Linking Purpose to Procedure During Interactions With Patients

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Occupational therapists' use of goal statements during interactions with patients can extend far beyond the care-planning session. Each treatment session provides an opportunity to match goals decided upon by the patient and therapist with a structured activity, thus endowing that activity with a therapeutic purpose. This article presents a rationale for discussing with patients the purpose and relevance of any procedure. The rationale for providing information and explanation is based on current health care trends, traditional occupational therapy assumptions, and the often ambiguous nature of activity. Occupational therapy's primary modality. Each of these realities provides a context within which the process of discussing goal statements with patients will be explored.

Rosen (1974, p. 292) used the term therapy set to refer to statements or directives that inform patients about a therapeutic procedure, motivate them to cooperate, and heighten their expectations of the benefits to be derived from treatment. When this treatment approach is used, patients (a) understand what they are doing and why they are doing it and (b) feel encouraged to engage in the process.

As applied to occupational therapy, a communication in psychiatric practice that encourages informed patient involvement might be the following:

We'd like to have you join us in the 9 AM craft group today. You will probably experience this as a pleasant hour since you enjoy working with your hands. Our main interest in having you attend this group, however, is that your participation will give you an opportunity to use several skills, such as your ability to concentrate, to solve problems, and to organize your thoughts.

Effectiveness of the Collaborative Approach

Although the purpose of this article is not to investigate the effectiveness of enlightening patients about and involving them in their therapy, but to explore a rationale for the use of such a collaborative approach in occupational therapy practice, some brief discussion of the effectiveness of the approach seems indicated. Rosen (1974) cited several studies involving subjects receiving desensitization therapy procedures accompanied by different forms of “therapy set.” He indicated that two primary approaches dominated the research on the effectiveness of informing and involving the patient. The first group of studies investigated the extent to which varied instructions might alter subjects' expectations for a therapeutic outcome. The second group of studies explored the effects of changing subjects' knowledge of the procedure through instructions. In the first approach, control groups were given a general therapeutic orientation,
were reported in these studies (Lomont & Brock, 1971; McGlynn, 1971; McGlynn & Mapp, 1970; McGlynn, Mealiea, & Nawas, 1969; McGlynn, Reynolds, & Linder, 1971; McGlynn & Williams, 1970; Woy & Efran, 1972). In the second approach, groups given therapeutic orientation were compared with groups who believed they were being studied for physiological reactions only. In this approach, subjects' knowledge of the purpose of the procedure was being manipulated. Most studies of this type demonstrated significant effects attributable to the type of instruction given (Borkovec, 1972; Leitenberg, Agras, Barlow, & Oliveau, 1969; Miller, 1972; Oliveau, Agras, Leitenberg, Moore, & Wright, 1969; Rappaport, 1972). Subjects who knew that the purpose of the treatment was therapeutic had better therapeutic outcomes.

In his own study, Rosen (1974) concluded that subjects aware of the purpose of procedures designed to make them less afraid of snakes demonstrated significantly higher mean behavioral changes, that is, became more desensitized to the offending stimulus, than subjects unaware of the purpose. Those informed that test procedures were therapeutic demonstrated more confident behavior in approaching snakes than those told that the procedures were simply experimental.

The collaborative approach's focus on patients' expectations resembles a construct called "expectancy of therapeutic gain." Historically, this construct emerged from research on the placebo effect described in the medical literature (Wilkins, 1973). Cartwright and Cartwright (1958) explained that in the 1950s the concepts of anticipation, belief, confidence, and conviction emerged in psychotherapy, giving rise to the concept of the placebo effect. Frank (1959) said that a patient's expectancy of benefit from treatment may in itself have enduring and profound effects on his or her physical and mental health. Krause, in 1967, wrote that the client's beliefs about treatment determine his or her valuation of the process, and that this valuation determines his or her motivation to participate. Kielhofner (1985) echoed this conviction in his conceptualization of volition as the human subsystem that provides the energy and desire for choosing an action, that energy being generated by what a person believes to be interesting and valuable.

Wilkins (1973) proposed that an individual's expectancy of therapeutic gain may be treated as either (a) an attitude that the individual brings to a situation concerning how much benefit he or she will receive or (b) a state that can be induced by instructions delivered about the effectiveness of procedures to which he or she will be exposed. The idea of the collaborative approach is predicated on the assumptions that instructions can induce an expectancy of therapeutic gain and that creating a state of expectancy potentiates the therapeutic procedure.

There is justification for the use of the collaborative approach in occupational therapy when one considers its efficacy; there is additional justification for its use when one reflects on current demands in health care practice.

**Current Demands in Health Care**

In light of the current emphasis on bioethical issues such as informed consent and patients' rights, there is sound reasoning for incorporating a collaborative approach into each occupational therapy procedure. Engelhardt (1986) described the patient's status as that of a stranger in a strange land:

Patients, when they come to see a health care professional, are in unfamiliar territory. They enter a terrain of issues that has been carefully defined through the long history of the health care professions. A patient is unlikely to present for care with as well-analyzed and considered judgments as those possessed by health care professionals. . . . The patient in this context is a stranger, an individual in unfamiliar territory who does not fully know what to expect or how to control the environment. . . . Things no longer happen as usual; they no longer take place in their taken for granted ways. As an outsider in a strange culture, the patient always runs the risk of being a marginal person. (pp. 256-257)

The care giver must explain this new and strange land to the patient, thereby reducing the patient's sense of being a marginal person. The care giver must augment the patient's sense of belonging by providing him or her with access to information and by giving him or her control in the form of consent over the treatment process (Engelhardt, 1986).

Current emphasis on patients' rights reminds those in positions of power that the ultimate power is changing hands. Patients have the right to know the precise relevance and nature of their treatment and to choose it or reject it on the basis of their understanding of its value to them (Bloomer, 1978). This patient/consumer right gives the practitioner a powerful incentive for explaining procedures and for collaborating with patients throughout treatment.

Clinicians face a demand from agencies, both accrediting and reimbursing, to be accountable for the treatment they provide. They face requests from patients and their families to prove the utility of their service and to clarify the expected outcome of their treatments. Current trends in exact statements of purpose from therapists can be perceived as the public's validation of a professional and ethical response that is their due.
Traditional Occupational Therapy Thinking

Even before the emergence of current trends, traditional occupational therapy assumptions supportive of the collaborative approach were well represented in the literature. The assumptions can be summarized as follows: The patient is rational. The patient is a collaborator with the therapist. The patient is free to choose or reject therapeutic services. The therapist, in turn, is a teacher and a motivator in the therapy process.

Excerpts from Willard and Spackman's *Occupational Therapy* highlight these assumptions. McNary (1947) wrote: "An activity entered into without a purpose is not occupational therapy" (p. 10). If the patient is the one entering into the activity, it is he or she who must understand the purpose. It then becomes the therapist’s responsibility to share that information. Edgerton (1947) said that “the ability to relate an activity to the need of the individual is one of the characteristics that distinguishes the occupational therapist from the . . . crafts instructor” (p. 42). Here is clear endorsement of any procedure that communicates the relevance of a therapeutic activity. If occupational therapists resent having their role minimized by others, they must take measures to ensure that they are not sabotaging themselves by failing to define their work so that others will recognize it unmistakably as therapy.

Wade (1947) said that “if the patient is unable to participate actively in the plan, its existence should be kept in his consciousness as a justification for the task” (p. 90). When meaningful collaboration with the patient is not possible, the therapist still retains responsibility for explaining the plan on some level. When the patient is elderly, psychotic, young, or cognitively impaired, it may seem easier to abandon explanations in favor of expediting the procedure. Therapists are encouraged to do otherwise. At whatever level of comprehension is possible, care givers need to inform. The information may be brief, simple, and even reductionistic. The information is nonetheless “placed in the patient’s consciousness.” When in doubt about the potential for awareness, one communicates.

An anecdotal contribution to *Reader’s Digest* (“Speedy Recovery,” 1987) illustrates a response that even patients assumed to be minimally aware can furnish. A nurse’s aide described her patient as a 96-year-old woman immobilized after a stroke. The aide’s task was to get the patient out of bed. She communicated her plan to her assistant as follows: “I’ll take an arm and a leg on this side, you take an arm and a leg on that side and then . . . .” The explanation was interrupted by the patient’s saying in a weary voice: “Oh, God, she’s not even going to make a wish!” (p. 53).

This anecdote clearly reminds therapists that the presence of a significant disability does not justify excluding the patient from an active understanding of any procedure. Exclusion constitutes treatment of the patient as a marginal person. The publication of this anecdote as a humorous short in a popular magazine reflects perhaps the universality of the situation. The treatment is all too familiar. The poignant of the story lies in the fact that the patient’s best defense was that of taking the offensive by being more humane and personable than the care giver.

Current literature supports these examples taken from the past. Reed and Sanderson (1983) described several attitudes and assumptions about the occupational therapy process consistent with those underlying the idea of the collaborative approach. They emphasized salient points made more subtly 40 years ago by encouraging therapists to regard the client as a “*valuable, worthwhile person*, even if the client does not respond readily to the program” (p. 153). Here stands a declaration of the patient’s right to challenge services offered on the basis of his or her understanding of them. A consequent responsibility for the therapist is to maintain the patient in high regard and to respond to the challenge with information. “The client has a right to be informed, but also the information should be in a manner that is comprehensive and at a rate that can be absorbed by the client” (p. 154).

Reed and Sanderson (1983) drew up a list of patient’s rights that included the following:

1. A person has the right to decide whether to seek and accept health care services within legal limitations.
2. A person has the right to determine the state of health and level of wellness that person will seek to attain and maintain, as long as the decision does not threaten or endanger the health and wellness of other persons.
3. A person has the right to be consulted regarding the objectives, goals and methods to be used in individual health care plans. (p. 71)

These three rights merit observance during daily sessions when specific treatments are being proposed. The patient’s right to be consulted and to decide needs to be reinforced daily. Providing the patient with the necessary information at each session can operationally reaffirm his or her rights.

Motivating the patient becomes an inevitable therapist responsibility if one endorses the patient’s right to choose. Reed and Sanderson (1983) identified the last step of the occupational therapy process as being “to facilitate and influence client participation and investment” (p. 81). This step constitutes a directive to communicate the rationale, the importance, and the relevance of the therapy process in such a manner as to facilitate the patient’s investment in a successful outcome.

Traditional occupational therapy has been a pro-
cess of teaching, motivating, and collaborating with the patient during therapeutic activity. More recently, proponents of a psychoeducational approach to occupational therapy have contrasted it with traditional occupational therapy. Fine and Schwimmer (1987) described the psychoeducational approach to occupational therapy as a derivation from social learning theory:

The life skills curriculum (LSC) is further differentiated from its traditional counterpart by structuring the educational format and techniques, emphasizing the patient's active participation in setting and evaluating treatment goals, identifying learning needs and influencing the teaching-learning process, planning the integration and continuity of problem-solving and communication skills among all groups, providing multiple opportunities to practice skills through graded repetition and homework assignments, and matching treatment tasks to patient's problems and priorities. (p. 3)

Excerpts from traditional and more current literature, cited earlier, support the premise that traditional occupational therapy (a) has incorporated the tenets of social learning theory to a considerable extent and (b) has promoted active involvement in goal formulation all along.

The Public's Knowledge of Occupational Therapy

The rationale for using the collaborative approach sharpens considerably when we reflect on the profession's unclear image. "Occupational therapy is not understood well by the average client because it is not a common profession, such as medicine, nursing, engineering, law, teaching or the ministry" (Reed & Sanderson, 1983, p. 161). Practitioners often find themselves explaining the word occupational, differentiating occupational therapy functions from those of other therapies, and otherwise clarifying their professional roles. If the public expects physicians, nurses, and engineers, whose professions are better understood, to clarify their procedures, the expectation increases for those representing less well understood professions.

Occupational therapy is often not understood; it can, in fact, often be misunderstood. A particularly noteworthy example of that misunderstanding appears in Joyce Rebeta-Burditt's novel *The Cracker Factory* (1977). In the story a young female patient, a self-described alcoholic, writes from the psychiatric hospital to a friend:

> I should write to you every day. I could not only unravel the Gordian knot in my psyche, but appear to be busy and involved when Brunhilde, the misplaced Viking lady, comes tapping on my door every afternoon in an effort to intimidate me into going to Occupational Therapy. She moves around the seventh floor telling all the patients that their doctor has "ordered" Occupational Therapy and they must come IMMEDIATELY. She herds them out in the hall where they mill around until she lines them up in two columns and goose-steps them out the door . . . .

Patients are forever trying to hide by taking a shower or even [having] a fit, but she doesn't care. Wet or screaming, it makes no difference. She drags them along anyway.

> I go sometimes and hate myself for it. I sit and dab grout on a metal shell and try to decide what color asthay I'm going to mess up that day. I listen to the conversations around me, and the tape recorder in my head jots down snatches and fragments and I smile and pretend that I am not listening in. (pp. 114-115)

Fiction will often exaggerate or satirize those aspects of our functioning that create interesting reading material, such as the dominating qualities of Brunhilde and the perceived irrelevance of occupational therapy. Fiction also mirrors reality. In this case the reality is that occupational therapy is sometimes misunderstood.

The consequence of this misunderstanding can be significant. Patients uninformed of the purpose of occupational therapy are free to infer its meaning based on their observations. The result may well be compliance with the procedure. It might as easily be noncompliance accompanied by hostility. One probability is that patients who are uninformed or misinformed will be less able to generalize to their life situations those concepts the therapist had hoped might be learned in therapy.

The Ambiguous Nature of Activity

Because occupational therapists use activity as a primary modality, they increase the risk of being misunderstood. Any single activity can have many therapeutic possibilities. Proficiency in activity analysis enables clinicians to recognize the multiple goals that can be attached to any one activity. Therapists need to apply that theoretical concept clinically and consider its practical consequences. Therapeutic methods can easily confuse patients. A patient can be given leather stamping as a task to achieve a wide range of goals, including (a) the enhancement of grip strength, (b) the redirection of nervous energy through gross motor release, or (c) the use of organizational and problem-solving skills in the planning of a balanced design. If the only focus patients have is the one they can infer while doing the task, the relationship between the leather-stamping activity and the treatment plan may elude them. Because they do not clearly understand the therapeutic concepts supporting the activity, they may be less apt to apply them to their personal life situations.

A pleasant staff development exercise that illustrates the multifaceted aspect of any activity is the following: Divide the total group into five working subgroups. Provide each small group with a bowl of sliced oranges. The primary activity will be to eat the oranges. From the list given in the appendix to this paper, provide each group with a different set of written directions. Allow each group to complete the ac-
tivity as directed. Following the group activity, ask a representative from each group to share both the directions given and the results of their activity. Reports from the representatives will reflect the different end points that one task with different directions can have. The exercise can stimulate reflection on the importance of clarifying the specific focus of a planned activity.

Methods of Providing a Collaborative Approach

A collaborative approach can be used creatively. Therapists can provide feedback formally or informally, use the printed or the spoken word, and communicate the purpose of occupational therapy procedures at various phases in the treatment process. Any method used that communicates the purpose of or the expectations for the treatment can qualify.

In an earlier article (Peloquin, 1983), I endorsed integrating information about the expectations and relevance of the occupational therapy program into the structure of an initial interview format in an acute care psychiatric setting. The three-part interview stresses the continuous provision of feedback to the patient. My conviction remains that, if nothing else, we give patients methods of self-help when we provide them with informative goal statements that they can readily apply to their personal environments after discharge.

One way to enlighten patients is to give them printed materials. A general description of the occupational therapy program might be a suitable accompaniment to the initial contact between a patient and a therapist. The descriptive introduction might include a statement of the various purposes of the occupational therapy program. Next, a brief, goal-oriented paragraph at the top of an occupational therapy schedule might serve as a motivational reinforcement. Posters listing typical occupational therapy goals for various groups can be displayed in both residential and treatment areas. In more financially comfortable settings, pamphlets or video messages discussing the programmatic goals of occupational therapy might be used as part of a general hospital orientation.

Feedback can be provided in formal groups and individual orientations. On a daily basis, a brief discussion can either precede or follow each activity group. More articulate patients can be asked to help clarify the purposes and expectations of various groups for new patients. Less organized patients can be reminded informally on the way to and from groups about the specific purpose of each group. Brief personal contacts reminding patients about individualized goals can occur during large parallel groups.

It might be helpful to include here a few illustrations of how the collaborative approach can be incorporated into occupational therapy. Each illustration includes vocabulary that can be adjusted upward or downward to match the intellectual level of the patient population being addressed. Any verbal delivery of the feedback needs to reflect, in its tone, rate, and inflection, the therapist’s perception of the patient as intelligent. A singsong or overly didactic delivery, suggesting condescension, could vitiate or at least compromise the purpose of the feedback. A respectful intent requires respectful delivery.

An introductory explanation of a psychiatric occupational therapy program might read, in part, as follows:

Occupational therapy adds to your total treatment by encouraging you to use activities and occupy your time in a therapeutic way. Purposeful activity has an organizing and beneficial effect on an individual. Because it involves the total person, activity meets several mental health needs.

Occupational therapy offerings here include crafts, exercise, greenhouse, relaxation, communication, and life skills groups. By participating in these activities you help ready yourself to return to your community. During group and individual sessions, you can set goals and practice skills essential to your coping more effectively outside of the hospital.

You will have daily opportunities to plan and organize tasks, to solve problems, to improve your physical condition, to interact effectively with others, to make decisions, to boost your self-confidence, to learn new ways of relaxing and coping with different life situations. Activity becomes therapy because of the adaptive skills you practice when you are active.

A poster mounted in the clinical area to provide information about a typical occupational therapy craft group might list some of the following goal statements:

**Why Crafts?**

- to improve your concentration
- to organize your thoughts
- to have you solve problems
- to help you make decisions
- to exercise your work skills
- to boost your self-confidence
- to increase your independence
- to help you interact with others
- to increase your sense of control
- to keep you alert and involved

A poster describing the purposes of a communication group might read as follows:
Why Communication Group?

The following format has been used with groups of adults having cognitive problems:

1. Explain the purpose of the group: "One of the goals for this particular group is to have you use your cognitive or thinking skills. During the course of this hour each of you has had some opportunity to use a number of thinking skills, such as concentrating, problem solving, decision making, comprehending instructions, or organizing your activity."

2. Set the stage for a discussion: "Take a minute to think about the thinking skills you used while working on your project. I'll be asking a few of you to share with the rest of us how you used your skills during the past hour."

3. Facilitate a brief discussion of skills used, making sure to clearly link for patients the various task steps they completed with the cognitive skills they used. Examples of therapist responses might be:
   a. "That's right, Jim. You had to follow several complex verbal instructions today. I also noticed that you were doing a lot of planning and organizing for the design you want to put on your belt tomorrow."
   b. "Lorene, you're feeling that you didn't use your thinking skills today, but I noticed that you had to make several color choices when you were painting. That's decision making. You also had to pay attention to the shapes you were painting. That required you to concentrate on what you were doing. You really were using thinking skills for the better part of the hour."

4. Summarize what was accomplished and encourage patients to return to the next session.

Formulating and providing a set of goals in collaboration with the patient can be a creative process evolving from the basic premise that patients have rights, capabilities, and a vested interest in knowing the relevance of therapy. Using the collaborative approach can potentiate our therapeutic activities by communicating their value to patients in the real world outside the treatment setting. An old proverb says, "Give a man a fish and you have fed him for a day; teach a man to fish and you have fed him for a lifetime." Sharing goal statements with patients can give them an understanding of a process that can provide a link to improved functioning.

Summary

There is a rationale for a collaborative approach with patients in the daily practice of occupational therapy. Effective collaborative procedures provide patients with (a) knowledge about what they are doing and why they are doing it and (b) encourages them to engage in the process.

The effectiveness of this approach has not been established conclusively, but studies suggest that subjects exposed to the therapeutic purpose of desensitization procedures tend to have better therapeutic outcomes than those unaware of the purpose. Current emphasis on the patient's right to be informed and on the therapist's responsibility to inform reflects the public's growing insistence that practitioners explain the utility of the treatments they provide to the patient.

Excerpts from past and present literature indicate that assumptions underlying the practice of traditional occupational therapy reflect similar assumptions underpinning the use of a collaborative approach. These assumptions describe the patient as rational, as having rights, and as a collaborator in therapy. The therapist is assumed to be a teacher and a motivator in the therapeutic process, the person who articulates the relevance of therapy and encourages the patient's participation.

The general public often lacks understanding of the occupational therapy process. Additionally, the versatility and multiple possibilities associated with any activity can confuse the patient about its purpose. The uninformed patient might be less inclined to participate in therapy and less able to generalize helpful concepts from the experience.

Feedback to patients can be provided in a number of creative ways throughout treatment. Providing such feedback need not require a major time investment, but can represent the therapist's renewed commitment to the therapeutic alliance and to the goal directedness of occupational therapy practice.

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Appendix

1. You have been given orange sections as a help in your discussion. The tangible and sensual experience of the orange will enable you to complete your task. As you are eating the sections, discuss as a group the various memories you have that are associated with eating oranges. Appoint a spokesperson who will later present a 30–60-second summary of your discussion.

2. You have been given orange sections as a help in your discussion. The actual taste of the orange will help you to better focus on your task. As you are eating the sections, discuss as a group as many dishes or recipes as you can think of that use oranges. Appoint a spokesperson who will later present a 30–60-second summary of your discussion.

3. You have been given orange sections as a help in your discussion. The visual and tactile experience of the orange will help you in your task. As you are eating the sections, discuss as a group as many other natural items as you can think of that share a similar color. Appoint a spokesperson who will later present a 30–60-second summary of your discussion.

4. You have been given orange sections as a help in your discussion. The sight of the orange will help you in your task. As you are eating the sections, discuss as a group as many other items as you can think of that have a similar odor, or that have the orange scent. Appoint a spokesperson who will later present a 30–60-second summary of your discussion.

5. You have been given orange sections as a help in your discussion. The smell of the orange will help you in your task. As you are eating the sections, discuss as a group as many other items as you can think of that share a similar odor. Appoint a spokesperson who will later present a 30–60-second summary of your discussion.

References


