Including Hope in Occupational Therapy Practice: A Pilot Study

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The concept of hope as a component of occupational therapy intervention has been left virtually unexplored in the literature. Writings from theology (Schweitzer, 1959), philosophy (Fromm, 1968), psychology (Srotaled, 1969), sociology (Murphy, 1990), medicine (Buchholz, 1990), and nursing (Miller, 1985), as well as lay literature, have long acknowledged a relationship between hope and survival (Frankl, 1959), hope and recovery (Cousins, 1979; Price, 1994), and hope and the will to overcome (Murphy, 1990). The Bible makes frequent references to the importance of hope, for example: “For to him that is joined to all the living there is hope” (Eccles. 9:4). The occupational therapy profession incorporated in its foundation values of healing through engagement in occupations “which anyone can hope to achieve” (Meyer, 1922/1977, p. 641). In the first edition of Principles of Occupational Therapy, Fay and March (1947) acknowledged that communicating hope to the patient belonged in the repertoire of the occupational therapist. They provided a list of do’s and don’ts concerning the therapeutic relationship. The therapist was told to “be encouraging and hopeful and foster a desire in the patient to get well” (p. 125). None of the subsequent seven editions of Willard and Spackman’s Occupational Therapy offered similar explicit guidelines about including hope in therapeutic interventions.

More recently, carefully crafted portrayals of patient-therapist interactions were created by Fleming (1991) and Mattingly and Fleming (1994) in their examinations of the narrative nature of clinical reasoning. These authors spoke about the therapist’s focus on the patient’s possibilities, including a hope that the solutions provided for the patient would make his or her life a little easier or more meaningful. However, these authors did not address the manner in which hope is conveyed to the patient. The silence surrounding that aspect of therapeutic interventions provided the impetus for this pilot study. The purpose was to explore the manner in which occupational therapists reported using hope as a component of their therapeutic interventions and how they reflected this in their documentation of treatment.

Literature Review

Defining Hope

In an effort to explore the influence of hope on survival and healing and examine more specifically how health professionals incorporate hope into their therapeutic interventions, literature from medicine, psychology, occupational therapy, and nursing was reviewed. This yielded a multitude of interpretations of the dictionary defini-
tion of hope: “desire accompanied with expectation of obtaining what is desired, or belief that it is attainable” (Webster’s Third International Dictionary of the English Language, 1986, p. 1089). Hope has been called “a state of being” (Fromm, 1968, p. 12); “an intrinsic component of life” (Miller, 1985, p. 23); “a window on the future, the drive to survive, something to live for, or the balance between the past, the present or the future” (Bruhn, 1984, p. 215); “a motivating force, an inner readiness to reach goals” (Herth, 1990, p. 1251); and “an expectation greater than zero of achieving a goal...a shorthand term for an expectation of achieving a goal” (Stotland, 1969, p. 2). Two constructs appeared to characterize most of these definitions: expectation of a future good and action toward an attainable goal. Bruhn (1984) and Herth (1990) characterized hope as a coping strategy. Stephenson (1991) extended her definition to state that “in health care, hope has been incorporated into the concept of caring” (p. 1456). The occupational therapy literature reflected only one definition of hope. In writing about caring attitudes of the therapist, Gilfoyle (1980) included patience, honesty, trust, humility, hope, and courage as ingredients, then went on to define hope as “an attitude of realizing the present with its possibilities and energies for the growth of clients” (p. 520). Although the occupational literature that addresses caring and coping is generally written in an optimistic, hopeful manner, direct references to hope were not found.

For purposes of this study, hope is defined as “a multidimensional dynamic life force characterized by a confident yet uncertain expectation of achieving a future good which, to the hoping person, is realistically possible and personally significant. Hope has implications for action and for interpersonal relatedness” (Dufault & Martocchio, 1985, p. 380).

Theories of Hope

This study was built on two conceptual frameworks related to hope (Dufault & Martocchio, 1985; Stotland, 1969). Stotland, a psychiatrist, outlined a theory about level of hopefulness and applied it to data from studies in psychology and psychotherapy. His theory stated that hopefulness is a necessary condition for action...people who are hopeful are usually described as active, vigorous, energetic. An organism’s motivation to achieve a goal is, in part, a positive function of its perceived probability of attaining the goal and of the perceived importance of the goal. (p. 7)

One of Stotland’s chief premises was that hopefulness is a necessary condition for therapy (in his case, psychotherapy) to be effective. Because of its action orientation fueled by motivation, this theory appeared relevant to occupational therapy.

A second framework used for looking at hope was the one proposed by Dufault and Martocchio (1985), who are both nurses. In their view, hope is a complex of many thoughts, feelings, and actions that change with time; therefore, there are many manifestations of hope. Dufault and Martocchio developed a detailed schema of observable manifestations of hope. They identified two spheres of hope: generalized, “casting a positive glow on life” (p. 380), and particularized, concerned with a “valued outcome, good or state of being” (p. 380). Similar to Stotland’s (1969) proposition, Dufault and Martocchio stated that particularized hope encouraged commitment to a specified goal toward which the energies of both the hoping person and others can be directed. They further characterized hope as a source for constructive coping with obstacles. Their six dimensions of hope—affective, cognitive, behavioral, affiliative, temporal, and contextual—form a “gestalt of hope” (p. 381). The majority of reviewed literature on hope has incorporated the structures of Stotland or Dufault and Martocchio.

The Hoping Person’s Perspective

In Frankl’s (1959) classic description of his survival of the concentration camp experience, he noted:

Those who know how close the connection is between the state of mind of a man—his courage and hope, or lack of them—and the state of immunity of his body will understand that the sudden loss of hope and courage can have a deadly effect. (p. 120)

Frankl attributed his own survival to his belief that there was a future waiting for him. Similarly, in Fine’s (1991) discussion of resilience and human adaptability, she described the hope and will to live reflected in the poetry of children in concentration camps who found comfort and inspiration in the “resilience of nature” (p. 497).

Cousins’s (1979) account of his recovery from a reportedly irreversible disease offered testimony that the will to live could be harnessed in the service of the patient as a physiological reality with therapeutic characteristics. He underscored not only the use of laughter, but also the importance of the physician–patient partnership in the search for a cure. Fine (1991) also described the therapeutic effects of linking hope and humor.

Murphy (1990) referred to the instinct for self-preservation as the driving force behind his decision “to rejoin the world” (p. 66) in spite of a progressive tumor that eventually robbed him of all voluntary movement: “Being alive was just too interesting” (p. 66). In his report of physical therapy, Murphy described the game played by the therapists that was intended to activate the patients:

The other therapists and their patients echoed him, telling [the patient] that she could do it, forming a cheering section as she strug-
Price (1994) related the manner in which his physical therapist played a tangible part in his survival from cancer through her constant understanding, frequent laughter, and “realistic caution” (p. 38), all of which set the stage for his “vision of healing” (p. 192). In these situations, hope communicated by others exerted a positive impact on survival and healing.

Strategies for Instilling Hope

Cousins’s (1989) report of his 10-year experience as a non-physician faculty member at the University of California provided scientific evidence that hope and the will to live, among other positive emotions, can help fight serious illness. His quest for proof that the brain could bring about improvement in the way human beings confront illness involved him in the development of psychoneuroimmunology as a new branch of medicine. His exhortation to medical students was not to do or say anything that would “rob patients of the hopes that are the physician’s strongest ally” (p. 270).

A review of occupational therapy literature yielded sporadic information on therapists’ use of hope. In an article on competence and adaptation, Smith (1974) provided several guidelines for the occupational therapist in moving patients to become agents on their own behalf. He advised the therapist to provide the patient with “clear examples of the impact of realistically confident hope” (p. 14). Almost 20 years later in a study looking at the therapeutic factors of occupational therapy groups considered by patients and therapists to be most and least helpful, Falk-Kessler, Momich, and Perel (1991) found that “instillation of hope” (p. 65) was the third factor most valued by all subjects in the study as “a necessary condition for growth and change” (p. 65). In a similar analysis of helping factors in a support group for patients with head injuries (Schulz, 1994), “feeling hope” (p. 307) was also identified by one subject. In her Eleanor Clarke Slagle Lecture, Clark (1993) related her role with her friend Penny:

I had begun functioning as her occupational therapist, through encouraging her to tell her story and by helping her to imagine new possibilities...I began to view my role as similar to that of the coach of an elite athlete or ballet student – needing someone to coach them along the way. (pp. 1072-1073)

The overwhelming majority of information about strategies for incorporating hope into daily practice came from the nursing literature. Nurses reported their use of hope with patients who had cancer (Defaut & Martocchio, 1985; Poncar, 1994), chronic illness (Gaskins & Forte, 1995; Raleigh, 1992), schizophrenia (Byrne et al., 1994), and severe burns (Anderson, Maloney, & Redland, 1993); who were elderly (Forbes, 1994); and who were terminally ill (Brown, 1989; Cutliffe, 1995; Herth, 1990). Development and use of scales for measuring hope in patients were reported by Herth (1990) and Miller and Powers (1988).

These articles yielded a number of recurring approaches for enabling hope: (a) engaging in active listening; (b) establishing sustaining support systems among family and friends; (c) communicating humor, courage, and determination; (d) teaching reality surveillance (continuous reorientation to reality, including comparing oneself with others who have the same health problems); (e) affirming personal worth; (f) sharing uplifting memories from the past; (g) increasing the extent of caring; (h) allowing choices; (i) fostering a spiritual base; (j) assisting patients in making plans; and (k) expanding the patient’s coping repertoire. The nursing studies provided the specificity that was lacking in the occupational therapy literature and offered a useful framework for the present study.

Method

Design

A qualitative design was selected for this pilot study to explore the manner in which occupational therapists reported using hope as a component of their therapeutic interventions and subsequently reflected this in their documentation of treatment. A convenience sample of occupational therapists employed at the Columbia-Presbyterian Medical Center in New York was targeted for participation in the study. Participants were recruited through an announcement inviting participation in a study of the use of hope in occupational therapy. The study would be conducted in one session at the start of a workday in the occupational therapy clinic. No other criteria were set for the potential participants.

Participants

Twelve occupational therapists volunteered for participation in the study. The sample included 10 women and 2 men whose years in practice ranged from less than 1 year to 28 years. All were currently employed by the Columbia-Presbyterian Medical Center. Eight worked in adult rehabilitation, two treated patients with hand injuries, one worked in psychiatry, and one had worked primarily in mental health home care. No other information about the participants was collected.

Procedure

The participants met as a group in the occupational therapy clinic. After completing the consent form, each par-
participant was handed a page requesting a written response to the following question: Considering your own practice—currently or in the past—would you say that you include the use of hope in your daily practice? If so, can you provide a specific example of a patient–therapist interaction in which hope was a component? If not, please state why you refrain from including hope in your treatment program. The definition of hope selected for the study (Dufault & Martocchio, 1985) was included. The participants were told that they had approximately 15 minutes in which to write their answers to the question after which there would be a group discussion.

During the second half of the session, an audiotaped group discussion of the ways that the participants do or do not include hope in their documentation of patient progress was conducted. The investigator presented the topic and allowed the discussion to proceed without further prompting. The participants chose to respond one by one according to their seating arrangement, which allowed each to contribute to the discussion.

The written responses were subjected to content analysis for recurring themes. They were subsequently compared to the dimensions of hope identified by Stotland (1969) and Dufault and Martocchio (1985) and the strategies for instilling hope identified in the literature.

After the transcription of the audiotape, the participants' reported documentation of their use of hope was reviewed and examined for agreement with the ideas of the underground practice, a construct first identified by Fleming (1991) in her seminal writing on clinical reasoning. Fleming described a dilemma that was reflected in occupational therapists' reasoning as a result of the conflict between certain deeply ingrained occupational therapy values and the values of the biomedical culture within which occupational therapists frequently worked. Out of this grew a process of conducting essentially two types of practice: one that emphasizes the procedural treatment of the patient's physical body and one that focuses on the patient as an individual. According to Fleming, “The point is that while two practices were conducted, only one was reported—the procedural practice. The interactive practice which was unreported practice, we called the underground practice” (p. 1010). As reported by Mattingly and Fleming (1994), this portion of practice, although often conducted covertly, was valued by both patients and therapists. The analysis of the study participants' report of documentation was intended to look for signs of the underground practice.

Results

Therapists' Hope Strategies

All 12 participants completed their written responses within the allotted time and responded that they used hope in their practice. After several readings of the “hope incidents,” a series of recurring strategies emerged and then were categorized with the following preliminary labels adapted from the 11 approaches for enabling hope identified earlier (Dufault & Martocchio, 1985): (a) encouraging the patient, (b) expressing enthusiasm for patient progress, (c) focusing on the future, (d) incorporating peer support, and (e) responding to the immediate needs of the patient. Examples of each strategy follow.

Encouraging the patient.

I use hope to encourage and motivate the patient to work toward a realistic goal.

Expressing enthusiasm for patient progress.

I offered a sense of hope with my own confidence in her and enthusiasm that through strengthening and practice she would soon be transferring on her own.

Incorporating peer support.

I offered a sense of hope with my own confidence in her and enthusiasm that through strengthening and practice she would soon be transferring on her own.

Focusing on the future.

In order to elicit her participation in treatment, I had to find her sense of hope about the present and the future.

Responding to the immediate needs of the patient.

I could not ignore the patient's anxiety and fear about outcome prognosis of his impending surgery... I focused our conversation on his work (he was an artist) and comments on how he could continue aspects of this immediately upon returning home from the hospital... After about 30 minutes, he attempted the dressing activity, although he did refuse certain parts, but again I felt his need to [regain] control was more important than completing the task.
think this was all about hope.

Christmas had always symbolically been hopeful to her. Her therapy used this belief and the feelings associated with it to help her prepare a Christmas surprise for her mother and brother.

Reports of Documentation

The reports of documentation of strategies to elicit hope varied considerably. One participant volunteered, “I never documented hope in my entire career—I didn’t think anyone would be interested.” Most of the other participants qualified their statements about not “formally documenting” the use of hope, but they did feel comfortable about reporting encouragement:

I will document that “patient requires encouragement to continue” and later on, “patient responded to encouragement.”

I don’t document hope but say, “Patient is doing better when given verbal encouragement.”

I’ll also document patient questions like, “Am I gonna get better?” “Is this gonna help me?” but not the interventions. Sometimes I’ll write “Had a discussion about patient’s status and concerns about his progress.”

I think that for me, the closest I’ve ever come to documenting it is when I’m doing a weekly progress note, and where it asks about cognitive-perceptual. I’ll say, “Patient was very discouraged during practice of transfers and was given verbal encouragement to continue working.”

One participant reported having worked with many patients with issues of death and dying. She commented, “I think hope is probably what drives most people to participate in activities…so I do document hope when I’m dealing with issues affecting death and dying adjustments.”

Discussion

It was apparent from the ease with which the participants in the study completed their written incidents that hope was a topic with which they could identify. As was expected, some of the responses were quite general, although several of the participants were clearly describing a specific patient. Length of experience as an occupational therapist was unrelated to this: The shortest and the most detailed incidents were written by the two participants with the longest experience. Not surprising was the superficial nature of most of the written stories, which was probably a result of the time limit. Individual interviews with each participant would have allowed the incidents to be developed to a greater extent; however, the written responses assured anonymity and were therefore less intimidating.

The concept labels that emerged from the analysis of the written incidents must be considered as a first step in a pilot study. They were useful in distinguishing the themes identified by the participants and as a basis of comparison with the theoretical framework. However, they only served to demonstrate the presence or absence of the themes rather than to distinguish among them. The expectation of goal attainment (Stotland, 1969) was apparent in the majority of strategies. The long-term, implicit goal for each patient was a restoration of occupational performance to the extent possible for that patient. Where the participants were describing a specific patient, the goals were articulated. The strategies reflected the six dimensions of hope delineated by Dufault and Martocchio (1985): The temporal and behavioral dimensions were reflected in the future directedness as well as the action components of the interventions; the life situation of each patient (contextual dimension) was incorporated into the participants’ hope strategies, as were the mental processes of the cognitive dimension; and the strategies addressed both the affiliative and affective dimensions, which include attitudes of persons in the patient’s environment and the patient’s optimistic or pessimistic feelings. From the examples of the participants’ stories it could be surmised that the Dufault and Martocchio framework is applicable to occupational therapy.

The spiritual component of hope frequently addressed in the nursing literature (Anderson et al., 1993; Gaskins & Forte, 1995; Miller, 1985) moves it into the realm of the underground practice. The discussion about documentation of hope reflected not only the participants’ hesitation in including this in their notes, but also their reluctance to refer to these interventions as hope. What they did report was through carefully worded terminology (i.e., encourage, motivate) that related to the functional goal rather than to the psychosocial needs of the patient. Only in the situation where patients were dying did a participant openly document her use of hope as an intervention, raising the question of whether impending death sanctions the use of spiritual interventions.

For most of the participants, using hope in their daily practice was implicit and readily discussed among themselves. However, as occupational therapists, they have been socialized to avoid reporting those aspects of treatment that are not considered reimbursable. Although this question was not included in the discussion, it is a widely accepted belief that in the current climate of cost containment, it would be difficult to justify the inclusion of spiritual content in a treatment session. Judging from the frequency with which spirituality was included in nursing literature, this appears to be a routine component of nursing practice and not one that needs to be justified in order to receive payment for services.

Occupational therapy thinking has incorporated ideas and strategies that other professions have identified as hope but has conferred other constructs on these concepts. Early work on the Model of Human Occupation

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(Kielhoffer & Burke, 1980) described the volitional subsystem in much the same terminology as that used by Stodland (1969). Kielhoffer and Burke spoke of "valued goals" (p. 577) that guide the productive behavior of the patient "as an agent placed in time with past actions, present circumstances, and future possibilities...yielding accomplishments" (p. 577). Equally, the writings by occupational therapists on the topics of care and coping closely resemble the descriptions of hope used by other disciplines. Because of the spiritual nature of hope, this study was deliberately focused on this construct and was not broadened to include an examination of related ones.

An implication for occupational therapy that has arisen from this study is the need to underscore the psychosocial core of occupational therapy, which includes the collaborative effort between the therapist and the recipient of care (Christiansen, 1991). Is the absence of references to hope in occupational therapy literature another example of the lack of acknowledgment of the art in our profession as eloquently discussed by Peloquin (1989, 1994)? Are there lessons to be learned from other disciplines about their open inclusion of hope in daily practice? Has hope become a politically incorrect term in occupational therapy, relegated forever to the underground practice? Or should occupational therapists position themselves to assist in the study of hope as part of psychoimmunology? These and other questions raised by this study are fruitful areas for future research. Notwithstanding the limitations of a pilot study (i.e., lack of generalizability because of the limited sample and setting, lack of depth in exploring the questions with the participants, lack of rigor in the analysis of the qualitative data), this study has opened the door to an interesting professional debate and the possibility for replication with a larger sample and a more rigorous analysis.

Conclusion
This pilot study examined the inclusion of hope in the daily practice of occupational therapists and explored the manner in which hope was documented. All the participants reported situations in which hope was a component of their therapeutic interventions; however, their documentation of the use of hope was limited, ranging from no documentation to describing their intervention by another term. Only one therapist used the word hope in her documentation. This finding supported the description of the underground practice where decisive and valued interactions between the therapist and the patient are not included in the documentation. The findings also reflect the therapists' response to restrictions imposed by the current climate of health care. ▲

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References


