The patient-therapist relationship in occupational therapy has been a blend of competence and caring with the emphasis fluctuating over the years between these two features. When patients tell stories about their experiences, they reveal widely differing views of occupational therapists, partly because of the different ways therapists manifest competence and caring during patient-therapist interactions. Images from stories suggest that some therapists unwittingly disappoint their patients. This paper examines the patient-therapist relationship as envisioned by therapists and patients to help occupational therapists recommit to the patient as a vital partner in a collaborative relationship.

Suzanne M. Peloquin, MA, OTR, is an Assistant Professor at the School of Allied Health Sciences, The University of Texas Medical Branch, Galveston, Texas, 77551.

This article was accepted for publication March 7, 1989.
The Patient–Therapist Relationship: In Search of the Occupational Therapy Vision

Perhaps no source better illustrates the evolution of the profession’s understanding of the patient–therapist relationship than Willard and Spackman’s Occupational Therapy. From the first edition (Willard & Spackman, 1947) to the sixth edition (Hopkins & Smith, 1983), this text has presented contributions from therapists working in a variety of practice arenas. Willard and Spackman has been a primary tool in the education of occupational therapy students and has often served as a therapist’s first introduction to the vision of the therapeutic relationship.

The therapeutic relationship, however, has been treated in a fragmented way in this basic text. Between 1947 and 1983, no chapter has specifically addressed the therapeutic relationship. No references are made in either the table of contents or the index to concepts such as rapport or relationship or to key relational words such as empathy or trust. The 1947 edition has brief sections entitled “Approach to the Patient,” “Personality Qualifications,” “Normal Atmosphere,” and “The Attitude of the Therapist.” The 1983 edition has pertinent sections called “The Therapist,” “Observation,” “Humanistic Approaches,” and “Psychological Considerations.” A discussion of patient–therapist communication as it affects the evaluation process is listed in the index under the heading Communication, and a discrete section entitled “Therapeutic Relationship” is in the chapter on functional restoration. It seems significant, however, that within a definitive text on occupational therapy, one can find the profession’s vision of the therapeutic relationship only after a chapter-by-chapter search.

If each treatment chapter addressed relational considerations for the patient population in question, one could argue that the concept of the therapeutic relationship is so basic that it permeates the text. But this is clearly not the case. Most of the material articulates the assumptions, theories, and methodologies essential to the application of occupation. Although this emphasis is essential in an occupational therapy text, the minimal acknowledgment that occupational therapy occurs within the context of the patient–therapist relationship suggests the curiously marginal status of this fact. Because fragments of information about the therapeutic relationship are scattered throughout several chapters, the reader cannot gain a clear understanding of the vision from this one source. The fragmented manner in which the patient–therapist relationship is covered compromises its significance and clarity.

The Evolving Vision: From Competence to Care

The vision articulated in Willard and Spackman’s Occupational Therapy has changed over the years, largely through changes in emphasis. Earlier contributors advocated skill-oriented and professional (impersonal) patient–therapist relationships; the emphasis was on competence. Later contributors focused on the essentially personal character of the patient–therapist relationship, with the emphasis on care.

For example, in the 1947 edition of Willard and Spackman, Wade characterized the development of the therapeutic relationship in treating the mentally ill in a rather impersonal way:

The development of a good psychiatric approach does not occur spontaneously, nor is it a natural gift but, like many other accomplishments, it is acquired through diligent effort, study and experience. (p. 83)

Wade viewed a good patient–therapist relationship as an achievement attained by a skilled therapist who could “command respect, admiration, hope and confidence” (p. 83). She identified “courage, patience, tolerance and friendliness” as innate personal characteristics that could be directed toward the achievement of a good approach (p. 83). Wade additionally characterized the successful therapist as one who had mastered two specific skills that supported patient equilibrium. First was the ability to make a “tactful approach,” one in which “adjustment is always made to the patient by the worker” (p. 84). Wade explained the rationale for this guarded approach: “These patients are hypersensitive to implications expressed in words, by tone of voice, mannerism or facial expression” (p. 84). Second, the therapist needed “complete self-control in order to prevent untimely expression of a spontaneous emotional reaction” (p. 84). Self-control and personal adjustment seemed critical to patient equilibrium; spontaneity and personal expression were suspect.

Other skills entailed reaching out to the patient, but always within the context of professional objectivity. The therapist had to identify with the patient, but at the same time maintain an objective attitude: “The technic [sic] of doing this is similar to that used by the adult in correlating his thoughts with those of a child” (Wade, 1947, p. 84). The therapeutic goal was primary; caring expressions were a means to that end. The therapist needed to be a good listener, for example, because “it is frequently necessary to play this role” (Wade, 1947, p. 84). The patient–therapist relationship was to be kept “within normal limits” and “restricted to matters of impersonal interest” (Wade, 1947, p. 85). The bottom line during interactions with the mentally ill was that one remain “impersonal in relationships” (Wade, 1947, p. 84).
The American Journal of Occupational Therapy

This emphasis on competence was not restricted to practice in mental health. Fay and March (1947) discussed the development of the therapeutic relationship in both general and special hospitals:

Skill in making the professional approach to each patient for occupational therapy may come more easily to some than to others, but it comes with experience in correlating the patient's history with the character as revealed by his face to one who is interested in enlisting the patient's co-operation. (pp. 124–125)

The relationship had to be professional. Toward that end, Fay and March enumerated several guidelines for a suitable approach. The following guidelines are representative of the list’s precision and direction:

Do's
3. Stand or sit where you can be seen easily.
4. Be encouraging and hopeful and foster a desire in the patient to get well.
5. Be understandingly sympathetic.
7. Be courteous, not flippant or bold.
11. Be patient and resourceful.

Don't's
3. Don't show alarm, horror or sorrow.
5. Don't be physically objectionable by body odor, the use of strong perfume or by having the clothes permeated with cigarette smoke.
7. Don't argue. Be a good listener.
8. Don’t talk of depressing or distressing subjects.
9. Don’t make promises that cannot be kept.
10. Don’t tick or jar the bed.
12. Don't show racial, religious or political prejudices. (pp. 125–126)

The predominant vision of the patient-therapist relationship in this 1947 edition reflected a self-conscious striving for precise skills that could professionalize the patient-therapist relationship. Personal, warm traits were seen as tools requiring guidance, monitoring, and objectification. Perhaps the closest any contributor in the 1947 edition came to the idea of personal investment and care in relationships with patients was Gleave in her chapter on pediatric services:

The occupational therapist should be an understanding, friendly and cheerful person. Ability to talk with children rather than to or at them is an asset. Every effort should be made to bring out the child’s ideas, to get him to express himself freely and naturally. In all contacts with the patient, the therapist should strive to keep the tone of her voice pleasant and well modulated. She must make the child feel that she is his friend while holding his respect and maintaining discipline when problems arise. (p. 148)

Gleave alone alluded to the concept of friendship in the therapeutic relationship. Her emphasis on a caring expression seemed acceptable in 1947 within the context of working with children, for whom, perhaps, the need to project a professional image seemed less crucial.

By the 1983 edition of Willard and Spackman’s *Occupational Therapy*, however, the term therapeutic relationship had taken root, and the therapist’s caring attitude had assumed greater significance than personality traits or interactional skills. As if in recognition of prior emphasis on competence and professionalism, Hopkins and Tiffany (1983) cited a new image: Purtilo’s characterization of “the personal–professional self” (p. 95). Purtilo (1978), a physical therapist, proposed a synthesis of personal and professional characteristics to facilitate the therapeutic relationship. She tried to minimize conflicts for therapists struggling with personal–professional tension in relationships with patients. This brief portion of Purtilo’s (1978) characterization reveals her vision:

> [The personal–professional self] incorporates actions that communicate caring into the patient health professional interactions; he recognizes efficiency as a trait which can express caring when it does not impose rigid limits on the interaction.

He is interested in the patient as a person with values, needs, and beliefs, but does not encourage a relationship that will lead to over-dependence (detrimental dependence). (p. 148)

This more balanced view of the therapeutic relationship communicated a sense of helping. Hopkins and Tiffany (1983) believed that patients need to feel that they can be helped and argued that “the therapist in a treatment setting is, by definition, a helper” (p. 94). The helping process required personal trust—a trust built on confidence in and respect for the patient:

Without the establishment of trust between the client and therapist, it is unlikely that a truly collaborative effort will be possible. The therapist’s own self-confidence, the therapist’s ability to be honest and open in the relationship, and the extent to which the therapist is able to communicate “unconditional positive regard” and empathy for the client will affect the client’s ability to invest trust in the relationship. (pp. 94–95)

Tiffany (1983) underscored her view of the therapist’s role: “Occupational therapy is attuned to the principle of facilitating the client’s own personal search for purpose, meaning, and self-actualization” (p. 291). Open communication between the therapist and patient seemed critical to understanding the patient’s purpose and personal values. Smith and Tiffany (1983) elaborated: “The communication process . . . lays a foundation for rapport and trust. The client needs to feel that communications have been heard and understood by someone who has not only some empathy but also some knowledge and skill” (pp. 144–145). A personal relationship was critical to this new vision. It was the relationship that might well
“determine the success or failure of the treatment plan” (Hopkins & Tiffany, 1983, p. 94), and within that relationship, “activities are used as facilitators for transactions between people” (Hopkins & Tiffany, p. 95). This singular distinction ought never be forgotten; occupational therapy's vision of “being with” is essentially a vision of “doing with.”

This later vision of the therapeutic relationship, with its emphasis on care, on the importance of each person, and on helping, transcended the awkward and self-conscious vision of earlier years. Both visions grounded themselves in competence and caring, and both highlighted competencies and styles of caring thought (in their respective eras) to be important and effective. A young profession, striving to be recognized as scientific, might emphasize competence. A more secure profession, leery of the objectification inherent in scientific practice, might more readily emphasize care.

When one pieces together the ideas of 1947 and 1983 regarding the therapeutic relationship, the ensuing vision lends itself to much individual interpretation. One therapist may feel that earlier directives to be “impersonally personal” should yield to more recent appeals for warmth; another may favor a relationship marked by more traditional objectivity and distance. If therapists demonstrate competence and caring in different ways in contemporary practice, this is consistent with their having been exposed to a fragmented and evolving vision of the patient-therapist relationship over the years.

**From Therapist’s Vision to Patient’s Image**

Stories about occupational therapists tell much about their relationships with patients. In this next section, I will attempt to explore stories from the 1940s through the 1980s that develop the therapeutic relationship, citing the stories wherever possible. Although in a previous article (Peloquin, 1989) I emphasized that fiction can contribute powerfully to therapists' understanding of their functions, I here draw primarily from nonfiction so that the stories will ring truer to those who might dismiss fictional accounts as fantasy.

**A Pioneer: Ora Ruggles**

One biography in particular presents a therapist with a clear vision of what she believes the therapeutic relationship should be. The *Healing Heart* (Carlova & Ruggles, 1946) portrays a competent and caring reconstruction aide and pioneer, Ora Ruggles. Ruggles's bold and humane vision contrasts markedly with that of her 1940s contemporaries; it reflects a patient-therapist relationship more characteristic of the vision of the 1980s. Her drive to relate to patients is clear: “It is not enough to give a patient something to do with his hands. You must reach for the heart as well as the hands. It’s the heart that really does the healing” (p. 69). Healing permeates the story. As Ruggles helps wounded soldiers at Fort McPherson, she says, “I have more to offer than pity. I’m here to help these men” (p. 12). Others say of her, “She [has] an intense desire to help every one, to give freely and fully of her strength, her skills, her compassion and courage” (p. 63). She realizes that a significant part of helping means caring for each patient, and she acknowledges the cost:

She and the other therapists had to fight to keep from becoming emotionally weakened by their atmosphere. If they turned hard, as many of the nurses did in self-defense, they would lose the sensitivity and enthusiasm so necessary to their work. If they allowed themselves to be touched too deeply by the tragedy around them, they would become mentally disturbed—as, in fact, several young therapists did. (p. 77)

Ruggles maintains her sensitivity, as Major Benson acknowledges:

The work that Miss Ruggles has accomplished here is little short of a miracle. The camp has been transformed into a model of its kind. The men’s morale has risen. Patients who had quite literally resigned themselves to death are more alive than ever. (p. 130)

Ruggles describes an early insight into caring as she reflects about a particular patient:

I had done very well when I first started with him, but he’s doing fine now. I asked myself why, and the answer had. I had become truly concerned about him. I wanted him to get well and I made him know I wanted him to get well. (p. 69)

Ruggles listens intently and understands her patients' values and goals. She responds by structuring activity options to meet the expressed needs of patients. She believes in the patient as primary healer. The story overflows with examples of Ruggles’s responsiveness. One poignant example is her successful work with an angry and unruly patient who cannot tolerate sedentary crafts:

“No, baskets aren’t for you, Kilgore, and we both know it. I want you to make some spurs I’ve designed.”

His interest was immediately aroused. “Say, that sounds good. I used to be a cowboy you know.”

From the moment Kilgore went to work in the blacksmith shop, he never got into a fight. His gambling ceased entirely and he drank only moderately. After his discharge from the Army, he started an iron works plant which grew into one of the largest in the Southwest. (p. 91)

Ruggles describes her aim: “Most people have resources and reserves they don’t even know about. My job, as I see it, is to bring out those resources and reserves. . . .” A captain responds, “Tell that to a man with no legs” (p. 52). Ruggles’s rejoinder en-
...dorses the therapeutic caring specific to occupational therapy:

"Oh, these aren't things you tell," Ora hastily explained. "These are things you do. The man with no legs would probably feel useless and unwanted...my problem is to get him to produce with his own hands something useful, beautiful or satisfying. By personally making something useful, he feels useful—and wanted. He belongs." (p. 52)

Ruggles acknowledges personal gain from helping others: "I don't see what's missing, I see what's there. I see real manhood. I see great courage. I see tremendous strength. I see true spirit. That's what gives me courage, strength, and spirit. I gain as much or more as the men I try to help" (p. 76). Her sense of the mutuality in helping, her caring, and her competence enables her to help others.

One passage in *The Healing Heart* creates a lasting image. Paul, Ruggles's fiancé, tells her, "You're an artist in the greatest medium of all. You're an artist in people" (p. 92). She reflects that "it was indeed true that there was artistry in her work as a healer. She dealt with the soul, the heart and the spirit rather than paints and palette" (p. 92). The image the reader takes from this story is one of a therapist personally committed to each patient. This image is congruent with a vision of a personal relationship that balances competence in technique with caring in a relationship. Ruggles is a professional therapist; she is also a friend.

**The Occupational Therapist as Technician, Parent, and Covenanter**

Not all images of occupational therapists convey Ruggles's balance of competence and caring. Other stories present occupational therapists who seem bossy or preoccupied with crafts. One wonders how to characterize these images, how to begin to name them, in order to better understand and evaluate them. I have found it particularly helpful to turn to the images that May (1983) finds images helpful, both in clarifying functions and in establishing standards. He argues that "the image tells a kind of compressed story" (p. 17). An image is storylike in that it describes not only the basic character (in this case the physician), but also the person with whom the basic character interacts. If one thinks of a physician as a priest, for example, the priestly image suggests a relationship in which the physician is powerful and inspires awe in the patient. May (1983) discusses various images that he feels characterize physicians: three of the images—the technician, the parent, and the covenanter—seem relevant to this discussion of occupational therapy because they emerge from stories about occupational therapists. Technical occupational therapists are chiefly concerned with technique and technical issues, parental occupational therapists perceive and relate to their patients as dependents or children, and covenanting occupational therapists see their patients as bonded partners in the pursuit of therapeutic goals. Each of these images mirrors a markedly different understanding and manifestation of competence and caring.

**The occupational therapist as technician.** The therapist who functions as a technician commits to excellence in technical performance (May, 1983). Competence in technique preempts relationships; the therapist refines technical skills above all else. Although this image may seem cold, the basic impetus is humanitarian, because to the technical therapist only superior technical performance, efficiency, and use of correct procedure serve the patient's best interests. The occupational therapist whose primary focus is on methodology, percentage of function, or the task at hand is perceived by the patient as a technician.

In *No Laughing Matter* (Heller & Voge, 1986), Heller describes his ordeal with Guillain-Barré syndrome and his experience with an occupational therapist who, though pleasant and humane, "possibly will be surprised or contrite to find out now of the very considerable anguish I experienced so often in my sessions with her or one of her co-workers" (p. 166). Methodology and gain are clearly important to this therapist:

But in occupational therapy, as soon as I could sand a block of wood (with a need to rest both arms, it was written, after seven repetitions), a change was made to a coarser grade of sandpaper, increasing the amount of force required, and it was just as punishing and demoralizing for me to have to execute them as it had been in the beginning. (pp. 166-167)

Heller's overall impression is that "what they intended was to keep me always at a standstill" (p. 166). His personal need seems clear: to experience and then to savor a sense of gain. The therapist, oblivious to this need, implements a strategy to improve a condition. Treatment goals become the therapist's and clearly do not emanate from a collaborative relationship in which Heller's personal need has meaning.

Seabrook (1935) tells of his stay in a private mental institution for the treatment of his alcoholism. Although Seabrook's experience of occupational therapy is generally positive, he, too, views the occupational therapist as a technician. He describes one therapist/superintendent as "conscientious and probably having a kind heart, but nobody like[s] him" (p. 62). The superintendent values technique over relationship. Any personal or collaborative function that can be associated with occupational therapy rests with...
Paschal, Seabrook’s psychiatrist. Paschal mediates with the occupational therapist for different crafts and a more individualized approach to Seabrook. The occupational therapist provides competence; the psychiatrist provides care.

Another patient’s story, this one in verse, portrays a predominantly technical occupational therapist. The opening lines introduce both the therapist and the elderly patient: “Preserve me from the occupational therapist, God. She means well, but I’m too busy to make baskets” (McClay, 1977, p. 106). The young therapist supports activity for its own sake. She makes no attempt to hear the patient or to discuss meaningful occupations; the patient–therapist exchanges merely parody the relationship:

Oh, here she comes, the therapist, with scissors and paste.
Would I like to try decoupage?
“No,” I say, “I haven’t got time.”
“Nonsense,” she says, “You’re going to live a long, long time.”
That’s not what I mean,
I mean that all my life I’ve been doing things
for people; with people. I have to
catch up
on my thinking and feeling.

The concept of therapy as something that uses purposeful and meaningful activity to promote healing is predicated on some mutual understanding of personal meaning and interest. This therapist matches technique to patient type; she uses age, diagnosis, and disability to determine the choice of activity without regard for the patient’s meaning and need. Activities chosen because protocol and the provider consider them meaningful may be reasonable forms of occupational therapy, but they are questionable forms of occupational therapy.

**The occupational therapist as parent.** The image of parent is clearly a more personal one than that of detached technician. The parental image, typically associated with the provision of order and nurture, can be positive or negative depending on the manner in which order and nurture are provided (May, 1983). An excess of either order or nurture can compromise the relationship; helpers become paternalistic while patients become rebellious or dependent. The best parental figure, although excelling in knowledge and skill, bridges the power/knowledge gap through caring self-expenditure and compassion (May, 1983). I believe that he or she projects the positive image of a supportive parent who guards against exercising imbalance in the provision of order and nurture. The occupational therapist who threatens the patient’s autonomy, rigidly and unilaterally enforces rules, or preempts the patient’s decisions and fosters overdependence, however, conveys a negative parental image. Conversely, the therapist who supports the patient while trying to meet his or her need for order and nurture conveys a positive parental image.

The story of Brunhilde cited earlier illustrates the overauthoritative parent figure who wields power for the patient’s own good (as defined by the therapist). Rule-bound Brunhilde eschews adult autonomy; caring for her, is parenting gone awry. By contrast, Hanlan (1979) praises the parental occupational therapists who treated her husband:

I was . . . impressed with the equanimity of occupational and physical therapists as they worked all day with severely handicapped people, some with terminal illnesses. If helping personnel—social workers, physician, or whoever—conceived of their function with the terminally ill as helping with discrete, day-to-day problems, I believe they would have less trouble just “hanging in there,” which is really the most essential ingredient. (p. 28)

The steadfastness of therapists who help patients with simple daily activities evokes a positive parental image.

The following fictional story about an activities therapist named Meg illustrates the parental therapist’s vigilance against overnurture and overorder. Meg comes up with the idea of having patients in a private psychiatric hospital design and make living room drapes as a therapeutic activity. She benignly manipulates the patients into regarding the idea as their own, and they are enthusiastic about “their” project. The psychiatrist later commends her for her skillful handling of the situation. She acknowledges that it was “handling” and questions the appropriateness of her conduct. Her psychiatrist friend answers:

I don’t think you did any—violence to their being, the idea was in them or you couldn’t have wowed it out. And dealing with patients always takes some handling, the question is only is it for their benefit or yours. (Gibson, 1979, p. 51)

The psychiatrist’s rationalization for this benignly paternalistic intervention is typical: The intervention is justifiable if it is for the patient’s own good.

**The occupational therapist as covenanter.** May’s (1983) image of the occupational therapist as covenanter illustrates a relationship equivalent to friendship. A friend (as covenanter) acknowledges an element of gift in human relationships. For one who covenants with another, a sense of reciprocity characterizes the giving and receiving. The professional steeped in the spirit of covenant regards his professional skills as gifts to be shared with a community of others. Services rendered occur within the context of a trusted relationship, and both parties receive as well as give. Although reciprocity characterizes the relationship within a covenanted bond, the stronger partner uses strengths and skills to nourish and build up the weaker (May, 1983). Above all, the friend, as covenanted person, professes commitment.
to the patient, based on personal respect. Within the context of this friendship, the therapist collaborates and cooperates with the patient's self-actualization. Petersen (1976) describes a way of collaborating in self-actualization that includes activity. It could well represent an occupational therapist who is a friend:

There is a shouting spirit deep inside me:
Take clay, it cries,
Take pen and ink,
Take flour and water,
Take a scrub brush,
Take a yellow crayon
Take another's hand
And with all these
Say you,
Say loving.

Certainly the image of Ora Ruggles from The Healing Heart is that of a friend. Other patients' stories also portray occupational therapists as friends: Benziger (1969) tells of her hospitalization for depression, remembering the occupational therapist as her "new friend" (p. 48). She notes her first impression of the therapist:

A few days later the first person I had met there who made any real sense came into my room. She was the occupational therapist—a term I've always hated. She was kind, interested, enthusiastic, full of ideas, and intelligent. (p. 47)

The occupational therapist trusts Benziger, follows through on promises made, and supports a desire to get well. Crafts serve as catalyst for their interactions about life. The following exchange shows how the occupational therapist is responsive to Benziger and respects her strengths:

"You know, you go at your work too hard, too fast, too desperately—and too frenetically."

"I guess it's true, but that's the way I feel. Time stands still for me now, it is endless, and yet if I have something to do, I get the sense that there will not be time enough to finish it, or that someone will stop me."

She said, "You are an intelligent person, and you will help yourself to get well quickly."

"You know," I answered, "you're the first person who has mentioned intelligence versus non-intelligence, instead of sanity. You make me feel like a human being." I was grateful. I should not forget her. (p. 49)

A third image of occupational therapist as friend appears in Donaldson's (1976) autobiographical account of his unwanted and unwarranted 15-year confinement in mental institutions. That Donaldson could, under the circumstances, perceive any staff as friendly comes as a surprise. Nonetheless, Donaldson considers the occupational therapy worker, Baldylocks, a friend:

While I waited, I found OT fun. Young, overweight Baldylocks had about five of us. He was a zealous worker in his church, and did not swear, drink, or smoke. He translated his religion to his work by showing compassion and understanding to all of us. He let me spend afternoons learning the touch system of typing. Baldylocks started taking the OT men and a half dozen from upstairs for a two-hour walk on the grounds each Wednesday. Under the umbrella of all this warmth, I began watching the news on TV again. (pp. 245-246)

In occupational therapy, Donaldson exercises, cooks, and learns lake work—all fulfilling activities selected in a spirit of collaboration and cooperation. Donaldson sees clearly this occupational therapy worker's commitment to caring, trust, and respect.

Patients' stories, then, suggest that occupational therapists can project an image of technician, parent, or friend, because therapists understand the therapeutic relationship in different ways. Images from patients' stories mirror the manner in which various patients experienced demonstrations of therapists' competence and caring.

Variable Emphases on Competence and Caring

Patients' positive images of occupational therapists reflect both competence and caring. Negative images reflect either a failure to commit personally to care or competence or caring gone awry. May's images are helpful both in characterizing occupational therapists and in understanding various interpretations of the occupational therapy vision of relationship. Each of May's three images—technician, parent, and friend—emphasizes competence and caring in a slightly different way. For the technical therapist, competence in performance is the primary expression of caring. Personal investment in the patient stimulates the pursuit of excellence in technique. The positive parental therapist, on the other hand, demonstrates caring, but the caring is powerful; the therapist must guard against falling into handling or managing the patient. Unlike the technician, for whom competence is assumed to be caring, a parental therapist's care presumes competence. The parental caregiver determines how care should be given. Although many patients value care, they challenge the assumption that the caregiver always knows best. The therapist-as-friend image works to resolve the caring-competence struggle found in parental and technical images by assigning equal value to both care and competence. A therapist who would be a friend to the patient commits to competence and caring because the patient is a person who deserves both.

Although there will always be individual patients who want therapists to function as technicians or parents, many patients and occupational therapists call for a different image, one that equalizes competence and caring and that generates images of occupational therapists as friends. Public distress over impersonal care has resulted in a series of measures to acknowledge patients' rights: quality assurance requirements,
the Patient’s Bill of Rights, informed consent legislation, and the regulation of experimentation on human beings. These measures create a systematic defense against a powerful and technologically advanced medical system that tends to depersonalize the individual patient. The health care system demands scientific and technical competence; the legal system demands the acknowledgment of individual rights. Practitioners must be competent to function in the health care system without creating a service that is devoid of caring. Commitment to caring about a person cannot be legislated; it can, however, be part of a profession’s vision.

Hodgins (1969) powerfully describes his post-stroke experiences in his article, “Whatever Became of the Healing Art?” He mourns the loss of the family physician who “was a friend to his patients, one function among many others which most of today’s practitioners have completely given up” (p. 838). He values occupational therapists who “have so much more a satisfactory grasp on the real needs of the stroke patient” (p. 841). Hodgins wonders about the patient in today’s health care system:

From whom, then, is he to draw the courage without which he will not truly recover? Not from a silent practitioner; not from a stuffy practitioner; not from a practitioner, whether doctor, therapist, or nurse, who is aloof. He will draw courage as he perceives human understanding underlying the professional techniques of those into whose care he has been given. (p. 841)

In 1980, several therapists addressed the concept of caring at the 60th Annual Conference of the American Occupational Therapy Association. Together their remarks echoed those of Hodgins; they endorsed a vision of the therapeutic relationship that approximates that of pioneer Ora Ruggles, that of the therapist as friend. At the heart of this vision is the belief that the patient-therapist relationship is integral to practice. Baum (1980) writes, “We are nothing more than a bystander in the life of [the patient] until a relationship is formed” (p. 514). Competence and caring remain key elements in the vision, but both are effective only to the extent that they reflect sensitive commitment to a patient who is first of all a person. Activity selection and treatment goals must have personal meaning for the patient; meaningful choice is essential because it fosters personal control. Baum (1980) clarifies the process: “Occupational therapy harnesses will and gives the individual control through activity. That is human, that is care” (p. 515). Technical skills work only within the context of a relationship: “Skills promote movement and flexibility within our therapeutic relationships. . . . Skills in caring provide us with the ability to modify the technique according to another person’s needs” (Gilfoyle, 1980, p. 520). King (1980) identifies the commitment to caring that must permeate competence: “Occupational therapy is one of the ‘helping’ professions, with the assumption that help is the outgrowth of caring” (p. 522). Competence must be rooted in caring for a person.

Caring also needs to be rooted in commitment to the patient as a person. Gilfoyle (1980) writes:

The caring therapist directly knows a client as a unique individual, as someone in his or her own right, not as an average, a generality, or a number on the Gaussian curve. Implicit knowledge is the art of “being with the person”; it is something you feel. (p. 520)

The person is experienced and respected as an “other” with strengths and capabilities; “the ‘caring’ is not the taking-care-of the person, but helping the person learn to take care of himself/herself” (Gilfoyle, 1980, p. 519). The same principle can be stated in another way: “Through our professional relationships we reach out and with empathy show that we care hoping that from this caring . . . the person will find his or her own strength” (Baum, 1980, p. 515).

Yerxa (1980) regards deliberations on caring as calibrations of the profession’s success. She says, “Our practice in the future should be evaluated not only on the basis of measurable scientific outcomes, but also by what it contributes to individual human dignity, a sense of mastery and self-respect” (p. 534). She identifies the challenge of the future as that of preserving and embracing a climate of caring “in the face of a society increasingly dominated by technique and objectivism” (p. 532). This type of caring resembles a friendship in which “patient and therapist enter into a partnership, and in which patients have the authority to determine their own needs” (p. 532).

Conclusion

The vision of the therapeutic relationship in occupational therapy has, despite its evolving emphasis and sometimes fragmentary form, encompassed two essential features: competence and caring. Images that patients have held of occupational therapists have varied, partly because of the ways in which therapists have understood and acted on their understanding of how to balance competence and caring during their interactions with patients. Negative images of occupational therapists found in patients’ stories suggest that therapists who present themselves primarily as technicians or parents are more apt to disappoint the patient.

A health care system that depersonalizes patients challenges occupational therapists to assess the vision of the therapeutic relationship that has inspired their practice. Recommitment to regarding the patient as a vital partner—as a friend—can lead to exchanges
marked by mutuality, caring, and competence. Commitment to a balance of technical competence and personal caring, for the sake of a friend, can shape a healing image.

Acknowledgments

I thank Sally Gadow, PhD, and Anne Hudson Jones, PhD, of the Institute for the Medical Humanities, University of Texas Medical Branch at Galveston, for their encouragement and suggestions. I also thank Paula Levine, School of Allied Health Sciences, University of Texas Medical Branch, for her editorial suggestions.

References


