The Development of an Occupational Therapy Interview/Therapy Set Procedure

(acute psychiatry, interview procedure, occupational therapy set)

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Emphasis on returning patients quickly to the community requires staff in acute psychiatric settings to maximize therapeutic efforts within limited time frames. To satisfy standards for practice, therapists must constantly apply time management techniques to their therapeutic endeavors. Despite patient stays as brief as 10 days, practitioners continue to evaluate, treat, and plan for the discharge of each patient referred to their service. This led to reassessment and restructuring of the initial occupational therapy interview in one psychiatric setting. The objectives of the interview, with particular emphasis on therapy set, are reviewed. These objectives were incorporated into a three-part procedure of interview therapy set. The forms that structure the procedure are discussed as adaptable tools for use in similar settings.

Whether structured around an interview format or a less formal schedule, the occupational therapy interview serves several purposes. Smith and Tiffany (1, p 158) identify these as 1, a collection of information about the client to help develop objectives and a plan for treatment; 2, an establishment of understanding on the part of the client about the role of the therapist and the purposes of the occupational therapy process; and 3, an opportunity for the client to discuss and reflect about his or her situation and to think about plans for change.

Particular emphasis has been placed recently on establishing an understanding of therapeutic procedures. Other health professionals, for example, Rosen, a psychologist, call this function therapy set (2). Therapy set provides patients with the rationale, goals, and expectations of the set of any therapeutic procedure.

Current guidelines for practice in mental health recommend the use of therapy set. The Consumer Bill of Rights supports the patient's right, as consumer, to know the precise nature and relevance of treatment (3). The Joint Commission on the Accreditation of Hospitals (JCAH) (4) specifically emphasized the right of the patient to know, and the responsibility of the professional to inform, about any therapeutic procedure.

Practitioners perceive all too clearly an ongoing need for therapy set to motivate clients, especially among psychiatric patients who oftentimes may see activity programs as irrelevant to their needs, problems, or lifestyle. Fidler and Fidler (5) encouraged occupational therapists to facilitate an increased understanding of the value of "doing." All too often, patients readily perceive the relevance of verbal modes of therapy but fail to recognize the integrative effect that activity can have on thoughts, feelings, and meanings.

Three specific forms—an open letter to patients; a Guide to Helpful Activity; and an Occupational Therapy Objective Checklist—are discussed as methods for providing occupational therapy set. Together the forms structure an initial interview procedure and facilitate an understanding of therapeutic activities in an acute psychiatric facility whose philosophy most approximates that of crisis intervention.

Problems and Purpose

An informal survey among both staff and patients before the development of any of the forms revealed that the majority of them perceived activities as supportive and primarily diversional. Activities were regarded by patients almost exclusively as "opportunities to get their minds off their problems" or "ways
to make the time pass more quickly. Few could identify any therapeutic goals inherent in the activity process itself. The nature of activity and its potential for therapeutic application to the needs of the patients were not understood.

The absence of an occupational therapist in the setting for more than two years and the presence of few occupational therapy programs statewide contributed to this lack of understanding. The situation seemed ideal for an occupational therapist new to the setting to establish a hospital-wide therapy set.

The procedure developed was meant to meet several criteria. There was the need to interview and orient all patients admitted in a manner that fulfilled the objectives of the occupational therapy interview, as well as the recommendations of the JCAH and the Consumer Bill of Rights. There was need for a method that a single therapist could use with a large case load of patients whose average length of hospital stay was 12 days. In addition, the procedure had to leave time available for treatment, supervisors, and administrative responsibilities.

Setting
The hospital is a 65-bed, private, nonprofit psychiatric institution—the only facility of its kind in the state of West Virginia. Diagnoses include the full range of the most common adult psychiatric disorders. Patients are screened by their admitting psychiatrists and assigned to one of three hospital groups depending on their degree of behavioral control and physical condition. Occupational therapy serves all three patient groups.

Seven psychiatrists with clinical privileges make brief rounds daily. Psychiatric nurses provide 24-hour nursing care. Social workers conduct a 1-hour therapy session 5 days a week for two groups housed on an open unit. All other therapy groups are offered by the occupational therapy department. Any one patient can be involved in up to 6 hours of occupational therapy groups daily throughout a 7-day week. The department is staffed by one occupational therapist director and seven aides with varying academic, experiential, and technical backgrounds.

Activities offered include crafts, recreational groups, yoga, progressive muscle relaxation exercises, hobby workshops, sports, greenhouse activities, community outings, and various parallel and cooperative task groups. Although all hospital staff emphasize the involvement of patients and the occupational therapist (OTR) encourages this involvement in appropriate groups, patient participation remains optional.

Considerations in Designing the Forms
Three forms—the letter, the guide, and the checklist—were developed to facilitate increased understanding of and participation in occupational therapy among patients. Since the reading level and language on all three forms had to reach a cross-section of West Virginia's population in a meaningful way, newspaper reading level was considered appropriate. Cultural considerations were made in the use of some analogies and in the reference to the physician as ultimate authority.

Each form developed is institution-specific in its reference to particular activities. Each articulates the therapeutic value of scheduled activity groups. Together the forms provide patients admitted to the hospital in a crisis with a rationale for the use of purposeful activity as a self-help tool toward individual symptom abatement and resolution of crisis.

Corry, Sebastian, and Mosey (6) caution that any occupational therapy approach in acute psychiatric care is based on the folk knowledge and common sense of the profession since "the formulated theoretical base for this type of treatment is not part of the professional literature." (6, p 301) The empirically based concepts that form the framework for the letter, the guide, and the checklist await verification via experimentation. The frame of reference reflected in the forms is essentially developmental in its endorse-
ment of the use and development of adaptive skills toward optimal social role functioning.

Since each form serves a distinct function in the initial interview, those specific differences of intent and implementation that characterize it are discussed next.

Specific Functions of Each Form

The open letter to newly admitted patients is distributed by occupational therapy aides to those later patients organized enough to comprehend it on their first day in the hospital. Meant to be part of the orientation, it communicates the overall relevance and purpose of the occupational therapy process. Given in conjunction with the departmental activities schedule, the letter provides a general rationale for those activities listed. A representative paragraph reads:

Occupational Therapy is not so much concerned with what specific project you make in crafts or what outing trip is planned. The real concern is helping you through activity. You need not be an artist or a sports enthusiast to participate. Activity becomes therapy because of all the important and adaptive skills you practice when you are active.

The Guide to Helpful Activity is a three-page form topically organized into the adaptive skill areas addressed in this acute setting (Figure 1). Each section consists of problem symptom identification questions followed by a brief therapy set highlighting activities potentially helpful in the resolution of those problems identified. Patient responses help the therapist to develop suitable treatment objectives—a second major interview function. One brief therapy set on medication, not preceded by questions, was included after a review of frequently used reasons for nonparticipation in activities; medication side effects ranked high on the list.

Designed for use with small groups of patients, the Guide format comprises rather close-ended questions. Every opportunity is thus given each patient to elaborate on his or her brief responses in the group session with the OTR. It was believed that engaging the patient in the three modes of reading, writing, and listening would ensure greater clarity and involvement during the session. A printed form adds structure and perhaps credibility to the content of the session beyond the presence of a professional therapist. The use of questions combined with therapy set directly facilitates an opportunity for patients to reflect on their needs as well as alternatives, a third interview function.

The last form, entitled Occupational Therapy Goals Toward Improved Functional Performance, is the objective checklist and serves to amplify and clarify those treatment objectives documented by the occupational therapist on each patient's care plan (Figure 2). Two types of the checklist exist, which relate to two core activity programs offered: open hall and constant care. Both checklists are structured to include those treatment objectives most frequently identified as relevant to patients over a period of a year in this setting. These objectives were clustered into the adaptive skill areas they most closely approximated. A section entitled other was included to permit documentation of more individualized objectives such as providing orientation to joint protection energy conservation techniques for the depressed arthritic patient.

The appropriate forms are completed in duplicate by the OTR who checks suitable objectives after an assessment of the patient's problems, strengths, and needs. One copy is given to the patient by either the therapist or an aide on the second day of admission. The second copy becomes a part of the patient's permanent record, to facilitate goal-oriented documentation by all occupational therapy staff.

Procedural Modifications

A major intent of this procedure has beenalue to maximize and prioritize occupational therapy functions. After a 2-year period of implementing the procedure, pragmatic considerations have made modifications necessary. The open letter and the objective checklist have been consistently used as described and have worked as designed. The Guide has been used more restrictively. When patient census exceeds 15, or when administrative responsibilities impinge on therapy time, one OTR Director cannot consistently implement the Guide session, nor could this function be delegated to an occupational therapy aide. A life skills questionnaire was therefore designed as a partial substitute for the Guide. Although replicating many of the Guide's questions, the questionnaire becomes a brief, more manageable data-gathering tool that patients can complete independently. Occupational therapy aides distribute the open-ended questionnaire, which contains representative questions such as 'When you are tense, can you get yourself relaxed?' and 'Do you have problems getting along with others? What?' Responses are reviewed at daily occupational therapy staff meetings, then charted. The total interview procedure, then, is adaptive, moving between the preferred initial procedure and the modified...
### Figure 2

**Checklist**

| OCCUPATIONAL THERAPY GOALS TOWARD IMPROVED FUNCTIONAL PERFORMANCE |
|-----------------|-----------------|-----------------|
| **NAME:**       | **ROOM:**       | **DATE:**       |
| **OCCUPATIONAL THERAPY WILL BE WORKING TO HELP YOU IN THE FOLLOWING AREAS, HOPING THAT YOU WILL EXPERIENCE THE BENEFIT OF ACTIVITY THAT HAS PURPOSE** |
| **With Your Thinking Skills:** | **With Dealing With Other People:** |
| - improving your concentration by providing crafts, hobbies, and daily exercises that require you to concentrate | - increasing your comfort level and ability to trust others by involving you in pleasant groups |
| - reducing your confusion through activities that provide clear directions for you to follow | - providing you with the support that comes from belonging to a group |
| - building your problem-solving skills through activities and puzzles that encourage you to figure out problems | - providing you with opportunities to communicate with others |
| - keeping you alert and thinking in order to prepare you to return to your home and community | - providing you with situations in which you must share, interact, and stay in touch with society’s demands |
| - helping you reduce racing thoughts through organized and calming projects | - encouraging you to use energetic activities to provide healthy outlets for the strong feelings you are experiencing |
| - providing you with opportunities to organize your thinking and behavior through structured tasks | **With Your Ability to Handle Stress:** |
| **With Your Feelings About Yourself:** | **With Your Physical Condition:** |
| - boosting your self-esteem through daily successes in activity groups | - improving your general health, strength, and coordination through chair exercise, yoga, recreational games, sports groups requiring physical activity |
| - increasing your self-confidence by having you work independently | - keeping you in a good physical condition and functioning at your best level |
| - increase your feelings of being in control by having you experience the control you have over yourself physically and emotionally | - helping you to reduce physical discomforts such as stiffness, shakiness, and pain, through relaxation exercises |
| - encouraging you to work through hurt or other upsetting feelings through energetic types of activities | - helping you to reduce any unpleasant side effects from your medication or treatment through exercises |
| - maintaining your work and social skills through a full and balanced daily routine | **With Your Use of Leisure Time and Available Coping Resources:** |
| **With Your Use of Leisure Time and Available Coping Resources:** | **Other:** |
| - teaching you ways to use your free time in a healthier, more satisfying way | - MORNING CRAFTS OR I.G EXERCISES (11:30) |
| - encouraging you to look around your community to help you find groups and activities that can help you better satisfy your personal needs | - RELAXATION (4:15) |
| - encouraging you to regularly use a part of each day for spontaneous fun and relaxation | - MORNING EXERCISES (11:30) |
| - MORNING EXERCISES (11:30) | - RECREATION WORKSHOPS (1:00) |
| - RELAXATION (4:15) | - RECREATION (6:00) |

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Copy given to patient.
contingency version. Therapy set
during these times becomes, more
increasingly, the function of the
other two forms.

Discussion
Since one primary purpose in establish-
ing this procedure was to facilitate
patient participation in occupa-
tional therapy, relevant observations
about participation since the
development and use of these forms
are highlighted next.

Brief length of patient stays has
made a significant research project
difficult. One pilot study was com-
pleted on a small sample of ten pa-
tients meeting the criteria of
first-time admission and literacy. The
Guide session was used with half
the group to determine whether use
of this one form had an impact in
any way on the participation among
these patients. Although signifi-
cance was achieved at the 10 level in
comparing differences in the num-
ber of activities attended by patients
in both groups (ES 1.41 with signifi-
cance established at 1.567), many
variables could not be controlled
even with random assignment to
groups. Results, therefore, only
suggest that the Guide may have
influenced increased participation
among patients in that group.

A second pilot study involving 20
patients attempted to identify sig-
nificant factors related to greater
daily participation in occupational
therapy. With significance estab-
lished at .05, there was a significant
correlation established between pa-
tients' self-report of a desire to
become involved in therapy and no
significant correlation between pa-
tients' IQ (Wechsler scores) and their
attendance. Intelligence was used as
a variable in exploring whether
"brighter" patients might inter-
ference from the activity process
itself.

These initial investigations are
mentioned to emphasize that, al-
though some attempts have been
initiated to investigate the possible
impact of the forms in this setting,
these exigencies that led to
developing the procedure have an
adverse impact upon researching it.

To extract percentage figures
reflecting overall patient partici-
ication in occupational therapy over
the 3-year period during which the
forms were being developed in this
facility, a 4-month interval (from
February through May) was selected
for study. This interval was selected
because the occupational therapy
staff had been most stable during
this period. During other intervals
there have been either 1. numerous
vacations covered by part-time help
less familiar with routine pro-
dures, or 2. hiring and orienta-
tion of new workers also less familiar
with routines, or 3. situations pre-
venting the OTR from consistently
maintaining the Guide session.
This period was also selected be-
cause daily occupational therapy
charges during the 4-month inter-
val were fixed. At other times fees
increased and relevant data were not
readily accessible, making precise
computation during the other in-
tervals impossible.

To compute percentage figures,
the total amount of money gener-
ated by patient charges during those
4 months was divided by the daily
fee charged for patient participa-
tion in occupational therapy. This
computation resulted in the num-
ber of "OT Days," which was then
divided by the total patient in-hos-
pital days during that period. The
final result is a percentage figure
reflecting the percent of total pa-
tient days that were "OT partici-
adion days": that is, days on which
patients participated in a minimum
of one occupational therapy group.

In 1979, before the development
of these forms and this procedure,
the percentage was 70.8%; in 1980, 73.1
in 1981, 78.2 percent. Although no
firm conclusions can be drawn from
these figures, one might infer that
something favorable had an impact
on patient participation during this
interval. These figures are pre-
sent as notable changes observed
in participation.

Summary
Together the forms have enhanced
occupational therapy set, fulfilled
interview objectives, and satisfied
consumer rights and JCAH stan-
dards. They have provided a viable
response to time management chal-
leges of the occupational therapists
in this setting.

Although primarily designed for
the patient group, the forms have
been highly visible to families of
patients, psychiatrists, and all non-
occupational therapy staff. A sec-
ondary benefit to having used them
has been improved public relations
and increased support for occupa-
tional therapy services.

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