Finding Common Ground With Patients: The Centrality of Compatibility

Susan Ayres Rosa, Betty Risteen Hasselkus

This research examines the lived experiences of six novice occupational therapists (0–2 years experience) and eight career occupational therapists (≥5 years in the everyday practice in adult rehabilitation. The study focused specifically on therapists’ experiences of working together with patients and the ways in which these experiences unfolded over the course of therapy. Data were generated using a combination of phenomenological interviews with all 14 therapist-participants (Phase I) and participant observation of four therapist-patient dyads throughout the course of rehabilitation therapy (Phase II). Verbatim transcriptions of all interviews from Phase I and Phase II and field notes from Phase II were analyzed using a narrative approach. The analysis revealed that Finding Common Ground was a shared meaning of working together with patients regarding therapy goals and expectations. Findings suggest that occupational therapists may resist negotiating differences with patients over therapy goals and expectations and instead rely primarily on compatibility as the basis of finding common ground. Findings reveal the importance for occupational therapists to be (1) open to negotiating differences with patients over goals and expectations, (2) aware of the ideologies that may influence their practices, and (3) adequately prepared to deal effectively with the challenging interpersonal aspects of practice.


In occupational therapy, an emerging body of qualitative research is helping us understand the ways in which occupational therapists experience their work with patients (Burke, 2001; Bye, 1998; Egan & Swedersky, 2003; Hasselkus & Dickie, 1994; Hooley, 1997; Rosa & Hasselkus, 1996). The research reported here focused on the lived experiences of 14 occupational therapists in the course of day-to-day practice in adult rehabilitation. This research extends previous work in which we found that experiences of “connecting with patients” were central to the meaning that occupational therapists attach to their work (Rosa & Hasselkus). In this earlier study, the themes of helping patients and of working together with them were two major dimensions of therapists’ experiences of connecting with patients. Helping as connecting occurred when therapists perceived that they had provided some aspect of care that was valued by patients and that resulted in outcomes that were meaningful to them. Experiences of working together involved a sense of joining together with patients in supportive partnerships. In this study, we focused specifically on therapists’ experiences of working together in order to better understand the nature of this phenomenon. The fundamental assumption underlying this line of research is that professional helping or caregiving involves a dynamic relationship between caregivers and care receivers that can contribute to the growth and well being of both (Marck, 1990).

Working Together With Patients

The strong sense of partnership that characterized experiences of connecting as working together in the earlier study (Rosa & Hasselkus, 1996) was consistent
with the stated ideal of collaborative therapeutic relationships in occupational therapy (American Occupational Therapy Association, 2002; Corcoran, 1993; Levine & Gitlin, 1993; Peloquin, 1993; Wood, 1995). Central to discussions of collaboration in the context of health care is the notion of patient as partner (Bartholome, 1992; Katz, 1984; Veatch, 1991). A “true partnership,” writes Veatch, is one that “results when two persons of widely different backgrounds find a point of mutual interest” (p. 4). The ideal of collaboration has been articulated in the occupational therapy literature in the model of patient-centered practice (Law, Baptiste, & Mills, 1995). We know, however, from research that has examined therapeutic interactions in occupational therapy, that actual practice many times falls short of this ideal (Allison & Strong, 1994; Clark, Corcoran, & Gitlin, 1995; Helm & Dickerson, 1995; Northen, Rust, Nelson, & Watts, 1995).

Among the factors cited in the literature on professional-patient relations influencing the extent to which professionals engage in collaborative practices are (1) the limited amount of time that professionals have with patients (Wilkins, Pollock, Rochon, & Law, 2001) and (2) the professional’s level of training, experience, and expertise (Benner, 1984; Crepeau, 1991; Jenkins, Mallett, O’Neill, McFadden, & Baird, 1994; Levine & Gitlin, 1993).

Regarding the former, in a longitudinal study of an occupational therapy home-based intervention program designed around principles of collaboration, Levine and Gitlin concluded: “clients’ real concerns were rarely expressed directly and became clear only with time” (p. 152).

With regard to level of training, Dass and Gorman (1991) have observed that feelings of insecurity on the part of inexperienced clinicians and an eagerness to pursue their own agendas can undermine partnership building with patients. Jenkins and colleagues (1994) reported that more experienced occupational therapists encouraged and invited patient participation to a greater extent than did less experienced therapists. Experience has also been associated with a professional’s sensitivity to patients’ needs and the capacity to respond to them quickly (Benner, 1984; Crepeau, 1991). Alternatively, some expert clinicians have admitted to being annoyed with patients who do not seem to share the clinician’s understanding of what needs to be done to address their medical problems (Norris, 1993; Nuland, 1994). The purpose of the study described here was to gain understanding of the nature of the phenomenon of working together for occupational therapists in everyday practice of adult rehabilitation, to examine these experiences in depth as they unfold over time, and to investigate the experiences of both novice and experienced therapists.

**Methods**

Because we wanted to gain understanding of the ways in which occupational therapists experience working with patients over time, we chose a combination of phenomenological interviews with therapists and participant observation of therapist-patient dyads throughout the course of rehabilitation therapy. The study was carried out in two phases—an interview phase (Phase I) and a participant observation phase (Phase II). The study alternated between Phase I and II according to the schedule described in Table 1. We hoped that observations made during Phase II could be informed by insights gained from Phase I interviews. Also, we wanted to set aside a period of time in the middle of data collection for data analysis and reflection to guide the remaining data collection.

**Participants**

For Phase I of the study, I (first author) recruited 14 therapists—six novice therapists, defined as having 2 years or less clinical experience beyond required Level II fieldwork, and eight career therapists, defined as having 5 years or more clinical experience. Among the factors cited in the literature on professional-patient relations influencing the extent to which professionals engage in collaborative practices are (1) the limited amount of time that professionals have with patients (Wilkins, Pollock, Rochon, & Law, 2001) and (2) the professional’s level of training, experience, and expertise (Benner, 1984; Crepeau, 1991; Jenkins, Mallett, O’Neill, McFadden, & Baird, 1994; Levine & Gitlin, 1993). The purpose of the study described here was to gain understanding of the nature of the phenomenon of working together for occupational therapists in everyday practice of adult rehabilitation, to examine these experiences in depth as they unfold over time, and to investigate the experiences of both novice and experienced therapists.

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity: Phase I</th>
<th>Activity: Phase II</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997 March–August</td>
<td>Completed first phenomenological interviews—five career therapists; three novice therapists; two interviews with each therapist</td>
<td>December–January: Completed first period of participant observation at two different sites—one dyad each site</td>
</tr>
<tr>
<td>1998 March–May</td>
<td>Completed remaining interviews—three career therapists; three novice therapists; two interviews with each therapist</td>
<td>June–July: Completed second period of participant observation at third site—two dyads</td>
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Table 2. Therapist Participants, Types of Facilities, and Months/Years of Experience

<table>
<thead>
<tr>
<th>Participants (pseudonyms)</th>
<th>Facility Type and Practice Area</th>
<th>Months/Years of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career therapists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Judy</td>
<td>Hospital, skilled nursing facility, home care</td>
<td>5 years</td>
</tr>
<tr>
<td>David</td>
<td>Hospital rehabilitation unit</td>
<td>14 years</td>
</tr>
<tr>
<td>Diana*</td>
<td>Hospital acute care and rehabilitation units**</td>
<td>16 years</td>
</tr>
<tr>
<td>Helen</td>
<td>Hospital-based home care</td>
<td>17 years</td>
</tr>
<tr>
<td>Deborah</td>
<td>Hospital acute care and rehabilitation units</td>
<td>18 years</td>
</tr>
<tr>
<td>Andrea*</td>
<td>Hospital rehabilitation unit**</td>
<td>18 years</td>
</tr>
<tr>
<td>Katherine</td>
<td>Private practice, out-patient clinic</td>
<td>20+ years</td>
</tr>
<tr>
<td>Ann</td>
<td>Hospital acute care, skilled nursing facility, home care</td>
<td>20+ years</td>
</tr>
<tr>
<td><strong>Novice therapists</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nancy*</td>
<td>Skilled nursing facility rehabilitation unit**</td>
<td>3 months</td>
</tr>
<tr>
<td>Naomi</td>
<td>Skilled nursing facility rehabilitation unit</td>
<td>6 months</td>
</tr>
<tr>
<td>Nora</td>
<td>Hospital acute care, rehabilitation unit, out-patient</td>
<td>12 months</td>
</tr>
<tr>
<td>Nina*</td>
<td>Hospital rehabilitation unit**</td>
<td>18 months</td>
</tr>
<tr>
<td>Nadine</td>
<td>Hospital rehabilitation unit</td>
<td>23 months</td>
</tr>
<tr>
<td>Natalie</td>
<td>Hospital rehabilitation unit</td>
<td>23 months</td>
</tr>
</tbody>
</table>

*Therapists who participated in Phase I and Phase II
**Phase II observation sites

allowing the researcher to be present during and to audio-tape their occupational therapy sessions. Patients were not interviewed. Throughout the study, our focus was exclusively on the experiences of therapists.

Approval for the study was obtained from the university institutional review board and from each clinical site. All participating therapists and patients gave written, informed consent prior to the start of data collection.

**Procedures**

In Phase I of the study, I conducted a series of two phenomenological interviews with each of the 14 therapist-participants. Interviews were scheduled 1 to 3 weeks apart and were conducted at therapists’ work sites. I asked therapists to think back over their practices and describe situations in which they felt they were able to work together well with patients and situations in which they felt that they were not able to work together with patients. Probing questions were aimed at eliciting details and clarifying meaning (Kvale, 1996). Second interviews provided an opportunity for gathering additional details and member checking. Most interviews lasted approximately 2 hours (range = 45 minutes to 2 hours), which allowed for considerable amplification and clarification of meaning as therapists went over material as many as four times in response to probing questions. In all, therapists related experiences involving more than 100 different patients. All interviews were audiotaped and transcribed verbatim for analysis. Additional data were recorded in field notes following each interview.

In Phase II, I was present for all treatment sessions involving the participating therapist-patient dyads beginning with the first session of rehabilitation following referral to occupational therapy and ending with the last visit prior to discharge from occupational therapy. Length of patient stays ranged from 8 to 21 days. The number of observed sessions per therapist-patient dyad ranged from 11 to 24. Observed therapy sessions in Phase II typically included a morning session at bedside and a second session later in the day in the rehabilitation clinic or the kitchen, laundry, mock-up apartment, dining area associated with the rehabilitation program, or the patient’s room. I assumed an observer stance closer to “observer as participant” than “participant as observer” (Bogdewic, 1992, p. 56) and strove for “a somewhat more detached role” (p. 56) that I characterized as “an extra pair of hands.” I was eager to maintain a marginal relationship with patients without being so distant and detached as to make them feel uncomfortable in my presence (Schatzmn & Strauss, 1973). I audiotaped all observed sessions and recorded extensive field notes following each one. I also interviewed therapists during Phase II. Therapists were interviewed in short (often just a few minutes), casual, unscheduled debriefing interviews typically immediately following observation sessions or at the end of that day. A more formal debriefing interview was scheduled with each therapist following the discharge of each patient. These typically lasted about an hour.

In addition to offering a valuable longitudinal component to data collection, being present during therapy sessions in Phase II and experiencing first hand what took place provided fuller access to how therapists experienced their work than the Phase I interviews alone could provide. For example, during Phase I, Nancy commented:

When I hear that phrase, “working together,” the way I think of that, as a therapist, being able to understand what are the goals and motivations of the patient in a way that will help them reach the goal that they would like to see and also allow me to fulfill the role that I see for myself as a therapist...those are sort of dual things, and sometimes that’s a little tricky, to make those two things work together.

In Phase II, I was able to observe Nancy trying “to make those two things work together” and experienced for myself the meaning of “tricky” in the context of Nancy’s work.

My own subjective experiences during the observations also served as a point of departure for exploring with therapists their lived experiences (Jorgensen, 1989). Because my perspective was as a researcher and an occupational therapist, I was able to draw on both. For example, I was initially prompted to explore the concept of “pushing” patients to do all they could after noting my own discomfort in response to a situation I observed.

Audiotapes of interviews from Phase II were also transcribed verbatim for analysis. Field notes, journal entries,
and a log of research activities provided an audit trail, background, and context. FolioViews 4.1 (Folio Corporation, 1997) was used to manage and organize all text data. Throughout much of the study, we both participated in regularly scheduled meetings of a research group of faculty and graduate students, providing ongoing opportunity for peer review.

**Analysis**

Analysis was ongoing throughout the study. We adopted a narrative approach to analyzing the data and considered the story the unit of analysis. A story was defined as a therapist’s experience with a given patient. All of the stories generated in both Phase I and Phase II were included in the analysis.

We began the analysis by reading through the transcriptions of the first group of Phase I interviews (see Table 1) and identifying and labeling all material associated with each story (Josselson, 1995). We assigned each story a title using an *in vivo* phrase (i.e., incorporating terms used by the therapists themselves) whenever possible that seemed to capture what the story was about or that highlighted an experience of the therapist that seemed central to the meaning of the story. Still focusing on data from this first group of interviews, we next examined each story for meaning units with *in vivo* phrases, then grouped them into categories by type of experience and according to whether they were associated with the beginning, middle, or ending of the story. We noted three story types: (1) those in which therapists described therapy as going smoothly right from the beginning, with patients working hard and making progress toward goals; (2) those in which therapists described challenges that they were able to work through or turn around; and (3) those in which therapists described challenging situations that they were unable to work through. In Table 3 we show examples of titles and meaning units associated with the three story types.

After working with the titles, meaning units, and story types for some time, we achieved a kind of breakthrough in our efforts to make sense of the data by applying Bruner’s (1986) notion that “narrative deals with the vicissitudes of human intentions” (p. 16). We strove to understand therapists’ intentions with regard to their work with patients (i.e., what they seemed to be trying to accomplish, and what they seemed concerned about). We also paid attention to what therapists talked about in terms of the vicissitudes of their intentions (i.e., the “complicating actions”) (Riessman, 1993, p. 18) that therapists viewed as supporting or interfering with what they were trying to accomplish. We continued to link these understandings to the beginnings, middles, and endings of therapists’ stories. We included all of the stories in both Phase I and Phase II in the analysis and found that we could categorize all of the stories into the three story types.

### Finding Common Ground

In both Phase I and Phase II, what the 14 occupational therapists in this study talked about included: the need to explain occupational therapy to patients, coming up with therapy goals, getting patients to work hard, and making progress toward therapy goals. The extent to which therapists’ experiences felt like working together with patients seemed to correspond to the extent to which therapists felt they were “on the same wave length” with patients with regard to these concerns. Several therapists referred to “being on common ground” or “finding common ground” in describing their experiences of working together with patients. Finding Common Ground emerged as a common, shared theme that captured the range of experiences of working together with patients for all of the therapists in this study.

Experiences of Finding Common Ground took on different meanings as therapy unfolded. In the beginning of therapy, Finding Common Ground meant Selling “OT” and Coming up With Goals. In the middle, it meant, Getting Patients To Do the Work of Therapy. At the end of therapy, the meaning of Finding Common Ground was associated with Seeing How Things Turned Out. Therapists’ experiences

<table>
<thead>
<tr>
<th>Story Type</th>
<th>Title</th>
<th>Beginning</th>
<th>Middle</th>
<th>Ending</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Therapy went smoothly and patients made progress</td>
<td>“He was an inspiration”</td>
<td>“He was . . . raring to go.”</td>
<td>“His attitude was, ‘Hey, I can do this.’”</td>
<td>“[His goal was] to ambulate again, and he reached it.”</td>
</tr>
<tr>
<td>2. Therapists worked through challenges</td>
<td>“The patient I’ve done the most for”</td>
<td>“We both want him to continue to live in his own home.”</td>
<td>“I’ve had to learn from him to be a better listener. He was afraid . . . you can’t do fear.”</td>
<td>“I’ve really come to understand him.”</td>
</tr>
<tr>
<td>3. Therapists were not able to work through challenges</td>
<td>“I bit the bullet”</td>
<td>“She liked to be waited on . . . I have a problem with that.”</td>
<td>“I was trying to get her to do more for herself.”</td>
<td>“I did what I had to do, but as soon as I could, I got out.”</td>
</tr>
</tbody>
</table>

*Table 3. Story Types, Story Titles, and In Vivo Labels by Beginning, Middle, or Ending*

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of Finding Common Ground paralleled the three story types referred to above (i.e., a story of therapy going smoothly, a story of successful negotiation about challenges, or a story of unsuccessful resolution of challenges).

In the Beginning: Selling “OT” and Coming Up With Goals

Early in the course of therapy, therapists described being interested in “getting a feel” for patients, which meant knowing what patients would be like to work with and ascertaining to what extent they understood and were interested in occupational therapy. As one therapist said, “We love it when people are interested in what we do” (Nina). All of the therapists who participated in this study talked about the need to explain occupational therapy to patients.

Therapists described working with patients with whom they “just clicked,” patients who seemed readily to understand and appreciate occupational therapy right from the start. Diana, for example, described a patient to whom she “did not have to sell OT” because, from the start, he didn’t question the need for occupational therapy and appeared eager to do everything that Diana asked of him. Alternatively, finding common ground in the beginning of therapy could also mean feeling the need to convince patients of the value of occupational therapy and working with patients who “never did see the value of occupational therapy.” Nancy referred to one patient as a “hard sell” because initially he seemed “resistant” to her ideas about what they should do in therapy. Other therapists described patients whose “anger” and “passive-aggressive behavior,” “agitation” and “cognitive deficits” made it seem difficult or even impossible to work together. Natalie described how she went home in tears after trying for a week to guess what a patient who had severe aphasia meant by his frustrated gestures and vocal outbursts: “I didn’t connect at all. There was nothing between us. . . . It was just awful.”

A second and related major concern for therapists early on was coming up with therapy goals. Therapists seemed genuinely interested in having goals be meaningful to patients. The best or easiest situations seemed to be those in which patients clearly articulated their own goals for therapy and those goals were in line with the therapists’. Naomi talked about a patient who “basically handed me goals on a silver platter.” Therapists also described patients as “cooperative.” Cooperative patients were described as those who went along with what therapists proposed for goals and who were willing to do what therapists asked of them.

Coming up with goals involved more of a challenge, however, if patients did not immediately “buy into” therapists’ goals or go along with what therapists proposed. Nancy, who talked about “struggling” to find ways to bring together what patients wanted and what she wanted for them, described how, after considerable effort, was able to persuade a patient who was determined to go back home that doing so would not be safe.

When convinced that their efforts to bring patients around to their way of thinking were not going to work, therapists sometimes backed off from the goals they had for patients in favor of what patients wanted. Helen described how, in spite of her efforts to get a patient to accept an environmental control unit (ECU—an electronic device with which an individual can operate lamps, appliances, unlock doors, etc.), “He found dozens of reasons not to need it.” Still, Helen seemed pleased with the outcome, explaining that she felt that she had come to understand this patient better as a result of working through their differences. Other therapists also described situations in which they were able to work through communication barriers, a patient’s initial lack of interest, or differences of opinion with regard to therapy goals, and in each case, therapists’ apparent openness to exploring ways of working through these challenges resulted in experiences that were especially satisfying for them and feelings of closeness to the patients involved. For one therapist, Natalie, disagreement over goals raised questions about how to balance the patient’s goals with therapy goals. When Natalie talked about this, she said, “It’s hard because . . . what I wanted for her [was] not what she wanted . . . it’s a struggle. . . . Where does what I want end and what she wants begin? . . . Where are we overstepping that balance?”

There were instances, however, when therapists persisted in pursuing their own goals even in the face of continuing opposition from patients. Again, Helen offers an example: “I always felt that . . . if he could just . . . tootle around in his electric wheelchair, he’d be a new person. . . . I pretended that if . . . I presented the solution, he’d buy it. . . . Didn’t work. Crash and burn.” Other therapists described similar kinds of experiences in which they felt they went “round and round” with patients with whom they never could reach any kind of agreement over goals.

Part of the struggle that therapists had in relinquishing their goals for patients seemed related to therapists’ eagerness for patients to achieve “independence” or, short of that, all that patients were physically capable of. The following quote illustrates the determination of one therapist to help a patient achieve independence, which was, for this therapist, “the whole point of rehab,” in spite of the patient’s apparent lack of interest in that goal:

“It’s just a constant battle one treatment session after the other. . . . “I don’t want to do it. I can’t do it.” But she can do it. She’s not sick...there’s nothing medically wrong with her and she doesn’t have a lot of pain . . . she just doesn’t
want to do it. . . . She could be independent probably . . .

she’s got the potential (Nadine).

In instances like this one, therapists seemed to want to hold onto their own goals, persisting for some time to bring patients around to their own way of thinking and relinquishing their own goals only after encountering considerable resistance from patients.

In the Middle: Getting Patients To Do the Work of Therapy

As therapists got a feel for what patients were going to be like to work with and after therapy goals were established, therapists’ attention focused more on the work of therapy and reaching therapy goals. Again, therapists described three kinds of experiences: those involving patients who were always “raring to go” and “gave 200%,” patients whom therapists felt they needed to “push” to do all they could or whom they backed off from pushing in the face of some concern or resistance from the patient, and those in which therapists and patients “never really [did come] to terms with some way to progress.”

For the therapists who participated in this study, getting patients to do the work of therapy seemed imperative. Therapists talked about feeling obligated to “cover all the bases, to “make sure” that patients were able to do what they were “supposed to do” by the time they left therapy and that they could do it safely. Therapists described a sense of pressure to “get therapy time in” so they could document, for insurance and other reasons, that patients were participating in therapy and making progress. They expressed eagerness for patients to achieve therapy goals or accomplish as much as possible before insurance benefits ran out. Therapists expressed the belief that by working hard, patients would get better. For all of these reasons, therapists seemed to want and expect patients not only to take an active part in therapy, but to work hard. Therapists spoke about “pushing” patients to do all they could and getting them “to do more every day.”

Therapists seemed especially to enjoy working with patients who worked hard, and they spoke of the “constant friction” between themselves and patients who they felt were not working up to their potential. At the conclusion of one story, Judy, who felt that the patient was resisting doing what Judy felt she was capable of, said, “I bit the bullet, you know, I got in there and I did what I needed to do, but as soon as I could get out, I got out, because it was not fun.”

We sensed a moral tone in therapists’ concerns about patients working hard in therapy. Therapists seemed to be saying that patients should do all they can. In describing the situation just cited, Judy seemed to express a kind of moral indignation when she said, “She liked to be waited on . . . I have a problem with that.” When Nadine said, as quoted earlier, “. . . she can do it. She’s not sick . . . there’s nothing medically wrong with her,” Nadine also seemed impatient over having to do battle with this patient every day in order to get her to do what Nadine was convinced she was physically capable of doing. Therapists’ belief that patients should work hard seemed reinforced by their stories of experiences with patients whom they felt they didn’t need to push. Nina, who considered herself a bit of a “slavedriver,” and who usually felt the need to “push” patients to do more, described the patient with whom she was working in Phase II as “an ideal patient . . . one of the hardest workers I’ve ever seen.”

There were times, however, when therapists backed off from “pushing” patients in the same way that they backed off from pursuing therapy goals. Therapists described doing this as a way of accommodating what they perceived were patients’ wishes, providing emotional support to patients who they felt were having a bad day, or responding to their sense that patients could not tolerate further physical activity and needed to rest. They also backed off in order to circumvent a confrontation with a patient or to avoid a patient’s anticipated outright refusal to do something.

Endings: Seeing How Things Turned Out

The end of therapy in rehabilitation was anticipated right from the beginning, and discharge planning was a concern for therapists throughout the therapy process. When Nina described a patient as someone who “understood what it was going to take to get outta here,” she was expressing this present concern about therapy endings. Endings, themselves, were a time when therapists concentrated on getting things done, “covering all the bases,” saying good-by to patients, assessing how therapy had gone, and, especially for novices, trying to learn from seeing how things turned out.

In cases where therapists felt that they had found common ground with patients, endings could be a time for celebrating victories. When Judy said, “We worked and we worked and we got her to a CBRF [community-based residential facility],” she seemed to be celebrating a shared victory with a patient with whom she had found much common ground on therapy goals and the need for hard work. When Nancy expressed her pleasure over having persuaded a patient not to return to live alone in his apartment, she not only seemed satisfied believing that the patient would be safe but also pleased about her own personal victory. When Natalie recalled how a patient with whom she worked had exceeded everyone’s expectations but his own, she seemed to be celebrating his success. To the therapists in this study, having therapy end successfully meant that goals had been achieved.
In cases where therapists did not feel that they had connected with a patient and had never really “reached any kind of agreement about what we’re doing here, where we’re going, and how we’re going to get there,” endings could mean relief from “constant tension” and unpleasantness. In these kinds of endings, therapists seemed to feel regret over not having connected with patients and frustration over not having accomplished all of the things they wanted to get done.

For both novice and career therapists in this study, seeing how therapy ended shaped the meaning of their experiences with patients. When therapy went as therapists planned and patients made progress, therapy endings were congruent with therapists’ intentions, hopes, and expectations. But sometimes the end of therapy brought surprises that caused therapists to reinterpret all that had come before. In one example, the therapist learned, just prior to a patient’s scheduled discharge from therapy, that the patient had withheld information about the difficulty she was having managing at home with her walker. This therapist, who up to that point felt proud of her ability to get patients to trust her, said, “I felt like a failure.”

Novices: Yearning for Solid Ground

We perceived a striking difference between the narratives of novices and those of career therapists. Running through the stories of novice therapists were comments like: “What’s gonna happen here?”; “I have no idea what I’m doing”; “I didn’t know what to think”; and “I’m never sure...” all of which imparted a pervasive sense of insecurity and lack of confidence related to working with patients. In contrast, comments reflecting confidence and self-assurance were the norm for the career therapists. Noticeably absent from the accounts of the career therapists were any concerns about knowing what to do or not having answers to patients’ questions.

The distinction we noted between the stories of novice and career therapists suggested to us a link between experiences of Finding Common Ground and feeling on solid ground. For novices, stories of working together with patients were about those unusual times when they did seem to feel on solid ground (i.e., when they felt confident and skilled, when they felt that they had answers to patients’ questions, or when something “worked”). Again, in contrast to the experiences of novices for whom working together well with patients seemed the exception, one career therapist said, “I work pretty well with most of my patients.” Novices appeared to be surprised when therapy did work, whereas career therapists seemed surprised when therapy didn’t work.

The end of therapy and seeing how things turned out seemed to have special salience for novices. Novices seemed eager to collect endings, if you will, as a way to learn what to expect in the way of rehabilitation outcomes, especially during the very early months in their careers, when they felt that they did not have a good sense for how rehabilitation would unfold and did not know what to expect from their interventions. As one novice therapist said, “I can’t say, ‘Well this person reminds me of so and so, and this worked with so and so, so let’s try that.’ It’s a fresh slate every time so far.” Only when they came to the end of the story could these inexperienced professionals see what was reasonable to expect or what potential was possible.

Discussion

The phenomenological data in this study suggest that the ideal of collaborative, patient-centered practice with patients may not always be evident or prominent in actual practice, that therapists may lack an openness to exploring differences with patients over therapy goals and expectations, and that therapists may often not even seek out collaborative relationships with patients. The findings from this study also raise questions about whether therapists, who wish to work together with patients in the spirit of partnership, have the skills they need to mediate substantial differences with patients over therapy goals and expectations when these are present.

Compatibility or Collaboration?

Both novice and career therapists in this study rejoiced in working with patients with whom they felt an immediate and easy rapport, patients who were raring to go, with whom they felt “on the same wave length,” to whom they did not have to “sell OT.” When they sensed patients could not do more or would benefit from some “pampering,” therapists backed off. But when therapists felt that patients were resisting doing what was being asked of them or not doing all that they were physically capable of, therapists struggled to bring patients around to their way of thinking and to push them to do more. In these situations, therapists tended not to relinquish their own goals until they were convinced their views of what was realistic and right would never be accepted (recall Helen’s exclamation, “Crash and burn,” when she failed to get a patient to embrace a power wheelchair, and others who persisted in doing “battle” or went “round and round” with patients with whom they never reached any agreement over goals).

At the heart of discussions of collaboration in the context of health care is the notion of partnership with patients who are capable of acting as autonomous agents on their
own behalf (Bartholome, 1992; Veatch, 1991). Finding the point of mutual interest for two persons of widely different backgrounds, as suggested by Veatch as the basis for a “true partnership,” suggests that one or both of those persons must find that point where the goals and purposes of each intersect.

In occupational therapy, therapists are assigned the responsibility of bridging differences with patients and doing whatever it takes to be sure that patients have the opportunity to tell their stories so that they are understood (Law et al., 1995; Wood, 1995). But as Mattingly and Beer (1993) have pointed out, it can be very difficult for therapists to understand patients, even when both share similar cultures, because what is at issue is “grasping a person’s deepest life concerns, fears, loves, and commitments” (p. 159). The bioethicist, Engelhardt (1996), points out that achieving mutual understanding in a pluralistic society like ours becomes that much more problematic because health care providers and patients come from “radically different communities of belief” (p. 298) and meet as strangers with vastly different views of the good life.

Bridging such significant differences between therapist and patient requires an openness to the experiences of others and a willingness to explore those differences. Daly (1987) contends that effective professional caregiving requires “the primary intellectual condition of simple wonder...openness to whatever possibilities the situation possesses” (p. 35). Openness in interpersonal relations has been associated with empathy, caring, and concern (Dass & Gorman, 1991; Davis, 1990; Montgomery, 1993; More, 1996; Peloquin, 1995). There were times when therapists who participated in this study seemed open to discovering meaning with patients, and when this happened, seemed to find their work especially rewarding and meaningful, but there were also times when therapists seemed open only to possibilities contained within their own established beliefs and values, as when Nadine insisted that the whole point of rehab was to be independent.

Theories derived from social-psychological research aimed at explaining spontaneous bystander helping posit three assertions that may contribute to our understanding of therapists’ approaches to working together with patients in this study (Schroeder, Penner, Dovidio, & Pilavin, 1995). First, people are moved to help others in response to empathic arousal, that is, when they perceive that others are in distress. Second, a person is more likely to help someone to whom he or she is attracted, and people are attracted to those with whom they feel some measure of commonality. And third, people communicate more readily with others with whom they have positive interactions. What these theories suggest is that perhaps it was only natural for the therapists in this study to be open to negotiation with those patients to whom they were attracted, with whom they felt some connection, and with whom their interactions were positive. Correspondingly, perhaps it was only natural for them to be less open to negotiation with patients with whom they did not feel any attraction or similarity.

But being open to possibilities is not the whole answer; skill at bridging differences is also important. Montgomery (1993) has pointed out that in professional caregiving, natural caring based on a “spontaneous expression of our innate generosity” is not enough: “Clients who have contact with helping professionals expect more than good intentions. Therefore, helping professionals not only must be competent in the skills and science of their profession, but also must possess sophisticated relational and communication abilities to handle a variety of interpersonal and relational challenges and demands” (p. 14). Katz (1984) has suggested that engaging in the kind of dialogue with patients that is necessary to achieve a meaningful exchange of information is “inordinately difficult” (p. xv–xvi). In this study, novice and career clinicians alike often responded to patients with whom they encountered differences over goals and expectations by either persisting in doing battle and going round and round without ever reaching agreement or reluctantly conceding in the face of what they perceived as defeat; these findings raise questions about whether the therapists had the level of relational and communication abilities they needed to handle the variety of interpersonal and relational challenges and demands that confronted them. Perhaps lack of skill helps explicate therapists’ reliance on compatibility with patients in finding common ground and their apparent lack of openness to seeking common ground with patients with whom they didn’t sense that same level of compatibility.

The experiences of the novices in this study seem especially important in this regard. As with the helpers described by Dass and Gorman (1991), the doubt and uncertainty of the novices in this study seemed to undermine their ability to find common ground with patients. Their openness to what patients wanted seemed limited when they themselves felt insecure.

Experienced therapists, however, may also feel unsure when it comes to dealing with some patients. Researchers have found that therapists feel unprepared to deal effectively with some of the more challenging interpersonal aspects of practice and point out the importance of interpersonal skills training (Fleming & Mattingly, 1994; Peloquin & Davidson, 1993; Wilkins et al., 2001). Thomson (2000) has suggested that “difficult” patients should perhaps be considered “specialist cases” (p. 11) because of the advanced skill level she feels is necessary to work with them effectively. It
seems possible that any therapist, regardless of years of experience, may feel on shaky ground when dealing with certain patients.

The Primacy of Goals

The centrality of compatibility to finding common ground with patients that we found in the experiences of the therapists who participated in this study is of special concern in light of the emphasis that these therapists placed on therapy goals. It seemed obvious that therapists who participated in this study cared about patients, wanted what they felt was best for patients, and wanted therapy goals to be relevant and meaningful to them. At the same time, therapists seldom questioned the goals that they, themselves, identified and encouraged patients to work hard to achieve. In pursuing their own therapy goals, it may be said that therapists were expressing the world view of rehabilitation or the rehabilitation ideology (Hasselkus, Dickie, & Gregory, 1997; Mattingly, 1998a). Among the traditional assumptions of rehabilitation is the notion that “patients ought to be as independent and socially active as possible” (Mattingly, 1998b, p. 164).

The ideological nature of rehabilitation goals suggests that, in rehabilitation, therapists pursue therapy goals with what Mattingly (1998b) has described as “an unmistakable evangelical streak” (p. 168). Mattingly points out that clinicians are “notably poor” (1998a, p. 277) at discussing the good that they take for granted, that they “do not explicitly acknowledge that . . . they are . . . developing a moral judgment about what ought to be done” (p. 290) when they argue for the goals they advocate. Even in the face of resistance, some therapists in this study persisted in pushing their own agendas without seeming to question the goals they were advocating and, sometimes, without initiating a conversation with patients about their differences.

Part of the problem may be what Maguire (1978) suggests as “group think.” Group think is a process relied on by many health care practitioners that, according to Maguire, is dominated by the “primacy of the common” (p. 250) where decisions are based on across-the-board application of universal principles. Maguire advocates, instead, placing greater emphasis on individual responsibility for making moral choices and basing decisions on the particulars of any given situation. He says, “Humanity is served when we crack the particular and liberate the universal while losing sight of neither” (p. 255). Only in the face of strong resistance from patients did therapists seem pressed to begin to crack the particular by considering patients’ definitions of the good that were different from their own. But when they did, they seemed not only to serve those patients better, but also to gain more satisfaction for themselves by coming to deeper understandings of patients and connecting with them in new and meaningful ways.

Implications for Research, Education, and Practice

It seems, from the findings reported here, that in spite of the recent professional emphasis on collaborative therapeutic relations with patients and patient-centered practice, these ideals may continue to elude occupational therapists, perhaps much of the time. The lack of negotiation between therapists and patients described by the therapists in this study and the apparent lack of openness on the part of some of these therapists to exploring differences with patients are matters of concern to the profession that deserve further study. The finding that occupational therapists may rely primarily on compatibility with patients with regard to therapy goals and expectations as the basis of finding common ground with them needs further investigation in order to understand the phenomenon more fully. In addition, focusing attention on therapists working in settings other than adult rehabilitation would extend the work of others (e.g., Finlay, 2001; Lawlor & Mattingly, 1998; Townsend, 1992; Wilkins et al., 2001) who have contributed to our appreciation of the powerful influence that social contexts can have on the work that occupational therapists do. Another aspect of therapists’ experiences that deserves greater attention is the nature of the tensions that arise between therapists and patients during rehabilitation. How do therapists negotiate the balance between what they want for patients and what patients want? To what extent are therapists aware of the ideologies of the cultures within which they work? How open are therapists to exploring and negotiating differences with patients over therapy goals and expectations? And, in order fully to understand therapists’ experiences with patients, it is also important to consider the ways in which what patients do and say may contribute to those experiences.

The findings from this study also raise questions about occupational therapy education. To what extent is the emphasis on patient-centered practice reflected in occupational therapy curricula and in the practices of clinicians who have graduated in the years since the data from this study were generated? Are occupational therapy curricula devoting sufficient resources to teaching students the skills they need to tackle the “inordinately difficult” (Katz, 1984, p. xv–xvi) task of engaging patients in the kind of dialogue that is necessary to achieve a meaningful exchange of information? Or, if Thomson (2000) is correct, that some patients should be considered “specialist cases” (p. 11) because of the relational challenges they present, what kind
of advanced preparation, expert advice, or other support is available to occupational therapy practitioners when working with such patients?

Conclusion

By bearing witness to a wide range of ways of being with patients, the findings from this study afford new opportunities for occupational therapists to contemplate their actions and the taken-for-granted understandings that shape them. These findings suggest that getting beyond compatibility in working together with patients may require a greater openness on the part of therapists to exploring differences and processes of negotiation. Changes in occupational therapy curricula that will help to insure that students appreciate fully the nature of therapist-patient partnerships and that they have the skills needed to be able to resolve differences in values and interests seem indicated. When we can embrace our differences with others, we will be able to enhance our potential for nurturing greater health and well being for all those with whom we interact, and for ourselves.

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Endnotes

1 A means of testing interpretations with those from whom the data were originally collected (see Lincoln & Guba, 1985, p. 314–318).

2 The one exception to this was the first observed dyad, in which case the first observed session was the second evaluation session and the last observed session took place on the day prior to the patient’s last therapy session and discharge home. It should be pointed out, however, that more observation time was spent with this therapeutic dyad than the others, 24 sessions in all.

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