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## **Discourses of collaborative failure: Identity, role, and discourse in an interdisciplinary world**

### **Abstract**

Discourses of interdisciplinary healthcare are becoming more centralised in the context of global healthcare practices, which are increasingly based on multi-system interventions. As with all dominant discourses that are narrated into being, many others have been silenced and decentralised in the process. Whilst questions of the nature and constituents of interdisciplinary practices continue to be debated and rehearsed, this paper focuses on the discourse of interdisciplinary collaboration using psychiatry as an example, with the aim of highlighting competing and alternative discourses.

The fundamental premise of this paper is that collaborative relationships form the basis of interdisciplinary practices in psychiatry. Through a critical engagement and a deconstructive reading of the pretext, context and subtexts of interdisciplinarity, we interrogate the concept of interdisciplinary practice within psychiatry. We contend that an important part of understanding and further conceptualising the discourse is through fracturing it. This process is illustrated in the successive stages of our conceptual map of discourse development: establishing, maintaining, and developing discourses. An understanding of interdisciplinary practice is not only critical for psychiatry but also offers important insights into the performance of collaborative failures and indeed successes across nursing and allied health professions.

**Key Words:** Collaborative failure; discourse analysis; interdisciplinary collaboration; professional identity; psychiatry.

In recent years there has been a global trend in the funding of healthcare research favouring interdisciplinary research teams. In the UK, the Medical Research Council (MRC) and the Economic and Social Sciences Research Council (ESRC) support a range of interdisciplinary studentships, fellowships and funding programmes and the research councils' commitment to interdisciplinary research is clearly evidenced in their strategy documents (MRC 2009; ESRC 2009). Across the globe, the National Institutes of Health (NIH) and the Australian Research Council (ARC) are evidencing similar drives to interdisciplinary research in their respective strategy documents. In addition, national and international health systems are prioritising and advocating trans-disciplinary education and training whilst simultaneously supporting the development of advanced practitioner and independent practitioner programmes. Collaboration and collaborative relationships are central in this process and are unquestioningly perceived to be the key to effective clinical and indeed interdisciplinary practice (Hornby and Atkins 2000; Lethard 2003).

However, the concept of collaboration in the context of interdisciplinary healthcare practice has not been fully interrogated, and has been formulated as a solution to a problem, a panacea for discontinuous practices, without critical analysis of the nature of collaborative success. We argue that collaborative success has not been adequately operationalised, rendering the determination of success, or failure, problematic. There are some key definitions we need to set out. We have chosen not to use the term 'interprofessional collaboration' as this implies interaction of team members across professions (Lethard 2003). Instead we use the term 'interdisciplinary collaboration' to refer to the concept of possible interactions across and between disciplines.

The term 'interdisciplinary collaboration' is particularly relevant to psychiatry and psychiatric practice, which requires and relies heavily on interactions across a number of disciplines such as psychiatry, psychology, neurology, and neuroscience. Each discipline develops its own particular discourses, each of which contributes to the construction of a composite discourse of interdisciplinary collaboration. The term interdisciplinary collaboration also reflects Lethard's (2003) definition of a process-based approach to understanding interdisciplinary working.

The common thread for this paper is the interrogation and deconstruction of the discourse of interdisciplinary collaboration, using psychiatry as an exemplar. During the process of deconstruction we also address other related discourses (interdisciplinarity, interdisciplinary practice) paying attention to how they inform and underpin the primary discourse of interest in our paper, interdisciplinary collaboration. We use psychiatry as an exemplar for two reasons. First, issues of definition and operationalisation surrounding interdisciplinary collaboration are particularly pressing within the specialism of psychiatry, which we believe is premised on a confounded concept of collaboration and collaborative care (Johnstone 2000). Second, we have been able to draw on the psychiatry literature to highlight the problems that can occur when commonly held assumptions about interdisciplinary collaboration in healthcare go unquestioned. We will specifically highlight the manner in which the discourse of collaboration is privileged and framed in the psychiatry literature, primarily in a positive context and without being critically analysed or contested. As a tool for deconstructing the discourse of interdisciplinary collaboration in this paper we use the conceptual map of discourse development (Freshwater and Cahill 2009; Freshwater and Cahill, 2012) which outlines the successive stages of discourse development.

In the context of this paper we use the term discourse to denote a formalised way of thinking that can be manifested not only through language, but as actions through social practices (Freshwater 2007; Butler 1990). Discourse is a term that is well rehearsed, not only in the research literature, but is also used as an umbrella term to cover a number of theoretical approaches and analytical constructs derived from linguistics, semiotics, social psychology, cultural studies, post structuralism and post modernism. Freshwater (2007) argues that the concept of discourse captures a variety of different approaches to understanding and goes 'beyond language to apprehend organised meanings on a given theme' (111). In this paper we define discourse as a detailed exploration of political, personal, media or academic 'talk' and 'writing' about a subject. We agree that 'it is designed to reveal how knowledges are organized, carried and reproduced in particular ways and through particular institutional practices' (Lyotard 1984; Maclure 2003; Freshwater 2007). In addition we would wish to highlight that in this paper we elect to argue for a definition of discourse that is a composite one which in going beyond language allows both linguistic and individual agency to exist in parallel (see Freshwater and Rolfe 2004; Freshwater 2007).

Using the lens of psychiatry, our argument is embedded in a plurality of understandings of the technologies of the self, identity, role. We are particularly interested in the way these discourses collide with and do combat with the inherently relational discourse of interdisciplinary collaboration and the concept of collaborative practices. The fundamental premise of this paper is that collaborative relationships form the basis of interdisciplinary practices in psychiatry, which is why we are focussing our argument on the discourse of interdisciplinary collaboration.

## **Discourse development: a conceptual map**

To aid understanding of how discourses of interdisciplinary collaboration within psychiatry are perpetuated and how in turn may be deconstructed, we propose the conceptual map of discourse development (see Figure 1).

Freshwater and Rolfe (2004) point to Thomas Kuhn's definition of a paradigm as 'ways of looking at the world that define both the problems that can legitimately be addressed and the range of admissible evidence that may bear on their solutions' (58). A discourse is defined by Freshwater (2007) as a 'set of rules or assumptions for organising and interpreting the subject matter of an academic discipline or field of study' (111). In that the sets of rules and assumptions are created, perpetuated and sometimes deconstructed by the reader or audience, they are constantly open to dynamic processes that we would argue are inherently relational in as much as the reader or audience through interpreting and responding to the discourse sculpt it. It therefore seems appropriate for discourse development to be understood as the formation of a relationship. For this reason we derived our conceptual map of discourse development (Freshwater and Cahill 2009; Freshwater and Cahill 2012) from the conceptual map of the therapeutic relationship (Cahill et al 2008; Hardy, Cahill and Barkham 2007).

Understanding discourse development as a relational activity which is contingent on the responsiveness of its recipients, allows unpacking of the processes through which the discourses surrounding interdisciplinary collaboration in psychiatry are established and perpetuated. This 'unpacking' is one way of critically engaging with a given discourse,

and is one of the underlying methods of our paper. This method has the potential to direct a critical lens on current psychiatric practice that will interrogate and contest the conceptual architecture that supports it.

Development of this conceptual map concerns issues of knowledge generation and production: that is, epistemology. We believe it is important to cultivate an awareness of how discourses surrounding psychiatric practice, and the evidence underpinning that practice, are produced and perpetuated as it enables critical reflection on the legitimacy of that evidence and how such evidence is used, or indeed manipulated within policy and practice. Moreover, the ability to stand outside a discourse and observe its development enables the viewer to impact its direction and ultimately its impact on practice.

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Insert Figure 1 about here

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We utilise the map in two ways: first as an heuristic device throughout this paper, to demonstrate the process by which we are deconstructing the discourse of interdisciplinary collaboration and second as an exemplar, in the final section of our paper to suggest how this discourse can be usefully refined through being contested and fractured. In the following sections, we interrogate **and deconstruct** discourses that underpin psychiatry, using the conceptual map to illustrate how these discourses have assumed prominence and how they may be deconstructed.

## **Critical engagement with the discourse of interdisciplinary collaboration:**

### **Problematizing.**

Health professionals in general, seem to practice with little awareness and indeed acknowledgement of the constructed and storied nature of the health field (Holloway and Freshwater 2007). We would **suggest** that paradoxically, this is particularly prominent in the field of psychiatry which itself rests on constructed and storied notions of mental illness as a way of perpetuating its practice which includes practices of interdisciplinary collaboration. We argue that critical engagement with the discourse (interdisciplinary collaboration) can be focussed on deconstruction phase indicated in Figure 1. This deconstruction phase is of course reliant on an awareness of the processes underpinning the previous phases such as how discourses are established and maintained.

First it is important to define what we mean by deconstruction. For the purposes of the conceptual map we define deconstruction in this context as the process of making the construction and development of a text explicit and subsequently posing challenges to that construction (Freshwater and Rolfe 2004) in the deconstructing phase. And it is this process of deconstruction by which we arrive at sharper definitions and contribute to the refinement of the discourse. Challenges include interrogations of the way in which language is used in text to define social systems. Language is not innocent - it does something, it is active and its actions have consequences (Widdowson 2004). Such consequences have implications for the way in which individual and professional identities are conceptualised within psychiatric practice. Individuals and disciplines both invent and are invented by the discourses or stories around them. **We demonstrate this point by our account of psychiatric diagnosis later on.** While we concede that there are a



number of ways of defining and understanding discourse, these consequences present a rationale for utilising the 'composite' definition of discourse presented earlier.

As a tangible example of the way in which language 'writes' subjects we turn to the practice of diagnosis within psychiatry. We would also highlight that in this example of diagnostic practice we illustrate the activity involved in the establishing and maintaining a discourse phases. Diagnosis is defined as the precise identification of a disease or condition after observing its signs. However, taking schizophrenia as an example, Johnstone (2000) highlights that identification becomes problematic in psychiatry given that diagnosis is reliant on reports and observations of behaviour (becoming withdrawn, hearing voices) rather than physical tests, X-rays, or blood counts. Notwithstanding the multiple revisions of diagnostic classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and its British counterpart the International Classification of Diseases (ICD), the criteria have not been sufficiently standardised, leading to controversy concerning how psychiatry has declared certain human behaviours and not others as representative of mental illness. (Crossley 2006; Glackin 2011). This problem of ontological relativity with regard to mental illness and how it has originated **is key to our argument.**

First there is the challenge of mutual understanding – there are currently no absolute standards for what constitutes normal behaviour that have been collectively approved. Szasz (1973) gives one such example of how the ontology of a disease, in this case psychosis, is indeed 'written' by the current dominant discourses of the time: 'If you talk to God, you are praying, if God talks to you, you have schizophrenia' **(113).** In this way the dominant discourse of psychiatric diagnosis, with the support of the medical

establishment, has proven to be a highly effective vehicle for perpetuating the myth of mental illness.

Second, the symptoms of schizophrenia as laid out in diagnostic classification systems, seem to cluster together fairly randomly so that two people with the same diagnosis may actually have no symptoms in common. Third, it has been observed that a diagnosis of schizophrenia does not predict the course or the outcome of the illness (See Bentall, Jackson and Pigrim 1998; Brown 1990). Yet despite these anomalies, diagnosis underpins every aspect of the patient's therapeutic journey and sets the parameters of their mental illness. That is certain behaviours that deviate from collectively agreed standards are defined as indicators of illness and malfunction. So in this sense the patient's mental illness, through diagnosis, is literally written into existence. What this example indicates is that deconstruction of the discourse of psychiatry involves both identification and unpacking of the processes involved in the establishment and maintenance of the discourse (process figured under the 'Learning to be part of a discourse' heading in Figure 1) . In this example, the unpacking uncovers anomalies.

As we have shown in the case of schizophrenia, definition of an other takes place through diagnostic practice, and misplaced definitions (which have a role in actively maintaining the discourse of psychiatry) can be compounded by the consequences of diagnosis in the patient's treatment plan. Language literally defining others is writ large in psychiatry. In this section we have outlined the process of deconstruction applied to the discourse of interdisciplinary collaboration. **In the following section we focus on the evolution of the discourse of interdisciplinary collaboration in order to arrive at an**

understanding of how this discourse has secured its privileged position. Understanding how a discourse has developed is, we suggest, a necessary precursor to deconstruction of that discourse.

### **Evolution of the Discourse of Interdisciplinary collaboration**

Discourses of interdisciplinarity and interdisciplinary collaboration have been and continue to be privileged and viewed as a pinnacle for the delivery of effective healthcare (Lethard 2003; Reeves et al. 2008; Rossen, Bartlett and Herrick 2008). These discourses focussing on the merits of collaboration are especially evident in psychiatric practice. But it is not clear if the constituents of interdisciplinary collaboration have been fully understood or contested as part of the decision-making process. This uncertainty is compounded by the lack of a robust evidence base or an evidence-base that is premised on a confused understanding of the concept of collaboration. The establishment and maintenance of an unquestioned evidence base described below maps onto the 'establishing' and 'maintaining' discourse phases in Figure 1 and suggests how discourses may be perpetuated by evidence bases that are themselves inadequately understood.

For example, Hornby and Atkins (2000) argue that: 'Making and maintaining the collaborative relationships necessary for optimal help takes time and effort and, since all face workers are busy, collaboration is often overlooked or shelved, until problems arise as a result of its absence' (10). This infers that collaboration is revealed by its absence, only known when it does not exist. Fewster-Thuente and Velsor-Friedrich (2008) comment that 'interdisciplinary collaboration has the capacity to affect both healthcare providers and patients'. They also state: 'Research has shown that the lack of

communication and collaboration may be responsible for as much as 70% of the adverse events currently reported' (44). Similarly proof of the importance of collaboration is defined by the adverse affects that occur as the results of its absence.

Given the **magnitude (70%)** of the adverse events accounted for by a lack of collaboration it seems important to arrive at a working definition of the concept. In Inter-professional education for collaborative patient centred practice (Brown 2006) a framework was identified comprising three types of collaboration in the healthcare team: interactional, organisational, and systemic elements.

- Interactional elements are described as interpersonal bonds among team members such as trust and willingness to engage in collaboration.
- Organisational elements include climate, resources, and structure.
- Systemic elements include issues outside of organisations that affect inter-professional collaboration such as social, cultural, and professional systems.

All of the above are problematic and dynamic as they pertain to the practice of psychiatry, but in this paper we focus primarily on interactional and systemic elements.

Whilst Clark et al (2009) argue that clinical trials provide opportunities to answer important questions and enhance interdisciplinary collaboration, much of the literature is based on the assumption that there is something that is not collaborative and not interdisciplinary, and it is this assumption that has figured largely in the maintenance phase of the discourse of interdisciplinary collaboration. However, even an adverse event takes place in the context of communication and collaboration, albeit dysfunctional. It is this maladaptive type of collaboration and communication that we

believe requires more understanding in order to arrive at a more functional and more clearly operationalised collaborative mode of practice. It is through unpacking the processes by which this discourse has been created and maintained that we may deconstruct the discourse in order to arrive at a more informed understanding of collaboration. A product of our increased understanding of collaboration is two different types of collaborative failure. Presenting these two types of collaborative failure will, we believe, be instrumental in leading to a more informed and considered account of interdisciplinary practice. .

With regard to psychiatric practice we have identified two types of dysfunctional collaboration through our analysis and deconstruction of the discourses underpinning psychiatry. First, there is dysfunctional collaboration arising from miscommunication – such as according to the accounts of the service user movement literature in which psychiatric nurses have been described as aloof, punishing, and coercive, colluding with psychiatrists in the use of treatments such as depot injections and electroconvulsive therapy (see Johnstone 2000). In that mental health nurses have reported themselves as aspiring to being empathic, adaptable, and patient centred, we might hypothesise that this mismatch in perceptions is a result of the division between what they believe and what the system requires them to do.

Through our analysis and deconstruction of popularly held assumptions concerning interdisciplinary collaboration in psychiatry texts we have uncovered a second form of maladaptive collaboration which is different in focus. We suggest, that in some cases professionals work cooperatively to perpetuate dominant and established practices within psychiatry which are not always commensurate with the patient's best interests.

We term this type of collaboration dysfunctional consonance, whereby practitioners uncritically accept the status quo and work harmoniously together to ensure that dominant practices are perpetuated. We would argue that this is the most misunderstood and undetected form of collaborative failure within psychiatry and we explicate this concept in the following sections drawing on literature and examples from practice.

What we have learnt from our reading of the literature on interdisciplinary collaboration is that in whatever form, functional or not, it requires a deep commitment of time and energy for problem assessment and development of new plans of care. Members of functional interdisciplinary teams work interdependently so that decisions are made jointly, and knowledge and resources are shared. (Danvers et al. 2002; Danvers et al. 2003). The following section continues an examination of the evidence base involved in maintaining the discourse of interdisciplinary collaboration.

### **Interactional elements: learning to collaborate**

According to much of the literature, inter-agency collaboration makes boundaries more porous so that patients and families can move more easily from one agency to another without care being fragmented (Danvers et al. 2002; Danvers et al. 2003). Traditionally however, each discipline is educated within its own walls, within which interdisciplinary practices are discussed but not often practised. Each discipline has its own language, its own discourse, and its own jargon. It is therefore ironic that a proposed model of care, founded on interdisciplinary collaboration is often taught within a mono-disciplinary framework. This is the case with psychiatry within which training is primarily underpinned by a medical model even while their curriculum incorporates elements of

the psychosocial model. This illusion of interdisciplinarity creates a mismatch between what nurses are taught and what they actually do, leading to symptoms of stress and burnout within this group of professionals (Handy 1995; Hopton 1995). This dissonant approach to interdisciplinary education is the hallmark of interdisciplinary practice within psychiatry. Indeed, this dissonance is more obviously laid out in the account of practice-based interventions to improve inter-professional collaboration as described in the 2008 Cochrane Review (Reeves et al. 2008).

Highlighting the dissonance that can occur in the gap between theory and practice, Rossen and colleagues (2008) report the findings of a study in which they teach collaboration to undergraduate nurses. Given that collaboration is essentially relational and based in relationships which are contextual, it would seem paradoxical to identify pre-defined criteria by which successful teaching of collaboration can be measured or indeed assessed. In other words, collaboration is contingent, contextual, and responsive and any teaching plan should reflect that. And part of teaching involves critical engagement and combat with the discourse of interdisciplinary practice. Unpicking the discourses surrounding interdisciplinary collaboration and directing a lens on the infrastructure maintaining the discourse raises more questions than it answers.

- What are the criteria for success?
- How is it assessed?
- What is the nature of the evidence to support widespread acceptance of interdisciplinary practice?

In order to further illuminate the complexity of the discourse of interdisciplinary collaboration and to answer the above questions we use psychiatric care, and

collaborative failure examples within that context, to reflect more closely on the questions we have raised.

### **Interdisciplinary practice in context: psychiatry**

Rossen and colleagues (2008) argue for a growing awareness that no one intervention, no one discipline, and no single approach can provide the comprehensive services needed to promote the recovery of persons with mental health problems. Psychiatry is a useful example to draw from when referring to interdisciplinary practice given that it purports to be predicated on the practice of interdisciplinarity while being firmly situated in the mono-disciplinary framework of the medical model.

Rossen and colleagues for example propose that 'multi system interventions from an interdisciplinary team of healthcare providers are necessary to address the needs of individuals in psychiatric and mental health treatment venues'. Quoting Lemieux, Charles and McGuire (2006) the authors found evidence that interdisciplinary team-based care was superior to un-coordinated care, both in terms of clinical outcomes and patient satisfaction. Yet, surely, no care is superior to un-coordinated care. Again, collaboration is defined here within the parameters of collaborative failure, without addressing the constituent components of collaboration, and this is a key explanatory mechanism that has been responsible for maintaining the discourse. We may ask when definitions of concepts depend on their inverse and vice versa, what are the consequences? Being defined by the opposite or negative is a postmodern concept that has been well explored (Fox 1993) and has parallels with Deviant Case Analysis which involves searching for and discussing elements of the data that do not support or appear to contradict patterns or explanations that are emerging from data analysis



(Creswell 1998; Mays and Pope 2000; Patton 2001). Interestingly, this is how the medical model within psychiatry works – the practice of differential diagnosis which involves ruling out diagnoses in order to come to what can only be known by what has been ruled out (First, Allen and Pincus 2002). The next section considers the influence of roles on interdisciplinary collaboration, roles that are constructed within an organisational context. In this sense, referring to Figure 1, the following section may be considered to describe the influence of ‘contextual factors’ as per our conceptual map on discourse development.

### **Systemic influences on collaboration: roles**

Hirschhorn (1988) writing over two decades ago on the psychodynamics of organisational life refers to the concept of the ‘anxiety chain’. Anxiety about work can lead people to step out of their roles, to turn away from work realities, and to create a surreal world in which challenges can be met with fantasies of omnipotence, dependence, or defensive denial. Within psychiatry this caring role also makes significant demands on the patient.

When people depend on each other to do effective work, when they must collaborate, one person’s anxiety may trigger an anxiety chain. Individuals may punish themselves for their own failings and/or imagine they are being persecuted. We are not alienated from one another, because our roles separate us; rather we lose touch with each other when we violate the roles that might help us to collaborate. Our internal anxieties are real, as are the external realities that pose a threat to professional identity. When we step out, or are asked to step out, or perceived we are nudged out, a boundary is violated, whether this be interactional, organisational, or systemic. Professional

identities are constructed through character roles, values, attitudes, and skills, but also by the discourses that have enabled the profession to be narrated into being and enacted (Menzies-Lyth 1998; Holloway and Freshwater 2007; Freshwater et al. 2012).

Threats to working identity and role security may also occur on a daily basis for practitioners. Not only externally enacted but also internally represented and enacted as many healthcare professionals struggle with the need to care and be cared for. And it is within psychiatry reform attempts such as Jan Foudraine's (1974) that such crises to identity have been crystallised. The reforms were designed around giving the patient more responsibility and these reforms struck at the heart of a very traditional set up Foudraine encountered when appointed to a small ward for chronic schizophrenic patients. When staff roles changed they experienced extreme anxiety and fierce reluctance to devolve more responsibility to patients. On a more concrete level, staff were afraid of losing their jobs if patients got too good at caring for themselves.

Also of significance is what the patients stand to lose when their sick role is threatened. Following Foudraine's reform attempts, patients were documented to resist extremely strongly. In looking at the benefits psychiatric patients had reaped before Foudraine's reforms were implemented, they had an escape from painful conflicts and decisions, care and asylum from pressures of the outside world, and a fleet of nurses to look after them and take care of domestic arrangements. A symptom of the strength of the patients' resistance to reform attempts was the downward spiral of the ward into complete and utter squalor.

Such resistance to reform may be understood by examining the process of role enactment. There are several ways to enact a role; two options include either to face the real work it represents, or to violate it by escape. More importantly, to take a role we must first understand the task. We struggle to take and enact roles in group, team, disciplines, and tribes. These are essentially systems. Groups create stable relationships, but such stable relationships (which may be illusory) can also support and engender role and boundary violation for those that live inside the system. A role can also feel like a system, but roles are not always alienating or imprisoning in themselves, rather they become so when they are distorted by a systematic and socially supported system of role violations (Menzies-Lyth 1998; Brown 2006).

It is our argument that psychiatry is underpinned by such a system of role violations for both professional and patient. For the professionals, role violation occurs when, owing to the innate contradictions of the psychiatric system, they collude with absolving all responsibility from the patient using a medical label to rescue them, administering treatments which are not self sustaining. For the patient, they are caught in a parallel paradox of self mastery and dependence: they have responsibility taken from them in effecting routes to recovery yet they are expected to master their symptoms – that is to show compliance within treatment regimes that remove responsibility and self efficacy.

It is our argument that such sustained role violations, resulting from unquestioning acceptance of systems within psychiatric care, pass for collaboration when they actually demonstrate collaborative failure or dysfunctional consonance. In this sense we are moving towards a second definition that sets out how both patients and professionals are failed by the very systems they collaborate to uphold. **The next section**

**demonstrates how deconstructing the discourse of interdisciplinary collaboration leads**

to refined operational definitions of collaborative failure that are at present missing from accounts of interdisciplinary practice in psychiatry.

### **From Interdisciplinary Collaboration to Collaborative failures: deconstructing the discourse**

First we will address the standard definition of collaborative failure: difficulties in working together. These may be enacted in the performance of a separatist position and/or the defended positions as well as many others.

Failure to realise and appreciate the contribution made by others, lack of clarification of roles, and poor communication masked by good will, all lead to defensive positioning, which in turn create a culture of blame. This process has been observed in the preceding section on 'roles'. To provide an example from a psychiatry text we draw on Jan Foudraine's account of his reform attempts. In Foudraine's account staff were left feeling deskilled at the prospect of patients attaining more self-responsibility and self-sustainability in management of their difficulties. As a result the staff mounted a vigorous opposition enacting out defended positions to support the status quo. As part of the process of reform or organisational change, collaborative failures become inevitable, and expected, in the context of discourses of the self as regulatory. And also within the walls of social systems that still enact and perform defensive narratives of blame and responsibility as staff experience anxiety as new roles are reconfigured and original ones threatened (Menzies-Lyth 1998).

We have shown through using the conceptual map as an heuristic aid that the discourse of collaborative relationships, which can be poorly understood and confounded

themselves, forms the basis of interdisciplinary practice in healthcare. We would argue that the discourse underpinning interdisciplinary collaboration requires much more conceptual development if collaborative relationships are to be invested in and appropriately sustained. Given the fault lines in the discourse of interdisciplinary collaboration, interdisciplinary practices themselves will be more vulnerable to failure.

In trying to understand the collaborative failures that occur when reform attempts are instigated we move on to a different definition of collaborative failure, based on sustained role violations, resulting from unquestioning acceptance of systems within psychiatric care. We argue that such role violations often pass for collaboration when they actually demonstrate collaborative failure. We call this 'dysfunctional consonance': the process by which patients and professionals are failed by the very systems they collaborate to uphold.

### **The conceptual map: a worked example**

To explain this paradox of collaboration failing consumers of psychiatric practice we use our conceptual map of discourse development. First we consider the establishment phase, which concerns the initial enablement of a discourse in which the parties of researcher and audience become engaged. The mechanisms by which this is achieved within psychiatry have been largely as a result of diagnostic practice and its dissemination through medical publications. So the practice of psychiatric diagnosis has supposedly become validated through successive reiterations of the Diagnostic and Statistical Manual of Mental Disorders (Helzer et al. 2008; Tamminga et al. 2009), which has been verified through the channels of publication and consumed by audience of practitioners supporting the medical model.

In the maintenance phase, it is necessary to employ a number of infrastructures that can maintain or perpetuate the discourse or to ensure the discourse is close to policy and able to respond to policy drivers and initiatives with sustained research outputs. This has been amply observed in psychiatry: for example with medically informed research informing NICE guidelines for treatment. However we would highlight that the limitations of NICE guidance have been highlighted with regard to deficiencies in appropriate organisational support (Whitty and Gilbody 2005) and with regard to the ethical implications of instigating guidelines when there are uncertainties with regard to diagnosis (Pickersgill 2009). At present research, policy, and practice in mental health care only emphasises short-term care, focusing on the issue of compulsion - the use of legal powers to commit patients to hospital against their will. Such short-term care focusing on a patient's symptoms takes precedence over a drive to understanding the underlying causes that lead to mental distress in the first place.

In the development phase, a discourse may be progressed, refined or deconstructed. This development phase is most critical for the future of psychiatric practice in terms of how its discourse can begin to reconfigure psychiatric care. Deconstruction is an essential part of this process. In deconstruction, discourses can be changed as a result of factors internal to the discourse. A discourse may be riven with inconsistencies, anomalies, and fractures which act as agents of change, creating the context for a shift in thinking.

As an illustration of how anomalies can effect a shift in thinking we refer to Lucy Johnstone's work (2000), specifically her reading of Jan Foudraine's account. Our

argument is that one of the ways in which an emerging discourse can be strengthened is ironically through its potential to create and provoke dissonance which in turn serves to focus attention on perceived factures and anomalies stimulating further debate which adds weight to its development. This particular example shows how the fracturing of the discourse of interdisciplinary collaboration was actually played out in practice during a period of chaos and unrest.

Returning to the accounts of Foudraine's reform attempts, in *Not Made of Wood*, the author recounts how his attempts at reform precipitated a crisis in the ward (Foudraine 1974). When Foudraine insisted that patients should take a share of responsibility for the cleaning, 'the result was a ward in a state of total squalor' and this provided the catalyst for a conflict between Foudraine and the wider institution. Two points: first, the crisis while dislocating for the staff in one sense nevertheless served as a turning point in that when faced with the threat from outside the staff started to rally round in defence of the new regime. Second, the media exposure, although unwelcome and threatening at the time, nevertheless stimulated further debate within the institution and beyond, debate which served to clarify and consolidate the emerging reforms. **So what this account demonstrates is how fracturing a given discourse leads to beneficial change for both practitioners and patients.**

**We would therefore contest that collaborative failures, in the traditional sense of practitioners experiencing difficulty and discomfort in working together, are a necessary stage as any discourse is deconstructed and contribute to the growth and strengthening of the emerging discourse.** So a period of collaborative failure characterised by

dissonance and unrest as consensus is temporarily lost, may also lead to an opening up of possibilities, providing a stage on which dissonance is allowed expression.

We would argue that it is through dissonance, as our internalised values are contested, that we become open to new lines of enquiry. And it is through listening and creatively engaging with the dissenting voices of those previously on the margins of the psychiatric system that psychiatric practice can be reconfigured. And in order to do this it is necessary for consonance to be questioned which inevitably and inescapably results in collaborative failures.

## **Conclusion**

The central issue that we have highlighted in this paper is how unquestioningly accepting a discourse – in this case interdisciplinary collaboration – without giving due consideration to competing and alternative discourses leads to problems for patients, practitioners and indeed the profession. We have suggested that using the method of deconstruction, with recourse to the conceptual map of discourse development, has the potential to direct a critical lens on interdisciplinary practice that interrogates and contests the conceptual architecture that supports it. This problem, and our suggested method, has wide applicability to interdisciplinary practice in nursing and allied health professions.

In this paper we have shown how interdisciplinary collaboration has been constructed by multiple truths that have been narrated into being. Interdisciplinary collaboration is only a partial view and a partial reading of current psychiatric practices. Interpretive readings facilitate a local, various and diverse version of interdisciplinary practices for



professionals to consider. What we have attempted to do in this paper is to deconstruct the discourse of interdisciplinary collaboration within psychiatry which we would argue is temporally and spatially located and founded on ambiguous, uncertain, and fragmentary evidence. We believe that to render the familiar and the taken-for-granted strange, is an important part of understanding and further conceptualising the discourse through fracturing it. This process is illustrated in the successive stages of the conceptual map: establishing, maintaining, and developing discourses. **And the mirror of fracturing discourse is perhaps effecting temporary collaborative failures in practice as in the account of Jan Foudraine's reform attempts.**

What we have attempted to explicate is the architecture of thinking and that in that architecture is the uncritical acceptance of discourses, which in turn lead to unquestioning practice and detrimental implications for nursing and healthcare practice.. Underpinning the architecture is the unrepresentable, which is not fore-fronted in dominant discourses, but nevertheless informs them, for example the failure of success. **Using the conceptual map as a tool to analyse any given discourse in nursing and healthcare practice is we argue a necessary precursor to understanding the successes or failures of interdisciplinary practice.**

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