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An Examination of the Components within the Interprofessional Process: Clergypersons and Collaborative Practice

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AN EXAMINATION OF THE COMPONENTS WITHIN THE INTERPROFESSIONAL PROCESS: CLERGYPERSONS AND COLLABORATIVE PRACTICE

By

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This manuscript is dedicated to my Heavenly Father and my family. They have been very encouraging to me both spiritually and emotionally. The maturation of my faith and determination is due to God’s unconditional love, grace, and guidance. The maintenance of my strength is due to my family’s never-ending prayers and understanding throughout my academic career.
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ABSTRACT

The purpose of this study is to examine the relationships among specific variables identified in research literature as obstacles and benefits to interprofessional collaboration-- academic education, interprofessional education, teamwork & communication skills, and trust-- as it relates to the participation of clergypersons in interprofessional collaborative practice. The sample consisted of ordained Christian clergypersons in Florida. The participants were asked to voluntarily complete a survey questionnaire. In order to adequately address the objective, standard multiple regression analysis was applied to analyze the data. The model of four variables can account for 25% of the variation of interprofessional collaborative practice. Stepwise regression was used to analyze significant influences in the model. The results revealed that the education (academic and interprofessional) variables explained significantly 20% of the variance of interprofessional collaborative practice. Clinical implications are discussed; this includes exploring opportunities to enhance clergypersons’ interprofessional education experience.
CHAPTER I

Introduction

In Proverbs 15:22 it is revealed that “without counsel, purposes or plans are disappointed: but in the multitude of counselors they are established” (NIV & KJV Parallel Bible, 1985). Collaboration among clergypersons and mental health practitioners is believed to be necessary to overcome providing fractionalized service delivery to help seeking clients (Nicholson, Artz, Armitage, & Fagan, 2000). Yet, it is uncertain what type of collaboration between these diverse groups of professionals is beneficial. Consequently, the objective of this study is to investigate the style or form of collaboration between clergypersons and mental health professionals. In this chapter, there will be an exploration of the role of clergypersons in mental health services, clarification of the theoretical foundation applied for this study, and an introduction to interprofessional collaboration.

Clergy and Mental Health Services

The church institution plays a major role in providing mental health services (Blank, Mahmoud, Fox, & Guterbock, 2002; Moran, Flannelly, Weaver, Overvold, Hess, & Wilson, 2005; Oppenheimer, Flannelly, & Weaver, 2004; Young, Griffith, & Williams, 2003). Pastors and ministers, otherwise known as members of the clergy, are becoming increasingly active in mental health services by spending a great deal of time in pastoral counseling. According to Weaver (1995), numerous studies have shown that tens of millions of people in the United States seek assistance from clergy when they have mental health concerns. It has been reported that members of the clergy help four out of ten Americans with mental health problems (Weaver, 1995). They have also been found to provide an equivalent amount of hours annually in pastoral counseling as marriage and family therapists (MFTs) in private practice (Weaver, Koenig, & Larson, 1997). In a research study of pastors who conduct pastoral counseling, Young and associates (2003) found that two out of five pastors reported that their congregations included individuals with severe mental illnesses, and over 50% of the respondents said that they worked with substance abusers and suicidal individuals in their congregations, and counseled individuals whom they considered to be dangerous to others. Researchers have found that
clergy have acknowledged their lack of training and competency to provide adequate counseling for people who suffer with such mental health issues (Oppenheimer et al., 2003; Weaver et al., 1997). Yet, more people are flocking to the church for counseling and support (Chatters, Taylor, Lincoln, & Schroepfer, 2002) than are seeking help from mental health professionals. Weaver and associates (2003), report that this frequent use of clergy is due to their availability, accessibility, and the high trust that people have in members of the clergy. As a result, clergy continue to be recognized in research as the “frontline” or “gate-keepers” to mental health care (Moran et al., 2005; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003; Weaver et al., 1997). How has this identified role as gate-keepers to mental health care influenced the development of a collaborative relationship among members of the clergy and mental health professionals?

Studies show that the collaboration between mental health professionals and clergy continues to be moderate. Blank and colleagues (2002) found that the clergy in 269 investigated churches reported very little interaction with formal mental health care services. It is believed that due to the participation of clergy in counseling, mental health professionals could benefit if their associations included clergy and other community religious professionals (Weaver et al., 2003). However, many researchers have found that there is a lack of collaboration between mental health professionals and clergy.

Most of the research on collaboration between mental health professionals and clergy has focused on the frequency of referrals that occur between mental health professionals and clergy. Blank and associates (2002) found that clergypersons do not strongly endorse making referrals to mental health providers, and mental health specialists made little to no attempts to include clergy in their interventions for members of a congregation. Researchers have shown that most clergy and mental health professionals make referrals less than “a few times a year” to one another (Moran et al., 2005). In a study of clergy who were surveyed about their frequency in making or receiving referrals, 84.7% reported making less than ten referrals to formal support services and 82.9% reported receiving less than ten referrals in the past year (Blank et al., 2002). Some researchers have found that referral patterns are sometimes unidirectional, with clergy providing more referrals to psychologists than vice versa (McMinn et al., 1998). What causes the lack of communication between mental health professionals and
members of the clergy? Researchers have suggested that several obstacles and benefits could develop with attempts of collaboration between mental health professionals and clergy (McMinn et al., 1998; Oppenheimer et al., 2004).

Obstacles and Benefits in Collaboration

Several obstacles are believed to occur in the collaboration between mental health professionals and members of the clergy. One obstacle frequently noted in research is the lack of trust between clergy and mental health professionals. Several studies have suggested that there is a presence of distrust (Blank et al., 2002; Moran et al., 2005; Oppenheimer et al., 2004; Young et al., 2003). Researchers have alleged that trust issues are possibly related to lack of interaction and to contrasting values and beliefs between clergy and mental health professionals (McMinn et al., 1998; Oppenheimer et al., 2004).

Lack of education or understanding is considered another possible barrier in collaboration between mental health professionals and members of the clergy. Oppenheimer and his colleagues (2004) found in their research that 38% of clergy and mental health professionals needed better knowledge and educational awareness about each other’s field.

Lastly, researchers have suggested that there is also a lack of knowledge about one another’s roles within a collaborative relationship. Most clergy and mental health professionals believe that not establishing clearly defined roles of each professional in collaboration, causes major conflict in understanding how, when, and where to make referrals (Oppenheimer et al., 2004). Although these problems have been identified as possible hindrances in collaboration between clergy and mental health professionals, there are researchers who provide information about how working together is beneficial and how to overcome these obstacles (Benes et al., 2000; Blank et al., 2002; Gorsuch & Meylink, 1988; McMinn et al., 1998; Moran et al., 2005; O’Malley, Gearhart, & Becker, 1984; Oppenheimer et al., 2004; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Weaver et al., 2003; Weaver et al., 1997; Young et al., 2003).

To overcome the obstacle of lack of knowledge and education awareness in collaboration, researchers recommend that more educational training be provided to develop a more basic knowledge of each others’ professional role in mental health counseling and the appropriateness of when to make referrals. This type of training could
also develop more respect and trust in the collaborative relationship with a broader perspective and understanding of one another’s value and belief system when counseling (Benes et al., 2000; McMinn et al., 1998; Oppenheimer et al., 2004; Weaver et al., 2003; Weaver et al., 1997).

Gorsuch and Meylink (1988) provide examples of the benefits of collaboration between mental health professionals and clergy in their research by suggesting that with collaborative work there will be an expansion in the network of communication by the availability of options such as referrals, consultations or co-therapy for mental health professionals and clergy. This would be beneficial to people suffering with psychological and emotional problems especially if there is a spiritual or religious component to the problem and solution. Also, collaboration between mental health professionals and clergy allows the development of more ecosystemic interventions, models or approaches (Gorsuch & Meylink, 1988; Oppenheimer et al., 2004) especially when conducting systemic or relational therapy with couples and families. Researchers reported that understanding the experiences and meeting the needs of each individual represented in a marital and family therapy session can be extremely complicated because just one professional can not provide all the necessary resources (Lowe & Herranen, 1981). Therefore, clients could benefit from the expertise and skill of a collaborative approach of several professionals (Lowe & Herranen, 1981).

Clergy and Marital and Family Therapy

Multivariate systemic complexity is one of the major challenges faced in the practice of marriage and family therapy, due to the belief that the more people, developmental layers, and processes involved in the session the greater the complexity (Wendel, Gouze, & Lake, 2005). It is clear that no one individual can possess all of the expertise necessary for the care of couples and families (Lowe & Herranen, 1981). According to Lewandowski and GlenMaye (2002), there are some states (i.e., New Jersey and Kansas) that are placing increased emphasis on collaborative services when focusing on the area of family preservation. Many social welfare advocates have called for greater linkage and collaboration to address the needs of families facing multiple problems (Waldfogel, 1998). How do clergy address the complexity of marital and family issues?
Clergy confront a number of cases where they have to work with people who suffer from mental illnesses. For instance, Moran and colleagues (2005) reported in their study that grief, anxiety, depression, substance abuse, domestic violence, and severe mental illness are just a few of the problems that are presented in pastoral counseling. Most of the people who seek counseling from ministers bring problems predominately related to marriage and family counseling (Meylink & Gorsuch, 1988; Weaver et al., 1997; Young et al., 2003). Privette and associates (1994) found that people who attend church frequently report that they are seven times more likely to seek the assistance of clergy for their marriage and family problems than the assistance of a nonreligious mental health specialist. Unfortunately, members of the clergy have reported that they perceive their lowest pastoral competency was in marriage and family counseling.

Weaver, Koenig, and Larson (1997) stated in their research that two out of five clergy feel competent in the area of marriage and family counseling. Orthner (1986) (as cited by Weaver et al., 1997) found that out of ten areas of ministerial skills, marriage and family counseling was the area of lowest perceived pastoral competency among surveyed clergy. Among experienced clergy who have been asked to suggest training areas in which they feel they could use the most help, the great majority of the topics suggested involved marriage and family problems (Wylie, 1984). Thus, these findings demonstrate that there is an increased need for collaboration in counseling between the clergy and mental health professionals (Bean, Perry, & Bedell, 2002; Blank et al., 2002; Carlson, Kirkpatrick, Hecker, & Killmer, 2002; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; Oppenheimer et al., 2004; Weaver et al., 2003; and Weaver et al., 1997).

Although researchers have established the need for more collaborative practice between members of the clergy and mental health professionals, there is reportedly a moderate amount of collaboration occurring and the research literature remains sparse (McMinn, Chaddock, Edwards, Lim, & Campbell, 1998). Throughout the rest of this introduction, an understanding of the theoretical foundation for interprofessional collaboration will be established as well as an in-depth comprehension of interprofessional collaboration in the mental health system.

Theoretical Foundations
In order to understand interprofessional collaboration it is important to examine it through the lens of the Human Ecology Theory. The Human Ecology Theory is grounded in General Systems Theory (GST), therefore it is important to understand the basic framework of General Systems Theory (GST).

GST is both a transdisciplinary field of study and a theoretical framework in which various micro-level approaches are known as “systems theories” (Whitchurch & Constantine, 1993). In General Systems Theory, the theorists seek to explain the behavior of complex, organized systems by exploring the way in which the objects are interrelated with one another (Whitchurch & Constantine, 1993). Hepworth, Rooney, and Larsen (2002) report that not only does systems theory provide useful metaphors for conceptualizing the relationship between complex organizations but the theory is applicable to concepts focusing on person-in-situation interactions. General Systems Theory stresses the term “system.” Therefore, it is pertinent to distinguish its’ meaning. A system is defined as a unit or component that can be distinguished from and that affects its environment (White & Klein, 2002).

General Systems Theory and the Human Ecology Theory share similar concepts and/ or ideas such as basic systems ideas as the links between parts and wholes; input and output; boundaries; and negative and positive feedback loops (Bubolz & Sontag, 1993). The concepts shared by these two theories and the framework of Human Ecology Theory further explain interprofessional collaboration.

Concepts

Hierarchy is one of the concepts of systems theory which is described as the layering of systems of increasing complexity: subsystems, systems, and suprasystems. Subsystems are a smaller part of a system that is analyzed separately as to its exchanges with the system and other subsystems (White & Klein, 2002). Suprasystems are the extended environments (e.g., culture, community, geographical region, national system) in which the system is embedded (Whitchurch & Constantine, 1993).

According to Whitchurch and Constantine (1993), interdependence or mutual influence is another concept of systems theory. It is conceptualized that the components in a system are held together (interdependent) and the behaviors of one component will
affect the behavior of every other component (mutual influence) (Whitchurch & Constantine, 1993).

**Boundaries** are recognized as another concept of systems theory. Klein and White (2002) define boundaries as borders between the system and its environment that affect the flow of information and energy between the environment and the system. Boss and colleagues (1993) believe that boundaries are an essential concept to systems theory. These theorists state that “identifying several components as a system is equivalent to drawing a boundary between what is included within the system and what is not part of the system (p. 333).” Boundaries represent the point of contact between the system and the other systems, subsystem or suprasystems (Whitchurch & Constantine, 1993). This point of contact is explored through the permeability of the system or whether the system is open or closed. Open systems allow or permit a transfer of energy and/or information between systems and closed systems have no input or output between the systems (White & Klein, 2002).

Lastly, the *feedback loop* is a concept of human ecology theory (Whitchurch & Constantine, 1993, White & Klein, 2002). The feedback loop is a circular pattern in which some of the systems output is brought back as input (White & Klein, 2002). There are two types of feedback: negative and positive (White & Klein, 2002, Whitchurch & Constantine, 1993). Negative feedback operates when behaviors in the system maintain homeostasis or reduce deviation and positive feedback is when deviation is increased/amplified or change is accepted (Whitchurch & Constantine, 1993).

**Human Ecology Theory**

Human Ecology Theory is unique in its focus on humans as both biological organism and social beings in interaction with their environment (Bubolz & Sontag, 1993). “Emphasis is given to creation, use, and management of resources for creative adaptation, human development, and sustainability of environments” (Bubolz & Sontag, 1993, p. 419). Human Ecology Theory focuses on the interaction and interdependence of human (as individuals, groups, and societies) with the environment. According to Bubolz and Sontag (1993), the assumptions about human-environment relations are: “social and physical environments are interdependent and influence human behavior, development, and quality of life; the environment is a source of available resources; and lastly, humans
can choose, design, or modify resources and environments to improve life and well-being” (p. 421). Ecology of human development is defined as

*the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing organism and the changing immediate environments in which it lives, as this process is affected by conditions obtaining within and between these immediate settings and the larger social contexts, both formal and informal, in which the settings are embedded.* (Bronfenbrenner, 1976, p. 2)

This theory emerged in 1869, when Ernest Hackel, a German zoologist, asserted that the individual was a product of cooperation between the environment and organizational heredity and he proposed that a science be developed to study organisms in their environment (Bubolz & Sontag, 1993). By the 1960s, the development of this theory had evolved to an increased awareness of the interdependence of human actions and environmental quality and the interest in viewing phenomena from holistic and systems perspective (Bubolz & Sontag, 1993).

In the 1970’s, Urie Bronfenbrenner became a major contributor to the Human Ecology Theory due to his research of ecology in human development (Bubolz & Sontag, 1993). He defines the ecological environment as “a nested arrangement of structures, each contained within the next” (Bronfenbrenner, 1976, p. 3). He acknowledged four levels in these structures of environmental systems (i.e., micro-, meso-, exo-, and macrosystems) and they are differentiated on the basis of their immediacy with respect to the developing person or target system.

*Four Levels of Environmental Systems*

**Micro-system.** According to Bronfenbrenner (1979), the ecological environment is conceived as extending far beyond the immediate situation directly affecting the developing person—the objects to which the person responds or the people with whom the target system interacts on a face-to-face basis. In his research, he regards as equal importance “the connections between other persons present in the setting, the nature of these links, and their indirect influence on the developing person through their effect on those who deal with him at first hand” (p. 7). Bronfenbrenner (1979) identifies this complex of interrelations within the immediate setting as the micro-system. The micro-
system is the “complex of relations between the developing person and environment in an immediate setting containing that person (e.g., home, school, work place)” (Bronfenbrenner, 1976, p. 3). Participates engage in particular activities with particular objects in particular roles (e.g., daughter, parent, teacher, employee) for particular periods of time is a setting while the factors of place, time, physical features, activity, participant and role are recognized as the elements of a setting (Bronfenbrenner, 1976).

_Meso-systems._ The setting in which the developing person actually participates is recognized as the meso-system (Bronfenbrenner, 1979). More specifically, the meso-system comprises the interrelations among the major settings containing the developing person at a particular point in their lives. According to Bronfenbrenner (1976), the meso-system is the system of micro-systems because it typically encompasses interactions among the systems within the micro-systems. For example, the meso-system could be the interactions of a child's family, school, church, and peer group, when the child is the identified target system or developing person.

_Exo-systems._ The environmental setting that may affect what happened in the person’s immediate setting but does not directly connect with the person is the exo-system (Bronfenbrenner, 1979). The exo-system is “an extension of the meso-system embracing the concrete social structure, both formal and informal, that impinge upon or encompass the immediate setting containing the developing person and thereby influence, delimit, or even determine what goes on there” (Bronfenbrenner, 1976, p. 3). These structures include the major institutions of the society, both deliberately, structured and spontaneously evolving, as they operate at the local level. They encompass, among others, the world work, the neighborhood, mass media, agencies of government, the distribution of goods and services, communication and transportation facilities, and informal social networks (Bronfenbrenner, 1976).

_Macro-systems._ All of these systems are embedded in the macro-system (Bronfenbrenner, 1979). The macro-system is “the overarching institutions of the culture or subculture, such as the economic, social, educational, legal, and political systems, of which local meso-systems are the manifestations” (Bronfenbrenner, 1976, p. 3).

The combination of concepts and structure of both General Systems Theory and Human Ecology Theory allows the developing person or target system to be identified or
recognized by the researcher. For the purposes of this research, the identified target system is the parishioner who is in need of marital or family counseling or therapy. The parishioner is the developing person or target system and the micro-systems are the church and mental health services. The focus of my study would be on the relationship among these micro-systems: church and mental health services. Thus, this research will be focusing on the meso-system which, as previously mentioned, is recognized as a set of interrelations or interconnections between two or more micro-systems in which the developing person or target system becomes an active participant (Bronfenbrenner, 1979).

According to Bronfenbrenner (1979), when a developing person or target system participates in more than micro-system within a meso-system, they are referred to as a primary link. For example, the parishioner is the primary link due to participation in pastoral counseling at church and therapy in a mental health agency. Those persons or associates of the developing person or target system who participate in the same two micro-systems are referred to as supplementary links (Bronfenbrenner, 1979). An example would be the clergyperson in the mental health services micro-system or mental health professional participating in the church micro-system.

The information or messages that transmit among these micro-systems is acknowledged as intersetting communications. In this type of interconnection among micro-systems, according to Bronfenbrenner (1979), there is intent of providing specific information to persons in the other micro-system which occurs in a variety of ways (e.g., face-to-face, telephone conversations, written messages, or social networks). In accordance with the concept of reciprocity in GST, this communication can be one-sided or may occur in both directions (Bronfenbrenner, 1979).

In a more explicit comprehension of the effects of intersetting communication in meso-systems, Bronfenbrenner (1979) hypothesizes that,

\[
\text{the developmental potential of a meso-system is enhanced to the extent that there exist indirect linkages between settings that encourage the growth of mutual trust, positive orientation, goal consensus, and a balance of power responsive to action on behalf of the developing person (p. 216).}
\]
In other words, the strength of the meso-system is based upon the positive styles or forms of interconnections among settings or micro-systems. The definition and hypothesis associated with intersetting communications among micro-systems of the meso-system develops a basis in which interprofessional collaboration for the purposes of this paper are acknowledged, explained, and established. Later in this chapter, the assumptions of interprofessional collaboration are addressed which clarifies how intersetting communication takes place.

For the purposes of this study, as previously identified, the parishioner is the developing person. The church and mental health services are recognized as the micro-systems because the parishioner is affected directly by these environments. The specific focus of this research is on the meso-system which is “the interrelations among the micro-systems” (Bronfenbrenner, 1979). According to the definitions established by Bronfenbrenner (1979) of meso-systems, the parishioner is identified as the primary link and the clergyperson or mental health professionals are the supplementary links when interacting in each other’s micro-system. In order to develop a comprehension of intersetting communications between these supplementary links, an exploration will occur of their interprofessional collaboration.

Interprofessional Collaboration

Random House Webster’s College Dictionary (1997) defines collaboration as “the act or process of working, one with another” or “to cooperate” (p. 257). In research, collaboration has been defined as “the undertaking of a joint initiative to solve shared problems and achieve common goals, usually characterized by reciprocity, equality, coordination and shared decision making” (Mizrahi & Abramson, 2000, p. 3). In order to complement the objective developed for this study, the definition of collaboration to be used is the act or process of working, one with another to solve shared problems and achieve common goals.

Collaboration is a broad term that focuses generally on any two or more persons working together. “Any two or more persons” could include anybody working mutually as a unit. A mother and a father working together to clean the house or two students working together to complete a project are examples of this broad term. Generally, collaboration regards the act or process of any two or more persons working together. In
this paper, however, I will focus more specifically on the joint operations of two or more professionals, otherwise, recognized as interprofessional collaboration.

Interprofessional collaboration is “conceptualized as consisting of purposeful sequences of changed-oriented transactions between or among 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, p. 147). To extrapolate, interprofessional collaboration is a series of actions or events that occur between two or more professionals who share mutual objectives while in working together. According to Billups (1987), interprofessional collaboration denotes not one process, but a series of multi-level, overlapping, and interrelated sub-processes that often take place not only sequentially, but simultaneously. Therefore, it is a highly integrated framework of collaboration among professionals because it uses a collective approach toward assessments and interventions with different practitioners (Geva, Barsky, & Westernoff, 2000).

Often the term interprofessional has been used interchangeably with interdisciplinary and multi-disciplinary process (Geva et al., 2000). However, there is a distinct difference between these terms. Geva and associates (2000) report that the term interprofessional emphasizes the nature of professions as opposed to disciplines, which is emphasized by inter- and multi-disciplinary. Essentially, “the term discipline refers to an area of study or particular branch of science, but profession refers to a group of practitioners who have a particular set of values, ethics, skills, and practice methods” (Geva et al., 2000, p. 2).

In general, interprofessional collaboration is a more specific focus of collaboration which, as previously mentioned, is the act or process of working, one with another; to cooperate.” Therefore, the focus within this study is on the interprofessional collaboration or the act or process of two or more professions working together, in cooperation with one another on mutually shared objectives.

Two or more professionals working together can entail or cover an array of different customs of practice. Consequently, it is critical to solidify the understanding of the practice of interprofessional collaboration. Interprofessional collaborative practice is the actual procedures or activities that occur within interprofessional collaboration. These
activities include exchanging information, consultations, referrals, planning and coordination, concurrent cooperative services, and joint operating responsibility (Billups, 1987; Nicholson et al., 2000).

It is essential to understand the basic assumptions of interprofessional collaborative practice in order to grasp the comprehension of the conceptualized definition. According to Billups (1987), there are four basic assumptions of interprofessional collaboration. The first assumption is that the dynamics include both what two or more professions do (e.g., their rational, task-oriented, or goal achievement functions) and how they go about doing it (e.g., their social-emotional, maintenance-oriented, or self renewing functions).

Second, there is an assumption that the unique quality of contributions of diverse professionals is central to the success of interprofessional collaboration and there are coordinated efforts of the various representative members to accomplish and sustain changes in complex situations while progressing toward shared objectives. As mentioned previously, when two or more professionals collaborate they are contributing different philosophies, models, skills and values. This is beneficial for when attempting to address complex, multi-facet and systemic issues. Interprofessional collaborative practice is designed to respond to and solve complex problems which are beyond the resources or capacity of any one profession (Nicholson et al., 2000). The approach or model applied is one that is creatively developed by the professionals involved in the process consequently allowing each member to stay in accordance with one another while adhering to the ultimate agreed upon goal or objective (Geva, Barsky, & Westernoff, 2000). For that reason, there is no one model or one size-fits-all approach for interprofessional collaborative practice. Researchers have revealed that the interprofessional collaborative practice approach reflects varying degrees of integration which depends upon the focus and goals of the group of professionals who seek to practice collectively (Nicholson et al., 2000). As a result, interprofessional collaborative practice does not adhere to a neat, consecutively staged pattern but instead is often improvised in order to deal with contingencies and develop practical ends in completing the shared goals, or tasks (Billups, 1987).
The third assumption is that the relationship between each member, the larger environment, and the people in whose behalf the team functions is mutually interdependent and ever-changing. Hence, interprofessional collaborative practice is a complex practice that requires flexibility and restructuring of the social delivery systems (Daka-Mulwanda, Thornburg, Filbert, & Klein, 1995). Interprofessional collaboration focuses on the use of collaborative versatile professional approaches that helps better understand and meet all of the required needs and resources of the task(s) while enhancing the range of options considered and skills applied in problem solving (Abramson & Mizrahi, 1996).

Lastly, it is assumed that there is a “synergistic quality in which the outcomes of an effective interprofessional team effort can be considerably greater in possibility and value than the cumulative effects of the performance of individual practitioners or educators working separately” (Billups, 1987, p. 147). It is made explicit in this assumption the ultimate benefit of interprofessional collaborative practice. Nicholson and associates (2000) found that interprofessional collaborative practice opens the door for an expansion of knowledge and expertise through exposure to other professionals. Also, practitioners reportedly establish better communication and relationships. Researchers have revealed several other benefits such as: sharing division of responsibility in solving problems, providing necessary support for colleagues, unifying fractionalized, fragmented, or duplicated service, breaking down social barriers, and even reducing burnout and compassion fatigue (Abramson & Mizrahi, 1996; Hepworth, Rooney, & Larsen, 2002; Holleman, Bray, Davis, & Holleman, 2004; Nicholson et al., 2000). Consequently, it is supposed that the benefits of professions working together outweigh the challenges or obstacles of interprofessional collaboration (Nicholson et al., 2000).

Most of the literature on the interprofessional collaboration between clergy and mental health professionals has been theoretical, exploring the possible benefits and obstacles of such a relationship (Edwards, Lim, McMinn, & Dominguez, 1999). The objective of this study is to investigate the practice of interprofessional collaboration. Due to the lack of research literature, it is not understood what allows interprofessional collaboration to occur between some members of the clergy and mental health professionals but not with others? As previously mentioned, in several studies, obstacles
and benefits are suggested by researchers that possibly effect collaboration but what variables actually correlate with the participation in interprofessional collaborative practice is unknown.

Research Questions and Hypotheses

The objective of this study is to comprehend the relationships of specific variables identified as obstacles and benefits such as the level of academic education, interprofessional education, teamwork skills, and trust of clergyperson(s) towards the participation in interprofessional collaborative practice in marital and family counseling.

These variables have been found to be relevant to collaborative practice and the overall interprofessional collaboration. However, there is an absence of research literature that examines the relationships among the relevant variables of teamwork skills, trust, and education in the context of interprofessional collaborative practice with clergypersons in mental health counseling. Therefore, the main goal of this current investigation will be to address this literature gap by exploring such relationships in interprofessional collaboration among the variables as it relates to clergypersons and collaborative practice.

The central research question is: To what extent do the variables--level of academic education, participation in interprofessional education, teamwork and communication skills, and trust--influence the level of participation of clergypersons’ in interprofessional collaborative practice? More specifically, what are the relationships among the clergypersons’ level of academic education, trust, and teamwork and communication skills, as it relates to participation in interprofessional collaborative practice? What are the relationships among the clergypersons’ participation of interprofessional education, trust, and teamwork and communication skills as it relates to participation in interprofessional collaborative practice?

Based upon past research literature, it is hypothesized that: (1) A negative relationship between academic education, trust, and teamwork and communication skills will be found in relation to participation in interprofessional collaborative practice, and (2) A positive relationship between interprofessional education, trust, and teamwork and communication skills will be found in relation to participation in interprofessional collaborative practice.
As previously mentioned, most of the literature on the interprofessional collaboration between clergy and mental health professionals has been theoretical, exploring the possible benefits and obstacles of such a relationship (Edwards et al., 1999). However, there are no standardized instruments to measure the clergypersons’ interprofessional education, trust, and participation in interprofessional collaborative practice therefore, to investigate these variables a measure was created based upon research literature. The variable, teamwork and communication skills, will be measured by using a standardized measure, University of West England Interprofessional Questionnaire (Pollard, Miers, & Gilchrist, 2004), and the variable, academic education, will be measured through a single question in the demographic questionnaire.

Assumptions and Definitions

The assumptions for all of the variables—academic education, interprofessional education, teamwork and communication skills, trust, and interprofessional collaborative practice—defined below are that each variable can be measured and that the participating clergypersons provide accurate and truthful information.

Academic Education

Academic education is operationally defined in this study as the level and the degree attainment in an educational program or institution. For example, degree attainment will be assessed by asking the clergyperson their highest educational degree ranging from high school to a doctorate. This variable is measured within the demographic questionnaire.

Interprofessional Education

The definition of interprofessional education in this study is a diverse group of professionals learning together toward a common goal or in providing a particular service in which each professional learns their roles and responsibilities through shared tasks, skills and protocols (Parsell & Bligh, 1998, Williams, Bracht, Williams, & Evans, 1978). It is operationally defined for the purposes of this study as the participation in an educational training, seminar, or workshop with mental health professionals to provide a particular service. This variable is measured by question two in Section III of the measure.

Teamwork and communication Skills
For the purposes of this study, teamwork and communication skills is defined as maintaining openness and respect towards the differences in values, knowledge, and problem-solving styles; willingness to share one’s own knowledge, values, and skills; and the capacity to work through rather than to avoid conflict (Abramson, 1990). The variable, teamwork and communication skills, is measured by a modified version of the Communication and Teamwork Subscale of the University of West England (UWE) Interprofessional Questionnaire (IPQ) (Pollard et al., 2004) in Section I of the measure, questions one through nine.

*Trust*

For the purposes of this study trust is defined as “the obligation or responsibility imposed on a person in who confidence or authority is placed: a position of trust; to have confidence in; rely or depend on” (Random House Webster’s College Dictionary, 1997). Trust is operationally based upon five components: benevolence, reliability, competence, honesty, and openness. It is measured by questions developed to understand the level of existence of these five components of trust with clergypersons in Section II of the measure, questions one through six.

*Interprofessional Collaborative Practice*

In this study, interprofessional collaborative practice is defined as the actual procedures or activities that occur within interprofessional collaboration. According to Billups (1987), these activities include acquaintanceship to, exchanging information, consultations, referrals, planning and coordination, concurrent cooperative services, and joint operating responsibility and are based upon a continuum from less to more intense. In this present study, interprofessional collaborative practice is measured by the participation of clergypersons in these activities with mental health professionals which is Section III of the measure, questions three through eleven.

*Delimitations*

1. Since this present study examines the quality of the collaboration or the effect of collaboration, outcome studies were not included in the literature review. Only studies that focused on the actual relationship between mental health professionals and non-mental health professionals were examined in the literature review.
2. The sample only includes one of the collaborators, clergypersons, in order to understand the style or form of collaboration from that professional’s perspective.

3. The sample only includes Christian clergypersons. A convenience sample of clergypersons was selected from the directories of ministerial associations.

4. This study only obtains information by survey distribution. No observations of actual interprofessional collaborative practices will be made or used in order to gather data.

5. For the purposes of this study, the Teamwork and communication Subscale of the University of West England (UWE) Interprofessional Questionnaire (IPQ) is modified to fit the identified populations: clergypersons and mental health professionals. Thus, the psychometric properties reported for the standardized measure can not be confidently applied in this present study.

6. Section II and III of the measure is developed based upon research literature to meet the objective and research questions for the present study. However, there has been no testing of reliability or validity.

In the next chapter, the focus is on an investigation of past research literature of collaborative practice relationships and how the following variables—education, experience, teamwork and communication skills, and trust—are identified as recurring variables in interprofessional collaboration which is identified for the purposes of this study as the communication between the micro-systems of the church and the mental health services within a meso-system.
CHAPTER II
Literature Review

In chapter one, interprofessional collaboration is recognized as the intersetting communication between micro-systems within the meso-system. In this chapter, the concentration will be on the evaluation of the quality and common findings in past research literature accomplished in the interest of clergypersons in interprofessional collaboration with mental health professionals. After the identification of the common findings or variables of interprofessional collaboration between clergypersons and mental health professionals, an assessment of these variables will take place.

Interprofessional Collaborative Practice Relationships in Mental Health

As previously mentioned, there is a lack of research literature when focusing specifically on the experiences of members of the clergy and mental health professionals in the practice of interprofessional collaboration. Two research studies were conducted where the goal was to establish a brief overview of what research has been accomplished in the area of collaboration between clergy and mental health professionals. Weaver and associates (2003) conducted a content analysis of all literature published in health care journals from 1980 through 1999 that focuses on how collaboration with clergy are viewed by mental health and health care professionals. Oppenheimer and her colleagues (2004) conducted a comparative analysis by reviewing psychological literature published in secular and religious journals from 1970 to 1999 to establish a better understanding of the issues surrounding collaboration between clergy and psychologists. The researchers of both articles have similar research findings when determining the overview of research established or conducted in the area of collaboration between mental health professionals and clergy in which the same themes were established. The themes that are identified in both studies regarding research accomplished with a focus on collaboration of clergy and mental health professionals are:

- The importance of referrals,
- The professional benefits of collaboration,
- Identified clergy as frontline workers or gatekeepers of mental health system,
- The barriers and obstacles to collaboration,
- The importance or need for more education,
The similarities or differences in professional values, and
- Establishing the role of clergy in prevention.

The authors also revealed that majority of the literature content published were classified as clinical (e.g., case studies and program descriptions), commentaries and/or reviews. Unfortunately, it is conclusive that the literature produced in this area not only has a limited focus but most of the literature is based upon individual cases or beliefs and not on validated or trustworthy research.

To build a more comprehensive overview of research literature with a continued focus on practice in interprofessional collaboration, the evaluation parameters were broaden or expanded by exploring research completed with focus on the practice of interprofessional collaboration of mental health professionals with non-mental health professionals. The goal of the review of research on interprofessional collaboration between mental health professionals and non-mental health professionals was completed to establish an overall general understanding of what happens in the practice of interprofessional collaboration. This evaluation of various research articles about interprofessional collaboration helped identify how and what activities take place during practice of interprofessional collaboration and recognize the similarities of variables that are commonly understood as beneficial or obstacles. Unfortunately, the quality of the research on this subject is lacking strength in several methodological areas which brings weakness and instability to the foundation of this topic of research.

In majority of the research that was critically reviewed, the researchers conducted qualitative methodology (Ellingsen, 2003; Konrad, 2001; Mizrahi & Abramson, 2000; Nicholson et al., 2000; Pereiral & Smith, 2004). Two out of the eleven articles were strictly quantitative (Badger, Ackerson, Buttell, & Rand, 1997; Williams et. Al., 1978) while only four were mixed methods (Abramson & Mizrahi, 1996; Kainz, 2002; McMinn et al., 2003; McMinn et al., 1998). This is not uncommon when researchers are attempting to build research in the understanding of processes because it allows an exhaustive amount of content by which events and actions take place on the area of investigated interest (Maxwell, 1998). However, many of the studies in which the researchers attempted to use qualitative methodology had several problems in their procedures therefore causing concerns with trustworthiness. Many of the studies did not
use the proper safety measures such as multiple techniques, multiple resources, or multiple researchers to secure the possibility of credibility, reliability, or trustworthiness in the findings. Although mounds of content are helpful to build the foundation of this area of research, the strength of the content is even more pertinent to the stability of the foundation. Regrettably, the methodological procedures applied in these critically reviewed qualitative research studies left the foundation of this area of research with very little stability.

Even the studies where the authors attempted to apply mixed methods or strictly quantitative methods were not strongly credible. In all of the studies the authors did not choose to operate with a standardized instrument. They all created or developed a survey/questionnaire to collect their data. In only two of the mixed method (Kainz, 2002; McMinn et al., 2003) studies, the authors utilized methods (qualitative software analysis or focus groups) to bring strength to the developed instrument used to collect the data. Strength of the developed instrument in most of the studies was not credible, valid, or reliable. In addition, few of the studies provided methods, samples, or analyses that allowed the study to have high confident levels. The sample, methodological design, and analyses limit the degree of significance within each study.

Most of the critically reviewed articles that investigated the collaborative relationship of mental health and non-mental health professionals fell into the category of mental health professionals with physicians. Six out of the eleven articles investigated this collaborative relationship (Abramson & Mizrahi, 1996; Badger et al., 1997; Kainz, 2002; Mizrahi & Abramson, 2000; Pereiral & Smith, 2004; Williams et al., 1978). Yet, as previously mentioned, there was a lack of credibility in studies due to the insecurities that have developed from the preference of sample, methods, instruments, and analyses.

A more notable conclusion is the fact that despite the differences in the methodological design and focus of the non-mental health professionals, the results and implications reported in the eleven studies were similar. Lack of trust, communication and educational awareness were consistently found in the results of these studies when acknowledging the conflicts that arose throughout interprofessional collaboration. Additionally, the lack of teamwork skills led to the struggle of relinquishing leadership and power which was also a common finding in the results of the studies (Abramson &
Mizrahi, 1996; Badger, et al., 1997; Kainz, 2002; McMinn et al., 2003; McMinn et al., 1998; Mizrahi & Abramson, 2000; Williams et al., 1978). The problems established in the findings of the critically reviewed articles are in accordance with the suggested hindrances or obstacles discussed in Chapter one.

The researchers who investigated interprofessional collaboration among multi- or inter-disciplinary team, and the models or tools they employ were actually found to be possible solutions to these issues (Ellingsen, 2003; Konrad, 2001; Nicholson et al., 2000). The findings in these critically reviewed studies were more like the confirmations of the benefits discussed previously in the studies that were reported in the introduction. When discounting methodological concerns within the review of research, it is almost safe to conclude that despite the professionals represented in the research, when involved in an interprofessional collaborative relationship, there are similarities in the experiences. Thus, research and clinicians would probably benefit from focusing more on the specified recurring variables within the practice of interprofessional collaboration rather than the continuous exploration of interprofessional collaboration as a whole (McMinn et al., 2003; Nicholson et al., 2000).

The research literature that focuses on interprofessional collaboration with mental health professionals and non-mental health professionals appears to focus more on uncovering the aspects that cause positive or negative experiences in collaboration. Majority of the literature addressed the obstacles and enhancements of interprofessional collaboration with the additional exploration of an application of a model or tool. However, as previously referenced, there is very little research that focuses on how these specific variables such as trust, teamwork skills, and education within these micro-systems collectively influence or are linkages to the occurrence of practice in interprofessional collaboration for the benefit of the developing person or identified target system which for the purpose of this study is the parishioner seeking counsel. Researchers believe it is time for research to take a turn into this direction (McMinn et al., 2003; Nicholson et al., 2000). This conclusion guides the direction of this research which investigates the practice of interprofessional collaboration with mental health professionals and clergy by exploring the relationships among the variables repeatedly considered as obstacles or benefits to interprofessional collaboration and their influence
on the frequency of practice in interprofessional collaboration. In the rest of this chapter, each individual variable -- teamwork skills, trust, and education -- and their relevance to the practice of interprofessional collaboration will be discussed.

Teamwork skills in collaborative practice. In collaboration, teamwork and communication skills are believed to be essential (Lowe & Herranen, 1981). Hepworth, Rooney, and Larson, (2002) report that there are four phases of collaboration which include: problem setting with mutual acknowledgement and common definitions of issues, agreement on the direction and expectations of outcome, implementation of the plan and skills between the various professional orientations, and creation of long-term structure that enables the collaboration to sustain, evaluate, and nurture practice over time. When recognizing the recurring themes that permit these four phases of collaboration to operate, teamwork appears to be the underlying repetitive variables necessary for the function of the phases to take place. Thus, it is pertinent to understand the role of the variable, teamwork skills, necessary for the operation of practice in interprofessional collaboration.

Teamwork is an ongoing process. According to Lowe & Herranen (1981), the building principles for teamwork are: “teamwork is an evolutionary process with identifiable developmental stages; teamwork can occur only while it is supported and sanctioned by the environment in which it exists; and lastly, teamwork as a concept must be understood, practiced and studied in order to fulfill its potential” (p. 2). It takes time, effort, evaluation, and a commitment to the concepts of teamwork. To work together effectively and efficiently practitioners must consider: what it takes to do the work, what is necessary to strengthen the team, and how to affect individual and team accountability (Lowe & Herranen, 1981). Effective teamwork is vital to collaboration (Cooley, 1994). Teamwork facilitates creative solutions to challenging problems (Drinka, Miller, & Goodman, 1996) due to the reciprocity of shared knowledge and skills between the team members which in turn provides a positive influence on client treatment (Way, Jones, & Busing, 2000).

Teamwork is defined as “a cooperative effort on the part of group of persons acting together as a team or in the interests of a common cause” (Random House Webster’s College Dictionary, 1997). Thus, by definition, in the context of mental health
services, teamwork brings together different practitioners and/or professionals with the expectation of developing a consensus on approaches to client care. Yet, each profession socializes its members differently in relation to which values, definitions of professionals’ roles and models of interventions are imparted (Abramson, 1990). These distinct differences between professionals can obscure the availability of completely unified collaborative practice. Consequently, the proper teamwork skills are necessary in order to close the gaps that the segregated professional socializations, roles and models produce.

According to Abramson (1990), teamwork skills are a reflection of the clinical skills employed in a therapeutic relationship. For example, clinical skills such as: beginning where ones’ colleagues are; maintaining openness and respect towards the differences in values, knowledge, and problem-solving styles; willingness to share one’s own knowledge, values, and skills; and the capacity to work through rather than to avoid conflict. These examples of teamwork skills illustrate the foundation in which communication is permitted to take place. According to Klein (1990), successful teamwork depends on attending to the communication process. Lowe and Herranen (1981) have suggested that determining the nature of interdependence or who needs what information from whom, which are forms of communication, is an essential part of teamwork. Consequently, it is probably safe to conclude that without teamwork communication cannot take place. For the purposes of this study, teamwork is understood to be the avenue in which communication can be demonstrated. Therefore, for this present study, teamwork skills are acknowledged as the variable that includes communication skills. In this section a more elaborate explanation is developed to illustrate communication skills and the connection between teamwork skills and communication skills.

Researchers on collaborative practice have found that the quality of communication within a team is a good index of its level of organization and the health of the relationships between members (Nicholson et al., 2000). Lewandowski and GlenMaye (2002) recognized in their research literature that communication was enhanced through personal contacts, regular progress reports, bimonthly team meetings, and reporting of results of transactions to the entire team. If such communication
activities did not take place on the team not only does it cause discord within the relationship but also foster fragmented services. For example, lack of communication can result in the patient being caught between two professionals with varying skills and differing perspectives on the same problem (McDaniel, 1995).

While there may be some interaction between collaborative practice activities and other descriptive variables examined, clergy seemed to voice the most discontent with the unequal relationship as perceived from lack of communication amongst professionals (Meylink & Gorsuch, 1988). In one study investigating the collaborative practice of interprofessional child welfare teams, Lewandowski and GlenMaye (2002) found that the respondents identified inadequate communication as the greatest barrier to team effectiveness. It was emphasized and reinforced in another study examining physician-social worker collaborative teams how critical communication truly is in collaboration (Abramson & Mizrahi, 1996). It was also revealed that communication appears to be the only intrinsic or universal aspect of collaboration that is equally important to both professions in positive or negative circumstances (Abramson & Mizrahi, 1996). Accordingly, Resources for Divorced Families celebrates its 12th year as a collaborative organization, and the members of this organization exclaim that the nurturance of interprofessional communication in collaboration is what continues to keep it a continually growing body (Konrad, 2001). Consequently, communication and problems in communication are frequently noted as integral to team functioning (Cooley, 1994; Lewandowski & GlenMaye, 2002). A successful collaborative relationship depends on the same interpersonal skills the psychologists uses with patients in psychotherapy: good communication, an understanding of the physicians’ world view, the development of a personal relationship, a common language, shared goals, and a contract to work together (McDaniel, 1995). As members of problem-solving teams, professionals will need to build effective communication skills.

When learning communication skills students are usually taught to focus on interactions with clients and families from the perspective of his/her profession, not on communication across professions (Hall, 2005). Yet, these same communication skills learned in practice can be applied when communicating with other professionals. For instance, Babyak and Koorland (2001) identify from past research literature that
genuineness, empathy, active listening, and paraphrasing are indicative of good communication skills. Other researchers have pointed out that effective communication requires avoiding the use of professional jargon and establishing clear guidelines concerning information exchange (Nicholson et al., 2000). Konrad (2001) discovered in her study interprofessional teams aiding divorced families, that the creation of a common language was cited by all of the participants as a critical component to bridging professional differences and developing a collaborative mission. Therefore, in the progression of a collaborative practice activity (e.g., referrals, consultation, co-therapy, etc.) understanding and applying communication and teamwork skills is essential.

**Trust in collaborative practice.** Interprofessional collaborative practice is characterized not only by effective teamwork or open communication but also by mutual trust (Babyak & Koorland, 2001). According to Romano (2003), several researchers believe that trust is considered a fundamental ingredient for motivating productive working relationships. For example, it was stated researchers suggest that trust facilitates strategic collaboration and cooperation (Romano, 2003). Konrad (2001) demonstrated this in his study of mental health practitioners and lawyers by revealing that these professions asserted that clients were better served as a consequence of the trust that had been built in their relationship.

Researchers have also found that trust in the collaborative practice efforts of mental health professionals and clergypersons play a major role in the relationship. For example, in their exploration of the interprofessional relationship of psychologists and clergy, Benes and associates (2000) revealed that for true successful psychologist-clergy collaboration establishing trust with clergy was an important part of their work. They also found that when clergymen are directly included in collaborative practice activities (e.g., consultation and co-therapy) it fosters trust and/or confidence in the relationship. When focusing on trust in a collaborative practice with mental health professionals and clergy, two separate groups in which values, beliefs, and trainings differ, it is logical to assume that trust would play a major role in that relationship. Thus, how does one develop that trust?

Trust is defined in Random House Dictionary (1997) as “the obligation or responsibility imposed on a person in who confidence or authority is placed: a position of
trust; to have confidence in; rely or depend on.” Cummings and Bromily (1996) define inter-personal trust as the good faith efforts of another individual or group to behave in accordance with commitments, to be honest in the negotiations preceding these commitments and not to take excessive advantage of another even when the opportunity is available. In their study, Goudge and Gilson (2005) recognize that trust is generally based on notions of confidence in the capability, reliability, and/or integrity of an exchange partner. Researchers report that trust involves taking risk and making oneself vulnerable to another with confidence that the other will act in ways that are not detrimental to the trusting party (Hoy & Tschannen-Moran, 2003). Goudge and Gilson (2005) reported that in past researchers have concluded that trust is understood as “the optimistic acceptance of a vulnerable situation in which the trusters’ believe the trustee will care for the trustee’s interests” (p. 1440). It was also reported that this belief demonstrates the general conclusion that “trusting attitudes are directed as much to motivation and intentions as to results” (Goudge & Gilson, 2005, p. 1440). In other words, trust could possibly have a direct effect on motivation and intentions even the motivation or intention of collaborative practice.

As previously illustrated, trust can be defined and understood in various ways. However, after reviewing research literature, Tschannen-Moran and Hoy (2000), is concluded that the meaning of trust consist of at least five multiple components: benevolence, reliability, competence, honesty, and openness. Benevolence is the confidence that one’s well being or something one cares about will be protected by the trusted party (Tschannen-Moran & Hoy, 2000). In other words, benevolence is the assurance that the trusted party will not exploit one’s vulnerability or take advantage even when the opportunity is available (Cummings & Bromily, 1996). Tschannen-Moran and Hoy (2000) report that reliability is the second element of trust. It is defined as the consistency of behavior and knowing what to expect from others (Butler & Cantrell, 1984). Reliability implies that there is a sense of confidence that one will meet one’s desires (Tschannen-Moran & Hoy, 2000). A third component of trust is the level of competence with the trusted party. Competence is the ability to perform as expected and according to standards appropriate to the task at hand (Tschannen-Moran & Hoy, 2000).
Many organizational tasks rely on competence or the knowledge and skills of the trusted party.

According to Tschannen-Moran and Hoy (2000), honesty is the fourth component of trust. Examples of honesty is believed by researchers to be demonstrated by making statements that are truthful when they conform to “what really happened” from that person’s perspective and when commitments made about future actions are kept. Moreover, another illustration of honesty is the acceptance of responsibility for one’s actions and not distorting the truth in order to shift blame to another (Tschannen-Moran & Hoy, 2000). The last component of the meaning of trust is openness. Openness is the extent to which relevant information is shared and it is a process by which individuals make themselves vulnerable to others (Tschannen-Moran & Hoy, 2000). These five components developed by Tschannen-Moran and Hoy (2000) provide a breakdown of the meaning of trust and clarity on how this term can be understood and measured.

Education in collaborative practice. Insufficient education or knowledge of one another’s role as counselors was frequently seen as an obstacle to collaboration. Both mental health professionals and clergypersons recognize that the training and education of clergy should be improved so they are better able to recognize psychological disorders, and are more familiar with existing mental-health resources in their communities to enable clergy to make appropriate referrals to mental health professionals (Oppenheimer et al., 2004). The increase of formal and informal interprofessional education, otherwise recognized as shared learning (Carpenter & Hewstone, 1996, Parsell & Bligh, 1998), opportunities was cited as improving professional practice by educating each profession represented in a collaborative practice about the regulations and procedures of the other (Konrad, 2001).

There has been mixed findings in research on whether education awareness is a benefit or obstacle. For instance, in research it was revealed that clergy with higher levels of education appear more willing to acknowledge their clinical limitations, and they often make more referrals (Oppenheimer et al., 2004). However, contrary to previous research, Mannon and Crawford (1996) found that clergy with higher education were not significantly more willing to make referrals than the less educated clergy. It was interesting, however, that clergy with no mental health training were not found to be
significantly different from clergy with advanced degrees in counseling or related fields in their confidence to handle the various mental health issues (Mannon & Crawford, 1996). Despite the contradictions in findings, researchers believe there seems to be a consensus that these barriers are both “structural and cultural” (Hall, 2005) of the profession and compounded by lack of knowledge. Carpenter and Hewstone (1996) believe that these problems will not be solved by education but ignorance can at least be tackled and, perhaps, attitudes changed.

The educational system can play a major part in inter-group perceptions (Mandy, Milton, & Mandy, 2004; Williams et al., 1978). Researchers suggest that academic education is believed to contribute to the fragmentation of professions. For instance, Hall (2005), states that traditional academic education is based upon profession-specific world-views, which merely prepare individuals to work within their own profession, not to communicate with individuals from another profession. This establishes a start of a career with interprofessional barriers of unfamiliar vocabulary, different approaches to problem-solving, and a lack of common understanding of issues and values (Hall, 2005). Thus, researchers have discovered that students with experience of higher education and students who had previously worked in health or social care settings held relatively negative opinions about interprofessional collaborative practice (Pollard et al., 2005). Given the lack of common education and interprofessional experience this poses a real challenge to practicing teams (Hall, 2005).

It is believed that interprofessional education has the potential to improve care delivery (Pollard et al., 2005). Interprofessional education is a diverse group of professionals learning together toward a common goal or in providing a particular service (Williams et al., 1978). In these shared learning experiences each professional learns their roles and responsibilities through shared tasks, skills and protocols (Parsell & Bligh, 1998). The philosophy underpinning interprofessional education suggests that it motivates and produces a learning relationship which will be productive, will optimize opportunities between professional groups and will translate into productive relationships in practice (Carpenter & Hewstone, 1996; Mandy et al., 2004). Experiential learning is particularly important in interprofessional education (Clark, 2002). Some researchers have discovered that after participating in an interprofessional education event (e.g.,
intervention, trainings, and workshops) the attitudes of different professional groups towards one another had changed to more accepting and less critical image (Carpenter & Hewstone, 1996; Lindqvist, Duncan, Shepstone, Watts, & Pearce, 2005). However, there is a lack of significant statistical findings in research literature that actually proves a strong influence of interprofessional education on collaborative practice (Pollard et al., 2005).

As stated in Chapter one, Bronfenbrenner hypothesized that when focusing on the interrelations between micro-systems in a meso-system it is believed that

*the developmental potential of a meso-system is enhanced to the extent that there exist indirect linkages between settings that encourage the growth of mutual trust, positive orientation, goal consensus, and a balance of power responsive to action on behalf of the developing person (p. 216).*

In other words, in order for intersetting communication to take place there is an existence of mutual support of collaboration through certain characteristics from each micro-system involved in the meso-system. This hypothesis relates to the belief and/or basis for this present investigation. There is moderate research that focuses on how these specific variables such as trust, teamwork skills, and education within these micro-systems collectively influence or are linkages to the occurrence of practice in interprofessional collaboration for the benefit of the developing person or identified target system which for the purpose of this study is the parishioner seeking counsel. The direction of this research study will investigate the practice of interprofessional collaboration with mental health professionals and clergy by exploring the relationships among the variables repeatedly considered as obstacles or benefits to interprofessional collaboration and their influence on the practice in interprofessional collaboration. In the next chapter, the methodology of how this investigation will take place will be explained.
CHAPTER III

Methodology

This research examines the intersetting communication of the identified church micro-system with the mental health service micro-system. Altogether these two micro-systems are understood as a meso-system on behalf of parishioners who might seek marital and/or family counseling. In order to understand what supports interprofessional collaboration, which is identified as the intersetting communication between micro-systems to take place, the relationships or associations of specific variables in interprofessional collaborative practice are investigated. In accordance with recommendations of past research literature on interprofessional collaboration, it is important to examine the components that previous researchers have found to be influential to the occurrence of the process in order to better understand what allow interprofessional collaboration with clergypersons and mental health professionals to take place, which in turn, establishes the goal or objective of this study.

The variables that are investigated in this study are the level of academic education, interprofessional education, teamwork and communication skills, and trust as they relate to the participation of clergypersons in interprofessional collaborative practice with mental health professionals in marital and family counseling. The central research question is: To what extent do the variables--level of academic education, participation of interprofessional education, teamwork and communication skills, and trust--influence the level of participation of clergypersons in interprofessional collaborative practice? More specifically, what are the relationships among the clergypersons’ level of *academic* education, teamwork and communication skills, trust, as they relate to participation in interprofessional collaborative practice? Also, what are the relationships among the clergypersons’ participation in *interprofessional* education, level of trust, and teamwork and communication skills as they relate to participation in interprofessional collaborative practice?

The developed hypotheses which are based upon previous research literature are:

1. There is a negative relationship between the level of *academic* education, trust and teamwork and communication skills as it relates to the participation in interprofessional collaborative practice.
2. There is a positive relationship between participation in interprofessional education, trust, and teamwork and communication skills as it relates to participation in interprofessional collaborative practice.

Sample

The sample consists of clergypersons of churches throughout the state of Florida. Clergypersons are defined as ordained persons in a religion (Random House Webster’s College Dictionary, 1997). A convenience sample of clergypersons was obtained from church institutions listed in the directory of a local community referral service and the directory of a community ministerial association. A list was compiled through the directories of the community referral service and of the ministerial association of all of the churches and faith-based institutions throughout Northeast Florida. The sample consists of clergymen and/or women of different religious denominations to have a strong representation of perspectives of various clergypersons who participate in pastoral counsel.

When conducting a research study, it is valuable for the researcher(s) to determine the considered necessary sample size in order for the research to have statistical power (Cohen, 1992). Several scholars have argued that power analyses should be conducted during the design of the study to determine adequate sample size (Cohen, 1992; Lipsey, 1998; Stevens, 1986; Tate, 1998; Weinfurt, 1995). There are three essential factors that establish power: sample size, alpha level, and effect size (Lipsey, 1998; Stevens, 1986). Although power is influenced by effect size (ES), power is heavily dependent on sample size (Steven, 1986). According to Cohen (1992), each statistical test has its own ES index which consists of a small, medium, and large effect size (p. 156). Reportedly, to determine adequate sample size researchers in behavioral studies use a medium effect size with an alpha of .05 (Green, 1991). According to Green (1991), when using Multiple Regression Analysis, the formula $N > 50 + 8m$ could be applied (where $m$ is the number of independent variables) in order to determine the sample size with a medium effect size at an alpha of .05. Therefore, in using this formula with 4 independent variables ($m = 4$), a minimum sample size of eighty-two participants is needed.

An adequate sample of clergypersons participated in this research study. There were 180 surveys distributed and 163 surveys were returned which is a 91% return rate.
Out of the 163 returned, fourteen were completed by persons who were not ordained clergypersons which means they did not fit the criteria of the investigated population. Therefore, a total of 149 surveys of clergypersons with a response rate of 83% are used in this research study.

The responses of this sample are explored and explained by 2 domains of characteristics of the participating clergyperson: personal characteristics and professional characteristics/services. In the demographic section of the survey questionnaire used in this study, the personal characteristics explored of the sample included age, gender, and the race/ethnicity of the clergyperson.

**Personal Characteristics**

In the survey, each clergyperson was asked to report their actual age. As a result, it was found that majority of the participants fall within a range of 25 – 80 years of age, with a mean age of 52.9 (see Table 1).

To explore the racial diversity of the participants, the clergy were asked to report their race/ethnicity which is coded as 5 = White/Caucasian, 4 = Black/African American, 3 = Latin American, 2 = Asian, 1 = Native American, and 0 = other. In this study, 71% were White/Caucasian, 25% Black/African American, 3% Latin American, and 1% of participants listed themselves as other (see Table 1). After coding for gender (0 = Male, 1 = Female), it was revealed that 80.5% of the participants were male while 19.5% of the participants were female. The clergyperson’s denomination is coded, 3 = Non-denomination, 2 = Protestant, 1 = Catholic, or 0 = other. In this sample, majority of the participating clergypersons listed themselves as Protestant by 71% (see Table 1).
Table 1

Personal Characteristics of Clergy Sample

<table>
<thead>
<tr>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>Gender</th>
<th>Denomination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean: 52.9</td>
<td>White/Caucasian: 70.5%</td>
<td>Male: 80.5%</td>
<td>Non-Denomination:</td>
</tr>
<tr>
<td>Standard Deviation: 10.9</td>
<td>Black/ African American: 24.8%</td>
<td>Female: 19.5%</td>
<td>8.1% Non-Denomination:</td>
</tr>
<tr>
<td>Range: 25-80</td>
<td>Latin American: 3.4%</td>
<td></td>
<td>Protestant: 71.1%</td>
</tr>
<tr>
<td></td>
<td>Other: 1.3%</td>
<td></td>
<td>Catholic: 2.0%</td>
</tr>
<tr>
<td></td>
<td>Other:18.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The values represent mean percentages of all participating clergypersons.

Professional Characteristics

In the demographic section of the survey questionnaire, the professional characteristics of the clergypersons were explored such as the denomination of the clergyperson as well as the frequency and the level of experience of pastoral counseling provided by the clergyperson. Therefore, the initial question in this section of the survey asked the clergy to state whether they provide pastoral counseling (1 = Yes, 0 = No). If the respondent stated yes in providing pastoral counseling then, they were asked to continue the remainder of the survey in which questions were developed to explore how often the clergyperson provide the services, the populations in which they provide the services, whether these services are open to the public, and how many years of experience in pastoral counseling. However, if they answered no then they were told that they have completed the survey.

It was found that 84% (N = 125) of the participants reported providing pastoral counseling. For the remaining questions in this section, the total sample was 125 participants. Thus, the demographic percentages in Table 2 and 3 are based upon the 125 respondents and not the 149 overall participants with the following questions.

The clergypersons were asked to report on the survey an estimated percentage of counseling they provide to each group (i.e. adults, children, couples, families) with a sum totaling 100 percent. The actual estimated percentage for each group stated by each participant was reported. For each respondent, the actual range of estimated percentages that could be reported for each group is 0% to 100%. As a result, reportedly the overall
mean of percentages reported for all of the respondents of each group are: 65.6% adults, 12.6% children, 28.6% couples, and 12.6% families (see Table 2).

Table 2

**Professional Characteristics of Clergy Sample of Pastoral Counseling Population**

<table>
<thead>
<tr>
<th></th>
<th>Adults (Individuals)</th>
<th>Children (Individuals)</th>
<th>Couples (Individuals)</th>
<th>Families (Individuals)</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>65.57</td>
<td>M - 12.57</td>
<td>M - 28.87</td>
<td>M - 12.6</td>
</tr>
<tr>
<td>SD</td>
<td>25.05</td>
<td>SD - 11.26</td>
<td>SD - 23.3</td>
<td>SD - 9.21</td>
</tr>
<tr>
<td>Minimum</td>
<td>10</td>
<td>Minimum – 1</td>
<td>Minimum – 1</td>
<td>Minimum – 1</td>
</tr>
<tr>
<td>Maximum</td>
<td>100</td>
<td>Maximum – 50</td>
<td>Maximum – 100</td>
<td>Maximum - 50</td>
</tr>
</tbody>
</table>

*Note.* The values represent the mean, standard deviation, and range of estimated percentages for each population that clergypersons provide pastoral counseling (N=125).

The participants were asked to report how often they provide pastoral counseling (1 = Daily, 2 = Weekly, 3 = Monthly). In this group, the percentages of clergypersons providing pastoral counseling are: 8% daily, 49% weekly, and 43% monthly (see Table 3). The population served was explored by asking the clergypersons whether they provide counseling to non-congregational members (1 = Yes, 0 = No). 83% of clergypersons stated that they provide pastoral counseling to non-members of the congregation and 17% stated that pastoral counseling was provided only with congregational members. The clergypersons were also asked how many years of experience they have in pastoral counseling (1 = Less than 5 years, 2 = 5-10 years, 3 = 11-20 years, 4 = 20-30 years, 5 = 30+). It was revealed that the most common choice was that 30% of the participating clergypersons reported 11 to 20 years of pastoral counseling experience (see Table 3).

Table 3

**Professional Characteristics of Clergy in Pastoral Counseling**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Non-Members</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>Yes – 16.8%</td>
<td>Less than 5 – 11.2%</td>
</tr>
<tr>
<td>Weekly</td>
<td>No – 83.2%</td>
<td>5 – 10 yrs. – 20%</td>
</tr>
<tr>
<td>Monthly</td>
<td></td>
<td>11 – 20 yrs. – 29.6%</td>
</tr>
</tbody>
</table>

*Note.* The values are mean percentages of clergypersons who provide pastoral counseling (N=125).
Measures

Five variables are examined in the current study: academic education, interprofessional education, teamwork and communication skills, trust, and interprofessional collaborative practice. In order to evaluate these variables, quantitative methods of survey research will be applied in the gathering and analyses of data. According to Nelson (1996), survey research is “a method of collecting data from or about a group of people, asking questions in some fashion about things of interest to the researcher for the purpose of generalizing to a population represented by the group or sample” (p. 447). The data was collected by using a demographic questionnaire, a standardized subscale measure of teamwork and communication skills, and a research based developed measure of the variables, interprofessional education, trust and interprofessional collaborative practice [Appendix A].

Demographic Questionnaire

The demographic questionnaire was used to gather information in 3 domains of the participating clergyperson: academic education, personal characteristics, and professional characteristics/services.

To capture a richer understanding of the nature of the participants, each individual clergyperson represented answers to questions in the demographic survey that addresses personal and professional characteristics. As previously stated, the demographic questionnaire includes questions focusing on the individual (e.g., age, race/ethnicity, gender) and on the individual’s context or church institution (e.g., denomination, population served, mental health services provided, and availability of mental health services to the community).

Academic Education (AE). In this study, the independent variable academic education is a categorical variable and is operationally defined as the level of education received in an academic institution. AE is addressed in the demographic section of the survey. Academic education is summarized into the following levels: High school diploma, Associates degree, Bachelors degree, Masters degree and Doctoral degree. In the demographic survey, participants are asked to report their highest level of education achieved by choosing one of the five levels of attainment, and note their academic major or program of study. Academic education is evaluated by the following categories and
coding pattern: Doctorate (1) – others (0), Masters (1) – others (0), and Bachelors (1) – others (0). Each category has a range of 0 to 1. Therefore, if anyone selected that they had below a Bachelors degree then they would have a zero.

*Standardized Instrument- Communication and Teamwork Subscale*

The standardized measure is used to explore the independent variable of this study, teamwork and communication skills (TWC), by applying one of the three attitudinal scales, *The Communication and Teamwork subscale of The University of West England (UWE) Interprofessional Questionnaire* (IPQ) (Pollard, Miers, & Gilchrist, 2004). The *University of West England (UWE) Interprofessional Questionnaire* (IPQ) (Pollard, Miers, & Gilchrist, 2004) is used to evaluate the variable teamwork and communication skills. The IPQ is a survey questionnaire developed by a team of researchers who collectively generated a number of statements based on issues identified from research literature. Three attitudinal subscales were generated which addressed these areas: *The Communication and Teamwork Scale, The Interprofessional Learning Scale, and The Interprofessional Interaction Scale* (Pollard et al., 2004). The three scales comprise the UWE Interprofessional Questionnaire (IPQ). However, only the Communication and Teamwork Scale (modified) is applied in this research study with a Pearson’s correlation coefficient of 0.78 (p < 0.001). The internal consistency of each scale was assessed by means of Cronbach’s alpha coefficient. The coefficient obtained for the Communication and Teamwork scale was 0.76 (n = 813), suggesting moderate to high reliability. Reliability was assessed by means of Cronbach’s alpha coefficient once data was collected. For this sample, the coefficient obtained for the Communication and Teamwork scale was 0.77 (n = 149) with a mean of 27.9 (s.d. = 3.27) with a range of 9 to 36 (see Table 4).

For the purposes of this study, the Communication and Teamwork subscale is modified with the permission of the authors. The items on the scale were restructured to address the specified populations: clergypersons and mental health professionals. For example, the term “group” was altered in the scale to a more specific group such as clergypersons or mental health professionals. Although the questions themselves were not changed, modifications to the terms were changed.
The Communication and Teamwork subscale is a 9-item measure. It uses a 4 point Likert-style format ranging from (1) strong disagreement to (4) strong agreement. Summary scores range from a minimum of 9 to maximum score of 36 (Pollard et al., 2005; Pollard et al., 2004). The subscale is found in Section I of the measure questions one through nine. The item responses range from Strongly Disagree = 1, Disagree = 2, Agree = 3, and Strongly Agree = 4, which results in a continuous score. For four of the questions (3, 4, 6, and 7) reverse scoring was applied. Overall, the higher the score means the higher the level of teamwork and communication skills of the participating clergyperson.

**Developed Measure**

No standardized instruments were found to measure a clergypersons’ interprofessional education, trust, or participation in interprofessional collaborative practice. Therefore, to investigate these variables a measure was created based upon research literature. The developed scale is focused on the exploration of the independent variables interprofessional education and trust as well as the dependent variable interprofessional collaborative practice. According to Nelson (1996), when utilizing survey research, one way to increase reliability is to test to “make sure that the questions one has developed are clear and unambiguous so that the responses are not as likely to change from respondent to respondent due to interpretations” (p. 464). Also, to increase validity or strength in data collected, Nelson (1996), recommends “using the opinions from independent judges, with expertise in the subject matter and who might be similar to the surveyed sample” (p. 465). Therefore, in order to assess whether the items or questions created in this developed scale are reliable or valid, a pre-test and individual feedback session occurred with a small group of clergypersons.

**Interprofessional education (IE).** In the previous chapter, interprofessional education is defined as a diverse group of professionals learning together toward a common goal or in providing a particular service in which each professional learns their roles and responsibilities through shared tasks, skills and protocols (Parsell & Bligh, 1998, Williams et al., 1978). It is operationally defined as the participation in an educational training, seminar, or workshop with mental health professionals to provide a particular service or meet a common goal. In Section III of the measure, the participating
clergypersons are asked to state whether they have participated in interprofessional education with mental health professionals such as seminars and/or workshops. The questions that explore this variable are the first two questions in Section III of the measure. These two questions are dichotomous in which the two questions are summed resulting in a continuous score. Every No or Yes response is scored with 0 or 1. Higher scores mean that the clergypersons have participated more in interprofessional education.

Due to the context in which the questions were asked, it was recognized that the two questions used to explore the respondent’s experience in interprofessional education were very similar. For example, in the survey, question one explored whether the clergyperson participated in workshops only with colleagues within their profession. The second question in section III of this survey investigated whether the respondents participated in workshops or trainings with mental health professionals with an objective to provide a common service or goal. It was also discovered that due to the lack of items to investigate this independent variable, it would not be in the best interest to code this as a continuous score scale because two items minimizes the level of reliability that can be placed on the items used to measure this variable. Consequently, it was determined that due to the similarity in questions and the lack of items to explore the variable interprofessional education, only question two in Section III of the measure would be applied in this research study. Therefore, in order to determine whether the clergyperson has participant experience in interprofessional education, question two of Section III of the measure was coded as a dichotomous variable with 0 = No and 1 = Yes. As a result, it was concluded that a clergyperson has interprofessional educational experience if they respond to question two with a yes response.

Trust (Trust). Trust is the “the obligation or responsibility imposed on a person in who confidence or authority is placed: a position of trust; to have confidence in; rely or depend on” (Random House Dictionary, 1997). In this research project, trust is investigated by survey questions and is based upon the operational definition of trust developed by Tschannen-Moran and Hoy (2000). As mentioned in Chapter 2, the meaning of trust has five components: benevolence, reliability, competence, honesty, and openness (Tschannen-Moran & Hoy, 2000). In accordance to the research literature, these
five components are used to measure the level of trust clergypersons have with mental health professionals.

After stating the definition of trust, the researcher will address the clergyperson’s level of trust, through six questions developed in a Likert scale format (e.g., On a scale of 5-strongly agree to 1-strongly disagree) in interprofessional collaborative practice with mental health professionals. The variable trust is addressed in Section II of the measure, questions one through six. The six questions are in a five response Likert scale format ranging from Strongly agree to Strongly disagree. For this study the responses to the six questions are summed resulting in a continuous score: Strongly Agree = 5, Agree = 4, Uncertain = 3, Disagree = 2, Strongly Disagree = 1. The higher scores in the summation of the scores mean that the clergypersons have higher levels of trust in mental health professionals. For this sample, a Cronbach’s alpha coefficient obtained for the Trust scale was 0.82 (n = 149) with a mean of 23 (s.d. = 3.14) with a range of 6 to 30.

Interprofessional Collaborative Practice (ICP). According to Snyder and Rice (1996), in initial scale construction there is a requirement of an item format. The true-false or yes-no format offers several positive features such as economy of administration, and scoring. The authors state that within given time and space constraints, yes-no or true-false items permit broader sampling of a construct domain as well as potentially higher reliability and generalizability.

The goal of this scale is to determine whether clergypersons actually participate in interprofessional collaborative practice. Therefore, I thought that asking the question in which specific activities stated by research to qualify as interprofessional collaborative practice would provide more information. For the purposes of this present research study, I am not interested in understanding the frequency of participation nor am I interested in knowing which activities are ranked highest among the list. These are possible future research projects. My interest is in whether or not they actually participate in the practice of interprofessional collaboration.

For the purposes of this research, interprofessional collaborative practice is recognized as the dependent variable and is defined as the activities that take place when one is participating in interprofessional collaboration. To explain how interprofessional collaboration takes place, Billups (1987) built on a seven stage process suggested by
Kramer (1956) to explain the concept of teamwork. Billups (1987) states that these seven stages of collaboration occur on a continuum from less to more intensity or complexity within cooperative relationships and they are: (1) acquaintanceship to, (2) exchanging information, (3) consultations, (4) referrals, (5) planning and coordination, (6) concurrent cooperative services, and (7) joint operating responsibility. In keeping with the theoretical perspective and the concept of reciprocity between systems, exchanging information, consultations, and referrals were separated into two questions. Thus, it is asked whether the clergypersons received but also provided these collaborative activities to mental health professionals. This variable is addressed in Section III of the measure questions three through eleven. For this study the responses to the nine questions are summed resulting in a continuous score for 0 to 9. That every No or Yes response is scored with 0 or 1 in which higher scores meaning that the clergypersons are participating more in collaborative practice. For this sample, a Cronbach’s alpha coefficient obtained for the Interprofessional Collaborative Practice scale was 0.80 (n = 149) with a mean of 3.70 (s.d. = 2.45) with a range of 0 to 9.

Procedures

To achieve a thorough investigation of the relationships among the variables believed to be associated with interprofessional collaborative practice, the information is collected by means of survey distribution. A packet is presented to each individual participant. The packet consists of a consent form to participate in the research study and the survey questionnaire. Upon receiving consent to participate from each individual clergyperson, they are then asked to complete the survey questionnaire.

On the survey questionnaire, the participating clergyperson is asked about demographics of the church (e.g., population served, mental health services provided, availability of mental health services to the community), the clergyperson’s personal characteristics (e.g., age, race/ethnicity, gender, and denomination), level of academic education, teamwork skills, trust, interprofessional education, and their participation in interprofessional collaborative practice. After the completion of the survey questionnaire, the participating clergyperson placed their completed consent and survey forms back in the packet and was assigned a subject identification number.
Summary

In summary, the representative clergypersons of this study are Protestant, White males with a mean age of 53 years of age. Out of a sample of 149 respondents, 84% (n = 125) stated that they provide pastoral counseling. The respondents report that they have more than 11 years experience providing pastoral counseling weekly, primarily to adults and couples who may or may not be members of their congregation.

As a result of the responses to the scales used in this study for the variables, teamwork and communication skills, trust, academic education, interprofessional education and interprofessional collaborative practice, the collection of the responses with each represented variable were diverse. For Teamwork and communication skills, the clergypersons were found to have a mean score of 27.9 with an actual score range of 9 to 36 (see Table 4). This shows a moderately high level of scoring of teamwork and communication skills among clergypersons. The overall mean score for the trust scale was 23 with an actual score range of 6 to 30. This result shows a moderately high level of scoring with trust among clergypersons with mental health professionals. Since academic education and interprofessional are only one item variables, there is no range of scores; therefore, for reporting purposes, the focus will be on the mode scores. As shown below in Table 4, the mode scores reveal that majority of the clergypersons had achieved a Master level degree in academic education and participated in interprofessional education.

When exploring the scores for the dependent variable Interprofessional Collaborative Practice, it was found that the mean score for the scale was 3.7 with an actual score range of 0 to 9 (see Table 4). This is a moderately low level of scoring for participation of clergypersons in Interprofessional Collaborative Practice. When evaluating more closely the mode or highest level of participation of the clergypersons in ICP, the mode score revealed that majority of the clergypersons participated in at least two activities of interprofessional collaborative practice. A more exploratory assessment was completed of each item on the scale to understand what ICP activities appear to have frequent participation by clergypersons and two activities were identified- an acquaintanceship with MHP and making a referral to a MHP.
Table 4

*Descriptive Frequencies of Dependent and Independent Variables*

<table>
<thead>
<tr>
<th></th>
<th>TWC</th>
<th>Trust</th>
<th>IE</th>
<th>B</th>
<th>M</th>
<th>D</th>
<th>ICP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>27.9</td>
<td>22.9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3.7</td>
</tr>
<tr>
<td>Mode</td>
<td>27</td>
<td>24</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Range</td>
<td>9 - 36</td>
<td>6 – 30</td>
<td>0 – 1</td>
<td>0 – 1</td>
<td>0 – 1</td>
<td>0 – 9</td>
<td></td>
</tr>
<tr>
<td>Minimum</td>
<td>19</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Maximum</td>
<td>36</td>
<td>30</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Interprofessional Collaborative Practice (ICP), Teamwork and communication skills (TWC), Interprofessional education (IE), and Academic education (Doctorate (D), Master (M), and Bachelor(B)).

In order to adequately address the specified research questions, Multiple Regression Analysis was applied to analyze the data gathered. In the next chapter, the results of the data analysis will be reported.
CHAPTER IV
Results

In the previous chapter, the demographics of the participants, the measures, and the procedures for the collection of the data were reported in accordance with the purpose of this research study. In this chapter, I will report the findings from the data analysis in answering the research questions. The central research question is: To what extent do the independent variables—level of academic education (AE), participation in interprofessional education (IE), teamwork and communication (TWC) skills, and trust—influence the participation of clergypersons in interprofessional collaborative practice (ICP)?

The specific research questions are: what are the relationships among the clergypersons’ level of academic education, TWC skills, trust, as they relate to participation in interprofessional collaborative practice? Also, what are the relationships among the clergypersons’ participation in interprofessional education, level of trust, and TWC skills as they relate to participation in interprofessional collaborative practice?

For these research questions it was hypothesized that: There is a negative relationship between the level of academic education, trust and TWC skills as it relates to the participation in interprofessional collaborative practice; and there is a positive relationship between participation in interprofessional education, trust, and TWC skills as it relates to participation in interprofessional collaborative practice.

As previously mentioned in Chapter 3, 149 clergypersons participated in this research study by voluntarily and anonymously completing a survey questionnaire. When entering the responses from the participants, it was found that some of the respondents did not provide complete responses. However, instead of deleting the responses that had missing values, replacement of missing observations was the method applied to replace the missing data (Tate, 1998). Replacement of missing observations is accomplished by replacing each missing value with the variable mean computed from the responses of participants who had provided responses for the variable. This method was chosen because it prevents the loss of sample size and statistical power (Tate, 1998).

In order to adequately address the research questions, multiple regression analysis was applied to analyze the data gathered. Multiple regression analysis is a general
statistical procedure for investigating the relationship of a dependent or criterion variable to two or more independent or predictor variables (Snyder & Mangrum, 1996). There are three major analytic strategies in multiple regression: standard (simultaneous) multiple regression, sequential (hierarchical) regression, and statistical (stepwise) regression. The differences between these three strategies are all dependent upon the method of ordering the entry of independent variables into the equation during the regression analysis (Tabachnick & Fidell, 2001). For this study, the plan is to use standard multiple regression analysis in order to meet the overall purpose of this study which is “to examine the overall utility of predictor variables considered in their entirety” (Snyder & Mangrum, 1996, p. 322).

Initially to examine the data, a case analysis and assessment of validity of assumptions was completed. In the case analysis, no apparent outliers were identified, with each having a studentized residual of approximately 2.4. Visual inspection of the scatter-plot of the model did not suggest any violations of the multiple regression analysis assumptions of correct fit, constant variance, normality, and independence.

Below is the correlation matrix which reveals the relationships or correlations of each variable with one another (see Table 5). When evaluating the variables within a correlation matrix, it is important to consider the measurement characteristics to determine whether to assess covariation using parametric (Pearson correlation coefficient) or nonparametric (Spearman rho correlation coefficient) analyses. Pearson correlation coefficient is used when the measure is based on an interval or ratio scale. Spearman rho (\(\rho\)) is used where the variable(s) are measured using ordinal or rank order without implied equal distance between adjacent ranks (Snyder & Mangrum, 1996). Therefore, for the purposes of this study, the interval and ratio variables such as teamwork and communication skills, trust, and interprofessional education are assessed using Pearson correlation coefficient. Academic education, an ordinal variable, is assessed using Spearman rho (\(\rho\)) correlation coefficient.

The findings within the correlation matrix showed that each independent variable: teamwork and communication skills (TWC), trust, interprofessional education (IE) and only one of the categories for academic education have positive relationships with the dependent variable, interprofessional collaborative practice (ICP). The categories, Master
degree-others and Bachelor degree-others, were not found to have a positive relationship with interprofessional collaborative practice. Thus, as TWC skills and trust increase so does the level of practice in interprofessional collaboration. This finding also reveals that clergypersons that have a doctorate level education are more likely to describe interprofessional collaborative practice than are clergypersons who have earned a Masters or Bachelors degree.

Also, revealed in the correlation matrix in Table 5, the independent variable, interprofessional education has the strongest correlation with the dependent variable, interprofessional collaborative practice. This finding show that the clergyperson who participate in interprofessional education have a positive association with practice in interprofessional collaboration. Therefore, teamwork and communication skills (TWC), trust, interprofessional education (IE) and Doctorate degree have a significant relationship with the dependent variable, ICP.

As previously mentioned, the correlation matrix shows all of the relationships each variable has with one another. When focusing on the correlations among the independent variables, TWC skills, trust, interprofessional education, and academic education (i.e., Doctorate, Master, and Bachelor degree) there are a couple notable findings.

There are several negative correlations in the correlation matrix. For instance, doctoral education was found to be negatively correlated with interprofessional education and the other two categories for academic education. Also, clergypersons with Master degrees were positively associated with participation in interprofessional education, but were less likely to report trust or TWC. With the academic education category, Bachelor degrees-others, the results revealed that it was negatively correlated with all other variables except TWC skills and trust. This result shows that clergypersons that achieved a Bachelor degree have positive association with teamwork and communication skills and trust.

It is also revealed in the correlation matrix that there is a lack of significant correlations between several independent variables (see Table 5). Specifically, there is a lack of significance in the relationships with the independent variables trust and TWC skills.
skills when in comparison with the variables focused on education (e.g., interprofessional education and the academic education categories).

Table 5

**Correlations Between Independent and Dependent Variables**

<table>
<thead>
<tr>
<th></th>
<th>ICP</th>
<th>TWC</th>
<th>Trust</th>
<th>IE</th>
<th>Doctorate</th>
<th>Master</th>
<th>Bachelor</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TWC</td>
<td>0.207*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>0.256*</td>
<td>0.271*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IE</td>
<td>0.349*</td>
<td>0.238*</td>
<td>0.121</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctorate (ρ)</td>
<td>0.267*</td>
<td>0.126</td>
<td>0.078</td>
<td>-0.010</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master (ρ)</td>
<td>-0.091</td>
<td>-0.164*</td>
<td>-0.003</td>
<td>0.064</td>
<td>-0.681*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bachelor (ρ)</td>
<td>-0.018</td>
<td>0.005</td>
<td>0.072</td>
<td>-0.017</td>
<td>-0.132</td>
<td>-0.372*</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: Interprofessional Collaborative Practice (ICP), Teamwork and communication skills (TWC), Interprofessional education (IE), and Academic education (Doctorate, Master, and Bachelor).

(ρ) Spearman Rho correlation coefficient
* Significant, p<0.05 level

The multiple regression was next examined (see Table 6). The ability of all of the predictor or independent variables to predict the outcome or dependent variable is represented by the multiple correlation coefficient (R) which is 0.50. The model R² of 0.25, reflecting the overall strength of relationship between participation in interprofessional collaborative practice (ICP) and the independent variables, is statistically significant at the 0.05 level. The adjusted R², compensating for the positive bias in R², is 0.22, reflecting a relatively modest overall strength of the relationship. The standard error of estimate is 2.16. The adjusted R² can be interpreted as meaning that the independent variables in this model explain 22% of the variance found in the dependent measure.

There is not a significant relationship between teamwork and communication skills and interprofessional collaborative practice. There is an estimated change of 0.060 participation units for every unit of change in teamwork and communication skills, controlling for all other variables. There is a positive effect of trust on interprofessional collaborative practice, not significant at the 0.05 level (p<0.06). There is an estimated change of 0.116 participation units for every unit of change in the level of trust, controlling for all other variables. There is a positive effect of interprofessional education on interprofessional collaborative practice, significant at the 0.05 level (p>0.000), in
which an estimated change of 1.543 participation units for every unit of change in the level of interprofessional education is reflected, controlling for all other variables.

Lastly, with academic education being a categorical variable, it is represented by 3 levels of academic education: Doctorate degree, Master degree, and Bachelor degree. The results for the 3 associated comparisons show that the Doctorate degree ranked highest with respect to predicted practice in interprofessional collaboration. With respect to significance, only the category Doctorate degree-other was found to be a significant at the p< 0.05 level (see Table 6).

Table 6

<table>
<thead>
<tr>
<th>Variables</th>
<th>Effect Estimate (β)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teamwork and communication (TWC) Skills</td>
<td>0.060</td>
<td>0.31</td>
</tr>
<tr>
<td>Trust</td>
<td>0.116</td>
<td>0.06</td>
</tr>
<tr>
<td>Interprofessional Education</td>
<td>1.543*</td>
<td>0.00*</td>
</tr>
<tr>
<td>Academic Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctorate degree-others</td>
<td>2.593*</td>
<td>0.00*</td>
</tr>
<tr>
<td>Master degree-others</td>
<td>1.132</td>
<td>0.10</td>
</tr>
<tr>
<td>Bachelor degree-others</td>
<td>1.137</td>
<td>0.23</td>
</tr>
</tbody>
</table>

*Significance, p<0.05 level

Although the results reveal that in the model the independent variables together explain 25% of the variance of the dependent variable, interprofessional collaborative practice, only interprofessional and academic education were found to be significant contributors. In order to understand how much these two independent variables, interprofessional and academic education explain the variance of interprofessional collaborative practice, a stepwise multiple regression analysis was accomplished.

Stepwise entry is applied in order to understand the strongest combination of predictor or independent variables (Snyder & Mangrum, 1996). Forward inclusion, combined with deletion of variables that no longer meet the predetermined statistical criteria (F<0.05), is selected for the purpose of this research. When using this procedure in SPSS (version 14.0), initially interprofessional education was the first independent variable to be included in the model, and then the academic education (i.e., Doctorate)
was included in the model. The last independent variable entered into the model was trust.

As previously mentioned and revealed in Table 7 below, the ability of all of the predictor or independent variables to predict the outcome or dependent variable is represented by the multiple correlation coefficient (R) which is 0.50. The model $R^2$ of 0.25, reflecting the overall strength of relationship between participation in interprofessional collaborative practice (ICP) and the independent variables, is statistically significant at the 0.05 level. The adjusted $R^2$, compensating for the positive bias in $R^2$, is 0.22, reflecting a relatively modest overall strength of the relationship (see Table 7).

When using stepwise procedures, the first variable to be included was interprofessional education. As revealed in Table 7, the ability of interprofessional education to predict the outcome or dependent variable is represented by the multiple correlation coefficient (R) which is 0.35. The model $R^2$ of 0.12, reflecting the overall strength of relationship between participation in interprofessional collaborative practice (ICP) and the independent variables, is statistically significant at the 0.05 level. The adjusted $R^2$, compensating for the positive bias in $R^2$, is 0.12, reflecting a relatively modest overall strength of the relationship.

In the next step, the independent variable academic education (doctorate) was included along with interprofessional education. The ability of interprofessional education and academic education (doctorate) to predict the outcome or dependent variable is represented by the multiple correlation coefficient (R) which is 0.45 (see Table 7). The model $R^2$ of 0.20, reflecting the overall strength of relationship between participation in interprofessional collaborative practice (ICP) and the independent variables, is statistically significant at the 0.05 level. As shown in Table 7, the adjusted $R^2$, compensating for the positive bias in $R^2$, is 0.19, reflecting a relatively modest overall strength of the relationship.

Lastly, the independent variable, trust is included into the model with interprofessional education and academic education (doctorate). The ability of interprofessional education, academic education (doctorate), and trust to predict the outcome or dependent variable is represented by the multiple correlation coefficient (R)
which is 0.49. The model $R^2$ of 0.24, reflecting the overall strength of relationship between participation in interprofessional collaborative practice (ICP) and the independent variables, is statistically significant at the 0.05 level. The adjusted $R^2$, compensating for the positive bias in $R^2$, is 0.22, reflecting a relatively modest overall strength of the relationship (see Table 7).

Table 7

*Summary of Models using Standard & Stepwise with Multiple Regression Analysis*

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>$R^2$</th>
<th>Adjusted $R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 1$^a$</td>
<td>0.50</td>
<td>0.25</td>
<td>0.22</td>
</tr>
<tr>
<td>Model 2$^b$</td>
<td>0.35</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>Model 3$^c$</td>
<td>0.45</td>
<td>0.20</td>
<td>0.19</td>
</tr>
<tr>
<td>Model 4$^d$</td>
<td>0.49</td>
<td>0.24</td>
<td>0.22</td>
</tr>
</tbody>
</table>

a. All predictor or independent variables  
b. Included IV variable: interprofessional education  
c. Included IV variables: interprofessional education and academic education (doctorate)  
d. Included IV variables: interprofessional education, academic education (doctorate), and trust

In the next chapter, I will summarize and discuss the findings reported from the analyzed data stated in this chapter. Also, I will report the limitations of this study and suggest recommendations for future research.
CHAPTER V
Conclusions

Most of the literature on the interprofessional collaboration between clergy and mental health professionals has been theoretical or applied, exploring the possible benefits and obstacles of such a relationship (Edwards et al., 1999). This research study investigates the practice of interprofessional collaboration, which is identified in this study as the intersetting communication between the micro-systems of mental health and the church, by exploring the relationships among the variables repeatedly considered as obstacles or benefits to interprofessional collaboration such as teamwork and communication skills, education (academic and interprofessional), and trust.

In order to examine the relationships between these specific variables suggested by previous researchers to be influential to the practice of interprofessional collaboration between other professionals, a convenience sample of clergypersons was recruited. The sample consisted of clergypersons of Christian churches throughout the state of Florida. One hundred forty-nine clergypersons voluntarily and anonymously participated in this study by completing a survey questionnaire. The questionnaire included measures of the clergypersons’ personal/professional characteristics as well as standardized and developed scales used to examine the dependent and independent variables. The data provided by the participating clergypersons were analyzed by multiple regression analysis (SPSS version 14.0).

The analysis revealed that the four independent variables, teamwork and communication skills, trust, academic education and interprofessional education each have a positive bivariate relationship with the dependent variable, interprofessional collaborative practice. This positive relationship suggests that participation in interprofessional collaborative practice increases as the level of academic education increases, and as trust, teamwork and communication skills, and participation in interprofessional education increase. Despite the positive relationships among all of the independent variables, interprofessional education and academic education are found to have the strongest positive indicators of variability in interprofessional collaborative practice. They were also the only variables found to significantly contribute to the variation in the dependent variable in the multivariate analysis. This finding led to a close
evaluation of these two variables, interprofessional and academic education, when exploring the overall variance.

Overall, the analysis revealed that the model of four independent variables together explain 25% of the variance of the dependent variable, interprofessional collaborative practice. In other words, this model of four variables can account for 25% of the variation of interprofessional collaborative practice. However, when stepwise regression analysis was applied it revealed that 20% of the variance of the dependent variable, interprofessional collaborative practice was explained by interprofessional education and academic education (doctorate) alone. Also, after the inclusion of education (interprofessional and academic) and the independent variable, trust, 24% of the variance is explained of interprofessional collaborative practice. The findings revealed as a result of using stepwise procedures established the conclusion that education (interprofessional and academic) overshadows the other two variables thus leaving very little variance of interprofessional collaborative practice to be explained. Therefore, in both procedures (i.e. standard & stepwise regressions) educational variables are found to be the strongest associated variables of practice of interprofessional collaboration in this model.

So what allows interprofessional education to have such an influential relationship with interprofessional collaborative practice? This finding could possibly be due to interprofessional education being the rationale for interprofessional collaborative practice. Operationally defined interprofessional education is the participation of clergypersons in an educational training, seminar, or workshop with mental health professionals to provide a particular service or obtain a common goal. Interprofessional collaborative practice is defined as the actual procedures or activities that occur within interprofessional collaboration such as acquaintanceship to, exchanging information, consultations, referrals, planning and coordination, concurrent cooperative services, and joint operating responsibility. When comparing the objectives stated in these definitions, one can possibly conclude that interprofessional education is the preparation to be involved in the activities of interprofessional collaborative practice.

Academic education was also found to be a positive significant contributing variable in the model. As previously mentioned in Chapter 2, there has been mixed
findings in research on whether academic education is a benefit or obstacle to interprofessional collaborative practice (Mannon & Crawford, 1996; Oppenheimer et al., 2004). According to the results in this analysis, it appears that academic education has a strong correlating variable to the analysis. The finding of this study runs contrary to those reported in past research literature which suggest that when people have a higher level of education they are less likely to be associated with people who are outside their profession (Hall, 2005; Pollard et al., 2005). In this research study, the findings reveal that lower levels of academic education were negatively correlated with participation in interprofessional collaborative practice.

Does this mean teamwork and communication skills and trust are not important contributors to the practice of interprofessional practice? No, although the results of this study show that these variables were not strong or significant predictors in the multiple regression analysis, they were still found to have significant positive correlations with interprofessional collaborative practice in the correlation matrix. In other words, as the participating sample of clergypersons’ TWC skills and trust increase so does their level of participation in interprofessional collaborative practice. The important relationships between these two variables and interprofessional collaborative practice found in this study confirms what past researchers have stated about trust and teamwork and communication skills being vital to interprofessional collaboration (Cooley, 1994; Nicholson et al., 2000). However, in the analysis in the model it was revealed that TWC skills and trust were not found to be significant may reflect an overlap with these variables by the educational variables (i.e. academic and interprofessional). This overlap may support past literature that suggest that education cultivates the opportunity for professionals to build and enhance their teamwork and communication skills and trust in interprofessional collaborative practice (Mannon & Crawford, 1996; Oppenheimer et al., 2004) thus being more significant to the participation in ICP.

As reported in Chapter 3, when exploring dependent variable interprofessional collaborative practice, it was found that the mean score of responses was 3.7 with an actual score range of 0 to 9. This mean score reflects that the average clergyperson participates in less than half of the activities for ICP. This is a moderately low level of scoring for participation of clergypersons in interprofessional collaborative practice.
When evaluating more closely the mode or highest level of participation of the clergypersons in ICP, the modal score revealed that majority of the clergypersons participated in two activities of interprofessional collaborative practice. A more exploratory assessment was completed to understand what ICP activities appear to have most the frequent participation by clergypersons by comparing the modal score for each question in the ICP scale which each question explores the participation of different activities of ICP. This assessment identified two activities that have the highest participation by clergypersons- an acquaintanceship with mental health professionals and making a referral to mental health professionals. This finding demonstrates that this sample of clergypersons have participated in ICP by establishing a relationship with a mental health professional or making a referral to a mental health professional within the last year.

*Limitations in this Research*

*Sample.* Due to the lack of diversity of the sample of this study, there is the lack of generalizability of the findings. The majority of the sample of clergypersons is Protestant (71.1%) White/Caucasian (70.5%) males (80.5%) which limit the application of the findings with populations that do not meet this sample make-up.

Another limitation with the sample of this study is that a convenient sample was recruited to participate. A random sample allows for an equal opportunity for all ordained clergypersons having a chance of participating in this study. In using a convenient sample rather than a random sample, a limit is placed on the opportunity to achieve a proportionate sample of the general population of clergypersons.

*Measures.* The instrument that was used to gather information about the clergypersons’ trust, interprofessional education, academic education and interprofessional collaborative practice was a developed measure. Although the developed survey was based upon past research literature, the scales used to measure these variables were not standardized instrument. Thus, there is a limit to the level of confidence or validity that can be placed on the results found in this study.

In order to meet the objective of this study, interprofessional education was assessed by one question. The number of items in a scale enhances internal consistency of the scale. Thus, the more items in a scale may strengthen the reliability of the results or
findings. The limitation in this study, with the developed measure applied, is that there is a lack of reliability due to the number of items used to measure interprofessional education.

**Procedures.** In this study, the means of gathering data was completed by the distribution of a survey questionnaire. According to Greenburg and associates (1996), data should be collected from different sources or methods (i.e., surveys, interviews, observations, etc) because this approach of data collection enhances theoretical sensitivity and ensures credibility of data. By using one source or method of data collection, there is another limitation to the findings.

**Analysis.** As mentioned in Chapter 4, for the participants who had missing values or responses the method *replacement of missing observations* was used to replace missing data. The limitation of this approach is that it can result in distorted sample statistics by reducing the variances due to adding many constant values (Tate, 1998).

**Recommendations for Future Research**

**Overall Recommendations.** This study has demonstrated that there is a link between education, interprofessional skills and levels of interprofessional practice. However, that link can only be determined in this study to covary. It is important to explore both the influence of education on collaboration, and the process of being more collaborative. In addition, it would be useful to explore the intended and unintended consequences of becoming more collaborative. For example, in future research, it would be valuable to conduct an experimental design exploring TWC skills and trust in relation with interprofessional education. For example, it would be practical to assess if there is a change in the level of TWC skills and trust before and after participation in interprofessional education.

Another constructive study would be an evaluation of clergypersons’ level of participation in interprofessional collaborative practice once they have completed an interprofessional education workshop that focuses specifically on training clergypersons and mental health professional on interprofessional collaboration.

In future research, a qualitative design would be beneficial to this area of research. It would be useful to explore the reoccurring variables in a collaborative relationship between mental health professionals and clergypersons while in their natural
settings and in the different stages suggested by Billups (1987) of interprofessional collaborative practice. This research could explore the development and establishment of the roles and responsibilities of the clergyperson and mental health professionals within each stage of interprofessional collaborative practice. This research could also explore the outcome of the target system at the different stages of interprofessional collaborative practice.

Sample. In future research, it would be beneficial to explore a more diverse sample of clergypersons. As previously mentioned, there was a lack of diversity in the sample, thus it would be more beneficial to have a sample where the ethnicity, gender and religious affiliation of the participants are more varied. Future research could identify differences among spiritual beliefs and values as it relates to the practice of interprofessional collaborative practice. There may be some religions that are not as likely to collaborate due to their belief system.

It is recommended that in the future, researchers would focus on intersetting communication of both micro-systems and not just one micro-system. In this study, only the responses of clergypersons of the church micro-system were investigated. It would be beneficial if in future research the mental health professionals are investigated to explore the relationships among the specified recurring variables with interprofessional collaborative practice.

Future research could also focus on how interprofessional collaborative practice between these two micro-systems affects the parishioner seeking treatment, the developing person or target system. It has been found in past research that there is a necessity of interprofessional collaboration for clergypersons; however, there is still a gap in research establishing the benefit of interprofessional collaborative practice for the parishioner seeking treatment. It is important to explore if the person receiving treatment from a collaborative effort is really better off.

Measure. As mentioned previously, the limitation in this study is that a developed measure was used to examine the variables. It is recommended that in future research, an instrument be developed and standardized that can be used to explore these variables to enhance the validity that can be placed on the results and findings in the study.
In addition, in future research the application of a measure with more items or questions for interprofessional education would be more beneficial. As mentioned previously as a limitation, the independent variables, interprofessional education was evaluated by one question. The design of a measure with more items to explore interprofessional education will possibly establish more support in the understanding of the relationship and predictability of interprofessional education with interprofessional collaborative practice.

**Procedures.** It would also be beneficial if in future research an observational evaluation of an interprofessional education training or workshop with clergy and mental health professionals is accomplished. This research would permit common themes or behaviors to be identified that appear to promote or encourage the development of activities or events that occur in interprofessional collaborative practice.

Observations and interviews could also be applied in future research by observing an interprofessional collaborative relationship between clergypersons and mental health professionals and interviewing the two groups about their experiences in the relationship. Applying these sources or methods of data collection would provide an opportunity to not only identify the reoccurring variables and what point of the relationship they are most apparent but these methods would possibly expose other variables critical to an interprofessional collaborative relationship between these groups.

**Implications for Clinical Practice**

As past research has shown, the need is definitely there for this collaborative relationship to take place. Reportedly, clergypersons have acknowledged in previous research literature that due to lack of competency and training of ministers as counselors, and the lack of time allotted to provide the service, interprofessional collaborative relationship is believed to be necessary to have with mental health professionals. This research is helpful to clinical practice because verifying the variables that associate with interprofessional collaborative practice will assist clergypersons determine the steps to take in order to develop or build a strong collaborative relationship with mental health professionals.

This study confirms that education is strongly associated to the practice of interprofessional collaboration. Therefore, it would be beneficial for clergypersons to
explore opportunities where they will increase their experience and participation in interprofessional education in which they are specifically working towards a collaborative relationship with mental health professionals. Increasing their experience and participation in interprofessional education will possibly enhance their trust with mental health professionals and teamwork and communication skills in interprofessional collaborative practice.

As a mental health professional, this research illustrates that the importance of developing relationships with clergypersons. This relationship may not only build upon the service provided but it could also build upon the service received by the target system or person seeking counseling. Also clergypersons may lack competence in training to counsel persons with mental health issues however the collaborative relationship may help clergypersons feel competent or confident in taking the appropriate steps to provide the parishioner the optimal counseling service.

This research study makes a small step on a long road of filling the gaps in this field of research. There is much more research to be accomplished in order to overcome the fractionalized service (Nicholson et al., 2000) provided when interprofessional collaborative practice between mental health professionals and clergypersons is not occurring for parishioners seeking counseling from a minister. This research study verifies the variables that past researchers have found to be influential to the practice of interprofessional collaboration. It is important to continue to build upon past research by establishing a much stronger foundation on this unrefined area of research.
APPENDIX A

Thank you for voluntarily participating in this research study by completing the survey questionnaire. Please follow the directions for each section and answer the questions accordingly.

I. Please CIRCLE the answer that most represents your opinion about each statement.

1. I feel comfortable justifying recommendations and/or offering advice face-to-face to professionals who are not members of the clergy.
   Strongly Agree  Agree  Disagree  Strongly Disagree

2. I feel comfortable explaining an issue to other professionals who are unfamiliar with the topic.
   Strongly Agree  Agree  Disagree  Strongly Disagree

3. I have difficulty in adapting my communication style (oral & written) to particular situations and audiences not associated professionally with the clergy.
   Strongly Agree  Agree  Disagree  Strongly Disagree

4. I prefer to stay quiet when other professionals in a group express opinions that I don’t agree with.
   Strongly Agree  Agree  Disagree  Strongly Disagree

5. I feel comfortable working in a group of varied professionals.
   Strongly Agree  Agree  Disagree  Strongly Disagree

6. I feel uncomfortable putting forward my personal opinions in a diverse group of professionals.
   Strongly Agree  Agree  Disagree  Strongly Disagree

7. I feel uncomfortable taking the lead in a group of varied professionals.
   Strongly Agree  Agree  Disagree  Strongly Disagree

8. I am able to become quickly involved in new teams and groups of varied professionals.
   Strongly Agree  Agree  Disagree  Strongly Disagree

9. I am comfortable expressing my own opinions in a group of diverse professionals, even when I know that other people don’t agree with them.
   Strongly Agree  Agree  Disagree  Strongly Disagree
II. Please CIRCLE the answer that most represents your opinion to the following statements.

Trust is defined as the obligation or responsibility imposed on a person in whom confidence or authority is placed: to have confidence in; rely or depend on. In using this definition, please answer the following questions.
1. I trust working collaboratively with a mental health professional and/or mental health professionals.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree
2. I have confidence I will not be taken advantage of when in collaboration with a mental health professional and/or mental health professionals.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree
3. I am secure that mental health professionals will be reliable or consistent in their efforts or methods when in collaboration.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree
4. I have a level of belief that mental health professionals are competent in the knowledge and skill necessary to counsel parishioners.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree
5. I am confident in mental health professionals being genuine or honest when in collaborative practice.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree
6. I have a sense of security that the mental health professional has a willingness to share information or demonstrate openness when in collaborative practice.
   Strongly Agree  Agree  Uncertain  Disagree  Strongly Disagree

III. Please answer the following questions and check or circle the answer that is applicable.
1. Have you only participated in workshops and/or trainings with colleagues from your own profession? Yes ____ No ____
2. Have you participated in workshops and/or trainings with mental health professionals with the purpose of providing a particular service or reach a common goal?
   Yes ____ No ____
3. Do you have an acquaintanceship with a mental health professional or mental health professionals?  Yes ___  No ___

4. Have you participated within the last year in meetings with mental health professionals to exchange information about church sponsored services? Yes ____ No ____
If yes, how frequently within the last year:
   a. A few times a year or less,
   b. Once a month,
   c. Less than once a month
   d. Once a week,
   e. Less than once a week

5. Have you received consultation from mental health professionals within the last year? Yes ____ No ____
If yes, how frequently within the last year:
   a. A few times a year or less,
   b. Once a month,
   c. Less than a month,
   d. Once a week,
   e. Less than once a week

6. Have you provided consultation for mental health professionals within the last year? Yes ____ No ____
If yes, how frequently within the last year:
   a. A few times a year or less,
   b. Once a month,
   c. Less than once a month,
   d. Once a week,
   e. Less than once a week
7. Have you referred parishioners to mental health professionals within the last year?
Yes ____  No _____
If yes, how frequently within the last year:
   a. A few times a year or less,
   b. Once a month,
   c. Less than once a month,
   d. Once a week,
   e. Less than once a week

8. Have you received referrals from mental health professionals within the last year?
Yes ____  No _____
If yes, how frequently within the last year:
   a. A few times a year or less,
   b. Once a month,
   c. Less than once a month,
   d. Once a week,
   e. Less than once a week

9. Have you planned and coordinated your services and programs with mental health professionals? Yes ____  No _____
If yes, how frequently within the last year:
   a. In the past but not currently
   b. Currently

10. Do you have concurrent (co-existing) cooperative (supportive) services with the services provided by mental health professionals (e.g., Similar related programs/services)?
    Yes ____ No _____
    If yes, how frequently within the last year:
    a. In the past but not currently
    b. Currently
11. Do you have services where there is a joint operating responsibility with mental health professionals? Yes ____  No ______
If yes, how frequently within the last year:
   a. In the past but not currently
   b. Currently

**Demographic Information**
1. Are you an ordained minister, pastor, or priest?  Yes ___  No ____
2. What is the highest degree you obtained?
   a. High school
   b. Associates
   c. Bachelors
   d. Masters
   e. Doctorate
3. What was the major/program of study in the highest degree obtained?
   ____________________________________________________________
4. What is your age? ______
5. What is your gender?
   a. Male
   b. Female
6. What is your race/ethnicity?
   a. White/Caucasian
   b. Black/African American
   c. Latin American
   d. Asian
   e. Native American
   f. Other--Please specify____________________________
7. What is your religious affiliation or denomination?
   a. Non-denomination
   b. Protestant
   c. Catholic
   d. Other: ______________________________
8. What is your title or role in your church? ____________________________________________

9. Do you provide pastoral counseling?  Yes ____ No ____
If no, you may stop here. Thank you for your participation in this research study. If yes, please answer the following questions (a - e).

a. How often:
   i. Daily
   ii. Weekly
   iii. Monthly

b. What estimated percentage of your pastoral counseling is with adults, children, couples, and/or families? (Totaling: 100%)
   i. Adults _____%
   ii. Children _____%
   iii. Couples _____%
   iv. Families _____%
   Total = 100%

c. What is the denomination of the church where you provide pastoral counseling?

   __________________________________________

d. Are the pastoral counseling services you provide available to non-congregational members? Yes ____ No _____

e. How many years of experience do you have in pastoral counseling?
   i. Less than 5;
   ii. 5 -10 years;
   iii. 11-20 years;
   iv. 20-30 years;
   v. 30+ years

THANK YOU FOR YOUR PARTICIPATION.
APPENDIX B

Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2742
(850) 644-8673 FAX (850) 644-4392

APPROVAL MEMORANDUM
Date: 3/26/2007
To: Michelle Thomas
Address: 10200 Belle Rive Blvd. #201/ Jacksonville, Florida 32256
Dept.: FAMILY & CHILD SCIENCE
From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
An Examination of the Components within the Interprofessional Process in Marital and
Family Therapy: Clergypersons and Collaborative Practice

The forms that you submitted to this office in regard to the use of human subjects in the
proposal referenced above have been reviewed by the Secretary, the Chair, and two
members of the Human Subjects Committee. Your project is determined to be Expedited
per 45 CFR § 46.110(7) and has been approved by an expedited review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit,
except to weigh the risk to the human participants and the aspects of the proposal related
to potential risk and benefit. This approval does not replace any departmental or other
approvals, which may be required.

If you submitted a proposed consent form with your application, the approved stamped
consent form is attached to this approval notice. Only the stamped version of the consent
form may be used in recruiting research subjects.
If the project has not been completed by 3/24/2008 you must request a renewal of approval for continuation of the project. As a courtesy, a renewal notice will be sent to you prior to your expiration date; however, it is your responsibility as the Principal Investigator to timely request renewal of your approval from the Committee.

You are advised that any change in protocol for this project must be reviewed and approved by the Committee prior to implementation of the proposed change in the protocol. A protocol change/amendment form is required to be submitted for approval by the Committee. In addition, federal regulations require that the Principal Investigator promptly report, in writing any unanticipated problems or adverse events involving risks to research subjects or others.

By copy of this memorandum, the Chair of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Human Research Protection. The Assurance Number is IRB00000446.

Cc: Thomas Cornille, Advisor
HSC No. 2007.245
January 17, 2007

Dear Dr. Thomas Cornille and Committee;

Ms. Michelle Thomas has our permission to use Beaches Women’s Partnership’s church directory for her doctoral research. These churches are located in the Ponte Vera/Palm Valley, Jacksonville Beach, Neptune Beach, Atlantic Beach and Mayport areas of Florida.

Sincerely,

Sharon L. Griffith, LMHC, NCC
Director
February 6, 2007

Dr. Thomas Cornille
Florida State University
Interdivisional Program of Marriage & Family Therapy
242 Sandels Building
Tallahassee, Florida 32306-1490

Dear Dr. Cornille and Committee:
Ms. Michelle L. Thomas has our permission to use the Beaches Ministerial Association’s (BMA) directory for the sole purpose of contacting members in connection with her doctoral dissertation research. It should be understood that actual participation in any related activity will be at the sole discretion of the individual member(s) and the directory is not to be used for any other purpose than that stated above.

We wish Ms. Thomas much success in this very worthwhile endeavor.

Sincerely,

Edward L. Asher
BMA Secretary
Dear Participant,

I am a graduate student under the direction of Professor Thomas Cornille in the Department of Family and Child Sciences at Florida State University. I am conducting a research study to examine the relationships of specific variables in interprofessional collaborative practice between clergypersons and mental health professionals in mental health counseling.

I am requesting your participation, which will involve completing a survey questionnaire. In the completion of this anonymous questionnaire you will be requested to answer survey and demographic questions about you and your church organization. The questionnaire will take 5 to 10 minutes to complete. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. The questionnaire is anonymous. The results of the study may be published but your name and title of your church organization will not be known.

If you have any questions concerning the research study, please call or email Michelle L. Thomas at (904) 234-6018 or mlt2538@garnet.acns.fsu.edu. You may also contact Dr. Thomas Cornille at (850) 644-4243 or tcorni@fsu.edu.

Return of the questionnaire will be considered your consent to participate. Thank you.

Sincerely,

Michelle L. Thomas, LCSW
APPENDIX F
Dissertation Codebook

**Teamwork Skills (I)**

*TWC1*
1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

*TWC2*
1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

*TWC3 (reverse)*
4 = Strongly Disagree
3 = Disagree
2 = Agree
1 = Strongly Agree

*TWC4 (reverse)*
4 = Strongly Disagree
3 = Disagree
2 = Agree
1 = Strongly Agree

*TWC5*
1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree
TWC6 (reverse)
4 = Strongly Disagree
3 = Disagree
2 = Agree
1 = Strongly Agree

TWC7 (reverse)
4 = Strongly Disagree
3 = Disagree
2 = Agree
1 = Strongly Agree

TWC8
1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

TWC9
1 = Strongly Disagree
2 = Disagree
3 = Agree
4 = Strongly Agree

Trust (II)

Trust1
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
Trust2
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
Trust3
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
Trust4
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
Trust5
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
Trust6
1 = Strongly Disagree
2 = Disagree
3 = Uncertain
4 = Agree
5 = Strongly Agree
IE/ Interprofessional Education (III)

IE1 (reverse)
0 = Yes
1 = No

IE2
1 = Yes
0 = No

ICP/ Interprofessional Collaborative Practice (III)

ICP1
1 = Yes
0 = No

ICP2
1 = Yes
0 = No

ICP3
1 = Yes
0 = No

ICP4
1 = Yes
0 = No

ICP5
1 = Yes
0 = No

ICP6
1 = Yes
0 = No

ICP7
1 = Yes
0 = No
ICP8
1 = Yes
0 = No

ICP9
1 = Yes
0 = No

**Academic Education (Demographics – Question 2)**

*AE*
1 = High School
2 = Associates
3 = Bachelors
4 = Masters
5 = Doctorate

**Demographics Questions**

*Dq1 (Ordained)*
1 = Yes
0 = No

*Dq3 (Major of Highest Degree)*
List Degree

*Dq4 (Age)*
List Actual Age

*Dq5 (Gender)*
0 = Male
1 = Female

*Dq6 (Race)*
0 = Other
1 = Native American
2 = Asian
3 = Latin American
4 = Black/ African American
5 = White/ Caucasian
$Dq7$ (Denomination)

0 = Other
1 = Catholic
2 = Protestant
3 = Non-Denomination

$Dq8$ (Church Position Title)

List position title

$Dq9$ (Pastoral counseling)

1 = Yes
0 = No

$Dq9a$ (Frequency)

1 = Daily
2 = Weekly
3 = Monthly

$Dq9b$ (population-Estimated percentages)

Adults
Children
Couples
Families

$Dq9d$ (non-members)

1 = Yes
0 = No

$Dq9e$ (experience)

1 = Less than 5 yrs.
2 = 5 – 10 yrs.
3 = 11 – 20 yrs.
4 = 20 – 30 yrs.
5 = 30+ yrs.
REFERENCES


Weaver, A. J. (1995). Has there been a failure to prepare and support parish-based clergy in their role as front-line community mental health workers?: A review. The Journal of Pastoral Care, 49, 129-149.


BIOGRAPHICAL SKETCH

Michelle Lillrose Thomas, LCSW

Education
Doctor of Philosophy December 2007
Florida State University-College of Human Sciences
Department of Family and Child Sciences - Marital and Family Therapy
Tallahassee, Florida

Master’s of Social Work August 2003
Florida State University-School of Social Work
Clinical Concentration
Tallahassee, Florida

Bachelor’s of Art May 2001
Paine College
Department of Psychology
Augusta, GA.

Refereed Publications
   Contemporary Family Therapy, 28(2), 201-210.

National Presentations
   Poster presented at the annual conference of the American Association for
   Marriage and Family Therapy, Kansas City, MO.
Professional Experience

Family Foundations
Jacksonville, Fl.
Manager, Westside Community Services
July 2007-present
Manage, design, and augment community groups and programs of the Westside community site. Responsibility includes: supervising staff, completing program reports, program research design and implementation.

Therapist & Community Development Social Worker
August 2006-July 2007
Conduct clinical intake assessments and individual, couple and family therapy. Also, design, facilitate, and implement community programs.

Florida State University-MFT Clinic
Tallahassee, Fl.
Therapist
August 2003-May 2006
Conduct clinical intake assessments as well as individual, couples, and family counseling.

Children’s Home Society
Tallahassee, FL
Family Therapist
May 2004-January 2005
Conduct clinical intake assessments and family therapy. Also, facilitated group and individual counseling in the Sexual Abuse & Infant Mental Health Treatment Program
FSU Student Counseling Center  
Tallahassee, FL  
Therapist  
January 2003-January 2004  
Conduct clinical intake assessments and facilitated group and individual treatment. Also, provide presentations and clinical workshops.

Gables Academy  
Stone Mountain, GA.  
May 1999-August 2001 (Summer)  
Counselor and Teacher’s Assistant  
Conduct group and individual counseling, and develop summarizations of students’ psycho-education files to present to faculty and staff. Also, taught classes in Math, Psychology, English, and Science to students ages 10-18.

Clinical Internships  
FSU Multidisciplinary Center  
Tallahassee, FL  
Intake Counselor  
January 2002-January 2003  
Interview parents for psychosocial assessments and write comprehensive reports. Also, formulate treatment referrals and recommendations and present case assessments during weekly staff meetings.

Volunteer and Associations  
Northeast Florida Association of Marriage & Family Therapists  
Jacksonville, Fl  
August 2006-present  
Student Member/ Newsletter committee—Co-editor of newsletter
Jerusalem Missionary Baptist Church  
Tallahassee, Fl.  
June 2002-August 2006  
Assist pastor in co-therapy with counseling couples and families

Tallahassee Association of Marriage & Family Therapy  
Tallahassee, Fl  
March 2004-August 2006  
General member/ Newsletter committee- Student editor of “Student News” Section

American Red Cross  
Tallahassee, Fl  
March 2004-August 2006  
Family Disaster Service volunteer

FSU Marriage and Family Therapy Graduate Association  
Tallahassee, Fl  
August 2004-August 2005  
Vice President

Professional Licensures, Certifications and Trainings  
Licensed Clinical Social Worker (LC# - SW 8552)  
Trained in Infant Mental Health Services  
Trained in Disaster Mental Health Services  
Certification in Sexual Abuse Treatment  
Certification in HIPAA Compliance  
Certification in CPR
Awards and Honors

- Kappa Omicron Nu National Honor Society (2005- present)
- Churches Homes Foundation Grant (2002-present)