Understanding Professional Behavior: Experiences of Occupational Therapy Students in Mental Health Settings

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A phenomenological study explored occupational therapy students' experiences in psychiatric fieldwork. Of particular interest was students' understanding of professional behavior toward persons who use mental health services. Data were gathered from 16 informants via in-depth interviews and participant observation on multiple occasions during fieldwork affiliations. Emerging from informants' views of professional behavior were difficulties in their reconciling conflicting expectations with regard to emotional and social distance from persons who use mental health services. Additionally, the informants experienced a need to assume authority and maintain control in their dealings with service users. Students' encounters with such issues during fieldwork are indicative of challenges they may face as health professionals in a changing climate of mental health services. These data are stimuli for reflection on features of professional relationships with service users, particularly in response to expectations of persons with disabilities regarding control over their lives.

Before entering an occupation deemed a profession, aspirants must undergo a rigorous program of professional education, which is usually divided between academic and practice settings. According to Jongbloed and Crichton (1990), "at the centre of the process of becoming a professional is acquiring the identity and outlook of a particular type of professional" (p. 36).

Socialization Into a Profession

The term socialization has been used to describe the process of "social development and the acquisition of attitudes, values, and behavioral orientations" (Mechanic, 1990, p. 96) central to a particular profession. The socialization process "is complex, with multiple dimensions impacting upon each individual attempting to find his or her place in the world of [the profession]" (Stroot & Williamson, 1993, p. 343).

It has been suggested that socialization is a dialectical process and that tension exists between the individual being socialized and the socializing agency. Certain ideologies, knowledge, and skills will be valued by organizations, and students will be rewarded for adhering to these over others (Stroot & Williamson, 1993). Although their power to act is limited, students are nonetheless attempting to develop their own understanding of the social real-
About the Researcher

It is important in an interpretivist analysis such as this that I convey something of my own stance as a researcher that has prompted my interest in exploring this question. In my work, I have developed links with several consumer groups that represent the interests of persons with psychiatric and other disabilities. These forays outside my professional culture, along with my analysis of literature in medical sociology and anthropology (e.g., Helman, 1994; Shapiro, 1989), have led me to reflect on the social construction of illness and disability and consider its implications for service delivery to persons with disabilities. I have also been influenced by occupational therapy literature that explores sociopolitical models of disability and concepts of handicap (e.g., Jongbloed & Crichton, 1990; Law & Dunn, 1993) to examine assumptions underlying occupational therapists’ clinical problem solving. Finally, as an educator, I have a deep interest in students’ acquisition of not only knowledge and skills, but also beliefs and values relevant to their future professional practice.

My research to date has raised questions about the socialization of occupational therapy students whereby processes and practices within fieldwork settings seem to have had mixed effects on students’ perceptions of persons with psychiatric disorders (Lyons & Ziviani, 1995). On the one hand, students had brought various stereotypes and fears about such persons to the fieldwork setting but had, to some extent, reflected on and revised these in light of their fieldwork experiences. On the other hand, students still struggled to appreciate the humanness of these persons in the face of certain service system processes that tend to depersonalize them (Lyons, 1996).

Thus, I bring to this analysis a particular “professional version” (Melia, 1984, p. 132) of occupational therapy reflected in our literature, some of which is referred to in the discussion that follows. To echo Wexler (1992): “I hear [informants’] words in my ears, and I speak my words, conditioned by my place in historical social movement and by the language and analytical resources available to me...and what follows is neither Truth nor Fiction, but a composition” (p. 2).

Method

An abbreviated account of procedures in the conduct of the research study that yielded the data under discussion is presented here. Further details are presented in Lyons and Ziviani (1995).

Informants

This study used a qualitative methodology to explore this question with 16 female occupational therapy undergraduates. Twelve were undertaking fieldwork in hospital settings and the remainder in community mental health clinics. These figures reflect a situation where the majority
of psychiatric fieldwork places currently available to students are within hospitals (i.e., where supervising therapists work).

The informants were selected by stratified purposeful sampling (Patton, 1990). Students were stratified on the basis of the type of setting in which they were undertaking their fieldwork. Identified setting types included public versus private hospital, hospital versus community clinic, and short-stay versus medium-stay to long-stay psychiatric unit. These facilities differed somewhat in their stated goals and anticipated outcomes for service users and, hence, differed in terms of their processes of intervention. I reasoned that they might constitute substantially different learning environments for occupational therapy students.

Data Collection
The primary data collection technique was unstructured (and later semistructured) interviewing (Bogdan & Biklen, 1992). Typically, informants were interviewed on four or five occasions, each lasting approximately 1 hr. With informants’ permission, I audiotaped interviews to provide for increased accuracy in capturing their words—the essence of what Maxwell (1992) has termed the “descriptive validity” (p. 285) of their accounts.

To strengthen what Maxwell (1992) has termed “interpretive validity” (p. 288) (or the accuracy of interpretation of informants’ perceptions), I drew on participant observation as a means of triangulating data gathering. Most of the participant observations were conducted around therapy groups in which informants were playing a major role (e.g., discussion groups, exercise and relaxation groups, cooking groups). Typically, I undertook one participant observation session with each informant, lasting from 30 min to 3 hr, from which I then prepared detailed field notes.

Data Analysis
The narrative data from interviews and observations were analyzed inductively. Analysis began while data collection was still under way. As data were being gathered, they were being subjected to preliminary inspection and comparative analysis (Henwood & Pidgeon, 1992). Furthermore, to maximize the trustworthiness of my interpretation, I regularly engaged in member checking (Krefting, 1991); that is, I questioned informants about my evolving interpretations of their fieldwork experiences. After collection, the data were subjected to a detailed coding, using concepts arising from the data—both indigenous concepts (i.e., those used by informants, such as “the occupational therapist’s role” and “being professional”) and sensitizing concepts (i.e., those developed by the research, such as “values” and “student role behavior”) (Patton, 1990). Issues emerging from this coding process were then grouped into themes, some of which have been discussed elsewhere (e.g., Lyons, 1996).

Results and Discussion
What it meant to these occupational therapy students to behave professionally will be discussed under several headings suggested within the aforementioned description of professional behavior by Hannah. These are: detachment, distance, control, and expert help. For reasons of brevity, each of these professional behaviors is illustrated with only two quotes selected from informants’ narratives.

Detachment
Health professionals may struggle with a perceived conflict between a personalized relationship with service users and a professional detachment from them (Illingworth, 1988; Peloquin, 1990). Some informants’ experiences highlighted this, for example:

I always have that problem: getting used to my professional role and putting that apart from my own feelings... I really felt for [one service user], and I felt like saying to him, “Look, I want to tell you this as a friend.” ‘Cause if you’re a friend it’s different [than] if you’re a professional. (Silla)

In the fieldwork setting of a community mental health clinic, Silla encountered a dilemma in dealing with a person whom she believed was being exploited in an intimate relationship. She viewed her personal feelings about this as having to be divorced from her professional behavior; it seemed to her that her feelings would only contaminate her responses to situations encountered by service users.

Occupational therapy and associated health professions, particularly those in which women predominate, are often loosely described as “caring” professions (Chinnery, 1991; Freedberg, 1993). However, opinion varies as to what caring means within therapeutic relationships. For example, how is caring appropriately expressed, and what level of involvement with service users is deemed acceptable?

In contrast with the scientific and technical aspects of health care, caring has been described as an “art”: one that enriches all interactions with service users by contributing to their sense of dignity, mastery, and self-respect (Peloquin, 1993). At the same time, most health professions promote the concept of professional distance as an organizing principle of day-to-day interaction (Peloquin, 1990; Stewart, 1990). In other words, as Nievaard (1987) stated, professionals are advised to avoid personal affective commitment to service users. Some informants were troubled by such a stance. For example:

I didn’t understand that for a while, but now I understand that...
there is a detachment, and a warmth, but there's still a coolness there... But it's not natural to me. I mean, I can understand being professional in terms of ethics and that kind of thing, but being professional in terms of being something that you're not, that's very distressing. (Jane)

Curzer (1993) proposed benevolence (as opposed to caring) to be a role virtue for health professionals. However, his exhortation that professionals should act as if they cared, while involving their feelings very little, may leave them believing that they are practicing an act of deception. This may create a tension within some professionals, arising from the perceived need to operate in a fashion contrary to other values they may hold (e.g., openness, honesty). This was quite difficult for some informants who believed that they were required to act in a completely different manner to what they in essence were (i.e., chameleon-like).

It is frequently alleged that objectivity is an attainable and desirable attribute of health professionals, which is likely to be compromised because of the strong emotional ties inherent in caring (Curzer, 1993). Emotional distance is also encouraged in the interests of self-preservation. Devereaux (1984) cautioned occupational therapists to recognize that it is not possible to care for every person and that caring feelings cannot be turned on and off at will. In her opinion, failure to recognize this may lead to “emotional hemorrhaging” (p. 794) and professional burnout, which, in turn, may lead to mistreatment of service users.

Distance

Closely allied with neutralizing personal feelings (i.e., maintaining an emotional distance) is the matter of maintaining a social distance from persons living with mental illness. For example:

That's difficult because you have to get to a certain level with that person and build up that trust. Yet, you refuse it in the area that they'd like it the most: They'd like a friend. (Andrea)

To establish an effective working relationship with service users, the informants revealed how they attempted to get close to people—to develop a rapport. Rapport is viewed as important in setting a shared context for interaction between therapists and the persons with whom they work as the basis of a caring relationship (Barrett-Lennard, 1993; Lamb, 1988). Building rapport involves taking a personal interest in the person, the way a friend would. Therein lay another dilemma for these informants. On the one hand, they perceived among persons with psychiatric disorders a largely unmet need for the caring support of friendship. On the other hand, they believed that giving friendship was incompatible with their professional role, which might require them to act in a way not normally associated with giving friendship.

Many students expressed surprise at the normalcy and similarity with themselves of some of the persons they encountered (contrary to the stereotypes about persons with psychiatric disorders to which they had previously subscribed). Sometimes, informants suggested that this made building up a relationship easier because of the sense of shared experience and the greater confidence it gave them as students. At other times, it complicated the type of professional relationship for which an informant was striving. For example:

I found this week that, when we went on an outing to the movies, I felt a little uncomfortable with the professional role there. I felt myself slipping out of it a lot of the time because the people we went to the movies with were roughly my age, and one had been a student. So we got on to a student sort of conversation and you can feel yourself slipping out of that role and being more of a friend sort of role. (Hannah)

A student's difficulty with taking on what is perceived as a professional role may be compounded by age and circumstance. Aging often brings with it a certain sense of authority that a young student may lack. As for circumstance, it seems that maintaining a professional relationship can be aided by the setting structure, such as the psychiatric hospital where Hannah was undertaking fieldwork. In a controlled clinical setting, the relationship between a therapist and client is likely to be well defined. It becomes harder to maintain this formality outside the clinic confines. On a social outing, for example, the more relaxed setting may encourage persons to step outside established role boundaries and be themselves. Hannah was alarmed by the insidiousness with which her professional demeanor could disappear.

Control

Many informants expressed anxiety early in their fieldwork about dealing with persons with psychiatric disorders in part because of their fears about the asocial behavior they anticipated from such persons. This raised the issue of students' maintaining control over people, particularly those displaying unruly or otherwise undesirable behavior. For example:

I've already realized I'm definitely going to have to be more assertive... in the sense that you can't let patients think that because they're ill or because you're a student—and I don't know whether that's the reason—that they can just take advantage of you. (Yvonne)

In the view of some informants, many persons with psychiatric disorders are inherently manipulative, this being interpreted as a symptom of their pathology. Understandably, this view gave rise to a strong desire for self-preservation in these informants. Yvonne, for example, felt the need to assert her control over the persons...
with whom she was to be involved during fieldwork in a community mental health clinic. She anticipated that they would be trying to take advantage of her inexperience and her sympathy with their condition.

Handling people (e.g., setting limits on their behavior) was viewed as a set of skills to be acquired over the course of the fieldwork placement. In fact, these students were being evaluated by their fieldwork supervisors on how well they demonstrated these skills. Under such circumstances, other goals relating to outcomes from intervention may become secondary. The game plan for an inexperienced and underconfident student may be principally to maintain control over what she sees as errant behavior, for her own survival.

On the basis of a fundamental view of service users as incompetent, Kalyanpur and Rao (1991) have suggested that professional helping relationships are too often characterized by a lack of respect for service users’ opinions. Persons using services may not be regarded as legitimate sources of opinion in making decisions about actions designed to benefit them (French, 1994a). Similarly, feedback from service users about the success of professional intervention may be discounted because of the challenge it poses to a professional’s sense of authority. For example, Jane, whose fieldwork placement was in a psychiatric hospital, made the following comment about a difficult experience where a participant in a therapy group was abusive toward her:

> About three patients came up to me after the group and said, “Oh, I felt so sorry for you.” And I said, “Well, don’t let it upset you.” I acknowledge it and thank them for it, but I don’t say, “Oh, I’m so glad you said that,” because that’s really putting them on top... it’s letting them have some sway, a big sway, in the way you feel and letting them be aware of it... I don’t think you want them to know that they do affect you a lot, ’cause they can play on it if they know it. (Jane)

There is evidence of mistrust (and even fear) in her response to other group members’ expressions of concern and support for her. So concerned was she about being manipulated by these persons, whom she did not trust, that she minimized the importance of their comments and deflected the comments back to them in an offhand manner.

**Expert Help**

From informants’ stories, the task of dealing with service users sometimes appeared to take on an air of benevolent control. From a position of professional expertise, these persons were considered to need management for their own good. For example:

> And if you want people to progress, sometimes they’ve got to be confronted and pushed on issues, and they don’t like that. But if you didn’t ever do it, they’d stay in the same situation all their life. (Jane)

There is a sense here of the notion of “you have to be cruel to be kind.” Yet, the argument for the end justifying the means has been used sometimes as a justification for maltreatment of the powerless by those in power (Wardhaugh & Wilding, 1993). When service users were assumed to be poor judges of what was good for them, the issue for some informants became one of getting the service users to cooperate with the occupational therapy program devised for (not in collaboration with) them—an issue of compliance.

As previously discussed, a great deal of emphasis was placed by informants on learning to exert their professional authority in the interests of achieving therapeutic goals (established by the therapist). In fact, part of the learning process with service users, as identified by some informants, included becoming sufficiently confident in disregarding signs from these persons regarding the limited value they placed on what the therapist was offering. For example:

> If the patients are falling asleep or not looking at me, that makes me think, “Oh, they’re not interested in what I’m saying,” and I just lose confidence. I was talking to [the occupational therapy supervisor], and she said, “That’s something that you build up with practice. You become more confident, and you believe in what you’re saying and don’t worry as much about how the patients react to what you’re saying.” (Hannah)

An exaggerated confidence in the expert knowledge and skills of health professionals (O’Hagan, 1992; Stewart, 1990) carries with it an assumption of knowing what is in the best interests of service users (knowing what they need)—the notion of “professional discretion” (Biklen, 1988, p. 128). Rather than questioning the effectiveness of her approach with people, this professional-in-training was being encouraged to see the issue more as one of a problem within the persons themselves (possibly recalcitrance because of their lack of insight into their problems and needs). This process of self-validation, in the face of an unfavorable service user reaction, is suggestive of socialization into an uncritical belief in professional expertise that has been described by Kalyanpur and Rao (1991) as “unempowering” (p. 526) of persons receiving services.

Another informant spoke of the difficulty she encountered in addressing a budgeting problem with a person in a community mental health clinic. Although the case manager saw the person’s overspending as a problem, the person himself was reportedly quite happy with the situation and actively resisted the informant’s attempts at well-intentioned intervention. This example highlights the discrepancy that may exist between professional and service user perspectives and the dangers inherent in the former ascertaining what is best without regard for the latter’s visions and values (Jongbloed & Crichton, 1990; Scullion, 1995). It is usually not a simple task for a help-
Reconceptualizing Professional Relationships

A major issue under discussion here, with regard to professional behavior, has been the dilemma students may face in reconciling inclinations toward a certain degree of intimacy in their relationships, with conflicting expectations for distance (both social and emotional). Another issue to emerge from these students’ fieldwork experiences is that of authority and control in the relationship between professional and service user about which a burgeoning consumer movement is asking difficult questions. The dilemmas that the informants faced regarding their professional behavior are indicative of uncertainties that may be faced by occupational therapists and others navigating professional relationships in a changing climate of mental health services.

Studies of service users’ views on relationships with health and welfare professionals have identified various features that characterize unsatisfactory relationships. These features include a lack of respect for service users’ opinions and an overriding view of such persons as incompetent, an uncaring attitude and a lack of sensitivity to their needs, and identifying them as the principal source of blame for their problems (DeChillo, 1993; Johnson, 1993; Kautzmann, 1993).

However, perhaps the issue that is at the heart of a contentious professional relationship is that of power (Crepeau, 1991; Peloquin, 1993; Scullion, 1995). Control over the interaction process typically resides with professionals. They are considered to have the expertise and authority to identify service users’ problems (e.g., through the capacity to manipulate symbols, such as diagnoses and disability labels). Then, they control the solutions to these problems (e.g., through the capacity to prescribe certain forms of treatment or to control access to the delivery of a service) (Goldin, 1990; Maynard, 1991).

Various authors (e.g., DeChillo, 1993; French, 1994a) have argued for professional relationships that are based on a more equitable distribution of power and on reciprocity and mutual respect: one that might be termed a collaborative relationship. In the same vein, Yerxa (1980) has identified “mutual cooperation” (p. 532) and “partnership” (p. 532) as fundamental to occupational therapists’ relationships with the persons they serve. The goal of these relationships, then, is one of empowerment of service users, which means that they act to change the conditions of their own lives and acquire the control to manage their own affairs. However, according to Kalyanpur and Rao (1991), “Since empowerment is an interactive ‘power sharing’ process…the professional’s role is as pivotal to its successful implementation as are the [service users’] efforts to meet [their] own needs” (p. 524).

Although the expertise of professionals is an integral part of an empowering relationship, crucial to its success is the manner in which this expertise is offered. Empowering relationships depend on the willingness of professionals to move from the stance of expert to that of ally or partner—a function of attitude and action (Crepeau, 1991; DeChillo, 1993; Stewart, 1990). Attitudinally, they require empathy, which means acceptance and adoption of a nonjudgmental stance, acknowledgment of persons’ competence, and a willingness to interact on equal terms. In action, it means providing enabling experiences for persons by creating opportunities for them to gain access to resources or to acquire the knowledge and skills necessary to further their active participation in the intervention process (French, 1994a; Kalyanpur & Rao, 1991; Peloquin, 1990).

It is acknowledged that power sharing with those who use health services challenges notions of being a health professional (Jongbloed & Crichton, 1990; Scullion, 1995); perhaps it threatens the very sense of self-worth and professional standing (Crepeau, 1991; French, 1994a). DeChillo (1993) questioned “whether a professional’s willingness to share power is related to the professional’s own sense of power (or powerlessness)” (p. 114). Perhaps some health professionals are themselves in need of emancipation from doubts and fears they hold about themselves and their dealings with persons living with mental illness or other disabling conditions.

Summary

I have reviewed some data on the socialization of a group of occupational therapy students during fieldwork in mental health settings. These students’ perceptions of professional behavior with regard to maintaining detachment, distance, and order in their dealings with persons with mental illness, while offering expert help, have provided a stimulus for exploring certain notions of professional relationships. Occupational therapists are encouraged to reflect particularly on the issues of control and collaboration in their practice with persons who use their services. In addition to moral considerations, this is an imperative in the face of increasingly strident demands by persons with disabilities for changes to structures and processes that maintain their social disadvantage. Health professionals associated with such systems are being challenged to change their practice in order “to work with [italics added] disabled people” (French, 1994b, p. ix)—changes from which French believed the benefits to professionals in terms of growth and satisfaction will far outweigh the costs.
References


