

PART I: INTERDISCIPLINARY TEAM MODELS

EXPLORING THE NATURE OF THE INTERDISCIPLINARY TEAM: AN EXCERPT FROM *THE HELPER'S JOURNEY*


by Dale Larson

In medieval times, alchemy was a symbol for transformation of what is most common (lead) into what is most precious (gold). So, too, do learning teams practice a special form of alchemy, the transformation of potentially divisive conflict and defensiveness into learning. — Peter Senge


In the health care field, the traditional biomedical model is being replaced by a biopsychosocial model that recognizes the complexity of the forces that affect illness, health, and healing. This model says that *biological, psychological, and social* elements must all be considered when we attempt to understand and treat any health problem (i.e., the whole person in his or her social context is the appropriate focus of our interventions).¹

The development of interdisciplinary teams has paralleled that of the biopsychosocial model. Interdisciplinary clinical teams draw upon the expertise of specialists in each of these separate domains—biological/medical, psychological, and social—to diagnose and treat the whole person and the context of the illness because these are inseparable from the disease or problem in living that the person seeking help brings to us.

The interdisciplinary health team can include physicians, nurses, social workers, physical therapists, clinical nurse practitioners, chaplains, psychologists, music and art therapists, volunteer caregivers, and other specialists. The hospice team, a good example of a comprehensive interdisciplinary approach,



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extends the biopsychosocial model to include the spiritual needs of dying persons.

The interdisciplinary team represents one point or level in a developmental sequence of team development, from unidisciplinary (where there is no team at all); to multidisciplinary (where independent disciplines function largely unaffected by one another); to interdisciplinary (where the interaction of the team is necessary to produce the final product); and, finally, to transdisciplinary (where team members train one another and there is a phenomenon of “role release” in which roles and responsibilities are shared).² Working together in a truly interdisciplinary or transdisciplinary fashion is an ideal state that most caregiving teams aspire to but not all achieve.

Interdependent collaboration—the key to successful interdisciplinary teamwork—is often undermined by the failure of team members to understand the unique contributions and expertise of their colleagues from other disciplines. Most professional training includes little attention to other disciplines and to what members of these other disciplines can contribute as caregivers. This lack of understanding and appreciation can be responsible for a variety of communication problems and conflicts. One is a kind of role competition commonly known as “turfdom”:

The major conflict in our hospice is a turf issue: Who is best able to deal with emotional/counseling issues with patients—the R.N. case manager or the M.S.W.? The M.S.W. wants nurses to deal only with physical problems and leave counseling to the M.S.W.

A related phenomenon is what I call the one-person multidisciplinary team—the [professional] caregiver who refuses to collaborate and attempts to do it all alone. This stance probably originates in feelings like these:

I often feel that no one cares as much as I do about the patients and their individual needs. Consequently, I feel ultimately responsible for the care the patients do or don't receive.

The resulting situation can look something like this:

A nurse complains about carrying the whole load of a patient and family's care. The other team members complain that the nurse refuses to call any of them into the care even when the care plan is developed to incorporate them. The nurse "controls" the case and is exhausted by it.

Teamwork Involves Personal Vulnerability

Working collaboratively in a highly interdependent mode is intrinsically difficult. Every caregiver team faces the challenges of blending cooperation and competition, working together and working separately. For the [professional] caregiver, meeting these challenges entails tremendous personal vulnerability.

When you are a member of a multidisciplinary or interdisciplinary team, your work is constantly exposed to the critiques of others. You don't have the comfort of working in a unidisciplinary context, where it is possible that no one will see what you do or how well you do it. The close scrutiny of other team members really forces you to look at your own behavior and your ability to receive feedback or give it.

For example, I feel much more comfortable doing counseling in my private office, where no one can observe me, than I do intervening in a health care situation as a team member. In the team setting, if I fail to communicate effectively with a patient but other

team members are successful, all my credentials and degrees won't protect me from the judgments of my fellow team members. One social worker shared similar feelings:

I am a social worker, and I am supposed to be the expert on our hospice team on psychosocial issues. However, during the course of everyday hospice practice, I see the nurse or volunteer providing this type of support as well or better

than myself. Even though I am the one with the master's [degree], education, and experience, at times the work seems easier and more natural for others.

Being a team member means looking at yourself—your needs for power and control, your difficulties with sharing or collaborating, and a host of other personal issues related to team functioning.³ This forced self-awareness can be painful, but it can also be an opportu-

WHY HAVE TEAMS?

Why do we have teams? The answer is simple: Caregiving teams are a response to complex human problems that demand the focused attention of experts from more than one discipline. An individual caregiver can't meet all the needs of a person who is terminally ill, or of a person coping with chronic illness or severe disabilities. The expertise of several disciplines is required to understand and care for people facing these kinds of difficult life circumstances. In the interdisciplinary team, for example, caregivers from a variety of disciplines work together to achieve goals that none could accomplish alone.

Acting in concert, team members can convert a collective commitment to a worthy purpose into specific caring acts that fulfill this shared mission. One essential team task is to reach agreement on the basic purpose or mission of the team and on the best way of getting there. If you are currently a member of a caregiving team, how would you define the mission—the shared purpose or "why" of the work as the members of your team experience it? Is your team's mission closely aligned with your own purpose in helping? What does the team allow you to achieve that you couldn't accomplish alone?

There is a big difference between the objectives and guidelines that are given to a team by the larger organization to which it belongs and the kind of personal ownership that results from the team members' discussing and arriving at what they believe the team's mission is.¹ Has the team you are on owned its mission statement, or is the statement just a set of guidelines that has been handed down to you?

The team must also have a clear sense of the goals that it is working toward, a vision of what it will actually do to fulfill its mission. Setting clear performance goals and priorities is something teams often bypass, but it is well worth taking the time to do so. This shared vision is like a compass that can keep the team moving on course toward its goals in difficult times.

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Excerpted from: Larson, Dale. *The Helper's Journey: Working with People Facing Grief, Loss, and Life-Threatening Illness*. Champaign, IL: Research Press, 1993.



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nity for personal growth if you approach yourself and the members of your team with an attitude of openness, flexibility, and respect.

Just as happens in your significant personal relationships and in your individual helping, working as part of a caregiving team will bring you face to face with both your strengths and your weaknesses. This usually leads to some combination of personal growth and personal distress; there is no pain-free way to be a team member.

Excerpted from: Larson, Dale. The Helper's Journey: Working with People Facing Grief, Loss, and Life-Threatening Illness. Champaign, IL: Research Press, 1993.

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**FROM INTERDISCIPLINARY
 TO TRANSDISCIPLINARY:
 STRENGTHENING THE
 HOSPICE TEAM**

Hospice of the Western Reserve (HWR) is an independent, not-for-profit, community-based organization that serves five counties in Northeast Ohio. It operates out of eight satellite facili-

ties in addition to its headquarters campus in Cleveland, which includes Hospice House, an inpatient/residential 42-bed facility that overlooks Lake Erie. HWR's service area has a population of 2.2 million and 21,000 deaths per year.

HWR's team and organizational philosophy is rooted in and informed by a profound foundational insight proffered by Dame Cicely Saunders. That is the concept of "total pain."¹ This definition incorporates physical, psychological, social, emotional, and spiritual elements of pain. From that perspective, it is clear that no one discipline or professional domain is adequate on its own to assure comfort from pain, freedom from distressing symptoms, and relief of suffering. The understanding of total pain leads directly to the appreciation of team. Only a comprehensive team approach can effectively address the array of pain issues that patients experience.

In addition, at HWR there is a dynamic and robust "transdisciplinary"² team culture. This approach to team de-emphasizes lines that tend to separate various disciplines and instead affirms the common ground that various team members share. Moreover, it recognizes that, like a hologram, each part or team member carries the entire team. Every team member may at some time need to be attuned to spiritual and existential aspects of suffering, or of the impact that family dynamics may have on a patient's capacity to achieve comfort, or of a cultural belief about sickness and physical pain. No team member may ignore the expectation to be an active listener and observer. No team member may use the specialization of a particular profession or discipline by responding to a presented problem with "It's not my job." It is not surprising that we associate the idea of transdisciplinary team with the person who gave us the paradigm of total pain, Dame Cicely, herself a nurse, social worker, and physician.

In addition to team being the optimal approach to total pain, this philosophy also serves the organization well by reducing or eliminating two unhealthy dynamics that

PART II: INTERDISCIPLINARY TEAM DYNAMICS

**STRATEGIES FOR TEAM
DEVELOPMENT: AN EXCERPT
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What can you do to make your caregiving team healthier and more productive? ... Here are some general guidelines for improving your team, including some specifics for making staff/helper support groups work more effectively.

Encourage Shared Leadership


Team development expert Irwin Rubin and his colleagues stress that to effectively achieve the team's goals, leadership functions must be shared throughout the team. Just as no single person can achieve the basic task or mission of the team, no single person can make the decisions, monitor and coordinate team progress, and lead the team in every situation. Instead, team members must assume shared leadership responsibilities.¹ These leadership functions can be divided into two categories: those that focus on *what* (content/task) the group is doing and those that are concerned with *how* (process) the group is working.

Task-oriented leadership functions include initiating problem solving or building work agendas, giving and seeking information and opinions, clarifying and elaborating on the various inputs of group members, summarizing where the group is and where it needs to go, and checking to see if people are clear on the goals and decisions of the team.

Process-oriented leadership functions include ensuring that everyone's contributions are considered, encouraging the participation of group members, harmonizing different points of view, and finding creative



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solutions to problems the group tackles. When these leadership functions are shared, an ethos of participation and empowerment and a greater sense of commitment to the team's goals can develop.

Enhance Team Members' Self-Esteem

Making team members feel good about themselves is another important leadership function that team members can share. To a large extent, leadership involves just that—making people feel good about themselves, enhancing their self-esteem. The praise, awards, and recognition dispensed within the team are part of this core leadership function. Burnout is much less likely when team members feel they and their work are truly valued and valuable. This is particularly important in the human services, where self-doubts, helper secrets, and self-blame can lower one's self-esteem. High self-esteem is an excellent buffer against stress and inhibitor of burnout. We all need occasional affirmation of the good things we do and of our importance to the team effort.

How much do you feel your work is recognized and rewarded by your team? Although you can't change everyone else's behavior toward you directly, you can recognize and reward the work of your teammates. These positive actions will earn the goodwill of your colleagues, making them more likely to reciprocate in kind in the future. The moral is, if the world feels cold, light a small fire, and it will spread. The positive effects of being more generous with your praise and thank-yous are more immediate, however. ... Caring for others is good for you as the caregiver; offering caring expressions to your

teammates will benefit you by improving your own mood and self-esteem.


How can we increase these kind of affirming behaviors among teammates? Too often, months or even years go by without team members sitting down and sharing their appreciation of one another. Some people might say that to be genuine, positive feedback and “thank-yous” must be spontaneous, unplanned, and “from the heart” But I believe that a structure is necessary in order to build these “spontaneous and heartfelt” communications into our busy helping worlds.

For example, I encourage caregiver teams to do a brief round of acknowledgments and “thank-yous” at least once every three months. The feedback should be specific, acknowledging things that you have seen the other person do that struck you as a positive contribution to either the team effort or your own work. For example, you might acknowledge a creative intervention, someone’s sense of humor, or anything else about the person that inspires or supports you. Don’t spend more than a minute or two on each person, but be sure that everyone is included. You might think that doing this regularly would lead to all the positive comments being saved for “appreciations day” and that the number of spontaneous expressions of appreciation between these sessions would decrease. But the reverse is actually true. Giving acknowledgments is a good habit that can be strengthened by occasionally giving it the team’s exclusive focus.


Build Caring Relationships

Your relationships with other team members will be most rewarding and productive if they are endowed with the same qualities of openness, trust, respect, and authenticity that you are striving for in your helping relationships. When teammates are in ... the midst of a personal crisis, it is natural to share our best helping selves with them:

I was being there—present, listening, feeling, receiving—for one of



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my staff, a social worker, who was going through a significant experience of a personal grief/loss/health crisis. As we sat together, sharing tea and a poppy seed muffin, she said, “I’m really not so different from the people we take care of.” Then she hugged me, and we cried.

An important kind of empathy to have for other team members, particularly members of other disciplines, is a clear understanding (both intellectually and emotionally) of what it is like to do their job. Here is an exercise you can try with your team: Have all your team members write what they think each other team member does and how they think each person feels about doing it on identical sheets of paper, then read these sheets anonymously.

What do you think this exercise would reveal? One discovery might be that most team members have surprisingly incomplete and erroneous pictures of what the other team members do and how they feel about doing it. If you try this exercise, be sure that the team members are given an opportunity to correct any inaccurate perceptions and to provide a more complete picture of what it is actually like to do their jobs. The group can also discuss how some of their ongoing communication problems might be related to the incomplete views they have of one another’s roles and work experiences. You can devote some time to renegotiating what team members expect of each other as well. This exercise is a quick technique for overcoming the interdisciplinary myopia that affects us all. You can also achieve this in one-on-one settings by arranging extra meetings with individual teammates for sharing these perceptions.

When there is empathy among team members and when there is an atmosphere of goodwill, trust deepens and expands, leading to greater openness, fewer negative interactions, and the sustained personal growth of team members. Fear has exactly the opposite effect on these qualities of team life. If every



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team had a “fear detector” and used it, the possibilities for team development would be enormous. Of course, not all our fears need to be discussed in the group context, but when an atmosphere of fear replaces one of goodwill, the negative effects on the team are pervasive. Then the team needs to be aware that this is occurring so the members can address the problem.

One fear-engendering behavior teams can engage in is spreading rumors and gossip. A rumor is a statement or opinion circulated among team members that has no known source. Rumors are hazardous to teams because innocent statements can, as they are passed from person to person and changed along the way, become explosive “news” items with serious implications for particular team members.

Gossip—rumors linked to a specific individual—is even more hazardous to the team. We all know this, but it is often difficult to politely resist participating in gossip. If all team members agree that gossip is unacceptable, and if each team member makes an effort to politely refuse to listen to gossip about teammates, the norm of no gossip will quickly develop.

An appropriate response to gossip is to say, in effect, that although you appreciate that the other person just wants to keep you informed about what is happening, you don’t think you need to know about this piece of information. Then shift the conversation to another topic.² Each person must find his or her own way to say no to gossip.

If you think that it is impossible to avoid participating in gossip, given your network of friendships within the team, then you might need to examine whether that network is really healthy for you and the team. The dilemma with gossip is that people don’t think they are doing anything wrong when they indulge in it and therefore see no need to change their behavior. We often partake in gossip because we don’t want to alienate the person who is sharing it with us and consequently have him or her also talking about us behind our backs.

But another part of us knows that a better response is to let the person know we are simply not interested.

Empower One Another

Empowerment has become somewhat of a cliché, but even so it retains its relevance for all our caregiving efforts. In essence, our human presence, support, and communication skills empower the people we care for—they gain a greater sense of control over the difficult situations they face so they are able to live in more fulfilling ways.

This should also be our goal in our relationships with our fellow caregivers. The helper’s journey is not that of the isolated individual working wonders on a mountain-top. It is more like being part of a team of climbers who are working together interdependently to get to the top of the mountain. In the end, each member is able to achieve something he or she could not alone.

High-functioning groups are exciting to participate in because the group often generates solutions to problems that all team members recognize as better than those any a single team member could have arrived at. This is the kind of empowerment that comes from participating in a team. Team members can also empower one another by teaching skills and sharing their knowledge. This kind of transdisciplinary team functioning gives the team added flexibility and confidence, and reduces disciplinary myopia and feelings of “This is *my* turf.”

Establish Caregiver Support Groups

Creating a support group where problems, concerns, and feelings are communicated openly is an excellent means of preventing burnout, reducing turnover, and improving team morale.³ A support group is a place where you talk with people who appreciate the difficulties and the joys of your shared work and who understand your motivations for doing it. “The secrets of life,” as Emerson wrote, “are not shown except to sympathy and likeness.”⁴

In helper support groups, as in personal support groups, members share a common concern (i.e., stress at work) and there is an emphasis upon peer help. Members meet to learn together and to support one another in their work as helpers. These groups provide a unique opportunity for interpersonal learning and for receiving assistance in coping with work stressors, dealing with issues of professional identity, and team building.

An important kind of learning that occurs in group members during these regularly scheduled meetings is a shift from believing that “I’m the only one having a difficult time with this” to knowing that “We’re all in the same boat” (i.e., that everyone has a difficult time with these stressful situations). Sharing common concerns in an egalitarian atmosphere can lead to a kind of instant empathy and a sense of we-ness among group members, and unrealistic self-expectation can be tempered and corrected. Difficult feelings and helper secrets can be shared and worked through. Once this occurs, the bias toward self-blame can be corrected, and one’s energies can be directed toward developing better coping and problem-solving skills and strategies.⁵

Many different kinds of support and learning can occur in an effective support group. These include direct assistance, feedback, sharing and modeling of problem-solving strategies, ventilation of feelings, and encouragement. Each of the six different forms of social support—listening, technical appreciation, technical challenge, emotional support, emotional challenge, and shared social reality—are usually exchanged among group members. These different support needs can also be met through unstructured interactions among team members.

Some characteristics that distinguish successful from less successful groups have been identified. Studying both personal and professional (i.e., caregiver) support groups, British psychologists Keith Nichols and John Jenkinson defined six core interactions that characterize successful support groups: (a) focusing on issues of personal significance,

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(b) confronting difficult issues-getting beyond superficiality, (c) making feeling-based reflective self-disclosures, (d) using the responses of other group members to increase self-awareness, (e) aiding other members with the previous tasks, and (f) learning to give and receive support.⁶ Groups vary widely in the frequency and intensity of these core interactions and needn’t be high on all of them to offer worthwhile help to their members.

It is important to realize what these groups are *not* as well as what they are. Most important, they are not psychotherapy sessions. In therapy groups, a professional therapist leads the group as it focuses on intrapsychic issues with the goal of personality change in the individual group members. Support groups can be self-led or can have a facilitator or consultant who is ideally not a member of the team. This person can be a mental health professional, but needn’t be. In the support group, the focus is on problem solving and strengthening relationships among group members, with the goal of increasing team members’ effectiveness and well-being.

Although personal problems do come up and are appropriate topics in a professional support group because they affect our work with the team, serious personal problems should be taken to a counselor rather than to the group. It is also important to note that staff support groups are not a palliative treatment for organizational problems (e.g., a lack of space, personnel, equipment, or quality leadership) and will only further demoralize caregivers if they are used in this way.⁷

Support groups can also fail for a variety of other reasons. Breaches of confidentiality, presence of a dominant facilitator, and failure to establish and maintain trust and a caring atmosphere in the group are just a few of the many problems groups can and do have. Michael Boreing and Leta Adler have identified ten behaviors that are counterproductive to group goals: silence or withdrawal, anger, intellectualizing, dominating the conversation, undermining the facilitator or group,



nonattendance, scapegoating, interrogating, rescuing, and forming coalitions.⁸ Training materials now exist that can help staff support groups avoid some of these predictable problems; they can also be profitably reviewed by newly forming or existing caregiver (or personal, i.e., for patients/clients) support groups.^{9, 10, 11, 12, 13, 14}

Here are some useful guidelines for successful support group functioning that come from the training literature and from my experiences with caregiver support groups:

For the group as a whole, decide:

- How big will it be? (5 to 12 members is optimal.)
- When, where, how frequently, and how long should meetings be?
- Will it be open or closed?
- Will it be facilitated or self-led?
- Will there be an educational component?

For group members:

- Remember that each member is the authority on his or her own experience.
- First make contact with other group members, then address specific needs.
- Let others know what your ideas are.
- Don't do all the talking.
- Help other members participate by encouraging them.
- Listen carefully to other members.
- Don't ask too many questions or give quick advice.
- Disclose your own experiences, especially those that convey empathy for the experiences of other group members.

For facilitators:

- Use open-ended communication skills to exercise the least amount of authority necessary to promote beneficial interaction in the group.¹⁵
- Don't dominate, sermonize, evaluate, teach, or moralize.¹⁶
- Do promote cohesion, develop a safe climate, reinforce productive behaviors, and give information when appropriate.¹⁷

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- Avoid carrying on a conversation with each member in turn. Instead, encourage members to speak directly to one another.
- Encourage the expression of feelings, exploration of problems, and sharing of coping strategies.
- Focus the group on topics pertinent to the main concerns of the group.
- Mediate when the friction gets too great.
- Establish rules of confidentiality.
- Manage the logistics (e.g., scheduling, physical setting, notices, refreshment) for the group.

Most experts agree that staff support groups should be held in addition to staff meetings and other ad hoc support efforts within the team.¹⁸ However, these same guidelines can also be used for the brief planned or ad hoc segments of team meetings devoted to staff support. The guidelines can also be applied to personal support groups (e.g., bereavement groups or cancer support groups) that might be part of the team's caregiving efforts.¹⁹

Although group members have needs for both security and structure, these must be provided without the facilitator's taking an overly directive role and becoming an authority figure for the group. Structure and security can instead be provided through the group's use of designed exercises or formats that can increase the participants' feelings of safety and prevent some problems that groups, especially unstructured ones, experience.

For example, occasionally dividing the time into equal segments for each group member will ensure that everyone will participate and prevent the monopolization of the group's time by one or more members. Another format that can quickly and safely promote intimacy among group members involves beginning meetings with each member's sharing for just a few seconds how he or she is feeling at the moment. In the *Common Concern* support group training program, this technique is called "Moodcheck."²⁰ ...




Another key to success is to have the support group study itself or evaluate how it is doing on an ongoing basis. A brief discussion (5 minutes) at the end of each session to focus on the best things and the worst things about the session can be useful. Howard Kirschenbaum and Barbara Glaser recommend that the group periodically give each member a few minutes to answer these questions: "What is one thing you appreciate about our support group?" "How do you see your own participation in the group?" and "How do you feel about the role you've played?"²¹

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 OF THE PATIENT
 AND FAMILY.



14. For a detailed discussion of patient support groups in oncology, see Vugia, H. D. (1991). Support groups in oncology: Building hope through the human bond. *Journal of Psychosocial Oncology*, 9, 89-107.

15. See note 8.

16. Trotzer, J. P. (1979). *The counselor and the group*. Pacific Grove, CA: Brooks/Cole.

17. Vugia, H. D. (1991) Support groups in oncology: Building hope through the human bond. *Journal of Psychosocial Oncology*, 9, 89-107.

18. Parry, J. K. (1989). Mutual support groups for hospice staff: Planned or ad hoc? *Journal of Palliative Care*, 5, 34-36; Richman, J. M., & Rosenfeld, L. B. (1987). Stress reduction for hospice workers: A support group model. *The Hospice Journal*, 3, 205-221.

19. See note 17.

20. See note 9.

**PERFORMANCE
 IMPROVEMENT/
 QUALITY ASSURANCE**

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**CREATING AN OPTIMAL CULTURE
 AND STRUCTURE FOR THE IDT**

The ideal culture for the IDT to thrive must be one that reinforces the concept of team and rewards the achievements of teams. The team members must be accountable, respect the contributions of the other team members, have common values, and be patient-centered. Team also applies at the macro level where the team is not the clinical staff alone but everyone in the organization who is there for the patient either directly or indirectly.

Achieving the Ideal Culture

To create the ideal culture where the IDT can thrive you must first have a thorough under-

standing of the culture of your organization. You must conduct an in-depth internal assessment. This involves collecting information from a variety of sources in a variety of ways.

To get the larger picture, you may do an organization-wide survey of staff. Depending on the size of your organization, it may be more beneficial to conduct individual interviews or focus groups, both conducted by a non-threatening third party. The big picture is just one piece of the puzzle. The most challenging part will be to root out those little things that people have adopted and now accept as part of the culture.

One example of a little thing that we probably overlook is terminology and how operations may be centered on one particular discipline or a particular group. Examine, for instance, the use of the word *non-clinical*. I consulted *Webster's College Dictionary*, 1997 to see how *non* was defined. It reads as follows: "A prefix meaning 'not,' having a simple negative force as implying mere negation or absence of something (rather than the opposite or reverse of it)."

Granted, the clinical teams have a big role to play in patient care, but the other staff in the organization has an equally important role. Without the business office staff, you could not process bills to generate revenue that ultimately pays the clinical staff. Without the dietary staff, you could not feed the patients who are being treated for pain or symptoms. Without the development and fundraising staff, you could not adequately thank the many donors who so generously contribute.

Why is there such focus on the nurses' caseloads when we speak of productivity? Aren't the caseloads of the other disciplines equally significant? Do we not treat the whole person? Look at staff availability after hours. Are all disciplines available, or are you asking the nurses to be a "jack of all trades"? When you have done this internal assessment, the next step is equally important and that is how you analyze and interpret this information. This is the beginning. Once you have a clear picture of what "is" and you have started to

the grief we all must bear, it conscientiously develops rituals and practices that keep the stream of sorrow flowing and prevent it from forming eddies or backwaters in any of us. This is one way the quality and caring of the team—individually as well as together—can aspire to remain high.

Some hospices, of course, are better than others at addressing the grief in their midst. The Hospice of Siouxland [see sidebar] is one that is especially adept at developing bereavement rituals and practices appropriate to each of its IDTs. Hospices like The Hospice of Siouxland are models for us, for how we can serve others best by serving ourselves well.

Just because grief is the common human experience it is, and just because we have all come to work in hospice, does not mean that all of us are equally adept at grieving. For one thing, loss occurs in our personal lives, too! The combination of events in our personal lives and the very personal qualities of our professional practices often weighs heavily on us. Even when we draw clear lines between our personal and professional lives, we are helped to remember that those lines meet within us. Each of us is one person, feeling these emotions, leading one life, and trying to strike a balance.

Hospice teams that function with a sensitivity to how the personal and professional in each of us interface and interact will find themselves practicing “whole person” medicine—among themselves. They will then want to establish bereavement rituals and practices that are open to expressions from the personal lives of the team members. What thus develops is a sense of belonging, vital not only to our coordination as a team but also to our individual sense of well-being.

When the individual team members come together for the IDT meeting, it is analogous to a family gathering itself for the family meal. What transpires around the table in the course of the IDT affirms each person’s place in that “family,” as well as each person’s functions in the families of the patients under

their care. Thus whenever a patient dies, the loss is felt both by the patient’s family and by the “family” of the team.

Over time, the effectiveness of a hospice team’s grieving will affect the accuracy of its bereavement assessments and the effectiveness of its bereavement services. For instance, all hospice teams do well to assess accurately the manner each family has of grieving, and the obstacles it will face in the course of its bereavement. Getting beyond reassuring generalizations (such as “the family is grieving appropriately”) to accurate and useful descriptions of how the family is grieving, turns to a great degree upon how comfortable a team is with its own grief. If we know our own experience well and can articulate it adequately, we become aware of what makes our experience *different* from others. Differentiated descriptions provide both accurate information and useful, emotionally accessible, understandings of the emotional processes our hospice families endure. In turn, by being better able to describe the experiences of our patients and families, we become more comfortable with the complexities of our own.

This helps us become more comfortable speaking from and about our own vulnerabilities within our intra-IDT conversations. What makes us more emotionally available to some patients and less to others? When we ourselves have had just about as much loss as we can take for the moment, how do we say thank you? Is there a way within the emotional process of the team that we can recognize when our grief has become overwhelming or otherwise disproportionate to our relationship with a patient or family? In other words, affirming as we do that grief is both a common and a complex human experience, how do we speak among ourselves about both grief’s complexities and its complications?

A hospice team grieves effectively when it develops rituals and practices that enable the unspeakable and invisible consequences of loss to be expressed, experienced, shared—and released. And an IDT meeting becomes

an effective and caring place when the “family” of the team becomes sophisticated in its conversations about grief, and accurate in its bereavement assessments, of its patients and families—and each other.

Team members benefit from the acknowledgement that grief touches them on a daily basis. Knowing they are supported and encouraged to own their feelings makes their work meaningful. This in turn leads to greater self-awareness and higher team functioning.

On the other hand, left untapped, grief can “collect” in team members. In time they may begin to blur internal boundaries. They may become unclear about *whose* grief they are experiencing — their own, or that of the patients and families for whom they care.

Providing true compassionate care requires emotional clarity. Thus when bereavement rituals become a standard practice for IDTs, they promote the well being of the professional caregiver, as well as that of the patient and the family.

CONFLICTS IN THE TEAM: AN EXCERPT FROM THE HELPER’S JOURNEY

by Dale Larson

If they don’t have scars, they haven’t worked on a team. — Balfour Mount

Interpersonal conflicts and other communication problems present the greatest challenges for most caregiving teams. The issue of communication problems with fellow team members is often the number one stressor reported by caregivers. These conflicts and communication problems can lead to the development of dysfunctional alliances or subsystems within the team. The structures of these team subsystems reflect the basic interpersonal dynamics associated with the conflict or communication problem.

Donald Bailey, an interdisciplinary team theorist and researcher, has outlined a number of possible dysfunctional team subsystems.¹ Each of the subsystems Bailey

identifies diverges from an ideal model of team functioning in which, he proposes, the leader acts as a member of the team, team members have comparable power and influence, and conflicts and other disagreements revolve around substantive issues, not personality conflicts. The following statements illustrate each of the dysfunctional subsystems Bailey identifies.

Factions within the team

Disagreements/conflicts are handled in 2s or 3s and avoided in a full-team discussion. Nursing area is the largest and tends to segment off at times.

As our hospice grows, old-time staff members have difficulty accepting changes. They view change as preventing them from delivering “good care.” Old-time staff view hospice as being too businesslike. [They think there is] too much concern over cost containment, and they feel this concern reduces quality of care.

Conflict between two team members

A personality conflict and power struggle between our medical director and executive director makes almost every discussion an issue of control.


A dominant leader

We have a dominant team leader who controls all meetings but skirts direct discussion or solutions to problems.


Our hospice director feels “It’s my hospice.”

A dominant team member

A member of the psychosocial staff has comments on all patients and all aspects of their care. She interjects at all times during the meeting and



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at other times. She is the ultimate expert in everything and enjoys arguments.

At the weekly team meeting, one nurse constantly runs on and on about peripheral details and many examples of patient/family behavior. Even though one of us may try and “rein her in,” nothing changes from one week to another.

An isolated team member

A patient care nurse is consistently delinquent in turning in paperwork. Her body language in team conference [reflects her] feelings because she is always sitting alone at another table. How can we turn her around?

One person who is in conflict with the rest of the team

The conflict is between the only male (a nurse) and three female nurses, one female MSW, and a female counselor. The male nurse functions as a one-man team, rarely seeks assistance from others or team, is not a collaborator, and if he’s corrected or spoken to about a situation, he goes back to the others and confronts each person about “who told on him.”

One nurse on the team clearly shows very poor clinical judgment, and when she asks for advice she always responds with “Yes, but that won’t work” No problem is ever solvable as far as she is concerned. The nursing supervisor refuses to intervene. Direct intervention by other nurses has not helped. Other nurses no longer trust her nursing judgments.

I am a hospice director. Although recognized at the local, state, and



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national levels, my own staff mistrusts me greatly. The direct care staff has gone “over my head” repeatedly. When I encourage them to share concerns with me, they are silent, but behind my back, they are very verbal. I do not like using “us and them,” and I feel strongly that we are all part of the same team. But some of the staff have been with hospice since the beginning of the program and feel an unhealthy degree of ownership. They are unwilling to change anything. For example, all direct care staff are involved with every patient.

There’s a continuous conflict between the doctor (medical director) and the hospice nurses. Whenever a nurse makes a suggestion, it is “cut-down” and “taken apart” by him. This causes the team to withdraw and become split and nonproductive.

Conflicts within the team sometimes stem from sharp differences of opinion about what to do in extraordinarily complex and difficult caregiving situations. There are no simple answers to the ethical, legal, and psychosocial problems that modern caregiving teams often confront, and team members can have widely diverging views as to the best course of action to pursue. Here are some examples of caregiving situations that challenge the team in these ways:

A 39-year-old patient with advanced cancer asks the R.N. about her prognosis. The R.N. states it is three to four weeks, which the M.D. has told the R.N. and which the RN understands was communicated to the patient. The patient becomes upset. The husband is enraged. He directs criticism towards the R.N. and the hospice. The hospice coordinator and other

staff are critical of the R.N.’s blunt disclosure. A team conflict ensues.

Our hospice takes a variety of students, who accompany regular team members. Recently, a nursing student who himself has AIDS was assigned to a patient. He would be doing home patient care. What are the rights of our patient to know the student’s diagnosis and of the student to confidentiality?

A young physician became a quadriplegic during body surfing. He was healthy physically but went into a major depression and was in a nursing home. He refused medication for bedsores (ulcers) and was slowly allowing himself to die of infection. It was taking a long time. This issue rocked the family, team, nursing home staff, and community. A court upheld his right to refuse medications. It caused major conflict and upsets within the team.

The team suspects that a patient and/or family members are abusing pain meds. The primary physician has pulled back from the situation. The patient needs more medication. The nurse has been hesitant to reveal the problem. A patient is in pain. The physician is unwilling to prescribe more or different medication. What should I do?

It is difficult to imagine that any team could deal with these complex, painful, and trying situations without gaining a few of the scars Balfour Mount described. However, if a team can openly deal with disagreements among its members, deeply reflect on what its mission is, and reach agreement on how its members are going to fulfill that mission, times like these can lead to tremendous personal growth for team members and a strengthening of the

team itself. Sometimes the team can even be surprised by how well it handled what seemed like an impossible situation.

However, a less appealing alternative is too often the case. Ethical dilemmas that tear at the soul, unresolved conflicts among team members, exponential growth and organizational restructuring, the departure or serious illness of a team member—all these can disrupt and threaten the helping team and leave it uncertain as to whether it can really cope with the new demands it must face.

Confronted with these threats, teams can opt to avoid difficult and uncomfortable feelings and engage in various defensive maneuvers that can be crippling to the team's growth and well-being. By doing so, the team can avoid the pain of looking at the core problems it is having. But it will suffer the consequences of that avoidance later. ... In other words, the short-term gains (anxiety reduction) of avoidance behavior outweigh the long-term pain associated with it, leading to what is ultimately self-defeating behavior.

Unhealthy Agreement, Team Secrets, and Defensive Routines

Many team and organizational experts emphasize that patterns of avoidance are among the most destructive and dysfunctional of all team dynamics. In *Groupthink*, psychologist Irving Janis documents how teams can make bad decisions even though some or all team members have serious misgivings about the wisdom of these decisions.² The team can ignore these misgivings and dissenting opinions as it works hard to be in a state of agreement, and then it takes the easy way out by accepting the first solution that rises to the surface. The guiding principle is that we are nice people, and nice people agree with one another. The problem is that important ideas and contributions can get lost along the way.

Pointing to similar phenomena, team expert William Dyer describes how a kind of unhealthy agreement can become a self-defeating pattern in organizations.³ When this kind of unhealthy agreement pattern

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exists, team members feel frustrated and powerless trying to deal with a specific problem, and they tend to blame one another for the problem. They also tend to discuss these issues in small subgroups of friends and trusted confidants, but they don't directly communicate their ideas in team meetings.

Therefore, in public situations, they try to figure out what other team members' positions are without sharing their own. Ultimately, they often feel that they should have said something at a certain point, but they don't do so: This pattern of collective avoidance and unhealthy agreement continues until the problem precipitates a major crisis.

I think of this kind of a team as having a team secret analogous to the secrets we have as individuals. Even though all the team members might be able to identify the problem or conflict, it is never discussed openly by the entire group. Because no one can talk about the problem, the team's decisions lack feedback and commitment from team members and thus usually fail. Low trust levels go hand in hand with this failure to deal openly with team conflicts. When team members don't trust one another's intentions, they feel threatened and perceive the risks of sharing information and addressing the conflict as outweighing the benefits. Ideally, team members should always feel safe enough to talk about not feeling safe. But the problem is that once you begin talking about the “elephant in the room” it is hard to selectively deny the particular aspects you *don't* feel safe talking about. If even a small piece of the truth is discussed, the rest inexorably follows, so denial is often carefully maintained.

In *The Open Organization: The Impact of Secrecy and Disclosure on People and Organizations*, Fritz Steele makes a strong case for openness:

Unless there is the opportunity and ability to disclose information about what is actually happening in the system, including both behaviors and feelings, then it is very difficult for that system's members to be





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masters of their own fate and for the system to be self-correcting. In this sense, the importance of disclosure is not only in doing the day-to-day work, which requires information flow (that kind of disclosure happens fairly regularly), but also in examining how things are being done, so that maintenance can be done on the system to keep it healthy.⁴

Steele also notes that we often blame the sharing of information about a problem, as if it had created rather than simply signaled the problem. When information is not being shared openly, the team encounters more rumors and gossip, it doesn't learn and self-correct, and then there are more elephants in the room that can't be discussed. In other words, what the team doesn't know can hurt it.

In *The Fifth Discipline*, organizational expert Peter Senge describes the forces preventing productive dialogue in working teams. "Chief among these," says Senge, are "defensive routines, habitual ways of interacting that protect us and others from threat or embarrassment, but which also prevent us from learning."⁵ Examples of defensive routines include "smoothing over" differences or having big theoretical debates that go nowhere. To retain their power, these defensive routines must, according to Senge, remain "undiscussable."⁶

Antidotes to Avoidance and Defensiveness

For Senge, the antidote to defensive patterns of behavior is a commitment to telling the truth about the team's current reality (i.e., a commitment to self-disclosure and to a quality of reflectiveness and openness that fosters a deeper understanding of what other team members are thinking and feeling). If these conditions are absent, though the individuals on the team may all be highly intelligent, the team itself will have a subpar IQ.

But I need to stress that openness in the organization or team doesn't just mean speaking out and airing every thought or

feeling you have. It is a more demanding stance, a kind of "reflective openness," as Senge describes it, in which we can challenge our own and others' thinking, "suspend our certainty," and share our feelings and ideas with a receptiveness to having them changed.⁷ This parallels what I suspect is true for the individual regarding his or her personal secrets: Confiding can have positive health effects, but telling the whole world your secrets probably has none.

The successful management of conflict requires what author Alfie Kohn calls a "cooperative framework for dealing with disagreement" so that competition and win/lose dynamics don't interfere with the healthy exchange of differing views by team members.⁸ When a cooperative context exists, Kohn notes, conflicts can become what Roger and David Johnson have termed "friendly excursions into disequilibrium."⁹ Senge also emphasizes that no team can avoid all conflicts and defensive maneuvers, but a healthy team is the one that learns from them.

I [have noted] that it is rare to experience significant and lasting personal growth without feeling any pain or suffering as an essential part of that growth. This idea applies to teams as well. Conflicts and defensive operations can make or break a team, but effective teams can recognize these phenomena, learn from them, and then continue to work toward the team members' shared goals.

Dealing With Conflicts in the Team

Openly dealing with conflicts and sharing potentially threatening information are tough assignments for any team. However, we can begin to develop a more workable approach to these tasks by first accepting that conflict is a natural—and often desirable—team experience, as Howard Margolis and Joseph Fiorelli indicate:

To view disagreement or conflict as unnatural is a mistake that disrupts effective team functioning. Realization that the expression of dissimilar opinions is more often a natural



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expression of differing worldviews by sincere, dedicated professionals is essential for combating the all too common proposition that “If they disagree with me, they’re bad, stupid, or both.” Accepting conflict or disagreement as a stimulus that can provide opportunities for achieving a more complete and comprehensive understanding of the problem and more alternatives to the solution enhances the probability of choosing a superior solution.¹⁰

When we see conflicts and disagreements as the inevitable concomitants of working so closely with others, we are more likely to approach these issues nondefensively, to feel less need to blame others, and to encourage a joint effort to solve the problem.

The examples of team conflicts presented earlier are good illustrations of the downstream consequences of not dealing effectively with conflict and disagreements over a long period of time. In the everyday work of the team, the small conflicts that can develop over time into major problems like these often begin with a simple failure to communicate clearly about what team members expect of one another.

In the productive and healthy team, members have a clear understanding of what their own and others’ job responsibilities are (i.e., there is a state of role clarity). Role ambiguity, in contrast, exists when team members don’t know what they should be doing, aren’t clear about what other team members expect of them, or aren’t clear about their own expectations of others.¹¹

Role conflicts are another related problem. Here there are inconsistencies in the expectations of team members. Team members can have expectations for themselves that are inconsistent with the expectations other team members have of them. Two or more team members can make conflicting demands of a colleague, or there can be a kind of role overload in which there is simply not enough time for certain members to meet all the expectations of the other team members.¹²

When not discussed and openly negotiated, role conflicts, role ambiguity, and differing views of what the team is trying to do can all lead to team strife and escalating patterns of conflict among members that eventually come to be seen as “personality clashes.” When we consider how these different kinds of conflicts are mismanaged or not managed at all, a common theme emerges. These conflicts tend to become personalized (i.e., they become expressed as different variations on the “they’re bad, stupid, or both” phenomenon Margolis and Fiorelli note).

This tendency to personalize conflicts is reinforced by our natural inclination to explain behavior by making attributions about the other person rather than the situation the person is in. ... Rather than seeing ourselves as struggling with a problem that is common to many teams or viewing the problem as a consequence of team members’ failure to do the hard work of getting clear about their goals and expectations, we tend to see ourselves as struggling against people who are “bad, stupid, or both.” The result is that the ensuing patterns of behavior become self-reinforcing and tend to escalate over time.

The personalization of conflict also means that the potential recipients of feedback are less open to that feedback because it is likely to be delivered as an unwelcome message about some perceived flaw within themselves. We all want feedback—and yet we don’t want it. We want to know how we are doing in the tasks of achieving our goals, but we don’t want to know that others don’t like what we are doing.

It is instructive to think about similar situations in your personal life. What is your first reaction when someone tells you they don’t like what you are doing or asks you to change your behavior and do something differently, whether it is closing the tube of toothpaste, wearing different clothes, or behaving differently at the dinner table? For most people, there is a natural tendency to resist this kind of feedback and the corresponding behavior change. This is because we want to feel good

about what we are doing, and accepting that we need to change our behavior implies that we are wrong in some way.

This is the point at which the request to change can be potentially threatening to our self-esteem and therefore potentially stressful. In our personal lives and on caregiving teams, we need to find ways to give and receive feedback and to change our behavior accordingly. The obstacle is that there usually isn't an easy and pain-free (i.e., self-esteem maintaining or enhancing) way to ask someone else to change his or her behavior, particularly when the other person is not experiencing any distress associated with that behavior. In fact, it is usually the case that the other person is fairly attached to this particular behavior and it is meeting various needs for that person, thus making it even more likely that he or she will resist changing.


In the ideal situation, our feedback to one another would be frequent and timely (not six months after the troubling event), nonjudgmental (not threatening to the self-esteem of the other person), and concrete (focusing on specific, observable behaviors).¹³ When these conditions are met, feedback and conflict resolution are much more likely to be effective.

Conflicts as Unmet Expectations: A Practical Model for Conflict Resolution


People are particularly motivated to give feedback to someone when his or her behavior doesn't match their expectations. This simple fact is the basis for a powerful model of conflict and conflict resolution that discourages the personalization of these kinds of problems within the team. This model defines conflicts simply as unmet expectations.¹⁴

When we experience a conflict with other people, they are either doing something we didn't expect them to do or they are not doing something we did expect them to do. Virtually all conflicts will fall within this model.

Unmet expectations are a major source of team stress; they underlie many interpersonal communication problems that team members typically cite as among the most stressful



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aspects of their work. When you are experiencing unmet expectations concerning another person's behavior, the first step toward conflict resolution is to let the other person know about these unmet expectations. Of course, I'm talking about unmet expectations that are worthy of such attention—namely, conflicts that cause you stress, interfere with the optimal performance of your caregiving duties, and so forth. There are more unmet expectations in our lives than we could—or should—ever address.

One fascinating phenomenon I've encountered as a team and organizational consultant is that when I ask people to think of the most troublesome unmet expectation they have regarding someone in their workplace, a majority of them admit that they haven't told the other person about it. Their explanations include statements like these: "She'll never change," "I've given him enough hints to sink a ship—if he wanted the feedback, he'd have figured it out by now," "She'd be devastated," or "I want to continue working here and don't want to make him my enemy."

Each of these reasons seems to have some validity. There *are* risks involved when you approach another person to ask for a change in his or her behavior. However, the consequences of the alternative course of action are more definite: If the other person is never directly told about your unmet expectation, there is no chance that the behavior will change, and the problem is likely to get worse.

A paradoxical finding is that, although most people say that they would like feedback on their *own* behavior if someone had a problem with it, these same people insist that the other person would not respond in a similarly positive and welcoming fashion. In these situations, we often believe that the other person couldn't possibly have the same psychological maturity, win-win attitude, empathy, or goodwill that we see in ourselves, and so it is difficult to imagine the person cooperating with our requests for behavior change.

There is a kind of self-deception operating here that also contributes to the perpetua-


tion of conflicts within teams. Although few of us really believe we are perfect, when we are having problems on the team, too often our first thoughts when we arrive at work in the morning are something like this: “If only this other person or these other people would get it together, things would be much better around here.” If all ten members of a ten-person team feel this way, the results are predictable. In contrast, if everyone approached the team with the attitude, “What can I do differently that would make things work better for other members of the team?” many conflicts would rapidly disappear.

Even if we recognize that others might be amenable to changing their behavior and that we might need to change our own behavior as well, dealing with these issues is usually uncomfortable for everyone. The good news is that there can be many more positive outcomes than our fears would suggest are possible. These positive outcomes are even more likely if structures and norms exist that support the ongoing negotiation of roles and expectations in the team. Successful conflict resolution is more likely if there is a group norm that all team members should routinely discuss unmet expectations with other team members as part of continual team development.


Let’s look at some skills that can make these exchanges of information safe enough for teams to embrace and practice openly. We will discover how you can ask others to change their behaviors in a way that doesn’t lower their self-esteem and evoke angry and defensive responses.

A key first step is to see the problem as existing in the relationship or in the fit between you and the other person, rather than in you or the other person. This more systems-oriented perspective will help you avoid blaming yourself or the other person and distorting the reality of the situation. It is better to adopt the expectation that successful resolution of the conflict will involve change on both your parts.

During the first few seconds in which you are presenting an unmet expectation to the



IN THE IDEAL SITUATION, OUR FEEDBACK TO ONE ANOTHER WOULD BE FREQUENT AND TIMELY (NOT SIX MONTHS AFTER THE TROUBLING EVENT), NONJUDGMENTAL (NOT THREATENING TO THE SELF-ESTEEM OF THE OTHER PERSON), AND CONCRETE (FOCUSING ON SPECIFIC, OBSERVABLE BEHAVIORS). WHEN THESE CONDITIONS ARE MET, FEEDBACK AND CONFLICT RESOLUTION ARE MUCH MORE LIKELY TO BE EFFECTIVE.



other person, the outcome of the encounter is rapidly being decided. The encounter is likely to go in one of two possible directions: mutual discovery or combative defensiveness. Think about the encounters of this nature you have had in your personal and work lives. When the outcome was positive, you and the other person were probably able to listen to each other and understand the impact of the behavior in question without getting locked into a competitive, angry, and defensive state. You weren’t thinking, “How can I protect myself?” or “What can I do to get my own way?”

How can we increase the likelihood of mutual exploration, empathy, and cooperation? One way to do this is to express our unmet expectations as “I-statements” or “I-messages.” This is the same talk tool that many self-help books recommend for parents, managers, and just about anyone who must solicit changes in the behavior of other people. When you present your conflict via an I-message, the key is to begin by stating it as a problem *you* have and not as a problem the other person has. This way of stating things is effective for two reasons: First, it *is* in fact your problem—the other person might be perfectly happy with his or her behavior; second, by stating it this way, you increase the likelihood that the other person will empathize with your position and not immediately adopt a defensive stance.

The next parts of the message should include a description of the behavior that is troubling you, how it affects you (include your feelings), and why. Help the other person understand and empathize with your point of view. The emotional issues in the conflict must be approached and resolved before the content issues are handled, and both of you really have to understand what this conflict looks like from the other side.

The more strictly behavioral (as opposed to personal) your description of the troublesome behavior, the better. If your comments contain even an implicit evaluation of the general abilities or worth of the other person (e.g., “I guess you just don’t care” or “You

have an attitude problem”), the possibility of a defensive or hostile response is much greater.

Here are some examples of I-messages: “Jean, I’m having some difficulty because when I don’t get the paperwork from you in time to do my own notes when they’re due, I get lots of complaints from everyone else.” Or “Ron, I’m really struggling with something. When you don’t let me know what happened on your shift, I’m left in the dark, and I’m afraid that I could make a serious mistake because of this. What can we do about it?”

Though I might not be stating these messages exactly the way you would, it is the form that is important, not the content. Own the problem. Be specific about what in the other person’s behavior is causing problems for you. Describe how it is affecting you, including your feelings. Then submit the problem for joint consideration rather than make a unilateral demand for behavior change.

Think of your conflict resolution intervention as a confrontation response. In other words, you are pointing to a discrepancy between something specific in the other person’s behavior and your expectations of that person’s behavior. There should be no aggressive element in your message. However, what frequently occurs is that we wait such a long time before bringing up a subject that by the time we do discuss it, our anger has built up and quickly comes to the surface if our comments meet with any resistance. This is why all the members of the team should give one another feedback frequently as an essential part of team maintenance. When these communication channels break down, the team suffers and the problems become increasingly more difficult to address in a productive manner.

Here are some additional principles that can make conflict resolution or role negotiation interactions more successful:

- Don’t confront anyone in a group setting, and never encourage ganging up on one person so that he or she will “get the point.”
- Be supportive. Go one *better* than the Golden Rule and treat others better than you want them to treat you.

- Find ways to share information without lowering the self-esteem of the other person. How would *you* like to hear the message you are about to convey?
- Imagine what the other person needs from you and offer it, and the other person will be more likely to give you what you need.
- Make frequent negotiations of role expectations among all team members a part of the normal ongoing life of the team. This prevents the buildup of tensions that lead to the crises and emotional eruptions that characterize the dysfunctional team.
- Write out your agreement. “I’d like you to do more of (or) less of ____.” Also write out how it will help you, give an example of how you would like the other person’s behavior to change, and include the behavior changes you are willing to make in exchange. The idea here is quid pro quo—something for something. If you want me to wear different clothes to work, you’d better be willing to change an equally important and central aspect of your own behavior. Many people find that a written contract, with a date for checking in on how the agreement has worked, leads to better results.
- Be sure the other person really wants to experiment with this new way of talking about working together before you initiate any conflict resolution sessions. Explain this model in some detail. You might even ask the other person to read this article before beginning.

Excerpted from: Larson, Dale. The Helper’s Journey: Working with People Facing Grief, Loss, and Life-Threatening Illness. Champaign, IL: Research Press, 1993.

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PART V: INTERDISCIPLINARY TEAM EVALUATION

ASSESSING AND STUDYING
THE IDT: AN EXCERPT FROM
THE HELPER'S JOURNEY
by Dale Larson

To be effective, the caregiving team, like the caregiver support group, needs to study itself. To paraphrase Irwin Rubin, football teams practice for 40 hours each week and play for only two. The typical caregiving team, in contrast, plays for 40-plus hours each week and doesn't have any time to practice (i.e., to discuss how the team can work together more effectively and to work through any problems that may exist).¹

This self-study requires that the team look at its own process by asking about *how* team members are talking and acting with one another, rather than studying *what* they are talking about. Process questions the team can ask might include the following:

- Who talks and for how long?
- How are decisions made?
- Are differing points of view encouraged or discouraged?
- How safe do members feel talking about a particular issue?
- Are there any “elephants in the room” that everyone is aware of but no one addresses openly in the meetings?

The content of the team's interactions is important, but if the team fails to look at how it is interacting, it will inevitably lose control of that process and of its helping outcomes. An atmosphere of respect, trust, and openness will encourage this kind of process awareness and self-study and will promote sensitivity to the changing needs of the individuals in the group. A process orientation is proactive because it detects team problems in their ear-



THE PRELIMINARY

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TEAM PROBLEMS

(I.E., SOMETHING

IS DONE AFTER

A PROBLEM

DEVELOPS).



liest stages and leads to adjustments that ensure the continued productivity and well-being of the team and its members.²

Proactive, process-oriented teams regularly assess how they are doing. The most essential task in this area is to stop and collectively take note of any team problems. Rubin and his colleagues emphasize that there is one leadership role that belongs to every team member—the “stopper.”³ A person acting in the stopper role says, in essence, “Something doesn't feel right here; let's look at our process.”

The team must listen to its members when they are having concerns like these:

- Things aren't getting done, and I always have to check to make sure they do.
- I don't feel safe enough to say what I'm thinking.
- It seems as though everyone is giving the work only half the attention it needs.
- Our meetings and conferences are boring, lack energy, and are dominated by a few people.
- There is a lot of complaining behind the scenes.
- We often seem to be working at cross-purposes.
- Things are getting done, but I'm being pushed to the breaking point.⁴

Rubin and his colleagues offer this list of concerns as warnings that signal a need for team development.⁵ The problems reflected by these concerns increase stress for the team as a whole because they threaten the members' self-esteem and prevent them from achieving the team's goals.

Questionnaires that assess different aspects of team functioning can also be useful. Many good instruments exist for this



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purpose.⁶ One extremely brief questionnaire can serve as an example of what the team needs to look at. Respond to each of the following items as they apply to your team, using this scale: (a) strongly disagree, (b) disagree, (c) neutral, (d) agree, and (e) strongly agree.

- There is a high degree of trust and openness in the group.
- The team is effective at achieving its tasks.
- I get all the information I need to do my work and make effective decisions.
- Good work is recognized and rewarded in this group. Assignments (who does what) are clearly defined.
- Differences and conflicts are recognized and worked through.⁷

Questionnaires like this can be an excellent starting point for team discussions. Responses from team members can be gathered anonymously, collated, and then reviewed by the entire team in a teambuilding session.

When I have used this scale in surveys and team development sessions with caregiving teams, I have found that members of teams functioning well believe that their teams are effective at achieving their tasks. They also generally get all the information they need to do their work and to make effective decisions and believe that task assignments are clear to all group members. However, even these teams often report problems with trust and openness, as well as difficulties recognizing and working through conflicts. These two dimensions of team functioning are, of course, highly correlated—if there is no trust, conflicts aren't acknowledged, and if there are too many conflicts, trust plummets. Highly distressed teams, suffering from severe communication breakdowns and organizational upheavals, score poorly on all six dimensions of the questionnaire.

In a survey of hospice teams, I asked respondents to indicate whether or not their team regularly evaluated its effectiveness.⁸ I found that 75% of the participants answered no and 25% answered yes. Those that said

yes reported that they used a variety of strategies for evaluating team effectiveness, including questionnaire studies, anonymous feedback, off-site retreats, videotaping the team conference and then reviewing it, and devoting time at the beginning of the team conference once a month to evaluation and development.

A videotape (or audiotape) review of group meetings can be a powerful technique for self-study if the review is effectively structured and facilitated. However, when no electronic recording is possible, immediate recall of the interaction can also be used.

A helpful model for reviewing group interactions like these is the Interpersonal Process Recall Method (IPR) developed by psychologist Norman Kagan.⁹ IPR is a simple, novel, and easily learned technique for reviewing videotaped interactions in a nonthreatening and nonjudgmental manner. The IPR training program is quite extensive, but the central feature of the process involves choosing someone to facilitate review by the rest of the group. It is best if the facilitator is not a member of the team doing the review. This facilitator encourages individual group members to stop the tape at any point during the review when they become aware of any feelings, thoughts, and other reactions they had during the videotaped session. The facilitator then helps that individual explore his or her thoughts, feelings, and reactions, using the videotape to stimulate recall of these experiences. It might take 90 minutes to review a 20-minute videotape, but the time is usually well spent. As the team reviews its behavior, many of the invisible patterns that form the core of the team's process become apparent.

In the survey of hospice teams just mentioned, I asked members to indicate whether most interventions to improve team functioning were made before or after problems developed in their team. An overwhelming majority (87%) of respondents marked "after"; the remaining 13% indicated "before." These preliminary data suggest that most hospice teams take a downstream, or



reactive, approach to the management of team problems (i.e., something is done *after* a problem develops). Only 13% take an upstream, preventive stance. How does your team deal with its problems? Is its approach reactive or proactive?

The proactive team also renews itself through regular teambuilding experiences. Strategies for self-renewal I have seen teams use include having an outside facilitator work with them; arranging retreats; holding brainstorming sessions; or having a planning day, a happy hour, an informal retreat or social occasion, a day at the pool, or a community activity day.

To summarize, in the productive and healthy caregiving team, we find that the following are true:

- Team goals and team roles are clearly understood.
- The team is intelligent—it learns.
- There is an atmosphere of goodwill and trust.
- Conflicts are addressed and worked through.
- Secrecy and gossip are kept to a minimum.
- Leadership functions are shared.
- Technical and emotional support and challenge are frequently exchanged.
- The team studies itself.
- The team accomplishes its goals, and team members grow and learn through their work together.

The high-functioning team—like the high-functioning caregiver has a sense of confidence that it can cope with the demands confronting it and that it is making a uniquely valuable contribution to the world. High team self-efficacy and the team’s collective self-esteem are powerful deterrents to stress and set the stage for the team’s continued success and well-being. This kind of team enables members to fulfill their personal missions as helpers while they pursue the team’s shared goals.

The openness and feedback of the high-functioning team are as essential to its adap-

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USE INCLUDE HAV-
ING AN OUTSIDE
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RETREATS; HOLDING
BRAINSTORMING
SESSIONS; OR
HAVING A PLANNING
DAY, A HAPPY
HOUR, AN
INFORMAL RETREAT
OR SOCIAL
OCCASION, A DAY
AT THE POOL, OR
A COMMUNITY
ACTIVITY DAY.



tiveness and ability to learn as they are to the individual caregiver. They are also essential for the larger social systems within which our caring is enacted. The high-functioning individual caregiver and the high-functioning team can be healthy and self-regulating, yet their success and well-being ultimately depend on the health of the larger social systems of which they are a part.

Excerpted from: Larson, Dale. The Helper's Journey: Working with People Facing Grief, Loss, and Life-Threatening Illness. Champaign, IL: Research Press, 1993.

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PERFORMANCE IMPROVEMENT/QUALITY ASSURANCE

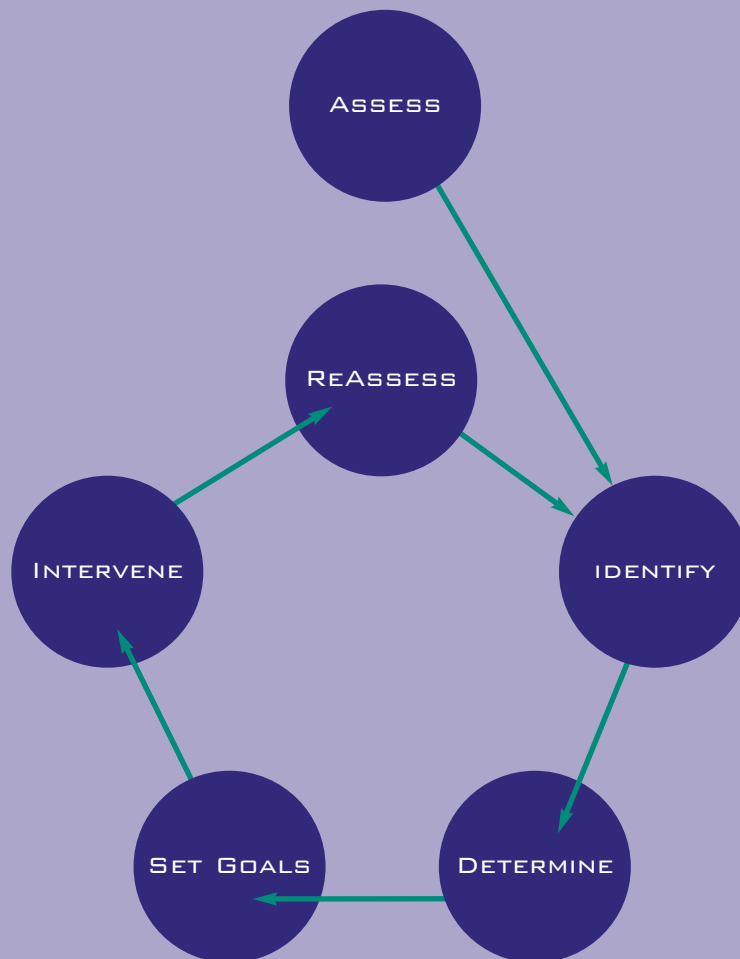
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MEASURING THE SUCCESS OF THE INTERDISCIPLINARY TEAM

There are two ways to look at measuring the success of the interdisciplinary team. One way is to look at the outcomes achieved by the team, or what the team does; another is to look at how the team functions and how the members interact with one another. Typically, hospice being the patient and family-centered care that it is, we focus on measuring our success by whether or not we have achieved the goals set forth by the patient and for the patient. I suggest that we also look at how the team functions as an entity also because ultimately the functionality of the team will impact the patient outcomes achieved.

MEASURING WHAT THE TEAM DOES



SAMPLE PROCESS MEASURES

Assess	<ul style="list-style-type: none"> ■ Were the appropriate assessments completed for all disciplines? ■ Were the assessments completed within the appropriate time frame? ■ Did the assessment include objective and subjective data?
Identify	<ul style="list-style-type: none"> ■ Did the team identify problems, and opportunities in all domains (physical, psychosocial, and spiritual)?
Determine	<ul style="list-style-type: none"> ■ Was there sufficient depth of patient/family interaction to determine the cause of problems?
Set Goals	<ul style="list-style-type: none"> ■ Do the goals reflect the patient and family wishes? ■ Are the goals specific, measurable, achievable, realistic, and time specific?
Intervene	<ul style="list-style-type: none"> ■ Were the interventions appropriate for the problem or opportunity? ■ Were the interventions timely?