The Nature of Clinical Reasoning With Groups: A Phenomenological Study of an Occupational Therapist in Community Mental Health

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Objective. The purpose of this paper is to examine the clinical reasoning of an occupational therapist in group practice in mental health. It emerged from a larger phenomenological study of expert occupational therapy practitioners in community mental health.

Method. Data were gathered through intensive, semi-structured interviews with 1 day of participant observation. Analysis was an iterative process in which emerging themes were identified for reflection and interpretation. Previously established categories of clinical reasoning were used as a structure for describing the results.

Results. A rich description of clinical reasoning in psychosocial task groups is presented using interactive, narrative, conditional, and pragmatic reasoning. The gestalt of community practice is illustrated, as the therapist describes the multiple levels of consciousness used in her consideration of, and response to, clients within the context of the larger environment.

Conclusion. This study suggests that an examination of occupational therapy with psychosocial groups is a rich area for research to extend our understanding of clinical reasoning in occupational therapy.


Occupational therapy studies of clinical reasoning have focused primarily on therapists who worked with individual patients (Creighton, Dijkers, Bennett, & Brown, 1995; Crepeau, 1991; Fleming, 1991a, 1991b; Mattingly, 1991; Mattingly & Fleming, 1994a) or who discussed a case study of an individual client (Fon-diller, Rosage, & Neuhauske, 1990; Neistadt, 1992, 1996; Niehues, Bundy, Mattingly, & Lawlor, 1991; Rogers & Holm, 1991; VanLeit, 1995). In those studies, the interaction studied was of two actors, the therapist and the patient. In psychosocial occupational therapy, interactions are often group interactions orchestrated by the therapist. The purpose of this phenomenological study is to examine clinical reasoning in group psychosocial practice. It is derived from a larger study of expert occupational therapy in community mental health.

Clinical Reasoning in Occupational Therapy

Studies of clinical reasoning in occupational therapy have described characteristic modes of thinking in practice. These modes include procedural, interactive, conditional, narrative, and pragmatic reasoning (Fleming, 1991a, 1991b; Mattingly, 1991; Mattingly & Fleming, 1994a; Mattingly & Gillette, 1991; Schell & Cervero, 1993).

Procedural Reasoning

Fleming (1994b) describes procedural reasoning as the process used by a therapist to define a client's problem and select the intervention procedures. In some occu-
nual therapy literature, Fleming’s conceptualization of procedural reasoning has been described as thinking about the physical problems of a client (Alnervik & Svidén, 1996; Roberts, 1996; Schwartzberg, 2002). In the study reported here, the discussion of procedural reasoning is not limited to reasoning about physical problems. Mental illness is a disease and impaired psychosocial function is a disability, thus, procedural reasoning is a good descriptor for discussing the reasoning about these problems and the planning for intervention in psychosocial dysfunction.

Interactive Reasoning

Interactive reasoning leads to an understanding of clients as people and how they experience illness (Fleming & Mattingly, 1994a). Mattingly and Fleming (1994b) emphasize the collaborative nature of interactive reasoning where the therapist is concerned with clients’ experiences of their disabilities in order to actively engage them to “work hard as partners in the therapeutic process” (p. 179). Schwartzberg (2002) has done an extensive review and description of the beliefs of philosophers, humanistic psychologists, and occupational therapists who have laid the foundation of occupational therapy’s concept of interactive reasoning. She has delineated elements of the interactive reasoning process used to understand clients in the therapeutic situation as: “(1) active listening, (2) being genuine and empathetic, (3) building an alliance, (4) observing cues and clarifying meaning, (5) giving and receiving information, and (6) reality testing” (p. 24).

Conditional Reasoning

Another element of clinical reasoning is conditional reasoning in which a therapist thinks about clients’ whole conditions, the personal, social, and cultural contexts of their lives (Fleming, 1994a). A therapist thinks about how a client was in the past and projects an image of the future for the client. It is this kind of reasoning that is employed when a client has experienced change because of disability and the therapist is imagining how the client will now fit into his or her world with the changes. In some cases, conditional reasoning contributes to a client’s reconstruction of self. Fleming (1994a) notes that conditional reasoning requires a deep understanding of a client and “takes all the therapist’s interactive reasoning skills and more” (p. 197).

Narrative Reasoning

Narrative reasoning is the method by which therapists create images in their minds about how clients could be in the world. It is the story a therapist constructs, which gives direction (plot) and temporal meaning to a client’s life and the clinical situation. When therapists construct their clients’ stories in their minds, “this picturing process gives them a basis for organizing tasks” (Mattingly, 1994, p. 240).

Pragmatic Reasoning

In addition to the concepts of clinical reasoning proposed by Mattingly and Fleming (1994a), I found that the therapist in this study also articulated the pragmatic reasoning process described by Schell and Cervero (1993). Pragmatic reasoning is the thinking that addresses the larger context of practice, beyond the therapist–client interaction. Pragmatic reasoning includes the consideration of factors such as availability of space and equipment, reimbursement guidelines, the organizational culture in which practice takes place, and the therapist’s personal motives and professional skills (Schell & Cervero).

The purpose of this paper is to present a study of clinical reasoning in group psychosocial occupational therapy practice. There is little discussion, in occupational therapy literature, of clinical reasoning with people who have mental illness and there is even less written on clinical reasoning with groups. This study is presented to illuminate practice and stimulate thinking in this domain.

Method

This study emerged from a larger study of three expert occupational therapy practitioners in community mental health (Ward, 1997). The purpose of that research was to obtain a description of practice that would take the form of a narrative that illustrated the therapists’ lived experience of community practice. The research methods used were primarily hermeneutic phenomenology (van Manen, 1990) with elements of ethnography and participant observation (Atkinson & Hammersley, 1994; Lofland & Lofland, 1984). The study was approved by a university institutional review board. The research procedures and confidentiality of participants were communicated through written informed consent and the names of people and places have been changed.

Participant Selection

The occupational therapist discussed here was one of three participants in the larger study. Participants were chosen on the basis of their reputations as expert occupational therapists in community mental health and for their ability to communicate and reflect upon the meaning of their practices (van Manen, 1990). The therapist’s expertise and reflectivity were established by processes described by Benner (1984) and Fleming (1994c). Expert practitioners are those who have a “refinement of preconceived notions
and theory through encounters with many actual practical situations that add nuances or shades of differences to theory” (Benner, p. 36). Experts also have the ability to make meaning of their practice through reflection (Fleming, 1994c). The Mattingly and Fleming (1994a) clinical reasoning study found that reflective therapists were observed to be “more competent, in both technical skills required of practice and, more importantly, in their interactions with patients” (Fleming, 1994c, p. 30). The participant, described here, had more than 17 years of practice in community mental health. Her expertise was verified by the nature of her participation in the interviews in which she demonstrated that she had a wealth of experience, could reflect upon the meaning of those experiences, and could articulate the nuances of practice.

The Researcher

The stance of the researcher in qualitative research is important since the “observations of qualitative research intrinsically involve the observer” (Kirk & Miller, 1986, p. 51). I pursued this research in response to the decline in the number of occupational therapists choosing to work in mental health (Standiff, 1996.) This decline took place in the face of my conviction that occupational therapists have much to offer people with mental illness who live marginal lives in the community. I felt that this aspect of occupational therapy was somewhat neglected and devalued. When Buckner (1991) in a letter to the editor of OT Week suggested that “It’s time to face the facts and admit that occupational therapy education is living in the past” (p. 54) because we devote too much of the curriculum to “psychiatry,” I felt compelled to explicate the complexity and importance of occupational therapy practice in mental health. Thus, I undertook the study of occupational therapists who were expert practitioners in community mental health.

Data Collection and Management

The method of data collection is based on Schutz’s philosophy of the phenomenology of consciousness in which the researcher and participant explore an experience through the actor’s stream of thought (Schutz, 1967; Wagner, 1983). Data were gathered through intensive, semi-structured interviews in which the researcher and participant engaged in an interactional system where each contributed to the process of making meaning (Holstein & Gubrium, 1995). Since the researcher and participant were both occupational therapists who had experience in mental health, some commonality of experience was a dynamic of the interview.

I studied Joan (pseudonym), the therapist described here, by engaging with her in a 3-hour audiotaped, phenomenological interview in a quiet place away from her worksite. The purpose of phenomenological interviewing is to gather a rich description of an experience in order to gain a deep understanding of the meaning of the experience (van Manen, 1990). I did not want just a description of Joan’s actions. I wanted to know what her actions meant to her. The letter of informed consent was given prior to the interview and was designed to develop a phenomenological mind-set to the interview process. I provided the following broad description of the purpose of the interview to encourage phenomenological reflection:

The purpose of the interview is to explore the experience of occupational therapy practice. I am not merely asking you to explain what an occupational therapist does in a community mental health setting. I would like you to talk about how you experience your daily life as an OT. I will ask you to describe, as graphically as possible, what it feels like to work within your setting. The interview will be unstructured to allow you to tell how you, personally, experience your work….As you work with patients and/or other therapists, how are you mentally processing your experiences?

In addition to the 3-hour interview I did 1 day of participant observation at Joan’s workplace, a community mental health center. During the quiet times of that day I asked her to describe her thinking as she worked. These responses were audiotaped and field notes were taken during and after observations at the center. Tapes of the interviews were transcribed verbatim and numerous phone checks were done to clarify data. Joan was given the opportunity to review the transcript of her interview but she declined.

Analysis and Verification of Interpretation

The hermeneutic process is an iterative process of analysis that includes reflection and interpretation. My analysis of data began with transcription of all taped material. I studied the text of the transcript and field notes. I read and reread the data to obtain a contextual understanding and perspective and I turned to literature related to the concepts that emerged from the study. This circular process of analysis (Heller, 1989) included sharing selected material with professional colleagues from diverse areas of occupational therapy practice for peer review. I presented portions of the material at a conference of The Society for Phenomenology and Human Sciences for a panel discussion by phenomenologists who were not occupational therapists. This triangulation of sources contributed to the verification of interpretation (Creswell, 1998).

As I analyzed the data, I chunked the material into broad units of themes of meaning. When I formulated the focus of the interview process I was not explicitly seeking clinical reasoning. I was thinking in terms of phenomeno-
logical description. However, when doing the thematic analysis, it became evident that Joan's discussion of practice illustrated clinical reasoning, particularly that described by Mattingly and Fleming (1994a). It also became evident that Joan's description of her experience could broaden our understanding of clinical reasoning to include reasoning about practice in psychosocial groups of people with mental illness. Joan's thinking is presented here to explicate aspects of clinical reasoning in a group setting in the community.

Results:
Joan: Reflections of a Reflective Practitioner
The Simultaneous Use of Procedural and Interactive Reasoning

Joan is an occupational therapist who, at the time of the study, had worked for 17 years in a day-treatment program of a community mental health center. Her clients were people with severe persistent mental illness who lived marginal lives in the community. Joan's daily professional activities in the community mental health center included attending patient and staff meetings, running client–consumer activity groups, and meeting with individual clients.

Joan began every day at a community meeting run by clients and attended by staff and clients. At the crowded meeting I observed, she stood quietly aside while others spoke. Later, she described her thoughts during this meeting:

- I'm tuned-in to the content [of the meeting]...but, looking around the room, assessing how the various folks look like they are doing today....Watching for their affect or lack of it—distractions—who's present—who isn't present. Some of them will be in another room, they can't tolerate the big group connection and that's a sign of how they're doing today—just by their nonpresence.
- If I have a group that I'm running that morning....I'm thinking about how do I...kind of draw them in and get them moving for the day—so they'll get something out of the day and feel a little bit more connected....We want these people to feel somewhat connected. We can't always say their day is going to be better, but if they can feel connected, sometimes that will get them through, until they can have better days.
- Joan's interpretation of the clients' behaviors (interactive reasoning) provided the impetus for her intervention planning for the day. The interactive reasoning served as a means of assessment (procedure) and provided goals that were to help her clients become connected and to get moving. This was accomplished through her interaction with them. Facilitation of interaction was the psychosocial intervention procedure.

Procedural, Interactive, and Conditional Reasoning:
"They think it's the project; I know it's the process"

Below, as Joan talks about the purpose and process of her task groups, she starts by mentioning humor, an interactive process, but then shifts to procedural reasoning about the functional goals of the groups: Learning to deal with the multiple frustrations that are part of the activity and part of being in the group. Conditional reasoning was also evident in her consideration of the clients' lives outside the day treatment setting.

- I have...two task-oriented groups [that] I try to keep fairly light, have it fun and enjoyable for the people....Each one has built-in frustrations, whether pieces break in ceramics,
which happens a lot—or they have sewn something improperly and need to take it out and start all over. Or, they have to wait a long time for me to get to [help] them. I kid them a lot [about waiting]....I kid them about things like having to take a ticket as you would at the deli to wait in line. And [I say] “Little did they know when they came into the group that they would have to deal with frustrations.”

I kid about the frustration because to them, very often, it’s all or nothing or it’s black or white. [The clients will say] “I quit”—because that’s what’s their life experience has been....Primarily...[I] use the opportunity to try, in conversation, to say, “See how you can apply this to other things in your life?” To have some carryover. It’s pretty difficult for a lot of these clients, who are real concrete, to do carryover. But occasionally we can get some of that idea across and they know it’s not the end of the earth if something goes wrong....So that’s kind of the tone of trying to set a lightness to it—and then have them understand how to deal with some frustrations....They think it’s the project; I know it’s the process.

This example illustrates the interface of the multiple modes of clinical reasoning. Procedural reasoning was involved in thinking about how the activity and how the interaction of the clients could develop social and coping skills for the future. The group interaction and the activity served as intervention, a treatment procedure. Joan tried to help her clients make meaning of the situation by relating the process of making mistakes and waiting for help to experiences in the larger community. This brought in conditional reasoning, reasoning about how the client could be in the world, another concurrent mode of reasoning.

Narrative. When Joan compared the dynamics of the task group to waiting at the deli, she also illustrated the overt nature of narrative reasoning with clients in psychosocial occupational therapy. Joan talked about the frustration of waiting and she related it to a facet of daily living—waiting at the deli. She used narrative to place the clients in the larger world of the community, the world of average people. This is a kind of conditional reasoning that encourages the clients to see themselves in this world. Narrative gives meaning to the present activity and places it in a current and future context (Mattingly, 1994).

Narrative was used to help clients gain perspective. The clients and Joan were often engaged in the same activity, in the same environment, but she and the clients may have had different points of view. Joan saw part of her job as helping the clients make meaning of their experiences in ways that foster optimism, a sense of efficacy, and enhancement of problem solving skills. She did this through narrative. And she encouraged the clients to join in the narrative:

I find that...gradually through time....they soon plug in when somebody’s frustrated. They’ll pipe up from across the room and say; “Oh, I’ve had that happen to me; don’t worry about it. It will be better.” And I know those are the kinds of things that I’ve said before....“Yes, it is OK. I can make mistakes and it’s not a failure.”

Joan used the clients’ narratives to give validation to or to reinforce the meaning she was making. In addition to using herself and the clients to make meaning, Joan also used the activity. In the task group, a problem solving approach to the activity became an exemplar for problem solving in life. It was the interaction of therapist and client, client and client, as well as the activity that constituted the therapy.

Pragmatic Reasoning. Consideration of the practical aspects of facilitating an activity group and keeping individuals involved requires pragmatic reasoning (Schell & Cervero, 1993). Initially, in Joan’s interview, when asked to describe her thinking in practice, she described the psychosocial cues to which she was attending. Since the therapeutic goals of the group were psychosocial, it made sense that these were the factors she discussed. However, when asked to describe her awareness of the mechanical aspects of facilitating the activity, she began to talk about how she had to grade the activities to meet the client’s cognitive, manual, and psychosocial abilities. She described the practical elements she considered (pragmatic reasoning):

What tool to use…the mechanics of how to do it....Using the tools they need....Constantly looking around the room to see who needs what next. That’s the part I guess I am taking for granted...doing all kinds of things, at the same time.

Definitely keeping my eye on everybody and what stage they are on—every project that they’re working on in their individual way. To see what they need next and actually then, prioritizing who needs me more right now....That kind of thing constantly is happening.

Joan also illustrated how her thinking about what she needed to do to keep the activity flowing was tacit (Fleming, 1994c). She takes this practical aspect of her role for granted and had to be prompted to discuss it. She continued:

Total assessment of the whole day, the whole group. Those kinds of constant assessments of what they need. Cognitive capacity too....Can they follow one or two steps? And then if I know that they have a skill and someone asks, “Can you help me thread the machine?”...I say, “So and so, could you help?”....I’ve had some clients actually be able to say, “I feel good when I help somebody else.”

As Joan discussed the pragmatics of the situation, she also described how the reality of trying to keep a large group going could be used as intervention (procedural reasoning). She encouraged group members to help each other, which...
led to social interaction. Thus, practical issues became tools for meeting psychosocial goals. Pragmatic reasoning became enmeshed with procedural and interactive reasoning. Joan also revealed her awareness and response to the total picture, the gestalt of practice.

Patterns of Interaction: The Gestalt of Practice. In community mental health, the therapist must be constantly aware of patterns of interaction that go beyond identifying the problem(s) of one client at a time. The therapist must recognize and act upon the dynamic interaction of diverse elements. Gestalt theory describes the importance of dynamic, functional wholes in which the total field of experience must be recognized in order to gain insight and understanding of a phenomenon. The total field consists of specific things, the self, groups, and events that form “live bonds of dynamic interrelations” (Kohler, 1947, p. 321). All kinds of reasoning are part of the gestalt of practice.

An element of the gestalt of practice is the therapist’s thinking about the effects of the larger community on the clients and the dynamics of the environment in which intervention takes place. This includes the relationship of the staff to each other. Although staff had individual responsibilities, they were part of the system in which Joan was working and she was sensitive to staff as well as to clients’ needs. She was tuned in to the various elements of the program.

[Crises are] before us most of the time; somebody’s got a client who’s...[suicidal] or just on the verge of going in the hospital for whatever reason. And we’re sensitive to plug in...if the staff person is particularly busy with this particular client who’s off the wall, then we’re here—sensitive to plug into whatever group and whatever responsibilities—even if it means talking to their individual caseload to get them quieted down or soothed.

The gestalt of practice in a community mental health center requires pragmatic, here-and-now reasoning applied to a multitude of environmental elements in which the interaction is taking place. The environment of Joan’s therapy group could, at times of crisis, expand to include the larger environment of the center. The group members might shift from being participants in an activity to being bystanders. Even when her clients were bystanders, Joan thought about how to put that role in perspective for the clients by “Having the client...understand that this staff person is needed [elsewhere] and if this client were in crisis, that staff person would be with them.”

Included in the gestalt of practice was Joan’s awareness of herself within this potentially unpredictable environment. She was conscious of her responses to individual clients while facilitating the group. She explained:

We’ll never know how they’re [clients] going to be. We have to be constantly flexible. It may be that someone’s concentration is so off that day that they can’t do much of anything. And I’ll let them know that I don’t expect them to do a lot that day...and we’re going to go easy on it.

In the process of doing that, it’s very comfortable to put our arm around somebody, put a hand on a shoulder, a hand on an arm, that kind of thing—just reach out and connect, in a caring kind of way. Certainly not any kind of harassment—judging that the person can tolerate that kind of intrusion on their body space. Some people you clearly know you have to sit across from the table. Today is not a good day at all and you don’t go in on that body space. But other times, they just need that sense of caring. So it is a constant adjustment to the client...to the perception of the client’s needs.

“Horizons on a Field of Consciousness.” Joan’s conscious consideration of her own reactions to clients can be conceptualized as another layer of reasoning. This is a kind of interactive reasoning that is the consciousness of one’s own behavior in relation to the client. Horizons on a field of consciousness is the phrase used by phenomenologists for this kind of awareness of or sensitivity to one’s inner and outer world (Wagner, 1983). Inner horizons are those ideas and fantasies that form the sense of self. Outer horizons are formulated around objects in the outer world that are apart from ourselves. Gardner (1983) considers both the inner and outer horizons in his concept of personal intelligences. He describes the inner horizon as the intrapersonal intelligence, the ability to “access one’s own feeling life” (p. 239).

To be able to immediately be in touch with one’s feelings gives us a way to understand and guide our behavior.

The interpersonal intelligence, the outer horizon, is the ability to understand others. Joan seems to possess interpersonal knowledge at the advanced level described by Gardner:

Interpersonal knowledge permits a skilled adult to read the intentions and desires—even when these have been hidden—of many other individuals and, potentially to act upon this knowledge—for example, by influencing a group of disparate individuals to behave along desired lines. (p. 239)

The Phenomenology of Joan’s Practice: Sharing and Caring

Joan spoke often of making connections. When examining what “feeling connected” meant to Joan, it seemed to relate to what she referred to as “caring and sharing.” This theme, which at first sounded trite, emerged early in the interview when describing the center’s mission statement that is read aloud every day at the community meeting. She said:
A mission statement that this is a caring, sharing supportive community—It's a whole paragraph that was created as a mission statement and it also sets the tone for the day. The clients and staff developed that several years ago. When new clients come in they fit into that...These folks who are really, really ill...really reach out to each other in a caring, sharing manner...the staff promotes it.

What struck me about Joan was that caring was placed in the foreground of her practice. There was a consciousness about caring that was conveyed to clients. Her activity groups fostered caring and she described how her clients reached out into the world to show that they cared by sharing with others:

About October...we start making stuffed toys...[for Christmas presents]. So that...[the clients] can have an altruistic component to what they're doing and have that sense of giving to others less fortunate than they are....Right now the clients in their sharing and caring have been collecting food and clothing to send out to [flood victims]...It would fill the back of a pick-up truck easily—what they've been bringing in. These guys are totally on welfare, so they've dug in their closets and they've put a little bit of extra food stamps to buy a few extra cans of food and things like that to send...And that was totally initiated by the clients.

The therapists at the center also show caring by supporting the clients’ freedom to assume responsibility for themselves. This is in spite of worry over suicide that overshadows all mental health settings. Clients in the community are more free than those in residential settings and consequently more responsible for their own actions. Joan discussed what it is like to support clients’ freedom to decide when they needed hospitalization during crisis periods. She conveyed the giving that is involved in this kind of caring. The therapist gives up her own peace of mind to support the clients’ control over their lives:

If we have somebody who’s in crisis, but is not ready for hospitalization...we make it real clear they can call emergency services on the off-hours. “Here’s the hospital that I would recommend if you need to use it during a nighttime situation.” And we just take the time to fill in the emergency services...make recommendations to the emergency service crew...and just hope that that is going to be OK.

Noddings (1984) said, “Caring involves stepping out of one’s own personal frame of reference into the other’s” (p. 24). Caring seems to be at the center of Joan’s practice. She believes, as Nodding claimed, “The receptive or relational mode seems to be essential to living fully as a person” (p. 35). A fundamental existential of the life world is relationships, human connection. People with serious mental illness have trouble connecting with other people in a healthy, gratifying way. Many have experienced abandonment and come to expect rejection. Or they are simply unable to get out of themselves to connect with others. When Joan said her hope is for clients to connect, her expectations are for each client to connect in whatever way each can at any particular time.

Joan pays close attention, a form of caring. Paget (1988) described what she called medical attention as consciously noticing. “Clinical intention aims at the care of others. It is purposeful and grounded activity of sentient and aware beings. The intention to care for others is manifested as attention: perceiving, apprehending and analyzing phenomena” (p. 76). This, to me, is clinical reasoning.

Discussion

This study reflects and expands upon the work of Mattingly and Flemming (1994a) and Schell and Cervero (1993) by explicating reasoning with groups in mental health practice.

Interactive Reasoning in Mental Health Practice

Interactive reasoning was very evident throughout this study. This raises the question: Is interactive reasoning more present or more overt in mental health practice than in occupational therapy intervention that addresses physical dysfunction? Or is interactive reasoning more overt in group practice? Alnervik and Svidén (1996) in their study of clinical reasoning of five occupational therapists who practiced in physical rehabilitation, found that “procedural reasoning, in particular comments [by subjects] on treatment implementation, was by far the most frequent mode of reasoning [observed in the study]. Subjects used interactive or conditional forms of reasoning only to a very limited extent” (p. 107).

In contrast, Monroe’s (1996) study of 30 occupational therapists in Scotland found that the decisions these therapists made were mostly based on interactive reasoning. The area of occupational therapy practice of the participants is not clear but it appears that the therapists were addressing physical limitations because Monroe states that “strokes, rheumatoid arthritis and general frailty accounted for the majority of conditions while problems of mobility, transfers and general safety within the home accounted for more than half the referrals” (p. 199).

Monroe (1996) noted that her findings “run counter to other research findings that emphasize [sic] technical [procedural] reasoning as the predominant mode” (p. 201). Monroe attributed the predominance of interactional reasoning to her study being of community-based practice and addressed the complexity of factors that are present in the community. She reported that the work of the therapists she studied “was varied and complex with very little that could be described as routine. They were confronted daily with
numerous paradoxes and dilemmas which required a high level of reflection, reasoning and decision making, particularly in relation to client–therapist relationships” (p. 201).

The participant in this study was quite explicit when discussing her interactive reasoning. Interactive reasoning guided her approach to the physical and social environment in which she interacted with clients. Using interactive reasoning she considered group or individual intervention, body space, physical contact, and the choice of activity. In essence, she did not separate interactive and procedural reasoning.

**Is Interactive Reasoning the Content or the Process of Clinical Reasoning?**

The phenomenological nature of the interview process and the method of analysis in this study, led to a thematic structure that reflects the findings of earlier clinical reasoning studies that were also phenomenological in nature (Mattingly & Fleming, 1994a). Others have articulated clinical reasoning from a “scientific” (Robertson, 1996a), information processing point of view (Roberts, 1996; Robertson, 1996a, 1996b; Rogers & Holm, 1997). Roberts brought up interesting and provocative points when she suggested that what Fleming and Mattingly (1994a) call interactive reasoning is really the content of procedural reasoning. She said, “It could be argued…that narrative, interactive and conditional reasoning are not forms of clinical reasoning but either parts of the process itself or aspects of content” (1996, p. 236). In this study of Joan it seemed particularly difficult to distinguish between interactive and procedural reasoning because when working with people with mental illness, interaction becomes procedure. One cannot distinguish the clinical condition from consideration of the person (interactive reasoning) because mental illness affects personhood. The therapist used interaction for assessment and for intervention. Does this support Roberts’s argument?

By naming the process of reasoning about a client's personhood Fleming and Mattingly (1994b) are “giving language to practice” (p. 3). By designating interactive reasoning one stresses the importance of consideration of the person. This is relevant in every area of practice, particularly when the goal is to improve social participation. Gardner (1983) describes the understanding of people as interpersonal intelligence.

Perhaps clinical reasoning and information processing provide different lenses for examining thinking. Fleming and Mattingly (1994a) gave their rationale for using the term clinical reasoning rather than calling the process decision making or information processing. They said that the information processing model does not adequately address the complexity of clinical reasoning because it implies an organized sequence of explicit steps leading to a clear point of decision. They point out that in their study, “the simultaneous consideration of, and rapid flow between, what are often seen as separate aspects of thinking led us to describe this problem-solving process as clinical reasoning rather than clinical decision making” (p. 335).

I think that even though it may be hard to differentiate interactive from procedural reasoning, it is an advantage to name the process of thinking about people. However, the relationship between clinical reasoning and the body of knowledge known as problem solving and information processing merits continued exploration.

**Conditional and Narrative Reasoning Made Explicit**

When Mattingly (1994) discussed narrative reasoning she emphasized how the creation of a narrative helps the therapist visualize the client in the world. Joan described how she used narrative to help the clients visualize themselves in the world. Through narrative, Joan encouraged her clients to use conditional reasoning. She used narrative to develop the clients’ thinking about their future, for example, when she compared waiting for help in the group to waiting in line at the deli. This is a small example but Joan was able to make the thinking explicit through her narrative. This may be particularly important in psychosocial practice where we want clients to not only gain the physical skills required to live, but to achieve cognitive and emotional restructuring of their self image and their view of their place in the world.

The effectiveness of Joan’s intervention depended upon narrative reasoning and the conscious use of narrative as part of the intervention process. Joan helped clients make meaning of their activities through her verbal mediation. In addition, she encouraged the verbal support of the group to reinforce and enhance meaning. In psychosocial intervention the narrative is likely as important an element as any other mode of reasoning. The narrative helped the clients reframe their thinking.

**Limitations and Directions for Future Study**

Qualitative research often serves to identify questions or point out areas for continued study. One may be surprised by the direction the study takes. This research has done that. The examination of clinical reasoning in this study emerged as the data from the larger study of expert practice in community mental health was analyzed. Joan was the only therapist in the study who discussed her work with groups. The study is limited because its primary focus was not clinical reasoning, nor was it focused on group practice.
However it suggests some avenues of continued research in clinical reasoning and in psychosocial practice.

The primary method of inquiry was the phenomenological interview and that is an essential tool for examining the thinking of participants. As van Manen (1990) notes, this form of interviewing serves as “a resource for developing a richer and deeper understanding of a phenomenon” (p. 66). If the interview was specifically focused on clinical reasoning and included more therapists, the study would be stronger. It might be strengthened if it included more participant observation, as well. More research on the nature of clinical reasoning is needed to further explicate the complexities involved in working with groups of people who experience psychosocial dysfunction.

Conclusion
This study conveyed the complexities and value of occupational therapy with people with mental illness. We should not neglect this area of practice when studying clinical reasoning. Occupational therapists work with groups in many settings and to accomplish a variety of goals. We often take for granted the clinical reasoning behind our group skills. It is important to make this reasoning explicit as a means of understanding and communicating the process of group practice. Group process is interactive and the study of groups gives an opportunity to examine and perhaps expand upon our understanding of interactive reasoning as articulated by Mattingly and Fleming (1994a).

Occupational therapists have always worked with groups and in times of fiscal restraints and we will continue to work with groups in a variety of settings. The study of pragmatic reasoning in the implementation of groups can contribute to our understanding of the therapeutic process in groups across specialty areas of practice. Often the use of groups is of greater benefit to our clients than individual intervention, particularly when the goal is to learn and practice skills related to social participation. The study of clinical reasoning in groups is a rich area for research in occupational therapy. The thinking process described here may be common to any activity group that is facilitated by a leader who acts as teacher, coach, or therapist and whose goals are to facilitate change through interaction of people and activity.

References

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