personality and training of psychiatrists:

I don’t know what the training is for psychiatrists, if it’s grilled into them that they can’t make a mistake and they... have to know the answer or they can’t really say ‘I
don’t know’ or they have trouble doing that and I don’t know if its more personality or training or how they integrate the training.

Ray also commented on aspects of psychiatrists’ training that might have an impact on how they interact with counsellors:

...I can honestly say that the complaints I hear from clients predominantly are about psychiatrists and that they don’t listen to other people’s perspective....So I think there’s definitely something lacking in their training or...I think maybe its not lacking but maybe something is present in their training – like they’re encouraged to think that they know more than, they’re more valuable than they really are.

Margaret reflected on what might be helpful for psychiatrists to learn ways of effectively collaborating at an interdisciplinary level:

I just think that physicians have a lot of work to do to be sensitive and have more respect and regard and maybe in their training – you know more community health training. You know, that puts them out more with clients working with people that are all providing a different level of interaction with families where there’s more of an expectation of being part of a team rather than directing the team.

In the follow-up interviews, there were some participants who said they had noticed a difference in the recent psychiatrists who were doing their internships at mental health teams. Aspects of these interns that were particularly noticed included a better quality of interpersonal skills and a more egalitarian attitude displayed toward professionals of other disciplines. Participants wondered if this was reflective of particular changes in their training programmes.
Assumptions and Biases of Participants

It is imperative to outline the biases and assumptions that were implied or stated by participants, as these would presumably have a direct influence on shaping the various narratives of collaboration experiences with psychiatrists. Some participants shared their preliminary expectations when they first joined the particular mental health team where they are currently employed. Kate stated:

I thought that most likely there would be a different lens that I would be looking at clients through that I wouldn’t necessarily be looking at them through a medical lens and framework – and I expected that that was probably going to be what I would be encountering when I was working specifically in med reviews with psychiatrists.

Ray had expected a positive working environment due to reports from colleagues. He also held an assumption that most professionals on other team settings were likely to complain about psychiatrists, but continued to say that the working environment was, in fact, quite positive:

When I came here... I got a lot of positive feedback about the doctors from the other clinicians, so that helped me. You know, I assumed they were client-centred and competent and all that because that’s what I kept hearing – which would be quite different if I had started at a place where they were complaining about the doctors being incompetent, which is probably quite often.

Participants with less overall counselling experience had a tendency to emphasize power dynamics when discussing their collaborative relationships with psychiatrists. This bias was clearly noted by Phillip, who believed that psychiatrists were the professionals who needed to make a greater effort to establish a collaborative rapport with the rest of the team:
And of course everybody is always cognisant of power dynamics you know with the psychiatrists having more of it...I mean just by virtue of, you know, the role that they’re given in society and in the medical system. You know they have more authority although here the team leaders probably have the most authority....Doctors are taught to believe they’re sort of top dog....I mean it’s a bias on my part too, but I think they oftentimes have a certain amount of entitlement because of their training and ... the position I guess that’s bestowed upon them by society....So I think because it’s a power imbalance it’s more, in a sense it’s more up to them....They’re kind of in a position to make things work better....When you are in a higher power position I think that the onus is a bit on you to make the first move.

It should be noted that in the follow-up interview, Eric strongly opposed the idea that it was up to the psychiatrists to make the effort to establish collaborative working relationships with counsellors. He said that if counsellors wished to have a collaborative relationship with psychiatrists, then it was up to the counsellors to make the effort. He said, “people expecting psychiatrists, who they think of as being very entitled, to come down from their pedestals and shake hands, it ain’t gonna happen!”

Kate admitted to a tendency to talk and consult more with the colleagues who shared a counselling psychology training background, and she was more interested in hearing their point of view because of their similar professional backgrounds:

If I’m sought out its usually around a client [issue]. There’s probably more of that [seeking out] that happens on a casual basis between the other professionals on the team. Maybe because our role as case managers, even though we come from different disciplines, is the same role – but we’re coming at it from different
strengths. Whereas with the psychiatrists on the team, they have a specific and unique and different role. So they’re very defined.

Kate also admitted to playing a different role depending on whether she was meeting with a client one-to-one in her office, or if she and the client were meeting in the psychiatrist’s office with the psychiatrist present:

If I have [the client] in my office and I start the interview... my role is just to do a general check-in with how things are going for [the client] – I leave it very open-ended, I let [the client] come up with whatever his or her particular concerns are, and it doesn’t tend to move in a direction of what’s happening around medication or symptomatology. It’s much more specific to how relationships are going, how things are going on a day-to-day basis... those kinds of issues. And its quite normalized... it’s very clearly client-centred, it’s their agenda, it’s very much my hope to empower them, etcetera. When we are meeting in the psychiatrist’s office it does feel like there’s a difference depending on which room we’re in. Then the client takes a different stance... very much a patient talking about symptomatology, asking questions about medication... There’s an imbalance in terms of directing most concerns to the psychiatrist and they are a different context, as a patient to a doctor.

It becomes clear that participants’ assumptions and biases regarding the role of psychiatrists within the team as well as those pertaining to their own roles within a team provide a lens through which to view their descriptions of collaboration experiences with psychiatrists.
**General Attitudes Toward Collaboration Experiences**

Participants expressed a range of attitudes toward collaboration experiences based on particular collaboration stories with particular psychiatrists. These attitudes varied from extremely positive to quite negative. Each participant had at least one current psychiatrist with whom they felt very positive about the professional collaborative relationship they had. However, all participants also shared stories – some which had occurred more recently than others – of negative collaborative incidents with other psychiatrists. While the general consensus of participants was that their collaboration experiences were for the most part quite positive, one participant admitted to occasional fatigue or frustration getting in the way of making an effort to collaborate. Ray stated:

...my own attitude about 'why should I have to keep doing this?' or frustration or ego. You know you get, sometimes you just give up and you think... ‘you know, this is too hard, this isn’t fair….The patient is just going to suffer this time because I’m not willing to keep playing this game.’ So – I mean that happens sometimes….I mean, that is the job but sometimes you just get tired and you don’t want to do it...probably if I have too many demands that happens. 

Raoul explicitly stated that he would opt out of collaborating altogether if the end result did more harm than good:

If I had a psychiatrist working with me who – and I know many colleagues who do – where at the end of the time you end up with a bad flavour in your mouth, like it just goes wrong in every way, I would choose not to collaborate as much as possible. I would be very hesitant to have that person there because of the harm that they do as well as the good. I would have to say I really need to know about this medication
thing, and I’ll put up with this person... I’m lucky that with both my consultants currently I don’t have that problem.

Raoul went on to say that he found it invaluable knowing that he could work with the psychiatrists in a team way. He found them to be the second most important people he came into contact with, “the client is obviously first... but I don’t consult broadly with anybody other than the client and consulting psychiatrists.” He shared what he believed motivated him to seek out consultation with other professionals:

I guess, oh BIG thing... I share certain clients with my consulting psychiatrists, and that is a unique thing because that really brings me around when I am sharing my concerns with somebody, uh, I feel a real bond – you know something that really says ‘I do want to consult!’... And it’s funny, when I am not – as soon as it goes out of that sharing thing I actually lose interest in talking about your case or mine.... that sharing is really, really important. And I would be a lot poorer if I didn’t have somebody that I was sharing that stuff with.... [The consulting psychiatrists] bring a co-responsibility with them, they bring a set of tools that I rely on...

Kate seemed to demonstrate an attitude of open acceptance and appreciation for what various disciplines have to offer within the mental health team:

I think people do stay very true to their discipline and they just tend to look at situations that have to do with client well-being through a different set of lenses – but that’s what I think is going on. So it’s truly interdisciplinary and I quite appreciate the input that comes from the medical staff.

Overall, participants felt that the model of community mental health teams was a very beneficial one, and the ideals of an enriching collaborative relationship had much to
contribute to the overall working environment. Margaret presented a summary of these ideals:

I think that psychiatry— I think they have a lot to offer and I think that that's a really important profession. In the same way as all these different perspectives bring their own area of expertise and focus. So I think that the model, it keeps us all outside of the box of our own profession so I think it's a good thing. And its been kind of an enriching thing for me overall to have the experience of working with each [discipline] of childcare counsellors, and counsellors with social work degrees and psychology degrees and psychiatry. So I think it's a really rich environment.

**Follow-up Interviews**

Follow-up interviews occurred after preliminary interviews had been completed with all participants. Beginning conceptualizations were brought back to the participants at the time of the follow-up interview in order to be commented on, critiqued, refined, or added to. In the follow-up interviews, participants typically expressed one or more of the following:

- The overall theme of quality of relationship outweighing credentials jumped out and validated what participants generally felt; the definition of collaboration that had been presented in the initial interviews took on more meaning and was appreciated more since the first meeting; there were expressions of pleasant surprise that most of the participants had described good relationships with some psychiatrists; there was no surprise at the general descriptions of factors that contributed to or were barriers to collaboration; and participants agreed with the description of beginning conceptualizations, saying that the aspects mentioned were true of their own general experiences of collaborating with psychiatrists. It was in the follow-up interviews that participants offered their perceptions on counsellor
actions and characteristics that were potential or actual barriers to collaborating with psychiatrists as nobody had discussed this in the initial interviews.

All participants unanimously agreed that the beginning conceptualizations were an accurate representation of their own experiences collaborating with psychiatrists. Comments that illustrate this agreement include: "the overall theme jumped out and validated what I strongly feel;" "there is nothing in this description that does not fit for me;" "this has been a thoughtful addition to my understanding of my use of the psychiatrists;" "I'm not surprised at all that it's more on personality style and way of being in the world than it is about credentials. This fits with my experience;" and "I think the whole description is really accurate, you've captured it!"

Because 'age' and 'gender' were aspects mentioned by only two participants in the preliminary interviews, all participants were specifically asked whether or not they perceived these factors as playing a role in the quality of a collaborative relationship in the follow-up interviews. The same two participants were the only ones who continued to express their belief that these factors did play an influential role in the collaborative relationships they had described. The other six participants, while they did not necessarily rule out the role that gender and age might play, asserted that personal styles and character traits were the most influential in determining the quality of collaboration.

Interestingly, most participants expressed surprise at the overall positive tone of the description. Several had believed that their positive collaboration experiences were unique, and chose to participate in the study because they wished to provide stories from the positive side of the spectrum. Only one participant said she was not surprised at the positive tone of
the description. She attributed this to her own general perceptions of primarily positive collaborative relationships with psychiatrists.

**Overview of Findings**

An initial question in the interviews related to counsellors’ reasons for participation in the study. These reasons included making a contribution to research, a desire to talk about some of the valuable relationships with psychiatrists and working models that currently exist, an interest in the topic and looking at how different professions relate to one another, and the belief that more information would be useful to the teams and for psychiatrists.

Counsellors mentioned various types of collaboration that occurred with psychiatrists. The more formal types included planned consultation sessions, assessments, audits, medication reviews, joint meetings with clients, and joint educational presentations to the team. Informal types of collaboration included discussions or queries in the hallways or file room, study groups, and stopping by the psychiatrist’s office to comment, question, or discuss any relevant client or case issues.

There were a variety of reasons for collaborating with a psychiatrist that were mentioned in the interviews. In most instances, the underlying reason was to provide a service that benefited the client. Avenues for providing a good quality of service included clarifying or consulting with the psychiatrist around medication or diagnosis issues, exploring therapeutic options, and gaining another perspective from the psychiatrist’s area of expertise. Sometimes it was necessary to update or inform the psychiatrist simply to keep the communication lines open. Exploring counter-transference issues, debriefing, providing
feedback, and mutual self-disclosure around issues that came up around a case were also aspects of some collaborations with psychiatrists.

Aspects of the actual work setting were mentioned as either contributing to or getting in the way of good collaboration. Aspects considered to contribute to collaboration included geographic proximity of psychiatric office space, regular team meetings, a non-hierarchical system in the team, having several psychiatrists on the team allowing for accessibility, and a smaller team contributing to a sense of safety and trust. Aspects of the work setting mentioned as barriers to collaboration included not enough hours of psychiatric time, large workloads, and a hierarchical system within the team.

A unanimous theme from the interviews was that, although the amount of time available for collaboration varied across settings, particular work schedules and workloads of psychiatrists, what seemed to be of utmost importance to the experience of collaboration was the quality of professional interactions both within the process of collaboration and in general. Most counsellors stated that the quality seemed to depend more upon personality and working styles than on actual credentials or areas of expertise.

Every counsellor mentioned attributes and actions of themselves and of psychiatrists that facilitated the process of collaboration. The qualities most frequently stated as crucial elements in relating with psychiatrists were mutual trust, respecting each other in terms of each particular discipline and what each brought to a session, and a rapport with one another.

Attributes and actions that were considered barriers to collaboration were also mentioned in the interviews. It is worth noting that most participants referred to undesirable qualities while talking about previous experiences with other psychiatrists rather than the
mainly positive current working relationships. Collaboration was more strained when counsellors perceived psychiatrists as lacking respect for other disciplines, insensitive, arrogant, and lacking communication skills. A few counsellors said they would choose not to collaborate with a psychiatrist who was too rigid in their practice patterns (i.e. someone who never prescribes medication or someone who has a tendency to see all clients as having the same diagnosis). It was also mentioned that, at times in past experiences, some counsellors have felt marginalized or discounted by a psychiatrist, feedback and perspectives were ignored, and they were talked down to or lectured to by a psychiatrist. A few counsellors questioned the training that psychiatrists received, wondering if a “pedestal role” is encouraged. Some counsellors also wondered about possible age and gender roles playing a factor in different working styles of psychiatrists.

A note of interest is that there was little mention of attributes and actions of counsellors that got in the way of collaboration. Attention was drawn to this omission at the time of the follow-up interviews, and participants reflected further on this. The main aspect that was cited as a barrier to collaboration was a lack of assertiveness in approaching a psychiatrist to share an opinion or give feedback.

As a general observation, all counsellors who participated seemed to be quite satisfied with their current quality of collaboration experiences with psychiatrists. While there were a few counsellors who felt very fortunate about the amount of time that they have for collaborating with psychiatrists, most mentioned that time constraints and workloads were barriers to collaboration. However, it is my general impression that counsellors have developed strategies to maximize the time they do have, and focus more on the quality of the time rather than the quantity.
When counsellors were asked if there was anything in their educational training that prepared them for collaborating with other professionals or psychiatrists in particular, most stated there was nothing in their university course work that related to interdisciplinary collaboration. Most of the preparation for collaborating on a team came from practicum experiences on a mental health team, previous jobs, and even previous professions. It was both implied and stated that having a section on collaboration in coursework would have been very helpful. Counsellors who were fairly new to a particular team setting mentioned that, since starting at the team, there had not been any discussion specifically on how to work with the psychiatrists or what role each profession plays. The general ‘method’ of defining one’s role on the team has been one of learning as one goes along, and talking with colleagues about how they go about collaborating with psychiatrists.

Summary

Interpretive description was selected as the method of inquiry in order to attain a description of counsellors’ collaboration experiences with psychiatrists in community mental health team settings. It was hoped that this description would capture both the shared and the unique aspects of the process as described by counsellors. This was a preliminary investigation into a topic that, up until this point, has been primarily written about in terms of health care teams such as doctor-nurse, physician-social worker, and pediatrician-psychologist relationships. In spite of the relevance of teamwork and collaborative relationships within community mental health teams, the counsellor-psychiatrist relationship has not been examined in the research. The current sample in this study is small, and any aspect of experience that was unique to one participant might actually be common for counsellors who work in mental health teams in general. Thus it
was essential that the articulation of collaboration experiences with psychiatrists include both the common and uncommon elements of participants’ descriptions. The implications of the present findings as they pertain to the existing literature, theory, ethical codes, counsellor training, and future research will be discussed in the following chapter.
Chapter V

Discussion

The ability to effectively collaborate is considered to be an essential component of working in a team environment (Casto & Julia, 1994; Nurses Association of New Brunswick, 1995; Paproski & Haverkamp, 2000; and Seaburn, 1996). Of specific relevance to community mental health agencies, collaboration aids in a more integrated and efficient service being provided to clients. Counsellors and psychiatrists tend to share at least partial responsibility for the treatment of clients and need to work with one another in areas such as assessments, medication reviews, and decisions around therapeutic options for clients. Each provides a service from one’s own unique area of expertise. As such, the purpose of this study was to provide some preliminary answers to the question, “What are counsellors’ collaboration experiences in collaborating with psychiatrists?” The counsellors who participated in the present study, in answering the research question, ascertained that much of the quality of a collaborative interaction arises from the actual quality of the professional relationship.

Aspects of collaboration experiences that were described seemed, to the researcher, to parallel the categories of external/structural factors and internal/cognitive factors described in Chapter Two. External/structural factors were those that existed apart and outside of any individual member of the team, and they pertained to the actual structure of the team such as the physical environment, geographic proximity of professionals involved on the team, and policies regarding how the team functioned. The external/structural component of collaboration experiences appeared to be dependent on the actual work setting and had very little, if anything, to do with the professionals themselves. Of course, reactions
to the organizational structure originated within individuals and those reactions were considered under the ‘internal/cognitive’ domain. The most commonly cited external/structural components included how accessible psychiatrists were both on and off site, workloads, amount of available psychiatric time, set-up of team meetings, and whether or not a hierarchy existed within the team.

Internal/cognitive factors described by participants existed within an individual counsellor and his or her perceptions of psychiatrists as a result of beliefs, attitudes, role definitions, and stereotypes that were formed as a result of both personal and professional experiences. Internal/cognitive factors, originating within the individual, seemed to have the most profound impact on collaboration experiences and are believed by the researcher to have had a far greater an impact on the results of collaboration than the external structural factors. Because only counsellors were interviewed in this study, the internal/cognitive category cannot apply to psychiatrists. Participants shared their perceptions of psychiatrist attributes, and these perceptions are reflective of their own internal processing of how they view psychiatrists’ contributions to collaboration. Internal/cognitive factors included beliefs and assumptions about psychiatrists, stereotypes, and the ways in which participants interpreted their collaborating experiences.

A third category that was not established in Chapter Two but emerged from the current findings is best described as social/relational factors. This category pertained to communication styles and ways of interacting that resulted from a combination of personality factors and socialization experiences in a particular profession. Social/relational factors stemming from interactions between counsellors and psychiatrists were not completely distinct from internal cognitive factors and external structural factors as these
were assumed to influence the interaction, but nonetheless are important to include as a separate category due to the relational context of collaborating. The social/relational factors mentioned most frequently by participants included treating each other with respect, mutual trust, and rapport in both formal and informal interactions. Every participant's description of collaboration experiences contained examples of all three categories.

All participants made comments about the value and necessity of collaboration, saying that differing roles within a team enhance the overall service provided to clients. The number of positive collaboration stories that were shared is encouraging, and aspects of these stories gave insight to the undercurrents of what can contribute to a beneficial collaboration experience for both counsellors and psychiatrists.

This chapter will consider the implications of the current findings as they relate to the literature on interdisciplinary collaboration, particularly examining the existing theory, codes of ethics for counsellors, and previous studies. Suggestions for educational training in collaboration at both a university level and for practicing counsellors and psychiatrists on mental health teams will then be articulated. Limitations to the current research findings will be reflected upon, concluding with a consideration of future directions for research in the specific area of collaboration between counsellors and psychiatrists.

Descriptions of Working Relationships

As has already been mentioned, each participant shared stories of at least one positive collaborative relationship they shared with a psychiatrist. The negative experiences that were shared were primarily about past working relationships, although there were a few exceptions to this. This leads one to question what might be happening here. There are several possible explanations that need further exploration. One possibility is that
participants may have a tendency for a biased desire to like those psychiatrists that they were currently working with, and once those working relationships have terminated they change their perceptions to a more negative bias. However, there may have also been a tendency to focus on the positive relationship because, as some participants had stated, they wished to shed light on some of the positive collaborative relationships happening on mental health teams. Of the negative experiences that were shared, some were from previous work settings and others had occurred with psychiatrists who were currently on the same team. Some of these negative experiences had been isolated events and a more positive working relationship had since been established. Some negative experiences had been with psychiatrists with whom participants made a conscious choice not to continue collaborating. One can assume that counsellors would naturally gravitate and choose to collaborate with those psychiatrists with whom they share a trust and rapport. This would also influence the positive stories that were shared.

A second possible explanation for the positive tone of participants' stories may be related to the actual sample selection. Counsellors who agreed to participate were not selected at random as they chose to contact the researcher. It may be that those counsellors who were primarily unhappy with the working relationships they shared with psychiatrists chose not to participate.

A third explanation is that psychiatrists who choose to work in a mental health team setting might have more of an affinity for working in a collaborative style. These psychiatrists may share very distinct characteristics and personality traits that differ from those psychiatrists who work in private practice or in more hierarchical institutions. Indeed, those who choose to work in team settings may display those very characteristics and
personality traits that were deemed by participants to contribute to the positive collaboration experiences that were shared.

A final explanation to consider is the possibility that those psychiatrists who are newer to the profession bring with them a more flexible and egalitarian style of working that may reflect changes in the way they view interdisciplinary work and overall changes in the ways community mental health services are currently delivered. One participant did express his belief that the residents who were coming into the teams have been more 'down to earth' than those of the past.

Perhaps there exists a feedback loop of collaboration experience-attitude-behaviour where even a few positive collaboration experiences caused most participants to have a positive expectation and reinforced collaboration-seeking behaviour. Some counsellors will avoid collaborating with specific psychiatrists due to negative experiences with them, lending support to the feedback loop hypothesis of experience-attitude-behaviour that is described by Kainz (2002). Future study is required to explore this idea.

**Collaboration Activities and Domains**

Participants' descriptions of activities that occurred within collaboration experiences included exploring ideas, questioning assumptions, consulting, and reflecting. These activities occurred both before and after sessions with clients, reflecting proactive and reactive forms of collaborating where ideas and reflections ultimately led to an action plan for a client. Exploring ideas, questioning assumptions, consulting and reflecting all support the notion of reflective intelligence, a concept described by the educational philosopher, John Dewey (1916). Dewey describes how resolving problems involves thinking before taking action. The process is described in Appendix E. This reflective experience is very
similar to the thoughtful inquiry described by some participants in the current study. Each
counsellor and psychiatrist draws on knowledge and experience of his or her own
profession, providing a unique point of view. The positive collaborative stories that were
told had in common the process of both counsellor and psychiatrist (sometimes in
conjunction with the client) wondering, questioning, and exploring ideas from their own
areas of expertise in order to "define and clarify the problem at hand" (Dewey, 1916, p. 150)
before determining a course of action with a client.

It was unanimously stated that the ultimate purpose of collaborating with other
professionals was for the benefit of the client, and this is consistent with the ethical principal
of beneficence, or 'doing good,' as described by Kitchener (1984). Of interest is the finding
that participants identified aspects of collaborating with psychiatrists that, on one level, had
nothing to do with any particular case but nonetheless had indirect benefits for the client.
Discussing models of therapy, forming study groups, and sharing interests or ideas aid the
client in several ways: (1) educational discussions and study groups foster professional
development; (2) when this development is shared between the two professions there is
mutual knowledge gained and a more egalitarian working relationship is fostered; (3)
rapport is enhanced between the counsellor and psychiatrist; and (4) this rapport flows over
into shared sessions with clients. This finding has not been documented in previous studies
and makes a worthwhile contribution to the literature pertaining to interdisciplinary
collaboration. The notion of collaborating in areas that are not overtly client-centred and
how actual client care is impacted is definitely worth exploring further.
The Work Setting

In the current study, several participants made reference to whether or not their particular work setting was a hierarchical one. The word 'hierarchy' held a negative tone for all participants, and it is an assumption of the researcher that participants were defining 'hierarchy' in terms of a rigid structure where each professional is slotted into an assigned position in a top-down model, with counsellors positioned at a lower level than psychiatrists. However, Seaburn (1996) refers to a 'flexible hierarchy' which holds a much more positive undertone. He asserts that every situation presents a hierarchy, whether it is implicit or explicit. For collaboration to be effective, there needs to be a differential sharing of power where “the professional with the most expertise in the problem at hand exerts the most influence” (p. 50). This flexible hierarchy was certainly apparent in the stories that were told by participants. One participant reflected on her ‘role change’ depending on the situation with a client. When part of a medication review, the psychiatrist holds the expertise in that area and subsequently takes on a more influential role. When part of a check-in session, the counsellor is the one who sees the client on a regular basis and therefore has the most current and detailed knowledge of where the client is at in a psychosocial context. A flexible hierarchy truly provides optimal care for the client in that the professional with clearly defined expertise in any given situation is the one taking charge for that particular situation.

Quality of Professional Relationship

The working relationship between counsellors and psychiatrists can generally be described in one of four ways: (1) referral-based, where there is minimal communication between the professionals; (2) consultation, where the counsellor or psychiatrist provide
information and suggestions about particular clients; (3) collegial, where the counsellor and psychiatrist share in the care of clients and each brings unique responsibilities according to their training and skills; and (4) collaboration, which refers to the general practice rather than being specific to particular clients. The working relationships that were described by participants in the current study encompassed all four of these models in ways that were both specific to particular clients, as well as fitting in with the general philosophy of collaborative practice that is specific to community mental health teams.

A pervasive theme throughout the interviews with counsellors was a focus on the interaction and relationship with psychiatrists. As one participant stated, any counselling textbook will stress the influence of the professional relationship on therapeutic outcomes. Indeed, most forms of therapy emphasize “an effective relationship and respect for the validity of each person’s perspective as essential parts of mental health care” (Seaburn, 1996, p. 49). Essential aspects of these ‘effective relationships’ include honesty, trust and respect (Freeth, 2001). Each member of a mental health team needs to value the perspective and expertise of other members in order to effectively collaborate.

A study on barriers and enhancements to physician-psychologist collaboration revealed that most of the content domains from focus-group discussions pertained to aspects of the relationship between physicians and psychologists (Kainz, 2002). In general, counsellors are trained to focus on interactions and relationships and therefore may actually be socialized to focus on these areas. It would be interesting to find out what areas psychiatrists might focus on if they were asked about their collaboration experiences with counsellors. Support for the speculation that psychiatrist’s responses might be quite different comes from a study of collaboration between physicians and social workers.
(Abramson & Mizrahi, 1996). They found that social workers tended to focus more on the relationship with physicians while the physicians tended to focus on what the social workers actually did. Perhaps psychiatrists might also focus on what counsellors do when collaborating as opposed to how they interact with others. Future research is needed to verify this.

Participants in the current study reported that the factors that encouraged them to choose to collaborate with certain psychiatrists over others included the following: (1) a good rapport with the psychiatrist; (2) mutual respect; (3) the competence of the psychiatrist; (4) the ways and tones of communication and feedback from the psychiatrist; (5) awareness of the particular working style of the psychiatrist; (6) confidence that the client will be dealt with in a sensitive manner; and (7) approachability and availability of the psychiatrist.

The Nurses Association of New Brunswick (1995) described a set of beliefs that would support a collaborative climate. Mutual respect, trust, caring, and synergy are required for the foundation of any truly collaborative interaction. The findings of the current study support these same beliefs. Mutual respect refers to an acknowledgement and consideration of the abilities and competence of other service providers on the team, trust implies a confidence and reliance upon the abilities and competence of team members, caring refers to a respect for other views and opinions, and synergy implies a belief that the whole is greater than the sum of the parts. Thus it becomes clear that the working relationship is the foremost important aspect in any collaborative interaction.

Seaburn (1996) also asserted the absolute necessity for a quality working relationship to exist in order for good collaboration to occur. He stated that: “sharing the same geographic space, and even optimizing all the other variables, means nothing if the
individuals trying to collaborate cannot develop a working relationship” (p. 47). He stressed the developmental nature of building relationships and the familiar stages of “self-disclosure, checking each other out, and building trust” (p. 48). Building relationships takes time, and there were several comments made by participants that alluded to the establishing of relationships with psychiatrists that happened gradually as they ‘tested’ one another and established rapport.

Findings from this study indicated that those participants with more years of experience on a particular team saw their role and the psychiatrist’s role as both distinct and equally valuable. Their stories contained more elements of a working relationship that were mutual and egalitarian, as opposed to hierarchical. Collaboration stories shared by participants who had fewer years of experience on mental health teams contained elements of power dynamics, and tones of inferiority on the part of the counsellors. This leads one to wonder if there is a developmental nature of collaborative relationships where, over time, counsellors learn to value the importance of their own contributions to the team as well as the importance of establishing good working relationships with the psychiatrists on the team. Perhaps there is an attitude change that takes place over time. The Contact Hypothesis described by Amir (1969) lends support to the possibility that, over time, counsellors change their views of working with psychiatrists. The next section describes this hypothesis.

**Contact Hypothesis**

The ‘Contact Hypothesis’ was originally described by Amir (1969) and refers to improving intergroup relations by way of associating with individuals from other groups. Researchers have conducted both laboratory and field studies in an attempt to identify what factors are involved in changing attitudes toward other groups. Carpenter and Hewstone
(1996) cite the following variables as being contributing factors to the success of inter-group encounters: "institutional support; equal status of participants; positive expectations; a cooperative atmosphere; successful joint work; a concern for and understanding of differences as well as similarities; the experience of working together as equals; and the perception that members of the other group are ‘typical’ and not just exceptions to the stereotype” (p. 244).

Hewstone et al. (1994) conducted two studies that evaluated programmes of interprofessional contact between doctors and social workers. They assessed four sets of dependent variables: Background perceptions of the status given to the two groups in society and expectations about contact with the other group; in-group and out-group attitude ratings; knowledge of the other group’s attitudes, skills, roles, and duties; and judgements of experienced contact with members from the other group. The studies did, in fact, reveal an improvement in attitudes toward the out-group as well as an increase in knowledge about the other group.

Findings from the current study showed differences in attitudes and perceptions of counsellors partially due to differing amounts of experience working on mental health teams. The Contact Hypothesis certainly lends support to the premise that counsellors with more experience in a setting also have had more contact with psychiatrists, therefore gaining any necessary evidence to disconfirm any faulty perceptions or stereotypes. Those who are newer to the team in which they work may be guided by their initial impressions, stereotypes, or ascribed societal status of the other profession. This is merely an impression of the researcher, and future studies are required to explore this speculation.
**Stereotypes and Perceptions**

One could speculate that collaboration might be enhanced if more positive stereotyping were fostered, and if negative stereotypes were diminished between professions. In the current study, when participants talked generally about negative qualities or aspects of collaborating with psychiatrists, questions were raised pertaining to whether these negative qualities were based on actual experiences or on stereotypes. When asked to elaborate on these perceptions, all participants referred to actual encounters that had taken place either in their current work setting or in previous jobs held in other settings. This raises a curiosity about how stereotypes are formed. Are these negative experiences perceived as isolated incidents or are they the foundation for overall attitudes held about psychiatrists? Looking closely at the transcripts revealed that these negative experiences seemed to be a combination of both isolated incidents and pervading stereotypes about the profession of psychiatry in general. The same can be stated about positive experiences that were shared by participants. These, too, were based on actual incidents with particular psychiatrists as well as overall positive stereotyping. There are no conclusive answers as to how stereotypes and experiences interact with one another to form attitudes toward interdisciplinary collaboration, and it is clear that more research is needed in this area.

It is interesting to note that some participants stated that they chose to participate in the current study because they believed their positive experiences were unique and held an assumption that other participants would be sharing stories that held a more negative tone. An underlying tone throughout the interviews was the desire of several participants to ‘tell their stories’ and ‘get the message out’ about some of the positive aspects of what is currently happening on community mental health teams. This leads one to wonder about
what the background is for this striking motivation of some of the participants. It was stated in the follow-up interviews that there is not much inter-team communication among the Greater Vancouver Mental Health Services, which raised the question of, ‘what are other teams doing that we could learn from, or what could they learn from us?’ It is my perception that participating in this study provided an opportunity for counsellors to share their impressions from their own experiences in order to deliver the message that there are positive things happening on some of the teams. A perception of mine, as the researcher, is that counsellors potentially do maintain some negative stereotypes about psychiatrists in general, holding the assumption that their own positive working relationships are unique rather than the norm.

One participant had shared his belief that it was up to the psychiatrists to put the effort into establishing a good collaborative relationship with counsellors because of the greater power and status ascribed to them by society. Carpenter (1995), who presented data about stereotypes held by medical and nursing students, asserts that:

It is simply unrealistic to expect the weaker partner in a relationship to change the behaviour of the more powerful. Change must be two-sided – if the stereotyped relationships are to change in the interests of patients, then doctors as well as nurses must change their attitudes and behaviour (p. 152).

But who is the ‘weaker partner’ when it comes to counsellors and psychiatrists on community mental health teams? The counsellor is the official case manager and generally provides ongoing therapy, while the psychiatrist leads the formal assessments and prescribes medication. These are two very distinct roles with very distinct and complementary responsibilities. I would therefore venture to say that one’s autostereotypes – beliefs about
one's own profession – would also influence interprofessional collaboration and any efforts, or lack of effort, to build professional relationships with others. The participant who believed that the counselling profession does not have the same 'power' as psychiatry and is the 'weaker partner' allowed this belief to influence his expectation for psychiatrists to make the effort in establishing working relationships, and his consequent lack of effort in the relationship-building process.

As Carpenter (1995) states, change must be a two-sided process. If only one professional is making the effort to work collaboratively and the other is not even trying, the interaction cannot be truly collaborative. If counsellors stereotype psychiatrists as 'arrogant' and 'elitist', it would be difficult for either professional to behave differently towards the other. Change in the interprofessional relationship is also more likely to occur if each group believes that the other group has changed their perceptions, for example if counsellors believe that psychiatrists perceive them as being more competent. Several participants did comment that they believed the psychiatrists had not valued their input as much in the beginning and had 'tested them out' to see if they were competent. Over time, as relationships developed, interactions became much more collaborative in nature, and counsellors perceived psychiatrists as respecting their competence and valuing their viewpoint.

It was the consensus of participants that developing relationships with psychiatrists over time had shaped their views of psychiatrists and impacted attitudes toward working collaboratively. This is all well and good, but one can imagine the possibilities of forming views and changing attitudes earlier on at the educational level. The interprofessional programme developed for final-year medical and nursing students by Carpenter (1995)
revealed an improvement of overall attitudes towards the other profession. This improvement can at least partially be attributed to an increased understanding of the knowledge, skills, roles and duties of the other profession. Before the commencement of the programme, each student had been given a questionnaire that included a list of eight characteristics. Utilizing a seven-point Likert scale, they were asked the extent to which each characteristic applied to their own group (autostereotypes), the other group (heterostereotypes), and their own group as seen by the other group (perceived heterostereotypes). The same questionnaire was distributed at the end of the interprofessional programme, and there were significant differences in the results. Carpenter (1995) concluded his evaluation by stating that interprofessional programmes should encourage ‘mutual inter-group differentiation’ where there is an acknowledgement of each group’s strengths and valued identity.

Folkins et al (1981) conducted a study that focused on interdisciplinary attitudes of staff working in community mental health teams. Participants included psychiatrists, psychologists, and social workers. The Adjective Check List was used to determined descriptions of how each staff member viewed ‘typical’ psychiatrists, clinical psychologists, psychiatric social workers, psychiatric nurses, and psychiatric technicians. One of the main findings of the study was that many of the generated stereotypes were quite positive, revealing very positive attitudes held by participants toward other disciplines as well as their own profession. These findings are attributed to the interdisciplinary emphasis in a community mental health setting that seems to have had somewhat of a shielding effect on the predominantly negative stereotypes that potentially characterized interdisciplinary attitudes in the past. It can be deduced that these same effects could potentially be the result
of an interdisciplinary emphasis in professional training programmes. If this occurred at university level, a tremendous foundation could potentially be formed for establishing collaborative relationships at the professional level.

**Strategies to Maximize Available Time for Collaboration**

The present findings make a contribution to the literature in the area of interdisciplinary collaboration by extending the list of strategies for counsellors to maximize the quality of time they have interacting with psychiatrists. The strategies that were cited by participants included: Utilizing other psychiatrists on the team when the one they primarily work with is not available; taking initiative in applying knowledge gained from working with psychiatrists so that only a short consult is required rather than a full-length session; and actively seeking out psychiatrists before a session for a brief check-in. These strategies provide evidence for the existence of good working relationship where psychiatrists are approachable and counsellors are assertive in that they initiate contact when necessary. The ultimate strategy cited by counsellors and supported in the literature is making an effort to establish professional relationships. Actively forming interprofessional relationships is likely to increase and enhance the amount of collaborating that takes place, and presumably will enhance the quality of service provided to consumers of the community mental health system. In lieu of extra time available for meeting with psychiatrists, maintaining the principles of collaborative care can be accomplished by utilizing the strategies mentioned above.
Implications of Research Findings

General Implications

The findings within this study certainly shed light on constructive ways of eliminating barriers and building bridges between the professions. While there were generally no surprises in the particular qualities or situations that were said to contribute to positive or negative collaboration experiences, the findings provide support for the literature on interdisciplinary collaboration and specifically address the unique professional relationship between counsellors and psychiatrists on mental health teams. Because there is a paucity of literature on collaboration between counsellors and psychiatrists, findings from this study make a contribution to the body of knowledge that currently appears to be based primarily on anecdotes and practical ideas.

Theoretical Implications

Chapter Two included a section that referred to the situated cognition and information-processing models used to theorize about interdisciplinary processes. Derry et al. (1998) viewed working teams as “living, evolving communities defined largely by their practices and the tools they use to carry out their practices” (p. 26). The authors refer to a process of negotiation where there is a clarifying of language and understanding among team members. Findings of the current study support this concept of ‘negotiation’. Participants referred to engaging in clarification, information-sharing, and querying ideas or diagnoses in order to ensure team members are on the same page when working with a client. Derry et al. (1998) refer to unequal member status potentially arising when an issue is associated with one discipline more than others. This is certainly the case when counsellors and psychiatrists collaborate about certain areas of a client’s treatment that may
fall into one professional's area of expertise. For example, medication is considered to fall on the 'turf' of psychiatry due to their expertise in the medical profession. It would be assumed that if a counsellor and psychiatrist were exploring the pros and cons of particular medications, the psychiatrist's opinion would weigh more due to his or her medical knowledge. However, there are certainly numerous other aspects of client care that are discussed where the counsellor's input would weigh more simply because they are the case manager and generally spend more time with a client.

In terms of information-processing within groups, Derry et al. (1998) ascertain that ideas that are held in common by individuals are more likely to be actively discussed, whereas ideas that contradict or are in the minority are less likely to be brought up. The degree of sharing within a group is influenced by status differences among group members. Interpretation of findings from the current study would add to this the assertion that the degree of sharing is also influenced by perceived status differences among group members. Evidence for this arises from participants who had relatively less experience sharing that, due to their perception of the psychiatrist having more power in society, they lack being completely open or confronting differences with psychiatrists. Furthermore, those with many years of clinical experience on mental health teams made reference to confronting psychiatrists if they did not agree with them, questioning diagnoses or medications (areas considered to be a psychiatrist's 'turf' of expertise), and presenting arguments for their differing opinions. In other words, those with more experience shared stories that had elements of assertiveness in common, and expressed their perception of having a role that is as equally important as the psychiatrists.
Negotiating language, definitions, and procedures for working collaboratively are all part of the process of developing interprofessional relationships (Derry et al., 1998). Interestingly, one participant made reference to a psychiatrist who took a course in a particular therapeutic approach that the counsellor was quite experienced in and was integrating this approach in her practice while consulting with the counsellor. Another participant referred to a study group that several members of the team, including psychiatrists, were involved in. This study group was reading a book that focuses on client-centred care, and members of the study group were actively working on incorporating this model into their practice as well. Thus the process of negotiating procedures within a team was certainly evidenced by some of the stories told by participants.

Negotiated understandings among counsellors and psychiatrists create compatible understandings of a task or therapeutic direction that are sufficiently aligned without being identical to one another. After all, different professionals are expected to contribute their own unique disciplinary knowledge about different aspects of a case rather than be exact clones of one another.

The description of counsellors' collaboration experiences with psychiatrists provided insight to several areas that either enhance or strain the process. Aspects of the collaborative relationship were categorized as external-structural, internal-cognitive, or social-relational. The interview data collected in this study quite clearly fit into each of these categories. Effective collaboration requires knowledge, skill, and attitudes within elements of self, other, context, and interrelationships (Germain, 1984). Relating this to the findings of the current study, the domain of ‘self’ would refer to the counsellor, ‘other’ would refer to the psychiatrist, ‘context’ would refer to the work setting within the community and subsequent
social system, and 'interrelationship' would refer to counsellors’ and psychiatrists’ professional relationship with one another. The qualities, beliefs, biases and assumptions shared by counsellors about themselves or the psychiatrists with whom they work fit into the ‘internal-cognitive’ category. Aspects of the environmental and social context, including the work setting, are considered under the category of ‘external-structural’ factors. References to the professional relationship – or interrelationship – with psychiatrists and ways of interacting would naturally fall into the ‘social-relational’ category.

**Ethical Implications**

There was consensus among participants that when they had started working at their respective mental health teams, no one had been given any specific guidelines for collaborating with other professionals. Participants reflected that guidelines definitely would have been helpful at the outset, as they were generally left to find their own way in the realm of interprofessional teamwork. Paproski and Haverkamp (2000) also draw attention to the fact that there are no explicit guidelines on how to conduct interdisciplinary communication and collaboration.

Before the researcher began interviewing participants, an exploration of ethical codes for counsellors was examined in order to note any guidelines for interdisciplinary collaboration. This examination was detailed in Chapter Two and concluded that there were no explicit guidelines for counsellors to adhere to when collaborating with other professionals. Upon embarkation of interviewing participants, the criteria for participation changed in light of the discovery that many counsellors on mental health teams have a degree in social work. Because the actual roles of counsellors were the same regardless of whether they had a counselling psychology degree or a social work degree, inclusion criteria
changed to incorporate a representative sample of community mental health team counsellors. In light of this change, it follows that an examination of ethical codes for social workers as they relate to interdisciplinary collaboration might be of interest. Interestingly, these codes of ethics also revealed no explicit guidelines for collaboration. However, similar to the ethical codes for counsellors, there are some guidelines that certainly imply general ways of engaging in working relationships with other professionals. For example, the National Association of Social Workers Code of Ethics (1990) suggests "the social worker should provide clients with accurate and complete information regarding the extent and nature of the services available to them" (F8). Regarding social workers' ethical responsibility to colleagues, they are told to "extend to colleagues of other professions the same respect and cooperation that is extended to social work colleagues" (J8). Again, there are no specific114(150,771),(202,808) guidelines for how to collaborate, only that when in contact with other professionals they should be respected.

One could argue that respect is something that is earned, and what better forum to work towards a general respect of professionals from other disciplines than at the educational level where students could be directly exposed to interdisciplinary programmes. Providing clients with complete information that pertains to the services available to them requires knowledge on the part of the social worker or counsellor that most certainly might be enhanced through collaborating with others who bring their own area of expertise to enhance the possibilities for clients.

As previously mentioned, there are no explicit ethical guidelines for counsellors that pertain to interdisciplinary collaboration. Indeed, any professional working in a team environment with other disciplines would benefit from an interprofessional code of ethics
that incorporates guidelines from a variety of disciplines. Casto (1994) suggested an ‘oath 
of commitment for members of an interdisciplinary health care team.’ Of particular 
relevance to the current study is the section entitled, ‘Duties to Other Health Care 
Professionals.’ This section includes a number of statements that will be included here due 
to their relevance:

1. Recognizing the limitations of my own competence, I will call upon colleagues 
in all the health professions whenever the patient’s needs require.

2. I will respect the values and beliefs of my colleagues in any other health 
profession and recognize their moral responsibility as individuals.

3. I will do my best to create interprofessional bonds of respect and deference 
whenever possible. Thus, I will try to the best of my ability to practice, embody, 
and teach the values of this code of ethics (p.141).

Also of importance to a conception of specific ethical guidelines pertaining to 
interdisciplinary collaboration would be statements about the responsibility and 
accountability for effective mental health services. Guidelines regarding appropriate 
education and competence for developing a deeper understanding of what it means to 
collaborate with other professionals would also be an asset to collaborative practice. One 
can imagine if each member of a mental health team ascribed to specific ethical guidelines 
or ‘oath of commitment’ there would be a pervasive atmosphere of collaborative intent. 
Any perceived or real threats to approaching another professional would be deterred due to 
the organizational expectation that each member has a right and responsibility to call upon 
other professionals to collaborate in the best interest and care of a client.
Educational Implications

With regards to counsellor training, the present research findings support several recommendations. All participants stated that their graduate school experiences did not contain any specific training on how to collaborate with other professionals. This finding is not unique, as the literature also makes mention of a lack of interdisciplinary training at an educational level (Perrin, 1999; Shalinsky, 1989; Casto and Julia, 1994). If professionals from other disciplines are not involved with training, then one cannot expect an interdisciplinary familiarity with the principles and practice of others' work or to have any experience in developing collaborative relationships. It is important to consider what type of training might be needed in order for professionals from different disciplines to work together more effectively. Classes that include students studying psychology, counseling, social work, psychiatry, nursing, or occupational therapy would contribute to future mental health practitioners learning early to relate and respect one another (McDaniel & Campbell, 1997). Indeed, if there is an interdisciplinary component to education there is the provision of a foundation for working together. Discussions of theory, research, and practice from each disciplinary perspective would provide avenues for widening the boundaries and enhancing awareness of other professions involved in mental health (Brabeck et al., 1997).

There have been several interdisciplinary training initiatives explored and, in some cases, implemented in various university settings in North America (personal communication with John Gilbert, May 2, 2001). While none related specifically to community mental health, these initiatives certainly provide a model that could easily be applied to mental health professionals. Brabeck et al. (1997) describe their counselling psychology program at Boston College as focusing on preparing students for
interprofessional collaboration. This program specializes in joining community, mental health, and schools in order to provide services to children and families. Aspects of this program are certainly applicable and transferable to a mental health service provider focus. They recommend that university and community partners co-teach courses, saying that: “These exchanges bring the world of practice from the community into an active dialogue with the world of theory and practice and can result in both teaching and learning for the instructors as well as the students, members of the community, and other professionals” (Brabeck et al., 1997, p.628).

It would be presumed important to gain knowledge of the content and culture of other disciplines, knowledge about collaborative principles of care for clients and for other professionals, and knowledge of the sociopolitical structure of the health care system (McDaniel & Campbell, 1997). Developing skills that enable effective teamwork such as “interpersonal communication, leadership, negotiation, facilitation, consensus building, conflict resolution, and time and stress management” are essential to foster a truly collaborative environment (Gilbert et al., 2000).

At the University of British Columbia, a committee of faculty and students from health and human service programs developed a workshop on interprofessional teamwork with upper-year students (Gilbert et al., 2000). Participants were provided with opportunities for exploring assumptions about each profession and about patient/client care. The workshop addressed topics such as the purpose of interprofessional teams, group dynamics, team communications, making sense of multiple professional paradigms, and team management. The outcomes that were hoped for as a result of participating in the workshop included students’ ability to:
(a) suggest ways to resolve conflicts; (b) utilize the skills of the team to solve
problems; (c) identify gaps in teamwork; (d) identify barriers to teamwork in
practice; (e) utilize team management tools and skills; (f) identify the health care
professionals that are needed to address client/patient needs; (g) work effectively
with other professions to assign specific tasks and activities to specific team
members and decide how these could be done; and (h) identify interdependent team
tasks and activities (p. 226).

The workshop utilized a number of teamwork simulations that had no basis in health
care. The purpose of these exercises was to focus on actual group process instead of various
positions of professions and any perceived status differentials. In the actual debriefing,
generic team concepts learned in the exercises were applied more specifically to
interprofessional health care. Case studies were then presented in order to put team theory
into practice.

The University of Bristol Departments of Social Work and Mental Health offered a
shared learning program for final year social work and medical students (Carpenter &
Hewstone, 1996). Rationale for this program was provided by the ‘Contact Hypothesis,’
which suggests that attitudes toward other groups can be changed via contact with them
(Amir, 1969; Rothbert & John, 1985). An evaluation of the effects of this program
demonstrated an improvement in the overall attitudes toward the other profession. Those
who participated in the program reported an enhanced knowledge of the various attitudes,
skills, and roles of the other profession as well as knowledge of how to work together more
effectively. Changing attitudes and increasing knowledge of the other professional as well
as broadening knowledge of components of good interprofessional relationships would certainly be necessary conditions for collaborating in practice.

**Implications for the Work Setting**

A number of variables that contribute to the quality of a collaborative interaction between counsellors and psychiatrists have been considered. The work setting has been categorized as an external structural factor and aspects that both enhance and strain collaboration have been identified. In light of these aspects, several implications for the work setting are identified. It is common sense that for a staff to work as a team, the organization must support teamwork. Ways of demonstrating that support have been mentioned by Cooper and Woodford (1999) and are stated as follows:

Organizations can support interdisciplinary teamwork by:

- Providing adequate resources to each team,
- Creating an organizational culture and structure that holds teamwork as the norm and establishes standards of excellence regarding team effectiveness,
- Respecting and valuing each discipline within the organization and its contribution and role in effective teamwork,
- Ensuring that the organization's structural values each discipline equally by avoiding a hierarchical structure which values one discipline over another,
- Establishing and reinforcing clearly defined routes of communication and accountability,
- Supporting team identity and the identity of each profession (p. 20).

One way for organizations to establish teamwork as the norm is to have specific guidelines for how to engage in collaboration in their particular work setting, and to include
discussion about interdisciplinary collaboration as part of an orientation session for new staff members. New staff members would also be likely to benefit from some form of mentorship program where the more experienced staff could share their expertise in collaboration. Providing information defining collaborative practice, delineating its principles and expected outcomes and describing real experiences where collaboration is working would serve to open up dialogue among practitioners pertaining to how they work with one another.

Given that workloads for counsellors and psychiatrists are not always equal and depend upon client populations, one suggested strategy is that team members be constantly aware of workloads and prepared to assist if and where possible. It is necessary for the existence of flexible and innovative communication processes, as well as a fluid process of re-allocating responsibilities, when required, for continuity.

When professionals collaborate with one another, clarifying each participant’s purpose and goals is necessary. Some specific points to consider while collaborating are as follows: identifying the general purpose of the collaboration; identifying the psychiatrist’s goal for the client; identifying the counsellor’s goal for the client; identifying the client’s/family’s goals and desired outcomes; identifying both the differing and common elements of all of these goals.

Peek and Heinrich (1995) suggested some tactics and procedures for professionals to hold one another accountable within collaborative practice. They stated that spending the right amount of time at the beginning of a case saves time in the long run. Taking the time to collaborate in the development of a therapeutic care plan at the beginning creates a ‘road map’ that can be continuously referred to and revised over time. They also suggested
ensuring that clients understand and embrace the therapy plan in order for them to play an active role in their own treatment. Two mottos worth quoting from Peek and Heinrich (1995) are: “[Mental] Health care relationship problems exacerbate [mental] health problems;” and “Watch the team score, not just your own score” (p. 338). In other words, what other professionals are doing within the team is also everyone’s business and professionals need to work together for the benefit of the whole team and ultimately the benefit of the client.

**Delimitations**

Findings of this study and subsequent implications are limited specifically to counsellors who work with psychiatrists on a mental health team. The composition of the participant sample limits the transferability of research findings to counsellors in general (Guba, 1981; in Krefting, 1991). However, the purpose of this particular study was to provide a description of counsellors’ collaboration experiences with psychiatrists within community mental health teams in order to depict both contributing and impeding factors within the collaboration process. Due to the qualitative nature of the study, the purpose was not to generalize but rather to inform and describe the experience.

Another delimitation worthy of attention is the lack of interviewing psychiatrists for their perceptions of collaborating with counsellors. The findings are limited to the perceptions and stories of counsellors, thus presenting only one side of the collaborative story. It would have been interesting to compare and contrast the collaboration contributors and barriers perceived by counsellors with those perceived by psychiatrists.
Limitations

A possible limitation to this study is that those counsellors who chose to contact the researcher in order to participate may have been characteristically different from those who were unwilling to have conversations about their collaboration experiences with psychiatrists. This raises the question of whether or not the findings would be consistent if other mental health counsellors were interviewed. Variation in experience was certainly evident from the stories that were shared by participants and is expected in qualitative research (Krefting, 1991). However, it is not known if the variations within the participant sample are accurate representations due to the small number of counsellors who were interviewed.

A final limitation to consider is the fact that the raw interview data were filtered through the lens of the researcher. Biases and assumptions are inherent within the researcher, which is why the effort was made to articulate them before data collection began. The findings of the preliminary interviews were merely an initial articulation by the researcher. In order to avoid the possibility of the researchers’ assumptions and biases infiltrating the findings, participants were given the opportunity to challenge or clarify the description of counsellors’ collaboration experiences with psychiatrists during the follow-up interviews. However, participants were in agreement with the description of collaboration experiences provided to them thus implying that the researcher’s biases and assumptions had indeed been kept in check.

Because this study was an initial exploration of counsellors’ collaboration experiences with psychiatrists, a broad scope was necessary to gain a preliminary description of the process. It was hoped that general themes would emerge from the data
and become repetitive as more participants were interviewed. While it is true that themes were repeating and no new themes emerged as latter participants were interviewed, there is reason to believe that there may be some missing pieces. While participants made reference to colleagues who 'would have a very different story to tell' or who 'would be able to articulate some current negative experiences with psychiatrists', none of these colleagues ever contacted the researcher. Thus it is not known what they would have or would not have said about their own collaboration experiences. However, the findings still provide insight to current collaborative relationships between counsellors and psychiatrists who work within some of the Greater Vancouver mental health teams.

**Implications for Future Research**

The present study presents a need to expand on collaborative aspects of interprofessional relationships that exist not only for counsellors on mental health teams, but also those who work in private practice and other counselling agencies. What might the similarities and differences of collaboration experiences in these settings be? Future research could do a comparative study that examines the collaboration experiences of counsellors in various work settings. The findings of the current study reflect only one side of the collaboration story. What might psychiatrists have to say about their experiences with counsellors? This question would be answered if both psychiatrists and counsellors were interviewed and compared with one another. It would be interesting to find out what aspects psychiatrists would focus on when describing their collaborative encounters with counsellors.

Given that participants in the current study agreed that training in interdisciplinary collaboration at an educational level would be beneficial, studying institutional attitudes and
policies relating to interdisciplinary curriculum would shed light on whether institutional norms support the reality of the need for learning how to effectively collaborate with other professionals.

A final suggestion to consider for future research is to examine the link between the quality of interprofessional collaborative relationships and the quality of clinical service provision. It would be beneficial to find out if mental health professionals’ perceptions of one another have implications for how they behave and for how clients are treated.

Conclusion

The findings from this study provide descriptions and conceptualizations of counsellors’ collaboration experiences with psychiatrists on community mental health teams, and specifically identify elements that are contributors and barriers to the experience of collaboration. It is hoped that the description and articulation of the elements, contributors, and barriers of collaboration, and the consideration of the implications of the research findings will potentially impact upon the knowledge and practice in the area of collaboration between counsellors and psychiatrists. The findings attained in the present study will hopefully encourage others to investigate and expand in the areas of theory, research, and practice as they relate to the practice of interdisciplinary collaboration.
References


APPENDIX B

Initial Contact Letter to Counselling Psychology Students, Personal Acquaintances, Classes, Listserv

Dear (Student/Name of Acquaintance/Class),

I am a Counselling Psychology Masters student at the University of British Columbia and am conducting thesis research on counsellors' collaboration experiences with psychiatrists. My research will involve interviewing counsellors about these experiences and I am requesting your assistance in nominating counsellors who work in a mental health team setting whom you think would be comfortable engaging in a candid interview on the topic of collaborative experiences with psychiatrists.

Within the literature, collaboration is referred to as an important component of effective care for clients. However, the frequency of collaboration between professionals is not as high as one would expect. While there is a wealth of literature on collaboration in health care settings, little or none exists that is specific to counsellors and psychiatrists. I plan to use the interviews with counsellors who work on teams in the hopes of contributing to our knowledge of current collaborative practice, as well as identifying possible ways to improve collaborative practice in the future.

The participants that I hope to recruit would be graduates of an accredited counselling psychology masters program who meet the following criteria:

1. at least two years post-graduation counselling experience,
2. working in a team setting where there are opportunities to collaborate with psychiatrists,
3. self-reflective, articulate reporters, and
APPENDIX C

Initial Contact Letter to Participants

To Potential Participants,

I am a Counselling Psychology Masters student at the University of British Columbia and am conducting thesis research on counsellors’ experiences on multidisciplinary mental health teams. I am interested in speaking with counsellors who work in a team setting that includes psychiatrists in some capacity. Within the literature, collaboration is referred to as an important component of effective care for clients. However, the frequency of collaboration between professionals is not as high as one would expect. While there is a wealth of literature on collaboration in health care settings, little or none exists that is specific to counsellors and psychiatrists. I plan to use the interviews with counsellors who work on teams in the hopes of contributing to our knowledge of current collaborative practice, as well as identifying possible ways to improve collaborative practice in the future.

This letter was sent or given to you by a student or colleague who believed you would be a good candidate for this study. At this point I am unaware of your identity. Your full identity will only be known by me if you decide to participate in the study.

Participation in this study would involve approximately 1 hour of your time, plus a half-hour follow-up interview. All of the information that you share will be kept confidential and, if you participate, you will be free to disengage from the interview at any point. The purpose of the interview is to attain a description of your range of work experiences with psychiatrists.
APPENDIX E

Orienting Statement

Before beginning the interview I would like to ask you to think about your counselling experiences at the particular team setting where you work. You most likely come into contact with other professionals who work in the same setting. Some of this contact may be casual such as short conversations when you pass each other in the hallway, or chats over breaks and lunches. You may contact certain professionals to consult about a particular client you are working with or they might contact you. Perhaps your team has regular scheduled meetings where various cases are discussed. Your meetings might take place in a shared space, or they might happen over the telephone. They may be scheduled or they may be impromptu as the need arises.

I would like to read the following definition of interprofessional collaboration:

- **Collaboration is “a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible”**

Now I would like you to think specifically of your encounters with psychiatrists. In a few moments, I will be asking you to think about specific experiences interacting with psychiatrists at work in your role as counsellor.

At this point there exists plenty of literature about collaboration in a health care setting, but little is known about the particular collaboration experiences of counsellors with psychiatrists. I am interested in learning more about counsellors’ experiences of collaborative practice with psychiatrists, in the context of a team setting.

Throughout the interview I might ask you for more information or clarification in order to ensure that I understand your experience. However, if you become uncomfortable
or do not want to answer a question let me remind you that you can pass on that question or disengage from the interview at any time. Do you have any questions before we begin?

You might find it helpful to think back to a typical week in your counselling practice and see if that brings to mind

- any situations in which you either considered collaborating or actually engaged in collaborating with a psychiatrist,
- any situations in which a psychiatrist contacted you for collaboration about a client

The specific question that I would like you to answer, when you feel ready, is: TALK ABOUT SOME OF THE PARTICULAR COLLABORATIVE EXPERIENCES YOU HAVE HAD WITH PSYCHIATRISTS.
1. Perplexity, confusion, and doubt resulting from one’s implication in an incomplete situation, the full character of which is not yet determined.

2. A conjectural anticipation or a tentative interpretation of given elements, attributing to them a tendency to certain consequences.

3. A careful survey (examination, inspection, exploration, analysis) of all attainable considerations that will define and clarify the problem at hand.

4. A consequent elaboration of the tentative hypothesis to make it more precise and more consistent by squaring with a wider range of facts.

5. Taking a stand on the projected hypothesis by drawing up a plan of action that is then applied to the existing state of affairs – that is, doing something overtly to bring about the anticipated result, thereby testing the hypothesis (Dewey, 1916, p. 150).