Applying Self Efficacy Theory to Increase Interpersonal Effectiveness in Teamwork

Mary Bumann[1] **and Sharon Younkin**[1]

[1]University of Wisconsin School of Medicine and Public Health

Abstract

Effective teamwork is a key element of today's healthcare environment, affecting everything from morale to patient outcomes. Increasing facility in interpersonal skills can enhance one's ability to be an effective collaborator within a health care team. For those individuals working in teams, effective interpersonal skills facilitate demonstration and sharing of expertise, maximize individual contributions, minimize burnout, and foster autonomy in professional practice. The foundational concept of this paper is that in healthcare practice, competence is necessary but not sufficient to sustain ongoing effectiveness in interpersonal interactions.

This article offers a framework describing how key skills necessary in developing effectiveness in teamwork can be developed using Bandura's construct of self-efficacy theory (1997). Interpersonal effectiveness requires negotiating the complex interactions at the intersection between the four sources of influence identified in self-efficacy theory (mastery, vicarious experience, social persuasion, and physiological response awareness) and two primary domains of interpersonal effectiveness (individual and group).

Developing and enhancing the key skills necessary to increase interpersonal effectiveness in health care practice is vital to job satisfaction and success (Drinka & Clark, 2000, Rafferty, 2001). This paper proposes a strategy for developing skill in health care practice through application of the theory of self-efficacy developed by Albert Bandura (1997), adding to this body of knowledge by applying the theory to the realm of interprofessional healthcare practice.

We describe how the sources of influence in self-efficacy theory can be employed to increase individual and group effectiveness within an interprofessional healthcare team. Our proposal elaborates on the tenets of Invitational Theory and Practice specifically in that every person within a health care team can add to or subtract from the likelihood of positive outcomes for the people they serve, and that every member of a team can choose to enhance his/her potential and capability within an inviting, respectful and trusting culture (Purkey, 1992). In a work setting in which everyone participates freely and intentionally, the needs of individuals and the team as a whole are considered and addressed, inviting and encouraging everyone to function optimally.

Background

The task for professionals in practice is to form effective relationships with a diverse array of patients and colleagues; including some that might be avoided if there were a choice (Wackerhausen, 2009). There is an important reason for forming and maintaining these relationships, which is to facilitate positive healthcare outcomes.

In every healthcare workplace, three broad factors affect human interactions: individual differences, group dynamics, and conflict (Axelsson & Axelsson, 2009; Drinka & Clark, 2000; Hall, 2005; Magrane et al, 2010; Pew-Fetzer Task Force, 1994). The complex interplay of these factors is critical because the way members of a health care team interact can have an impact on the quality of care provided. This impact is intensified around crises, errors, delays, and continuity of care—all of which influence patient outcome risks.

Increasing effectiveness in key skills can facilitate one's ability and capability to be a collaborative practitioner. Individuals with effective interpersonal skills working in teams can demonstrate and share expertise, maximize their contribution, minimize burnout, and foster professional autonomy.

Self-Efficacy

People with a sense of self-efficacy (Bandura, 2010, 1997) believe in their ability and capability to succeed in attaining their goals. A sense of efficacy provides staying power and resilience to endure and move beyond obstacles and

Corresponding Author:

Mary Bumann, M.A., R.N., is Senior Outreach Specialist Emerita, UW School of Medicine and Public Health, Madison, WI

mbumann@wisc.edu

setbacks, and allows for a creative response to failure and disappointment. Individuals with high self-efficacy view failures and disappointments as indicators of the need to learn more or to use different problem-solving strategies. In the absence of self-efficacy, such challenges are more likely to be seen as personal flaws or lack of ability.

Bandura's theory of self-efficacy can be used as a tool to reinforce ability and promote capability in successful attainment of new skills. Understanding the process of acquiring efficacy while practicing new skills and behaviors will increase resilience and endurance in the face of setbacks (Bandura, 1997). Getting started requires recognizing current skills, abilities and aspirations and committing to work toward efficacy in unfamiliar domains. Self-efficacy is domain-specific, meaning that it does not generalize to a global feeling of self-confidence, competence or self-esteem.

Bandura (2010, 1997) described four sources of influence that can increase potential for success in a new domain. Mastery experiences refer to accomplishment of feats or tasks, sometimes incrementally, acknowledging successful accomplishment. Vicarious experience or social modeling happens while observing others, preferably peers, modeling behaviors and accomplishments, and seeing and believing that it can be done. Social persuasion occurs when others, especially trusted colleagues, encourage and reinforce attempts, and provide feedback as new behaviors are attempted. Physiological response awareness means knowing and being able to explain physiological reactions under stress and finding ways to manage stress factors related to performance by modifying behaviors.

The strength of self-efficacy in any domain is reinforced by these influences, which can be used to support and monitor progress. Increasing self-efficacy in new and ongoing situations, such as bridging individual differences, addressing conflict, and functioning comfortably in a group, enhances effectiveness. It is important to remember that deciding to learn a new skill is a choice and that believing success can be achieved supports resilience and incentive to keep trying.

Progressing from Competence to Effectiveness

An underlying concept of this paper is that in healthcare practice, competence is necessary but not sufficient to sustain ongoing effectiveness in interpersonal interactions. It is important to distinguish effectiveness from competence. In most academic and professional development programs, skill is measured by attainment of particular competencies (Schmitt et al., 2011). This paper is informed by the belief that moving beyond attainment of individual competence in particular skills, toward achieving an array of skills for responding effectively to ongoing interactions is fundamental to effective teamwork. We will describe a process for acquiring the knowledge and skills necessary to be effective and to thrive in the workplace. To be effective requires a willingness to respond to inevitable interpersonal challenges and modify and choose behaviors that contribute meaningfully, building on the foundation of particular competencies (Drinka & Clark, 2000). The key is to intentionally identify and develop the skills to exercise the most appropriate action in any given situation with any type of individual or group. Interpersonal effectiveness is not reaching an end point or ultimate skill level. It is an ongoing, evolutionary process. Interpersonal effectiveness means employing the skills necessary to respond optimally in situations arising in the two primary domains of interactions; individual and group.

In service-oriented professions, the task is to interact with others effectively enough to express professional expertise and to form therapeutic relationships. Expert knowledge and/or congenial patterns of relating alone won't accomplish that goal—developing a deep understanding of self, others, communication and conflict is important, as well as learning to interact with individuals, groups, teams, and communities in ways that allow everyone to thrive and allow individual and shared goals to be achieved (Bandura, 2000).

Skill in self-awareness, communication and reflection can facilitate the development of interpersonal effectiveness and increase confidence in responding to anyone — from those most similar to those most different. Interpersonal effectiveness can help enhance satisfaction, quality and enjoyment of work and facilitate positive outcomes for the people served (Pew Fetzer Task Force, 1994). In the following sections, using Bandura's theory of self-efficacy as a foundation, principles and skills necessary for interpersonal effectiveness will be explored, first through an "individual lens" and then a "group lens."

Individual Domains of Interpersonal Effectiveness

Self-Awareness

Self-awareness is critical to skillful navigation of interpersonal interactions in a healthcare setting (Bumann & Younkin, personal communication, 2008). Everyone has perceptions that arise from feelings and beliefs that are unique to them alone. A person can know and understand his/her own "insides," but can know and understand only the "outside" of others—what is shared and revealed. No two people will understand and interpret the world in exactly the same way. There is always a choice about whether or not to share one's truths and ideas. Being mindful of that choice and respecting the choices of others is key. Moreover, being

"entitled" to an opinion does not mean that voicing it is appropriate or helpful. Sometimes the most productive choice for a team is silence and careful listening. Everyone's perspectives are valid. Along with the choice to speak comes the freedom to affirm, question, and change. Differing perspectives can be useful in learning about self and others. Failing to share a different perspective may actually hamper learning, inhibit dialogue and increase stress in a situation. It is not uncommon for people NOT to understand their own reactions, motivations and sometimes their behaviors. No one can achieve total self-awareness. Acknowledging that which is not and sometimes cannot be known is an essential part of self-awareness.

Table 1. *Individual Domains of Interpersonal Effectiveness in Healthcare Practice*

Individual Domains	Self-Awareness	Individual Differences	Communication	Reflection
Mastery Experiences	Accurate self-knowledge	Comfort with differences	Clear & direct exchange of information	Application of new behavior based on understanding
Vicarious Experiences	Pay attention to self-disclosures of others	Learn from interactions of others	Observe & learn communication patterns of others	Notice reflection techniques of others
Social Persuasion	Openness to feedback about self	Responsiveness to input about strategies	Responsiveness to feedback about skills	Openness to suggested reflection techniques
Physiological Stress Response	Manage fear & resistance to self-understanding	Explore personal biases related to difference	Manage content and context of interactions	Manage resistance to changing beliefs & behaviors

In 1955 Joseph Luft and Harry Ingham created a tool identified as the "JOHARI Window" (see table 2) in order to describe how to think about the known and unknown information within interpersonal interactions. In this schema, awareness is separated into four quadrants: what everyone knows, what the self knows that is unknown to others, what others know that is unknown to self, and what is unknown to everyone. Luft (1961) posited that this compartmentalization of knowing exists within every individual and in every relationship. Clarity about one's own motivations, culture and professional roles contributes to informed understanding in every experience. This clarity in self-awareness increases the probability of a mutual sense of understanding as well as emotional safety in interpersonal interactions.

Individual Differences

Every healthcare team is influenced by obvious and hidden diversity, perceived roles, and the larger institutional culture (Hall, 2005). To understand the complex interplay occurring in professional interpersonal interactions, it is essential to remember that everyone is a unique product of overlapping experiences based on race, ethnicity, education, economic status, occupation, sexuality, age, etc., which combine to produce an identity. As individuals continually refine and redefine these identities, they develop "lenses" through which they observe, consider, and make sense of the world around them. For example using one's personal experiences of feeling "different," or in the "minority," or having others make assumptions which were surprising or false, can increase awareness of bias and assumptions about others. Everyone experiences some degree of comfort when interacting with others perceived as similar to themselves and trepidation when interacting with those perceived as dissimilar. In reality, there may be much less or much more in common than is realized. Approaching intercultural interactions as opportunities (to learn, engage, or foster a relationship) helps create openness to new experiences and fosters a keen awareness of one's own and others' uniqueness. Although no one can become an expert in every detail of the many cultures and belief systems held by individuals across the globe, it is important to develop a deep understanding of the powerful influences that culture can have on interactions. Interpersonal efficacy can improve interactions among individuals and groups that are vastly

Table 2. *The JOHARI Window (Luft & Ingham, 1955)*

	Known to Self	Not Known to Self
Known To Others	Public Knowledge	Blind Spot
Not Known To Others	Private Knowledge	Unknown

diverse—whether the individuals are aware of the differences or not.

Communication

Communication skill and style can have enormous influence on the process and outcomes of healthcare practice. Along with elements of effective communication such as clarity, directness and responsiveness, every communication should reflect an awareness of the key points of the subject at hand. Strong communication skills allow team members to interact effectively --even if that means simply conveying respect for differing points of view when individuals disagree.

Listening with attentiveness begins by focusing on what is being said, not thinking about what *you* are going to say next, not assuming you know what the other person is going to say before they say it, and not interrupting. Frequently, miscommunication is simply the result of not listening attentively, whether from distraction by a personal issue, composing a response, judging the person speaking, and/or discretely checking a phone. It is a common deception to think that listening happens simply through not talking.

There is more to effective communication than listening; checking for understanding of what others have said helps to establish meaning and makes space for self-disclosure of personal perspective. While no one wants to sound like a parrot, carefully checking understanding of what the speaker said may reveal that what the speaker thought they expressed was quite different from what the listener actually "heard."

Responsiveness or reciprocal acknowledgement of another's perspective is essential. This allows the other person to share a personal perspective and contributes to the potential for a positive and meaningful outcome of the interaction. Typically, this requires thinking before speaking. A mutual and ongoing combination of ideas can lead to the creation of

new insights and meaning and a discovery of consensus. This requires trust in the process of the conversation, as well as the content (Suchman, 2006).

Effective communication includes ownership of feelings, ideas, experience, and perspective. For example, "In my experience, the French are rude" allows others to have a different point of view rather than simply stating, "The French are rude." Similarly, "I don't think critical feedback is welcome in this team," allows for a more productive discussion than a unilateral statement such as "Critical feedback is unwelcome in this team." Feedback must be behavior-specific, timely, concise, and respectful (Kaprielian & Gradison, 1998; Bandura, 1993).

Self-disclosure is pivotal in the development of trusting relationships, but the importance of making careful choices about self-disclosure cannot be overstated. Attentively observing others and choosing what and when to disclose promotes authenticity, respect, and understanding of individual differences.

When expressing thoughts and feelings, it is important not to rebuff or reject others' ideas in order to make a point. While it's natural to want to share a parallel experience, sometimes the most valuable thing one can do is provide an opportunity for the speaker to focus on his/her own experience. For example, if a patient chooses to share a current struggle with grief over the loss of a loved one, it might not be helpful or productive to take that moment to share a personal experience with that issue. Sometimes, the most appropriate choice is NOT to self-disclose. Conversely, not everyone is comfortable with self-disclosure, thus boundaries must be respected when asking questions designed to elicit personal information.

It is important to notice accommodation in communication, some of which is conscious and some of which is

unconscious (Giles & Ogay, 2007). The ways in which we adapt our behavior in response to the statements and demeanor of others influences the outcome of the interaction. For example, the phrase "Yes, but" commonly used in conversation, can discount another's statement. For example, "YES, I hear you, BUT here's my (better) idea". The tone would change if one said, "YES, AND" instead, as in "YES, I hear you, AND I would like to offer an additional point of view."

Reflection

The desire to understand the meaning of our experience is fundamentally human (Mezirow1990). However, a commonly held stereotype is that every healthcare professional finds meaning in the work. This may be an unrealistic assumption. Reflection has to be an active and ongoing element of personal and professional learning. It can occur individually or in groups (Mann, Gordon, & MacLeod, 2009; Suchman, 2006). The process of reflection engages external and internal levels of examination and integration of experience (Le Cornu, 2009). It can be as simple as clearing one's mind of distracting details and focusing on one situation or experience. Three basic questions useful in beginning a reflection process are: What happened? What does it mean to me? What could I do next time? Skill in reflection requires allocation of time for closer observation, receptiveness to other points of view, exploration of feelings and thoughts, and examination of beliefs, goals, and practices. In order for reflection to have an impact, it must be followed by action or change in behaviors based on what is learned.

Group Domains of Interpersonal Effectiveness

Teamwork

The most prevalent and promoted approach to providing health care is interprofessional teamwork, which brings together individuals with diverse education, training, and cultural experiences working together on a mutual task (Grumbach & Bodenheimer, 2004). Working with colleagues to help patients requires developing and maintaining a diverse array of relationships (Pew Fetzer Task Force, 1994). Satisfying, rewarding and effective teamwork requires a workplace where all practitioners are energized by engaging in multiple interactions with others and invested in the mission of the team: positive patient outcomes. Ideally, groups sharing a collective commitment and mutual trust determine their overall mission, establish shared explicit goals and responsibilities, and work collaboratively to respond to health care problems and dilemmas. However, most healthcare teams do not begin together as cohesive

groups; more often, they are random and diverse. Teamwork is a long-term and constant process of reiterating and reinforcing commitment to the mission and trust in each other (Axelsson & Axelsson, 2009; Siver, 2004).

When team members are doing their best, believe in their work, and share information clearly and directly, everyone's work is enhanced. To be effective, members of the team must understand and value their own as well as others' professional roles, recognize the influence of culture in individual and professional differences among team members, and acknowledge their own and others' reactions and responses within the group (Drinka & Clark, 2000). Skills learned and refined through modeling and encouragement from other team members over time, enhance individual efficacy, which optimizes the collective group effort (Bandura, 1997).

Interprofessional Roles and Expertise

A critical component in high functioning healthcare teams is the degree to which the relevant expertise of every discipline is acknowledged, utilized and valued (Brown, 2000). To collaborate across professional boundaries, group functioning is optimized when all members are able to see beyond their own interests and are willing to give up professional territory to accomplish a common goal (Axelsson & Axelsson, 2009). This requires each professional to be aware of his/her specific expertise. Assumptions and stereotypes related to someone else's role and capability are frequently mistaken for this awareness. Educated professionals have a natural desire to illustrate mastery in the specific skills of their discipline; unfortunately that desire can frequently interfere with developing an understanding the specific skills of other members of their healthcare team. When team members do not know or ask about the expertise of other members, it is unlikely that the team will be able to leverage the full extent of everyone's expertise. This is complicated further when clear communication is not a group norm or expectation. Individuals have to recognize and acknowledge their own expertise, as well as model, encourage and reinforce the expertise of all other members of the team.

To develop interprofessional expertise, the healthcare team must define and clarify all the necessary roles and functions needed to fulfill the work of the team. This clarification can enhance interprofessional relationships by inviting all members to share how they would like to contribute to the work of the team. As the team engages in this clarification process, individual members can develop a clear understanding of other team members' unique capabilities, observe the evolution of everyone's role and contribution within the group and invite and encourage everyone to

practice at the top of his/her professional capacity.

The four sources of influence (mastery, vicarious experience, social persuasion, and physiological response awareness) can facilitate understanding the expertise of other professions, contribute to a sense of professional autonomy, and enhance teamwork (Rafferty, 2001). Intentionally acknowledging expertise, modeling professional practice, fostering engagement, and creating an inviting and inclusive atmosphere can encourage and highlight the expertise of all team members.

Elements of Culture

The cultures of every health care profession and interprofessional team encompass similar elements. These include communal values and beliefs, codes of behavior, language, knowledge and information, strategies for solving problems, cultural practices, methods of orienting new members and sets of relationships.

The way the above elements are expressed and practiced by a healthcare team can affect the way any individual within the group functions. Being an accepted member of a profession or a team implies embodying a group of rules, beliefs and habits: ways of speaking, understanding, seeing, valuing, etc. A sometimes unspoken expectation in any cultural group (including professions) is to "become one of us and stay one of us" (Wackerhausen, 2009). Sometimes going outside these norms and expectations causes conflict between one member and the group or among the entire group (Wackerhausen, 2009; Brown, 2000).

It can be useful to view cultural systems dialectally, for example inclusive v. exclusive, cohesive v. divisive (Estes, 1992). Depending on the way members of a team interact, any group will create a climate in which individuals feel safe or vulnerable. A negative climate can manifest in inconsistent ways, increasing negative outcomes and creating a sense of perceived oppression. On the other hand understanding a group's culture and reconciling its healing and injuring aspects can create an environment that promotes positive outcomes for individual team members, the group as a whole and the population served. Positive goals for a team might include creating a climate of emotional safety and inclusivity within the group, particularly related to new members.

Group Dynamics

Along with cultural characteristics, every team has group dynamics, which describe the interactions and relationships that take place among group members as well as between the group and the rest of society (Brown, 2000). Dynamics are created by interactions among the personalities of the group members, as well as the context and environment of the group's work. These dynamics set the group's basic energy and tone and affect its performance. Group dynamics can affect each individual's behavior differently, depending on status, assigned work in the group and idiosyncratic behavioral patterns. There is no absolute standard for how to respond effectively in a group and no direct correlation between comfort and effectiveness. There is no simple explanation for why some groups thrive and others do not.

When some team members experience ongoing discomfort and a sense of being overwhelmed by the dynamics of the group, overall group dysfunction can result. Sometimes one person's comfort may come at the expense of another person's sense of safety and an absence of emotional safety may result in team members feeling negatively affected by the dynamics of the group. Individuals are always making conscious and unconscious choices about group interactions and the way those choices affect others may reflect inattentiveness or lack of awareness of one's own and other's reactions and responses. Ultimately, interpersonal dynamics among team members do influence healthcare outcomes for the clients, patients, and communities served (Grumbach & Bodenheimer, 2004).

Conflict

Dynamics and diversity, workload stress, and the close physical proximity of a teamwork setting inevitably create conflicts. The way individuals deal with conflict determines whether the process will be productive or destructive. Conflict is often an indicator of an ongoing discussion and engaged relationships within a healthy group of unique people. Working through conflict effectively requires engaging in a resolution process and communicating concern about the relationships involved.

It is reasonable to assume that everyone on the health care team has the best interests of the patients in mind. While there may be unusual cases in which this is NOT true, operating from the assumption that it IS will help bridge differences and manage conflict. A fundamental commitment to a shared goal (the best interest of the patient) can promote interpersonal and group effectiveness.

Mastering conflict allows for successful resolution of potentially destructive interaction patterns in a group. This requires learning to communicate directly and respectfully. Team communication left to chance or impeded by unresolved or ignored barriers or conflicts is unlikely to produce a clear and accurate response when a complex or serious situation arises (Drinka & Clark, 2000). In the face of conflict, exacerbated by individual differences, group dynamics and the stresses of health care practice, group members are as likely to revert to self-protective patterns of

behavior as they are to altruism (Axelsson & Axelsson, 2009; Drinka & Clark, 2000).

Every member of a team encounters diverse and unfamiliar situations, which can cause negative or uncomfortable interactions. For those directly and indirectly involved, addressing conflicts promptly and appropriately is critical. Moreover, when one or more members of the team are disrupting the group's work and the rest of the group is avoiding confronting the behaviors, that group has to find a way to solve the problem (Drinka & Clark, 2000). Every

group member can learn how to give and receive feedback, express his/her feelings and address unproductive behaviors, and any one person can begin this process. Avoidance, blaming, gossip and speculation are some of many ways individuals can sabotage attempts to resolve conflict effectively. One complicating factor is the fight or flight response to conflict, thus it is important to take time to address one's physiological reaction to stress before taking any action.

Table 3. *Group Domains of Interpersonal Effectiveness in Healthcare Practice*

Group Domains	Teamwork	Professional Expertise	Team culture	Group Dynamics	Conflict
Mastery Experiences	Collective recognition and responsibility for mission	Acknowledgment & utilization of everyone's expertise	Inclusive, supportive & safe climate	Optimal function of all members	Conflicts resolved & relationships repaired
Vicarious Experiences	Observe & learn from effective teams	Explore & learn others' skills sets and roles	Assess cultural climate of other teams	Notice interpersonal outcomes of group process	Learn conflict resolution strategies from others
Social Persuasion	Encouragement & education from trusted peers	Integration of best practices of all members	Responsiveness to feedback about emotional climate	Acknowledgement and attention to group process issues	Accurate feedback about identified areas of conflict
Physiological Stress Response	Enact willingness to trust & depend on others	Overcome reluctance to ask questions	Manage stresses related to diversity	Develop atmosphere that accommodates uniqueness	Create safe climate for exploring conflict

Conclusion

Every individual's sense of self-efficacy contributes to achievement of the team's collective goals, just as the team's successes enhance every individual's satisfaction. Self and group-efficacy in any of the domains described in this paper are achievable, through attention to personal culture, emotions, and beliefs. It is important to remember that self and group efficacy require believing that success in any chosen domain is possible, which reinforces resilience to continue in the face of failures and obstacles. Use of this theory individually and in groups could facilitate professional effectiveness and satisfaction. Although it takes

the entire team working together to achieve team effectiveness, it may take only one person to initiate a process toward working together more effectively (Magrane, et al., 2010). Individuals do influence the whole team atmosphere, which could explain how one team member can have a positive effect on the overall team performance (Purzer, 2010). One person can conceive of an idea, share and explain it to others, who demonstrate how it could work, and eventually make it a norm (Palmer, 1998). A potent outcome of this pedagogy is that individuals and/or teams will support and encourage each other's goals and aspirations. Because many outcomes are achievable only

through interdependent efforts, groups have to work together to accomplish what they cannot do on their own (Bandura, 2000). Through engaging in the processes described in this paper, health professions teams can move beyond competence toward effectiveness, resulting in high functioning teams and consistently positive patient outcomes.

References

Axelsson, S.B., & Axelsson, R. (2009). From territoriality to altruism in Interprofessional collaboration and leadership. *Journal of Interprofessional Care*, *23*(4), 320-330.

Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: W.H. Freeman and Company.

Bandura, A. (2000). Exercise of human agency through collective efficacy. *Current Directions in Psychological Science, 9*(3), 75-78.

Bandura, A. (2010). Self efficacy. In *The Corsini encyclopedia of psychology* (4th Ed. pp. 1534-1536). Hoboken, NJ: John Wiley & Sons.

Brown, R. (2000). *Group process: Dynamics within and between groups*. Oxford, UK: Blackwell Publishing Ltd.

Drinka, T. J. K., & Clark, P. G. (2000). *Health care teamwork: Interdisciplinary practice and teaching*. Westport, CT: Auburn House.

Estes, C. P. (1992). *Women who run with the wolves*. New York, NY: Ballantine Books.

Giles, H., & Ogay, T. (2007). Communication accommodation theory. In B.B. Whayler & W. Samter (Eds.), *Explaining communication: contemporary theories and exemplars*. Mahwah, NJ: Lawrence Erlbaum Associates.

Grumbach, K., & Bodenheimer, T. (2004). Can health care teams improve primary care practice? *Journal of the American Medical Association*, *291*(10), 1246-1251.

Hall, P. (2005). Interprofessional Teamwork: Professional Cultures as Barriers. *Journal of Interprofessional Care*, May; Supplement 1: 188-196.

Jezewski M. A., & Sotnik P. (2001). Culture Brokering: Providing Culturally Competent Rehabilitation Services to Foreign–Born Persons. *Center for International Rehabilitation Research Information and Exchange*, Retrieved from http://cirrie.buffalo.edu/culture/monographs/cb.php

Kaprielian, V., & Gradison, M. (1998). Effective feedback. *Family Medicine*, *30*(6): 406-7.

Le Cornu, A. (2009). Meaning, internalization and externalization: Toward a fuller understanding of the process of reflection and its role in the construction of the self. *Adult Education Quarterly: A Journal of Research and Theory, 59*(4), 279-297.

Luft, J. (1961). The Johari window: A graphic model of awareness in interpersonal relations. *Human Relations Training News, 5*(9), 6-7.

Luft, J.& Ingham, H. (1955). "The Johari window, a graphic model of interpersonal awareness." *Proceedings of the western training laboratory in group development* (Los Angeles: UCLA).

Magrane, D., Khan, O., Pigeon, Y., Leadley, J., & Grisby, R.K. (2010). Learning about teams by participating in teams. *Academic Medicine, 85*(8), 1303-1311.

Mann, K., Gordon, J., MacLeod, A. (2009) Reflections and reflective practice in health professions: A systematic review. *Advances in Health Science Education*, *14*, 595-621.

Mezirow, J. (1990). *Fostering critical reflection in adulthood: A guide to transformative and emancipatory learning*. San Francisco, CA: Jossey-Bass Publishers.

Palmer, P. (1998). *The courage to teach: Exploring the inner landscape of a teacher's life*. San Francisco, CA: Jossey-Bass Publishers.

Pew-Fetzer Task Force. (1994). *Health professions education and relationship-centered care: Advancing psychosocial health education*. San Francisco, CA: Pew Health Professions Commission. from http://rccswmi.org/uploads/PewFetzerRCCreport.pdf

Purkey, W. (1992). An Introduction to Invitational Theory. *Journal of Invitational Theory and Practice, 1(1), 5-15.*

Purzer, S. (2011). The Relationship Between Team Discourse, Self-Efficacy, and Individual Achievement: A Sequential Mixed-Methods Study. *Journal of Engineering Education, 100(4), 655-679.*

Rafferty, A. M., Ball, J., & Aiken, L.H.(2001). Are teamwork and professional autonomy compatible, and do they result in improved hospital care? *Quality in Health Care, 10*(2), ii32-ii37.

Schmitt, M., Blue, A., Aschenbrener, C.A., & Viggiano, T.R. (2011). Core competencies for interprofessional collaborative practice: Reforming health care by transforming health professionals' education. *Academic Medicine, 86*(11), 1351.

Siver, S. (2004, April). Shadows of Peace. Presented at NATO sponsored conference on Conflict Resolution at Russian Academy of Science, St. Petersburg, Russia. Retrieved from http://stanfordsiver.net/archive/

Suchman, A.L. (2006). A new theoretical foundation for relationship-centered care. *Journal of General Internal Medicine, 21*, 40-44.

Wackerhausen, S. (2009). Collaboration, professional identity and reflection across boundaries. *Journal of Interprofessional Care*, *23*(5), 455-473.