An Exploratory Study of How Occupational Therapists Develop Therapeutic Relationships With Family Caregivers

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Family members, who provide 70% to 80% of all long-term care, have often been perceived by occupational therapists as a barrier to, rather than a partner in, effective care for elderly persons. This perception suggests that in order to build effective partnerships to manage complex issues, occupational therapists working with elderly persons must develop effective strategies for involving family members in the therapeutic process. This article describes a pilot study that examined how occupational therapists engage family caregivers of elderly persons receiving home care services. A qualitative descriptive approach was used to explore the behaviors demonstrated by two occupational therapists working with family caregivers. The findings point to four primary types of occupational therapist-caregiver interaction, categorized as: caring, partnering, informing, and directing. These interaction styles were compared with current literature describing state-of-the-art occupational therapy practices with older adults and family caregivers. An emphasis was placed on examining how therapeutic interactions can evoke different caregiver responses and influence the development and maintenance of collaborative therapeutic relationships. The results of this pilot study can serve as a framework for further exploration of interactive strategies that promote caregiver empowerment and ultimately influence the ability of families to assume responsibility for the long-term care required by many chronically disabled older adults.

According to the U.S. Bureau of Census (1990), the fastest growing segment of our population consists of persons aged 85 years and older. Due in part to advancements in acute health care and longer life expectancies, elderly persons and their family members are increasingly required to manage complicated chronic conditions and their social consequences. In fact, it is well documented that family members assume the primary responsibility for providing physical, emotional, and financial support to elderly persons with cognitive and physical impairments (Artetas, Gibeau, & Larson, 1990; Biegel, Sales, & Schulz, 1991; Cutler, 1994; Pepper Commission, 1990). Because of family members’ involvement as well as their personal need for service, a growing body of literature has demonstrated the value and need for health care professionals to actively engage family caregivers in treatment when working with older persons (Baum, 1991; Bower, 1987; Bowers, 1987; Chenoweth & Spencer, 1986; Clark & Rakowski, 1983; Corcoran, 1993; Hasselkus, 1988, 1994). Nevertheless, studies that have examined the caregivers’ perspective of their relationship with health care professionals have identified discrepancies between their values, priorities, and ethics and those of health care professionals (Hasselkus, 1988, 1989, 1991;...
Kaufman, 1988). In a study of intergenerational caregivers, Bowers (1987) found that caregivers tended to describe health care professionals as lacking a sufficient understanding of the family caregiving experience. The few studies that examined the specific nature of occupational therapists' involvement with caregivers (Chiou & Bursten, 1985; Corcoran & Gitlin, 1991; Gitlin, 1993; Hasselkus, 1988, 1990, 1991; Watson, 1985) have confirmed discrepancies in treatment goals and values. Gitlin (1993), for example, found that occupational therapists in rehabilitation often view family members as a barrier to effective care for an older client, especially when the treatment goal of functional independence is not fully supported by the caregiver. Hasselkus (1991) compared the values, beliefs, and ethics of family members who were caring for an older adult in the community to those of occupational therapists. The results revealed that whereas occupational therapists were most concerned with enhancing the care receiver's independence, caregivers were more concerned with making sure that routines ran smoothly and that no harm was brought to the care receiver or to his or her sense of identity.

If family members' concerns are different from therapists' concerns, caregivers may not use treatment recommendations effectively. Caregivers need to feel empowered to shape recommendations to fit their life-styles, values, and goals, so that they can adapt and successfully use treatment recommendations beyond the period of service delivery. Occupational therapists can use techniques described in the literature on collaborative therapeutic relationships (Corcoran, 1993) to help bridge the gaps between what caregivers and therapists deem as important in the treatment process.

Very few studies (Gitlin & Corcoran, 1991; Peloquin, 1990) have been directed toward examining occupational therapists' perceptions of the client-therapist relationship and the specific types of therapeutic approaches that therapists use to involve caregivers in the therapeutic process. As a basis for further research, we conducted an exploratory study to describe the types of therapeutic relationships that emerge between family caregivers and occupational therapists in home health care and the types of interpersonal behaviors that influence caregiver involvement. By understanding current practice, we can develop and refine new approaches by which to promote family member involvement and strengthen caregiving abilities.

Methodology

This exploratory study used a qualitative approach to describe how two occupational therapists engage caregivers in the therapeutic process. Data were gathered and analyzed thematically to derive categories of therapeutic interactions.

Procedure

Two occupational therapists were selected by convenience for the study. At the time of this study, each of these therapists was treating elderly clients who required care from a family member. Both therapists were women who had at least 5 years of experience in home health care, had a bachelor's degree in occupational therapy, and worked for the same health care agency. Each unstructured observation took place in the clients' homes at a time when the client, occupational therapist, and family caregiver were present. Each therapist was observed while treating one of two clients for two sessions each—a total for both therapists of eight observations of 30-min to 60-min duration. Three of the four clients were observed during their first and second occupational therapy treatment sessions. The other client had been working with her therapist for 3 weeks before the observation and was observed at that point in time.

The first author conducted unobtrusive observations, audiotaped the sessions, and took extensive notes regarding observations and nonverbal communication as well as her personal thoughts and reactions. The audiotape and written notes were transcribed after each treatment session.

Data Analysis

A thematic analysis that used two coding techniques borrowed from grounded theory research (Leininger, 1985; Strauss, 1987; Strauss & Corbin, 1990) was used to analyze the audiotapes and field notes. These techniques used open coding and axial coding to conceptualize and compare related phenomena within the data. The transcriptions from the treatment sessions were first reviewed with the use of open coding in which the first author searched the data for emerging themes. This review required labeling the phenomena, discovering categories, and naming the categories. The notes taken during the treatment session were also used to confirm and support the categories. Once the initial categories emerged, axial coding was used for further analysis and creation of subcategories. This analysis involved examining the various categories for specific properties and dimensions such as who was involved, when did it happen, what was the meaning, and why did it occur.

Several strategies suggested in the literature (Depoy & Gitlin, 1994; Kefring, 1991) were used to address the accuracy, credibility, and trustworthiness of the data. Reflexivity (the first author's use of self-reflection to determine personal beliefs that may have influenced data gathering and analysis) was used in this study. The first author documented her personal thoughts, feelings, and reactions after each observation. Peer examination (Lincoln & Guba, 1985) was another strategy that was used in order to enhance credibility by having colleagues and method-
ological experts check the research plan and its implementation. The research plan and emerging themes were continually cross-checked among the authors to minimize distortions and validate perceptions. The information obtained from the analysis was compared and contrasted with select articles on family systems approach, therapeutic relationships, and collaboration (Bailey, 1989; Bonder, 1987; Corcoran, 1993; Hasselkus, 1994; Peloquin, 1990).

Results

The results of this study emphasize the importance of the role of therapeutic interaction for engaging family caregivers of elderly persons with disabilities in occupational therapy home care treatment. Analysis of the data revealed four categories, or types, of therapeutic interactions that were designated as: caring, partnering, informing, and directing. Although empirically these four categories emerged as conceptually distinct interaction types, overlap among them suggests a continuum of therapeutic interactions. Caring interactions at one end of the continuum reflect those interactions that focus on the caregivers' personal needs, whereas directing interactions at the other end of the continuum, reflect therapist-driven interactions that focus on treatment techniques and therapists' goals (see Figure 1). Furthermore, each type of interaction occurred within a specific therapeutic phase of evaluation (e.g., determining the problem), intervention (e.g., introducing treatment), or logistics (e.g., taking care of detailed business). In addition, the relative frequency of different types of interaction was examined (see Figure 2).

Caring Interactions

Caring interactions by the occupational therapists were characterized by their demonstrating interest in the caregivers' well-being. The therapists' caring interactions shaped the nature of treatment with both the caregiver and the care receiver in that they promoted a sense of connectedness and contributed to establishing and maintaining an alliance with the caregiver. Caring interactions directed toward the caregiver were most notably evident during the evaluation phase of the treatment session, but they were also evident during the intervention phase. During the evaluation phase, the therapists' caring interactions were particularly evident as a way to establish rapport, thus contributing to the development of the therapeutic relationship. In contrast, during the intervention phase, the therapists' caring interactions tended to focus on maintaining connectedness while improving the therapeutic relationship. The subcategories of the therapists' caring interactions that emerged from the data were those that focused on support and those that demonstrated friendliness.

Support. Supportive interactions were used primarily to build and maintain rapport with caregivers that promoted trust. Both therapists demonstrated support by reassuring caregivers of their well-being and that of the care receiver. For example, a comment from the therapist such as “you are doing a good job of taking care of your-

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**Figure 1.** Therapeutic interaction continuum.
self," represented a supportive interaction. Supportive interactions such as "you cannot do it all yourself," communicated to the caregivers that their personal needs mattered.

**Friendliness.** As with support, the therapists' friendliness contributed to establishing and maintaining rapport in the therapeutic relationships. Friendly interactions were manifested in casual conversation, small talk, and compliments (e.g., "You have really nice skin"). The therapists' friendly exchanges created an accepting atmosphere and showed an interest in the caregiver that extended beyond the care receiver's illness. These exchanges suggested an awareness by the therapists that the caregivers were more than their role as caregivers. Recognizing the aged as a "real people" has been viewed as a humane way to work with elderly persons that encourages involvement and participation in treatment (Gross, 1990)

**Partnering Interactions**

The therapists used partnering interactions to actively involve caregivers in decision making about treatment issues. Partnering interactions were based on a two-way communication process in which there was an open exchange of dialogue between the therapist and the caregiver. These mutual interactions were distinct from caring and directing interactions in that they involved active participation of the caregiver that extended beyond answering questions, responding to the therapist, or engaging in small talk. Partnering interactions were used less frequently than other types of interaction; however, they did occur during all three phases of the therapeutic process (evaluation, treatment, and logistics). Two subcategories of partnering interactions are presented here: seeking or acknowledging input and reflective feedback.

**Seeking or acknowledging input from the caregiver.** The caregiver's contribution to the treatment session was a focus of partnering interactions because it allowed the caregiver to experience a sense of control and responsibility. Most of the partnering interactions in the study involved the therapists initiating broad-based suggestions and then requesting the caregivers' input on specific suggestions. These interactions appeared to be directed by the therapists in that caregivers were invited to comment on those suggestions and ideas that were offered by the therapist. The caregivers' autonomous perspective was not solicited. For instance, in one question, the therapist inadvertently suggested a goal: "Do you envision her at some point sitting at the kitchen table fixing cold food?" Although the therapist wanted to elicit input from the caregiver about the specific goal, she imposed her own suggestion first, rather than asking a more open-ended question such as "What do you envision her

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**Figure 2. Frequency of interactions during different phases of therapy.**
Informing Interactions

Informing interactions included those interactions in which the therapists provided or gathered information. Because informing interactions usually precipitated or followed a directing or partnering interaction, they formed a distinct point on the continuum (see Figure 1). The three subcategories of informing interactions included gathering, explaining, and clarifying information.

Gathering Information. Gathering information was most frequently observed during the evaluation phase. Gathering information is different from seeking input, in that seeking input is specifically intended to involve the caregiver in the decision making or goal setting of treatment. However, while gathering information, the therapists directed questions to the caregivers in order to collect information about the clients' functional status rather than involve the caregiver in the decision making.

Explaining Information. Explaining usually occurred in relation to a directing interaction. Rather than simply telling the caregiver what to do, the therapists took time to explain or provide a rationale for a particular assessment or treatment procedure. The following therapist comment exemplifies this type of interaction and shows the relationship between instructing and explaining: "She can get herself in and out, it's just a matter of you having to set her up [explain]—you have to lift the arm rest off and you gotta put the chair sideways to the bed [instruct]." The therapist offered other explanations when attempting to enhance the caregiver's understanding of occupational therapy. This general education had the effect of moving the caregiver toward either a directing or a partnering interaction.

Clarifying Information. This type of interaction differed from explaining information in that it referred to elucidating a particular situation, either something that was said or something that had occurred. There was often a reparative quality to clarification in which therapists reinforced or assured caregivers. Sometimes clarification was used to simplify a previous explanation and make sure that the caregiver understood certain aspects of an assessment or an intervention. On other occasions, clarification was used to confirm or interpret information that was assumed by the therapist, as in the following therapist comment, which was stated in a question-like manner: "It seems to me you're the one in charge, you know more what's going on than everyone else." Thus, clarification seems to be an important tool for involving caregivers in the therapeutic process because it can elucidate their questions, concerns, or misunderstandings, which in turn strengthens the therapeutic relationship between the therapist and the caregiver.

Directing Interactions

Both therapists used a directing style of interaction to have caregivers perform various tasks during the treatment session or during follow-up. The effect of directing interaction was one of minimal active involvement of the caregivers in the decision-making process. Rather, the caregivers appeared to assume a more passive role and either followed or rejected the therapist's directions. Two subcategories of directing interactions were identified: instruction and advice.

Instruction. Instruction was commonly used in the treatment sessions and tended to evoke a submissive type of involvement in which the caregiver followed orders or directions. During one treatment session, the therapist recommended an adaptive strategy to the client for using eating utensils. During the next session, the therapist discovered that the care receiver did not follow through with the recommendation because he did not like eating with a built-up handle. Rather than talking with the caregiver about her perception of the care receiver's feeding skills, the therapist then asked the caregiver to "take a look at how he feeds himself, and let me know if he gets through the whole meal without the silverware dropping." The suggestive intent of such interactions is that instruction will lead to caregiver compliance. In other words, the therapist instructed the caregiver to check up on the care receiver and, based on her expertise (suspicion that the care receiver could not hold his utensil independently), she believed that the caregiver would follow through with her instruction and report back the following session.

Advice. Advice was less directive than instructive and seemed more like a suggestion than an order. Advice was often given in conjunction with some type of informing interaction (i.e., if you do x, then y will occur).
Discussion

A total of four primary interaction types and nine subcategories of interactive behavior were identified. The two therapists used multiple interaction strategies throughout each treatment session, highlighting the dynamic aspect of therapy and the variety of ways in which therapists engage caregivers while treating elderly clients.

The methodological limitations of this study include the small, heterogeneous sample and the lack of opportunity for the therapists or subjects who were involved to comment on or validate the first author's conclusion. Although these limitations are important, the four emergent interaction types were supported in all eight caregiver-therapist observations. This suggests that despite study limitations, the results are compelling as a starting point for further research describing therapeutic interactions.

Both therapists demonstrated the tendency to primarily engage the caregivers in treatment by using informing and directing interactions. Directing is a traditional way to practice and reflects a medical model approach to treatment in which the occupational therapist assumes responsibility for solving a problem. This type of interaction and that of an alternative approach is similar to Peloquin's (1990) description of "technical occupational therapists," who are primarily concerned with technical issues of treatment (p. 1). Directing interactions and often informing interactions indicate that therapists are working on their own goals and following their plans, rather than working on client-generated goals (Patton, Nelson, & Oser, 1990).

Although directing and informing interactions can lead to efficient outcomes and are familiar to therapists and appear to be time efficient, the literature has suggested that such an approach may have negative outcomes for caregivers and clients in a variety of therapeutic settings (Corcoran, 1993; Hasselkus, 1994; Patton et al., 1990). For example, instructive interactions are limited in that they do not facilitate client input or promote independent problem solving. It has been suggested that the more input clients have in the planning process of treatment, the more energy and commitment they will have to carry out recommendations (Hasselkus, 1988, 1994).

Caregivers of elderly persons have reported dissatisfaction with their therapists when they are not included in the overall treatment planning and implementation process (Bowers, 1987; Hasselkus, 1988, 1991). Therapeutic interactions that are centered around the goals of the therapist, without consultation with the caregiver, may result in misunderstandings and misinterpretations (Hasselkus, 1988; Peloquin, 1990). When therapists actively encourage caregiver input and show interest in the caregiver as a person, there is a greater likelihood of meaningful participation and overall satisfaction (Hasselkus, 1988; Patton et al., 1990; Peloquin, 1990). The importance of valuing and respecting caregiver input correlates with a fundamental principle of collaboration and has been highlighted in the literature as the optimal way of working with family members of elderly persons with disabilities (Bowers, 1987; Corcoran, 1993; Girlin & Corcoran, 1991, Girlin, Corcoran, & Leenmiller-Eckhardt, in press; Hasselkus, 1988, 1994; Peloquin, 1990).

In this study, caring and partnering interactions such as support and seeking input reflect some of the characteristics of a collaborative relationship that have been described in the literature (Corcoran, 1993). Nevertheless, these interactions were embedded in a directive therapeutic medical model approach. Furthermore, the findings of this study indicated that a basic component of collaboration was not evident (i.e., one in which the therapist acknowledged the caregiver as an expert or lay practitioner in caring for the care receiver and asked open-ended questions that enable the caregiver to contribute her or his expertise [Hasselkus, 1991]). Open-ended questions facilitate problem solving and can promote greater interaction and participation of the caregiver in treatment and in follow-through (Hasselkus, 1994; Patton et al., 1990). Viewing the caregiver as a lay practitioner suggests a sharing of responsibility within the relationship. A therapist who is involved in a collaborative relationship with a caregiver may in fact use all four types of interactions found in this pilot study (caring, partnering, informing, and directing) to achieve a balance of responsibility within the relationship. For example, being friendly (caring) can contribute to building trust, whereas explaining (informing) might be part of providing education.

Responsibility of treatment is often difficult for occupational therapists to share with caregivers for several reasons. It requires therapists to relinquish full control of treatment. It also calls for engaging in less directive types of interaction and helping clients begin to assume ownership and responsibility in treatment planning and implementation. The difficulty is complicated even more in that caregivers do not always volunteer their input because they are accustomed to a health care system in which the professional is responsible for providing treatment and recommendations. In addition, collaboration can be complex because it requires the skill of searching for the caregiver's true values and meaning of the caregiving experience to determine what is most important. In addition, the reality of many home care situations is such that reimbursement potentially dictates treatment, thereby making it difficult to actively involve the caregiver in the treatment process.

These problems suggest that the skills needed to work effectively with caregivers in home health care go beyond traditional training in areas such as activities of daily living. Occupational therapists need to develop the competence to work collaboratively with caregivers within the reimbursement and administrative constraints of health care practices. Therapists must learn strategies to
help caregivers identify, accept, embrace, and exert their own knowledge and expertise while caring for a family member. Although still relatively small, there is a growing body of literature describing techniques for teaching effective collaborative strategies and providing home care services that involve the perspective of the family members and elderly client (Gitlin & Corcoran, 1991; Gitlin et al., in press; Levine & Gitlin, 1990; Hasselkus, 1991, Payton et al., 1990). For example, Payton et al. (1990) outlined an educational plan for teaching students how to involve clients in the process of goal setting and treatment planning by first applying such techniques to their own lives, then by extensive practicing of interviewing techniques and, finally, by using the process with clients in a therapeutic setting. To evaluate the needs of family caregivers, Gitlin et al. (in press) developed an ethnographic framework from which to develop individualized service approaches in the home. Such strategies will enable caregivers to develop competence in their roles as caregivers and ultimately be effective in dealing with the day-to-day problems associated with caring for persons with a chronic disability.

Conclusion

In the past decade, literature (Anastas et al., 1991; Biegel et al., 1991, Cutler, 1994; Pepper Commission, 1990) has documented the extensive involvement of family members in the long-term care of elders and the complexity of their needs. With this knowledge and the increasing population of elderly persons, occupational therapists must examine, develop, and refine treatment strategies to actively involve family members in treatment. This pilot study used qualitative methodology to examine the ways in which two occupational therapists engaged family caregivers in home health care treatment. The findings emphasize the role of therapeutic interaction in caregiver involvement. Because of the small number of subjects, the findings cannot be generalized to other occupational therapists working in home health care. However, the results can serve as a framework for further exploration of therapeutic interactions between occupational therapists and family caregivers.

Therapeutic interaction can enhance client participation in all areas of occupational therapy practice, but in home health care, where environmental influences are more numerous than they are in the controlled hospital setting, the nature of the therapeutic relationship is even more likely to affect treatment outcomes. By identifying and refining therapists' styles of interaction, we can improve our ability to establish and maintain effective therapeutic relationships and work optimally with caregivers of older adults. Despite the limitations, this study highlights the need for increased educational efforts for occupational therapy students and practicing clinicians in the areas of therapeutic interaction and collaborative therapeutic relationships. A framework such as the continuum identified in this study could provide a basis for educational opportunities designed to sensitize students and practicing therapists to collaborative and empowering treatment techniques.

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References


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