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A Guide to Training Therapists in Dealing with Difficult Patient Care Situations

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A GUIDE TO TRAINING THERAPISTS IN DEALING WITH DIFFICULT PATIENT
CARE SITUATIONS

by

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of the

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This Scholarly Project Paper, submitted by Tegan Aymond and Andrea Kuhn in partial fulfillment of the requirement for the Degree of Master's of Occupational Therapy from the University of North Dakota, has been read by the faculty advisor under whom the work has been done and is hereby approved.

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ABSTRACT

A literature review was conducted on the difficult issues faced in occupational therapy to gain general information on how these issues and situations were being addressed. After reviewing the literature, it was noted that there is a high rate of over-involvement when working in occupational therapy that can lead to stress and burnout. It was found that defining the role of occupational therapy is difficult and trying to establish boundaries within that role is a constant challenge. The lack of knowledge on issues such as ethics, therapeutic relationship, and core values can be difficult when establishing a personal and professional balance in occupational therapy.

The purpose of this project was to develop an in-service for occupational therapists to help them deal with difficult patient care situations. The in-service was designed to increase the occupational therapists' awareness on these difficult issues and how they are dealing with them on a personal basis. It is the authors' intent that through this in-service and by providing resources and strategies that the occupational therapists will be able to better deal with these difficult patient care situations. It is also hoped that the therapist will be able to identify what their involvement level is in their relationships with clients and be able to establish a balance.

The in-service is therapist friendly and is written specifically for occupational therapist using terminology from this profession. The in-service is organized into three specific modules. Module one contains information on ethics, therapeutic relationship, over-involvement and boundaries. Module two includes information on stress, burnout,

and desensitization. The third module combines the first two modules together and contains information on core values and establishing a balance. Throughout all three modules there are discussion questions, worksheets, small group activities, reflection activities, and client scenarios. It provides specific strategies and resources to help deal with the difficult issues faced during practice.

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CHAPTER I

INTRODUCTION

The practice of occupational therapy requires repeated involvement with difficult patient care situations. These patient care situations include therapeutic intervention with individuals who are chronically or terminally ill, and those who have experienced sudden traumatic injuries. According to Sachs and Labovitz (1994), caring is the role of an occupational therapist, and one key issue in relation to occupational therapy practice is the caring relationship between the therapist and his or her client. Maintaining a balance between the professional and caring role can be a challenge for the occupational therapist.

An extensive review of literature was completed that indicated that working in difficult patient care situations can have an impact on occupational therapists and therefore, there is a need for therapists to become more aware and prepared as to how to work with these client populations more effectively. It was found that the roles and boundaries of occupational therapists are difficult to define. Sachs and Labovitz (1994) note that, “using a broad professional definition to guide the scope of occupational therapy’s role raises difficulties in defining the professions boundaries” (p. 1003). In order to have validity, the materials developed for use in the in-service need to be supported with evidenced-based research and current literature. Chapter II of this document is a review of the literature used to develop the in-service for occupational therapists. This in-service will be provided in order to increase awareness on finding a personal balance between over-involvement and becoming desensitized due to burnout.

The Occupational Adaptation Model (Kramer, Hinojosa, & Royeen, 2003) was chosen to guide in the development of this in-service. One of the main principals of the Occupational Adaptation Model is the assumption that adaptiveness leads to overall increased occupational performance. It also states that if the client or in this case the person attending the in-service is responsible for the changes that they make. The client selects the occupational role for intervention and is involved in evaluating the outcome. It also suggests that the adaptation of the client is highly internally motivated. According to Kramer, Hinojosa, and Royeen (2003), “occupational adaptation does not tell the therapist what to do. It tells the therapist what questions to ask” (p. 209). The facilitators are trying to enhance awareness and ask questions to help adapt the way the therapists are providing therapy to improve their overall wellbeing.

The Humanistic Adult Learning Theory (Bastable, 2006) was chosen to help guide the way the information in the in-service was presented to the therapists. This model focuses on the individual’s desire for growth, feelings, needs, choice and interpersonal relationships. The learners are encouraged to change their subjective feelings, choices, self concept and relationships with others in order to change their behavior. Using this model educators provide support, freedom to choose, and opportunities to make changes in everyday life. This model assesses an individual’s source of emotional support, choices that they make, and the desire for unconditional positive self regard.

This project includes five chapters; this chapter is an introduction to the proposed project and defines the problem that the population faces. Chapter II, section one contains a review of literature that deals with defining difficult patient care populations and issues faced by occupational therapists. The second section of Chapter II addresses ethics, the therapeutic relationship, and boundaries. The third section addresses burnout, client-centered practice, and desensitization. The final section deals with the impact of these issues and finding a balance for practicing therapists. Chapter III is a description of the methodology used in designing the in-service. Chapter IV contains the product in its entirety; it includes all three training modules and handouts for the in-service. Chapter V is a summary of the product and includes recommendations and ways to implement the in-service.

CHAPTER II

Difficult Patient Care Populations

The results of Collins and Long's study (2003) show that the consequences of working with clients who have sustained sudden traumatic injuries show decreased therapist's ability to provide intervention. The authors also state that there are psychological implications that affect both the therapist and the client after a sudden traumatic event. There is current research and literature that is reviewed in this section, describing many different difficult patient care situations and the issues that may arise for a therapist when working with this client population. The three difficult patient care populations that will be addressed in the product of this scholarly project are described below.

Chronically Ill

The Profinancial Group Incorporated uses the Health Insurance Portability and Accountability Act (HIPAA) to define Chronically Ill as, "someone who is incapable of performing at least two activities of daily living, such as eating, bathing, or toileting, or who requires substantial supervision"(Pro Financial Group, n.d.) . This definition gives a broad overview of what patients can be considered chronically ill. The World Health Organization in 2005 provided a list of the most common chronic diseases which include: cardiovascular disease, stroke, cancer, chronic respiratory disease, diabetes, mental

disorders, vision and hearing impairment, oral disease, bone and joint disorders, and genetic disorders.

One major difficult patient care situation is working individuals who are chronically ill and suffer from any of the above diseases. According to Felton (1998), one of the most difficult areas for a therapist to work in is oncology due to the fact that some of the clients are dying regardless of the amount of therapy given. Situations like the one above obviously have an impact on the clients and their attitudes toward therapy, “the patients are depressed, knowing the diagnosis and prognosis, and they are not in any emotional state to be considerate, responsive, or grateful for the care received” (Felton, 1998, p.243). Felton also wrote that the attitude of the client has a direct effect on his or her motivation in therapy; this also affects the therapist’s ability to be productive, and constantly working with this type of client results in therapist burnout and an inability to stay positive throughout treatment. Bodenheimer, Wagner, and Grumbach (2002) developed a chronic care model for primary care given to patients with a chronic disease. This model is being used as a guide for helping caregivers provide effective care for chronically ill individuals. The model is described, “as the ultimate goal, the chronic care model envisions an informed, activated patient interacting with a prepared, pro-active practice team, resulting in high-quality, satisfying encounters and improved outcomes.” (Bodenheimer, Wagner, & Grumbach, 2002, p.1777). The study provided case studies in regards to how it was implemented in different settings. One example was used in Minneapolis at the HealthPartners Medical Group in 1998. They joined a diabetes team and implemented some of the components of the chronic medical model. The study findings showed that if the patients become an active member in their self-management

along with their therapists and doctors providing information, they exhibited better LDL-c levels. Working with chronically ill patients can be a challenge due to the motivation aspect. By having therapists encouraging the patient to be an active member in their treatment can help therapists see the progress they can make. Finding the appropriate methods and strategies to keep patients with a chronic disease motivated can become exhausting for therapists; this is why it is important to share ideas with co-workers and develop a better understanding of how to handle these situations (Bofenheimer, Wagner, & Grumbach, 2002).

Terminally Ill

Attitudes of patients have a strong impact on therapy and for the people who are working with them on a day to day basis. Breitbart, et al. (2000) conducted a study with terminally ill patients about their feelings of depression, hopelessness, and desire for a hastened death. In this study, 92 terminally ill patients were administered a self-report measure entitled, *Schedule of Attitudes Toward Hastened Death*. The findings showed that 17% of the patients were classified as having a high desire for a hastened death, and that 16% were currently going through a depressive episode. In general, the study also suggested that feelings of depression and hopelessness added to the desire for a hastened death. Occupational therapists may be working with patients that have a terminal illness and depression in these patients is very common. "There is a general consensus that individuals with major depression can be effectively treated, even in the context of terminal illness... A more challenging question is how to address hopelessness." (Breitbart, Rosenfeld, and Pessin et al., 2000, p.2910). The authors make a critical point that depression and hopelessness are not the same thing, and that interventions for

addressing hopelessness have not yet been studied. Working with patients that have the attitude that there is no hope to their recovery can be an overwhelming and extremely challenging situation in the terms of occupational therapy. Chochiniv, Wilson, Enns, and Lander (1998) conducted a similar study on hopelessness and suicidal ideation. They found that hopelessness correlated more highly with suicidal ideation than depression; this is a clinical symptom that health care providers need to be aware of in therapy. Hopelessness is difficult to work with in therapy due to the fact that it's an attitude, not a diagnosis. Depression can be clinically treated, but the idea of not caring about life anymore is a much more difficult concept. More needs to be done to help prepare therapists in how to work with patients that are having feelings of hopelessness and the lack of motivation to fight for their lives.

Traumatic Events

A traumatic event is one of the main reasons that occupational therapists need to provide therapy to patients. One of the most common traumatic diagnoses that occupational therapists work with are individuals with a traumatic brain injury. Darragh, Sample, and Krieger (2001) discuss the wide range of skills needed when treating a person with a traumatic brain injury. The authors also state that the occupational therapist should become an advocate for his or her client, and provide extra help in the area of community reintegration. Areas of community reintegration include housing, finding a job, and providing psychosocial support. According to Darragh, Sample & Krieger (2001), provision of this extra support can be overwhelming to a therapist with a full client load. These factors not only affect therapists who are working with people with traumatic brain injuries; these sudden traumatic events have an overwhelming

impact on the client because the injury affects all areas of their life which is why this is considered such a complex population to work with. Another article by Collins and Long (2003) describes the Omagh bombing as another traumatic event that occurred in Northern Ireland. The authors asked thirteen healthcare workers to participate in a quantitative and qualitative longitudinal study in order to gain a better understanding of the effect of working with the victims of this bombing. The therapists worked with individuals who experienced injuries including burns, amputations, and orthopedic conditions. The authors noted that the bombing not only affected the individuals that were part of the bombing, but the individuals who helped those injured after the bombing.

Issues Related to Difficult Patient Care Situations

Working with chronically ill, terminally ill, and individuals who have experienced sudden traumatic injuries results in many issues for practicing therapists. The main concepts that present themselves include over-involvement, under-involvement and striving to find the balance between the two. Maintaining client centeredness and a positive therapeutic relationship at all times can result in serious issues of over-involvement which can lead to therapist burnout. These issues can be further broken down into several categories including: knowledge of ethics, establishing an appropriate therapeutic relationship, developing personal and professional boundaries, stress, burnout, and desensitization. Establishing a balance in occupational therapy is a constant battle. Reviewing the core values of occupational therapy can help therapists find this balance (Collins & Long, 2003, Darragh, Sample, & Krieger, 2000, Eberhardt, 1995, Peloquin, 2007, Sachs & Labovitz, 1994).

The first year of practice can be a difficult time for new therapists. Tryssenaar, and Perkins (2001) conducted a qualitative study using a phenomenological approach looking at experiences of new graduates in their first year of practice. One participant in the study was quoted as saying, “ ‘I left work because I was either going to start crying or be sick to my stomach from exhaustion’ ” (p.23). There are many factors that increase the stress in the first year of practice, but one of the most prominent is lack of preparation in regards to working with the difficult patient care populations described above. In their article *From Student to Therapist: Exploring the First Year of Practice* Tryssenaar and Perkins describe the importance of educating students and preparing them for the transition process. They also suggest providing resources as a means coping with the stress and burnout during the first year of practice. The whole process is defined as professional development which is vital to the first year of practice. These issues are not only relevant to new occupational therapist, but to any therapists working with difficult patient care populations.

Ethical considerations are described by Denend and Finlayson (2007) as choices given to occupational therapists that have both positive and negative consequences. The authors note there is a need for more preparation in regards to addressing ethical dilemmas in occupational therapy. Strategies for helping occupational therapists need to be provided in order for them to make informed decisions when ethical challenges arise (Denend & Finlayson, 2007). According to Sachs and Labovitz (1994) an appropriate definition of a therapeutic relationship is hard to develop; they write that “because they cared for their patients, the participants made themselves available to and were responsible for patients far beyond their perceived professional role definition” (p. 1001).

This statement leads to the question of how to develop appropriate boundaries with clients. Since occupational therapy is holistic in nature, it is difficult to define professional boundaries. One participant explained that the more she would empathize with a client, the more she took on outside of her professional boundaries (Sachs & Labovitz, 1994).

According to Sachs & Labovitz, (1994) taking on extra responsibilities in occupational therapy practice is a common theme; by taking on the extra work therapists can become stressed at the job which in turn leads to burnout. Felton (1998) defines burnout as, “the exhaustion of physical or emotional strength as a result of prolonged stress or frustration” (p.237). Stress and frustration can be brought on by many different factors in the field of occupational therapy. Since working with difficult patient care situations is a common theme in the field, many professionals suffer negative physical and mental health symptoms (Felton, 1998). Burnout is especially high in the mental health field for occupational therapists. According to Bassett and Lloyd (2001), the cause of burnout in the health field is brought on by the combination of the therapist’s lifestyle and human characteristics and the client’s diagnosis along with the pressures of the work task. All these factors can lead to feelings of apathy and lack of concern for the patient’s wellbeing. This desensitization process is a factor that all occupational therapists need to become more aware of.

Ethics

Occupational therapists are provided with a document entitled, *Code of Ethics and Professional Conduct* (American Occupational Therapy Association, 2000). However, ethical decisions still remain difficult and much is unclear in relation to ethical decision

making for practicing therapists. Ethical decision making is based on a subjective viewpoint where the therapist uses his or her own core values and level of compassion in order to make decisions for the client (Barnitt, 1998). Christiansen and Lou (2001) describe ethical considerations and the use of Evidence-Based Practice. The authors describe evidence-based practice as an objective and measurable tool and it is used so therapists can provide the best quality of care while avoiding harm in the process. However, evidence-based practice can be skewed by conflict of interest, informed consent issues, and bias in research selection. The study data shows that the therapist might forget that clinical decision making is an ethical matter and the therapist might lose sight of the dilemmas that are behind his or her efforts to produce the most effective rehabilitation. Feelings and how patients understand their difficult situations are not often considered in measurable data. Yet, occupational therapy focuses on these issues and the importance of the client's quality of life and overall well-being (Christiansen & Lou, 2001).

Barnitt (1998) wrote about ethical dilemmas in occupational therapy and physical therapy in regards to day to day practice. One major point that the author explains is that many professionals are not aware of the ethical considerations that are faced in day to day practice. This study used a four-page structured questionnaire that was given to 361 therapists in Wales and England. One finding suggested that more ethical dilemmas were seen in the community context rather than in an acute hospital. Some of the main issues identified for occupational therapists were: difficult or dangerous behaviors in patients, unprofessional or incompetent staff, and lack of respect for vulnerable patients (Barnitt, 1998). The issues identified in this study are ethical dilemmas that many

therapists encounter in practice. Finding the appropriate way to deal with these ethical dilemmas can be unclear and frustrating for the therapist that is witnessing them.

Denend and Finlayson (2007) described the use of a clinical tool that assists therapists in working through ethical decision making called (CELIBATE) *Clinical Ethics and Legal Issues Bait All Therapists Equally*. Resources are useful and necessary in helping therapists make those critical decisions in regards to ethics. CELIBATE helps guide therapists through 10 steps to help them work through the specific scenario. The authors provide a specific example in which an interviewer was torn between reporting an elder abuse case or respecting the client's confidentiality and autonomy by not reporting the case. However, the interviewer lived in a state where she was not mandated to report the case, only recommended to do so. The participant used CELIBATE in order to make her ethical decision which was reporting the case to Adult Protective Services. The ultimate dilemma was choosing which action was maintaining the ultimate good of the client. This specific example shows how difficult it can be in choosing between two ethically sound decisions; therefore, therapists need an outlet or guide to assist them in making these difficult decisions.

Therapeutic Relationship and Boundaries

Tickel-Dengnen (2002) described the therapeutic relationship as involving two separate parts, the formation of rapport and the ability to have a working alliance with a client. Client centered practice requires an open and ongoing communication process provided by both the therapist and the client. The author breaks down the development of rapport into three main categories: gathering information, cooperative intent, and regulating involvement. She describes gathering information as sharing information

between the therapist and client while deciding the direction of therapy together.

Cooperative intent is using client centered practice to respect the client's goals and objectives while bringing in the therapist's ideas as well. The term *regulating involvement* is defined as using evidence based research to help the client make appropriate decisions that will positively affect his or her quality of life. It is important for the therapist to monitor how much information is presented throughout the relationship so the client can continue to be involved in their treatment process.

Throughout the process of developing the therapeutic relationship, clients will face many emotional challenges. Tickel-Dengnen described some of the emotions the client may be feeling such as being misunderstood, becoming frustrated or angry and blaming the therapist for failed interventions. This blaming can be detrimental to the working relationship because of the pressure placed on the therapist by the client. It is easy for the therapist to take on a lot of responsibility in the client's treatment, but the responsibility of the outcomes should be shared by the therapist and the client (Tickel-Dengnen, 2002)

Darragh, Sample, and Krieger (2001) conducted a study that evaluated clients with traumatic brain injuries perceptions of healthcare providers and their personal and professional characteristics. Working with people who have sustained a traumatic brain injury is a reoccurring theme in occupational therapy which requires care and empathy, and the authors found that there are certain qualities in therapists that clients respond to best. These qualities include being: an active listener, understanding and empathetic, competent, caring, an open communicator, and holistic. There were 51 participants who had sustained a traumatic brain injury who were included in this qualitative study. These participants were all interviewed using four broad questions relating to their relationship

with their practitioner. Three main themes were developed from these interviews: the role of the provider, helpfulness of the services provided, and personal characteristics. The strength of the relationship between the service provider and the client seemed to affect the client's perception of the treatment provided. Some of the roles defined by the client for the therapist were a friend, mentor, and a team member (Darragh, Sample & Krieger 2001). Being defined as a friend can strain the therapeutic relationship and makes boundaries between the client and therapist difficult to define. Darragh, Sample, and Krieger (2001) simply state after their research with traumatic brain injury patients that, "further research will increase understanding about how these persons are able to maintain positive practitioner-client relationships in this challenging area of practice" (p. 198).

Another study was conducted by McDaniel, et al., (2007) and it addressed the effectiveness of physician self-disclosure (MD-SD) and its effectiveness within the physician-client relationship. Little research has been conducted in this area and the results can be transferred across healthcare professionals. A descriptive study was done with the use of 113 standardized patient visits to determine the number of times the physician disclosed personal information and whether or not this was helpful to the physician-client relationship. The results of this study indicated that there were a total of 38 visits out of 113 that included MD-SD. According to the authors and their research team 85% of these MD-SDs were not useful to the client, 11% of the comments made were noted as being disruptive, and 21% of the encounters were related to the patient's topic. There was no indication of a positive effect of MS-SDs on the client's in this study. The authors suggest the use of empathy, compassion, and understanding may be more

effective in these physician-client relationships. The authors also noted that MD-SD can take valuable time away from the client asking questions or the physician gaining a better idea of their symptoms. It is important to recognize the way the health professional is being perceived by the client. The focus of conversation and discussion should be based around the client and his or her recovery. It is easy to confuse self disclosure with building a relationship with the client, but the main difference is the focus of conversation; using other supportive methods to build the relationship would be much more effective (McDaniel et. al., 2007). In the previously mentioned study conducted by Sachs and Labovitz (1994) the authors noted the difficulty in defining professionalism and the constant definition of professional identity as recurring themes in occupational therapy. The participants in this study all had difficulty defining their role as an occupational therapist. The therapists described their role as holistic in nature and a feeling of being committed to responding to patients' needs; not just his or her illness. One therapist described her role as very broad and ever-changing; she believed her responsibilities extended beyond their perceived professional role definition. It was noted by the authors that, "other professionals...focused mainly on patients' symptoms and neglected many other areas. These occupational therapists undertook the neglected responsibilities and found themselves involved with patients' families and with community services to a degree greatly beyond the occupational therapist's role" (p. 1002). Other participants pointed out difficulties in working with the medical model because of its lack of focus on patient's well-being. Another factor that makes defining the therapists' role difficult are the characteristics of the organizational setting in which an occupational therapists' work takes place. There are a wide variety of settings in

which occupational therapists work; each of these settings makes the therapist take on different roles and responsibilities which can be difficult for the therapist. In the conclusion of the article the authors note that the lack of role definition causes the therapists to become overworked by taking on the responsibilities of other professionals (Sacks & Labovitz, 1994).

Stress, Burnout and Desensitization

Burnout and desensitization in the field of occupational therapy is brought on by stressful situations during practice. Working in difficult patient care situations is one of the main factors causing stress for therapists. Bassett and Lloyd (2001) describe stress as, “the psychological, physiological, and/or spiritual discomfort that is experienced when environmental stimuli are too demanding or exceed a person’s coping strategies” (p. 406). Bassett and Lloyd list several specific factors that increase stress for occupational therapists including: the job itself, stress related to roles, relationships with co-workers and managers, career development and the context in which the individual works (pp. 406-408). Although stress is not always a negative feeling it becomes counterproductive when it is present at all times leading to the syndrome known as burnout. Burnout is seen across the context of occupational therapy practice due to the type of direct patient contact required in the healthcare field. One major finding is that personal frustration and a lack of appropriate coping skills can lead to burnout along with high levels of job stress experienced over time (Bassett & Lloyd, 2001). According to Felton (1998), it is important to identify burnout and stress early in order to prevent the desensitization of the patient-provider relationship.

The effects of burnout on the client can be a devastating and complicated process. The therapist develops a tendency to withdraw from the relationships with the patient, and with this withdrawal comes feelings of cynicism, rigidity, apathy, and loss of empathy and concern for the recipients of care (Bassett & Lloyd, 2001). Since occupational therapy prides itself on empathy and caring, burnout can be a major problem especially when working in difficult patient care situations. Although burnout is seen across contexts, Sturgess and Poulsen (1983) used the Maslach Burnout Inventory and found that mental health occupational therapists showed more burnout than therapists involved in physical rehabilitation. Felton (1998) also found that mental health workers experienced burnout on a larger scale than other professionals, “the primary coping strategy of escape/avoidance related to three symptoms of burnout: emotional exhaustions, depersonalization, and lack of personal accomplishment” (p. 244). There is a general consensus that identifying the factors that contribute to burnout and finding strategies to cope with stress along with finding a balance in the workload is the important in preventing burnout.

A research study by Collins and Long (2003) showed the psychological effects when working with trauma. The researchers had 13 healthcare workers participate in this study after the Omagh bombing. They hypothesized that working with seriously traumatized clients may have negative consequences for personal functioning of the therapist themselves. They measured levels of compassion fatigue, burnout, and compassion satisfaction. Some of the main areas of concern expressed by the participants were the lack of rest, exercise, work stability, relationships, and communication between friends and family. This study showed that work was starting to affect therapists and was

taking a toll on their personal lives. Compassion was one of the main factors of the study. It was found that if a participant had a higher level of compassion, there was less compassion fatigue and burnout. Collins and Long concluded that working with individuals with trauma can have both a positive and negative consequence on personal functioning and it is important to find coping strategies in this area of practice.

In their article Bassett and Lloyd (2001) described several factors that contribute to burnout. One of the main factors was the nature of the clients. Occupational therapists often work with patients over a long period of time especially in the mental health field. Overtime, the relationship can become somewhat weighing on the provider due to the fact that they are constantly giving and not always receiving back from the patients. For example, if a patient were to relapse or get sick, the therapist might place blame on themselves, resulting in added stress. Other factors that contributed to stress and burnout were lack of resources and training. Frequently occupational therapists were not able to use a specific intervention due to some type of contextual barrier, which lead to feelings of disappointment in the therapy they were providing. Lack of supervision can also be a major factor especially for new graduate students. The authors wrote, “without supervision occurring, the therapist can feel alone and unsupported within his or her work environment” (p. 408). In another study by Tryseenaar and Perkins (2001) a comment was made by a new grad student, “I now know what everyone was talking about when they mentioned ‘new grad burnout’” (p. 23). It is important to know that even if therapists are comfortable with the therapy they are providing, some type of support or back up is needed to help them know they are making the right decisions and that not all the responsibility is placed on them. (Basset & Lloyd, 2001).

There is another completely different concept in regards to burnout and occupational therapy, and that is the occupational therapy role and professional identity issue. Several studies have found that there is a weak sense of identity in occupational therapy and that many therapists struggle with giving an adequate and concise response in defining their own profession. (Bassett and Lloyd, 2001). The authors quote Leonard and Corr (1998) stating, “the occupational therapy profession has struggled over the years to gain recognition and professional identity” (p.408). This, in turn, also leads to extra stress and complications when trying to provide therapy services that are strictly related to occupational therapy. The issue of finding professional identity is also influenced by the role conflicts in the health care profession and deciding what specific tasks and services should be provided to patients by occupational therapists. If occupational therapists already have a hard time defining what their profession actually provides, how can they eliminate role confusion with other health care providers? This question leads to insecurity and stress especially in the mental health field when defining their position within the team. With this type of stress and confusion, patients can miss out on the valid and complex skills that can be provided by occupational therapy to help enhance their life skills. (Bassett and Lloyd, 2001). In order to prevent this from happening, strategies for coping and going back to the roots of occupational therapy are critical to keeping the profession alive.

One major strategy for coping with stress is being able to first identify signs or symptoms of stress. Bassett and Lloyd (2001) suggest that therapists need to be aware and address their own personal symptoms of stress. Some of these symptoms include: feeling exhausted, overwhelmed, developing a negative attitude, and lacking excitement

in the field. Cox (1988) stated that since occupational therapists are aware of applying techniques such as relaxation, stress management, and coping strategies, they should be able to identify stress factors and find appropriate strategies to help reduce their own stress. Another issue related to using coping strategies is balancing the workload. Bassett and Lloyd claim, “occupational therapists are well aware of the fact that every individual needs to have a balance between work, rest, and play” (p.409). Since occupational therapists are well versed in knowing the importance of balance, it is important that therapists do not sacrifice all their time and skip lunches or chart while eating; this type of activity is not a positive factor in contributing to one’s own well-being. A study reviewed by Bassett and Lloyd done in 1995 by Cushman suggested that more resources need to be provided to occupational therapists along with supervision and training. Encouraging better communication skills and providing more support systems along with set guidelines and expectations will better help the performance of the staff. Bassett and Lloyd (2001) contribute a note-worthy statement relating to stress and burnout. They state,

Stress and burnout take a high toll on the individual therapist, the service recipients and society. Occupational therapists need to become aware of the factors that contribute to stress and burnout and the impact this may have on their professional and personal lives. They need to implement strategies within their own lives and work practices that will protect them from the effects of stress and burnout... By increasing knowledge in this area, programs can be devised and management practices changed to decrease the amount of burnout occurring in the occupational therapist working in mental health (p.410).

Core values, Holistic practice, and Finding a Balance

In order to truly understand an occupational therapist’s role in any setting it is important to understand the core values in occupational therapy. Peloquin (2007) states that the core values in occupational therapy represent an occupational therapist’s morals

as well as his or her ethics as a profession. The core values document consists of seven values: altruism, equality, freedom, justice, dignity, truth, and prudence. Therapists rely heavily on these core values in order to make clear ethical decisions. The author suggests adding five more values to this particular document including: courage, imagination, resilience, integrity, and mindfulness. The author believes that this addition to the core values would help occupational therapists understand and use the code of ethics to a greater degree in practice. These added values could increase the value of this document by including the unique, holistic features of occupational therapy. The author notes that occupational therapists as practitioners are courageous in nature and that therapists engage clients personally and emotionally. According to Peloquin, occupational therapists face many challenges by being excessively involved with clients. This addition to the document of core values could help therapists become more aware of the challenges and make changes accordingly.

Bassett and Lloyd (2001) note the importance of finding a balance in occupational therapy practice. The authors outline several strategies occupational therapists can use to keep balance within their lives. Lunch is discussed as a time that should be used for activities other than work such as socializing, or spending time working on another activity that is unrelated to work. It is also noted that a cut off point should be made at the end of the day to show that the role of the worker has ended and the role of a mother or friend has begun. This cut off point can be shown by going to the gym or having a snack after the work day is complete. The authors state that it is important to have difficult tasks and simple tasks throughout the day so that all of the work is not left until the end of the day.

The therapeutic relationship is also an integral part of occupational therapy. Bassett and Lloyd (2001) wrote that occupational therapists may not have a full understanding of the persistent deficits of some of their clients and that the awareness of this should be increased in order to help therapists understand their roles in different settings to a greater degree. According to Darragh, Sample and Krieger (2000) personal and professional characteristics are vital to successful treatments and positive outcomes. In this article, emphasis on clear and honest communication was appreciated to the greatest degree by clients who have survived a traumatic brain injury. Great appreciation was also placed on the therapist's understanding of the client's specific needs and the extra effort put forth by the therapist to understand the client's specific situation.

The article written by Sachs and Labovitz (1994) entitled *The Caring Occupational Therapist: Scope of Professional Roles and Boundaries* summarized research involving seven female occupational therapists; the methodology used was observation and in depth ethnographic interviews. After the research was conducted four main themes evolved including: self-perception as a caring person, definition of professional caring, scope of professional roles and boundaries, and contradictions between caring and conditioning of caring. The study results showed an internal and external dimension to professional roles and boundaries. The internal dimension included defining their roles in their own perspective according to their specific job, whereas, the external dimension included their professional responsibilities that were defined through their specific place of employment. The authors write that the profession of occupational therapy is not easy to define. The word professionalism is used often in literature and this term is also not completely defined. According to Sachs and Labovitz

(1994) the literature shows that there appears to be difficulty in defining the profession, the specific role in practice and its intrinsic value. Caring is a big part of an occupational therapist's job and it is defined as, "that range of human experiences that have to do with feeling concern for, and taking care of, the well being of others" (p. 998). Analyzing the caring component of occupational therapy may show the nature of stress many occupational therapists face due to their professional role. Due to the caring nature of the participants in this study they made themselves more readily available which then led them to increase their responsibility beyond their professional role (Sachs & Labovitz, 1994).

The issue of professional identity is complex; occupational therapists struggle with finding a balance between their caring nature and understanding where their role ends. This is why the role of occupational therapy is so difficult to define and why it is easy to become over involved which can lead to burnout. The core values are important within the practice of occupational therapy, but finding a balance can be difficult because the therapist is thought to be responsible for the whole person to the greatest degree.

CHAPTER III

METHODOLOGY

The product described in the next chapter is an in-service for increasing awareness of establishing a balance within the field of occupational therapy. This in-service is comprised of open ended questions, group discussion, resources, personal strategies, and case studies. It is formatted as a Microsoft® Power Point® lecture with notes pages that are provided for the presenter. The in-service materials also include handouts, worksheets, and a list of resources for the learners to increase the understanding of the material. During the presentation the learners will be given the materials for the learning activities and a handout of the Microsoft® Power Point® presentation.

The process of developing the educational in-service began with a review of the literature. Several data bases were utilized including: PubMed, OT Search and AJOT. Initially the literature search included topics of over-involvement and desensitization in the healthcare industry. However, the literature search was expanded to include all the issues that occupational therapists face when dealing with difficult patient care scenarios such as ethics, therapeutic relationship, boundaries, client-centered practice, stress, burnout, and core values.

The selected articles were summarized and analyzed to establish the needs, problems and what could be done to address these problems in occupational therapy. The next step involved separating the information into three modules and creating an outline

for the in-service presentation. Module One contains information on the occupational therapy code of ethics, the therapeutic relationships, over-involvement, and boundaries. Module Two contains information about stress, burnout and desensitization. Module Three was titled Establishing a Balance and it includes information on holistic practice, core values and a further discussion of developing a balance in occupational therapy. Finally, the Microsoft® Power Point® presentation was developed slide by slide with additional information in the notes pages. The in-service materials are included in Chapter IV of this product and they are based on the research and literature reviewed in Chapter II.

CHAPTER IV

PRODUCT

Information obtained through the literature review was foundational to the development of this in-service training program (Appendix A) for therapists dealing with difficult patient care situations. The in-service includes three modules that include information on over-involvement, under-involvement, and finding a balance. The information is presented in an interactive form where discussion and reflection is encouraged from the participants. The information covers issues that are faced by occupational therapists on a daily basis.

The in-service training program was developed to increase awareness about the issues faced in practice and as a way to provide strategies and resources to help work through them. It is also provided to bring attention back to occupational therapy's core values and ethics. It is the author's intent to introduce this in-service in a variety of settings and to occupational therapy departments that feel it would benefit their employees. This in-service facilitates communication and discussion between the occupational therapists and is a guide to help reflect on the way they handle these difficult patient care situations.

CHAPTER V

SUMMARY

Finding a balance while working in the field of occupational therapy can be quite a challenge. The focus of this project was to help increase awareness for practicing occupational therapists about the issues they face when working with difficulty patient care scenarios. The final product, *Too Little? Too Much? Finding the Balance*, was broken down into three different modules to provide a clear understanding of all the different levels of involvement that are present in the healthcare field. The issues that are covered are relevant to all experience levels in occupational therapy whether it be new graduates or therapists with many years of experience. All therapists can experience feelings of stress and burnout which can affect their ability to provide quality of care due to the lack of empathy and client-centered practice. When stress and burnout are present therapists can also experience over-whelming feelings of caring too much leading to difficulty making ethical decisions and keeping boundaries. Because of this it is important for therapists to be aware of their roles and boundaries in the workplace and in their personal lives.

Without knowledge about our code of ethics and core values therapists can lose sight of what occupational therapy means to them individually and how they can set their own boundaries based on these two documents. By increasing awareness about the difficult issues that are faced in practice, occupational therapists as a whole, can learn

from each other's experiences and gain a better understanding of how to deal with their own situations effectively. Therefore, an in-service was developed for any occupational therapist that wants to gain a better understanding of how to find a balance in their professional and personal lives.

The main limitation of this project was that it is a subjective topic and we did not find a lot of quantitative evidence-based research. Much of the research was qualitative or based on how different individuals dealt with specific situations and experiences. The information that is presented in the in-service is not hard objective data and does not have set guidelines or answers to problems that arise; however, it provides options and opinions as to what therapists can do to help them set their own boundaries. Another limitation is that since the in-service has not yet been presented so there is no input about the value of this type of information from therapists in the field.

In order to implement this project, we as authors need to meet with directors of occupational therapy departments in a variety of practice settings to determine if the in-service would be of benefit to their therapists. The in-service could also be used in a classroom setting for graduate OT students who have completed at least one level-two fieldwork. The issues covered would be beneficial to them, but a fieldwork experience would increase their awareness about the issues faced in the field. By implementing this in-service in various occupational therapy settings the authors hope to increase therapists' awareness of these issues. They also hope that this knowledge will help therapists develop a more productive and better balanced workplace for all individuals and department itself.

Recommendations for the future include: 1) additional research on the impact of over-involvement and on effective ways to set boundaries while incorporating ethics, 2) research to identify the outcome of the in-service and if there is an impact within an OT department as a whole, 3) additional resources may need to be added to match the setting or context that the in-service is being presented in, and 4) research or surveys to determine the effectiveness of the in-service for individual therapists.

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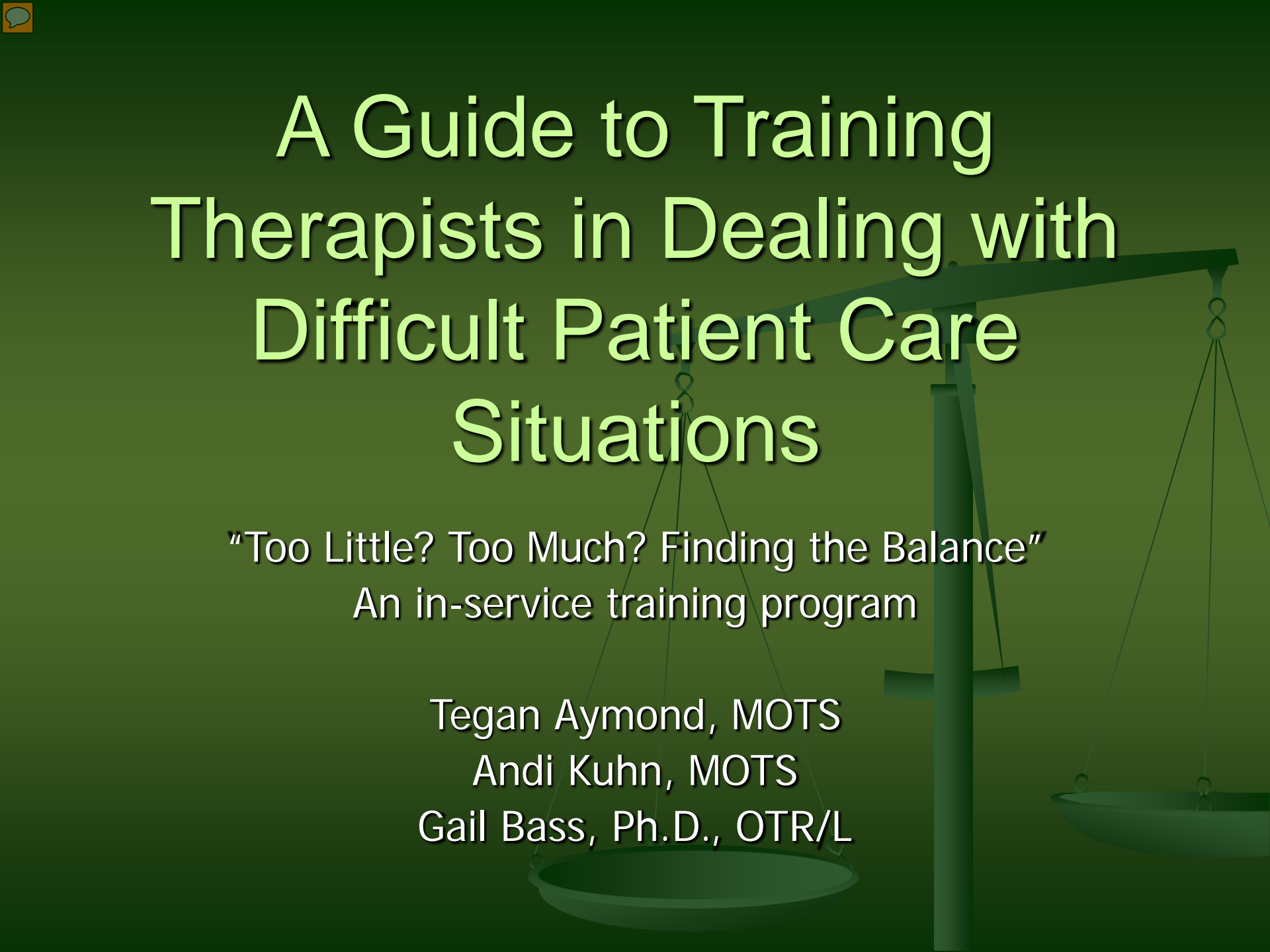
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Appendix A



A Guide to Training Therapists in Dealing with Difficult Patient Care Situations

“Too Little? Too Much? Finding the Balance”
An in-service training program

Tegan Aymond, MOTS
Andi Kuhn, MOTS
Gail Bass, Ph.D., OTR/L

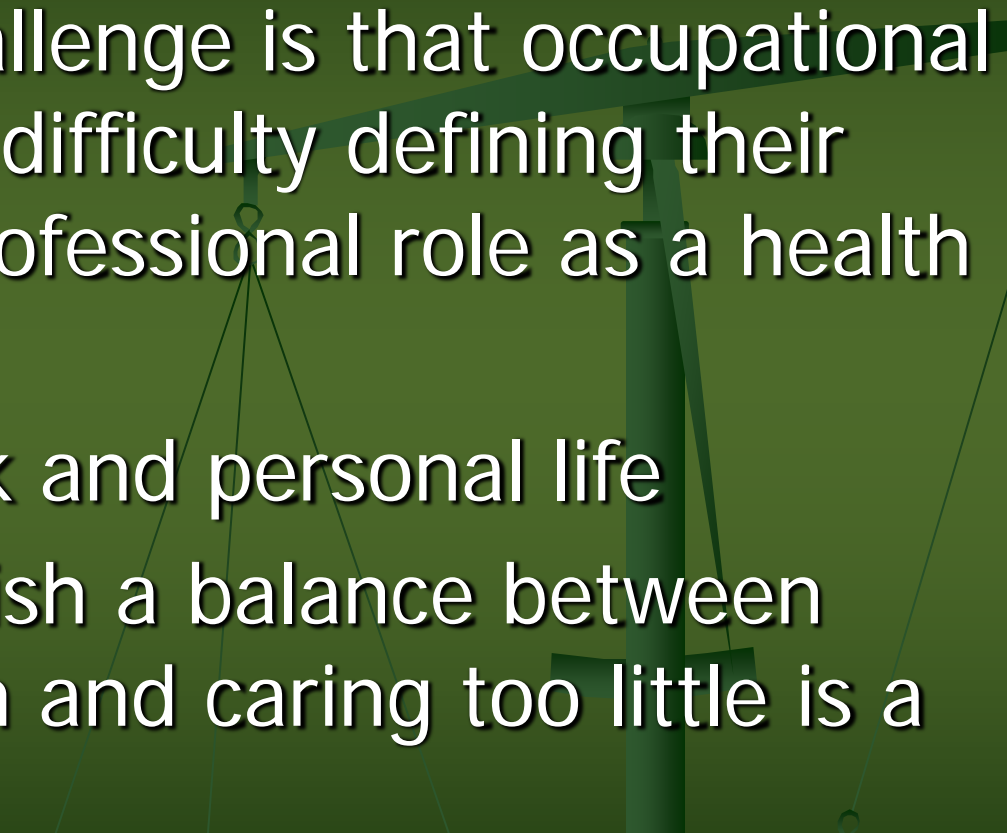


Background

- Inspirational Article
 - "When A Child Dies the World Should Stop Spinning: An Autoethnography Exploring the impact of Family Loss on Occupation."
- Personal Interest
 - Becoming New Graduates
- Level II Experiences
 - Elks Idaho Rehabilitation Hospital
 - Hennepin County Medical Center

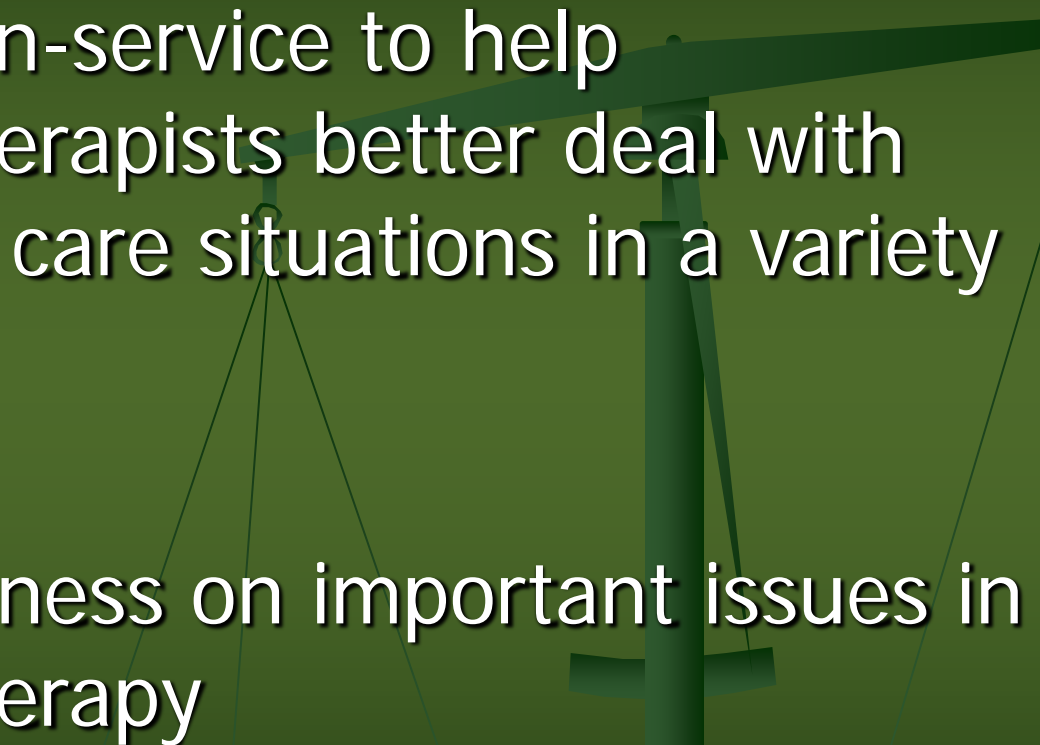


Problem Statement

- One current challenge is that occupational therapists have difficulty defining their personal and professional role as a health care providers.
 - Separating work and personal life
 - Trying to establish a balance between caring too much and caring too little is a constant issue
- 



Purpose

- 
- To develop an in-service to help occupational therapists better deal with difficult patient care situations in a variety of settings
 - Increase awareness on important issues in occupational therapy

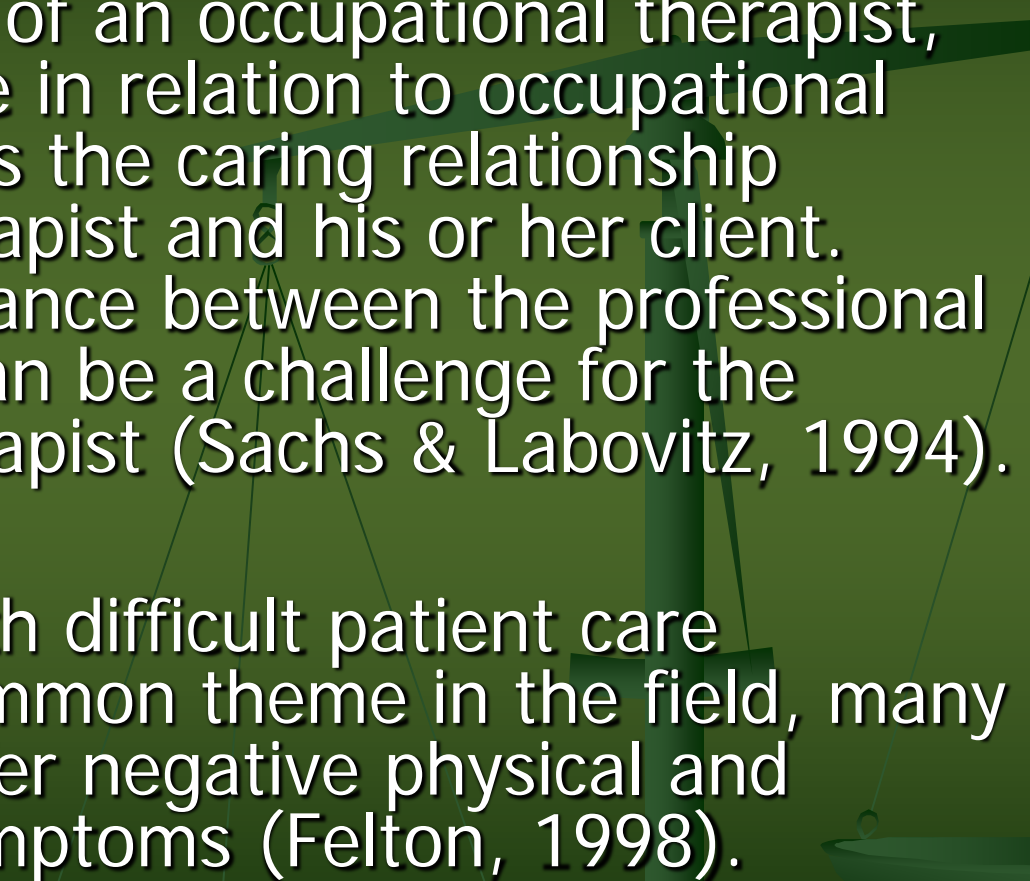
Methodology

- Literature Review
 - To gain a full understanding of the issues faced in occupational therapy settings.
 - To define the difficult populations, core values, ethics, and strategies used in occupational therapy.





Significant Findings

- 
- Caring is the role of an occupational therapist, and one key issue in relation to occupational therapy practice is the caring relationship between the therapist and his or her client. Maintaining a balance between the professional and caring role can be a challenge for the occupational therapist (Sachs & Labovitz, 1994).
 - Since working with difficult patient care situations is a common theme in the field, many professionals suffer negative physical and mental health symptoms (Felton, 1998).



Significant Findings

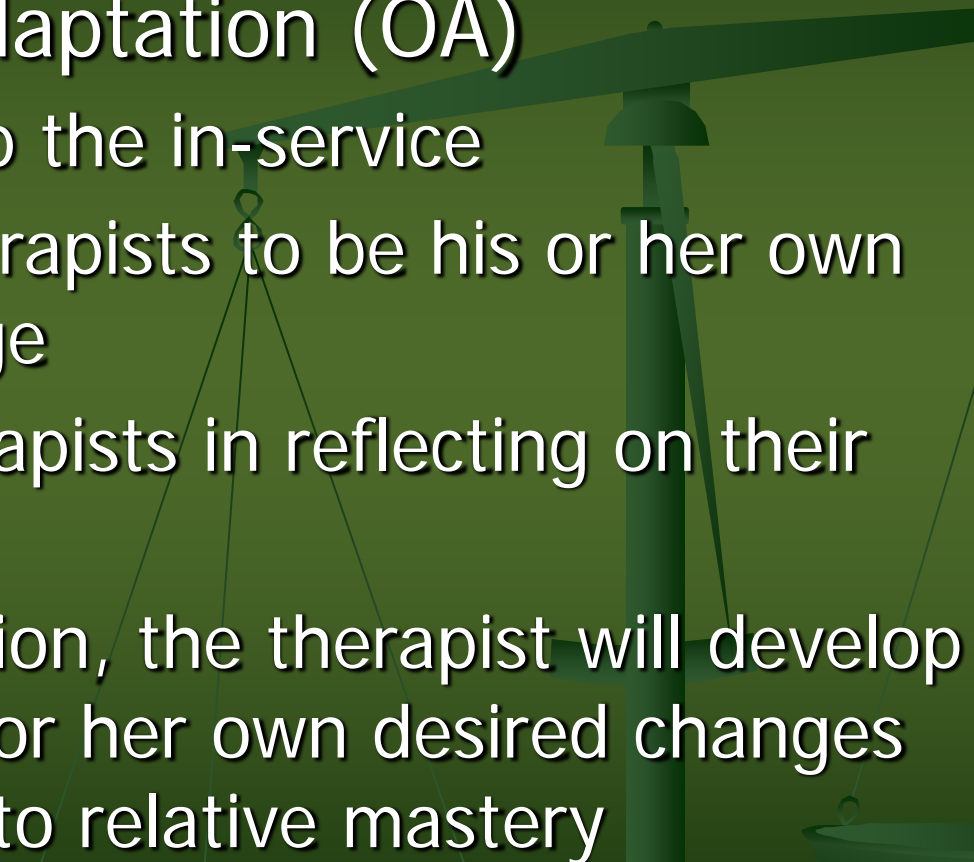
- “Using a broad professional definition to guide the scope of occupational therapy’s role raises difficulties in defining the professions boundaries” (Sachs & Labovitz, 1994, p. 1003).
- Strategies for helping occupational therapists need to be provided in order for them to make informed decisions when ethical challenges arise (Denend & Finlayson, 2007).



Significant Findings

- The attitude of the client has a direct effect on his or her motivation in therapy; this also affects the therapist's ability to be productive, and constantly working with this type of client results in therapist burnout and an inability to stay positive throughout treatment (Felton, 1998).
- One major finding is that personal frustration and a lack of appropriate coping skills can lead to burnout along with high levels of job stress experienced over time (Bassett & Lloyd, 2001).

Theory

- Occupational Adaptation (OA)
 - Used to develop the in-service
 - Enables the therapists to be his or her own agent for change
 - Assists the therapists in reflecting on their own practice
 - Through reflection, the therapist will develop insight into his or her own desired changes which will lead to relative mastery
- 

Theory



- Humanistic Adult Learning Theory
 - Using this model educators provide:
 - Support
 - Freedom to choose
 - Opportunities to make changes in everyday life
 - The learners are encouraged to change the following in order to change their behavior:
 - Subjective feelings
 - Choices
 - Self-concept
 - Relationships with others



Product

- "Too Little? Too Much? Finding the Balance" An In-service Training Program
 - Module 1: Ethics, Therapeutic Relationship, Over-involvement, Boundaries.
 - Module 2: Stress, Burnout, Desensitization
 - Module 3: Establishing a Balance

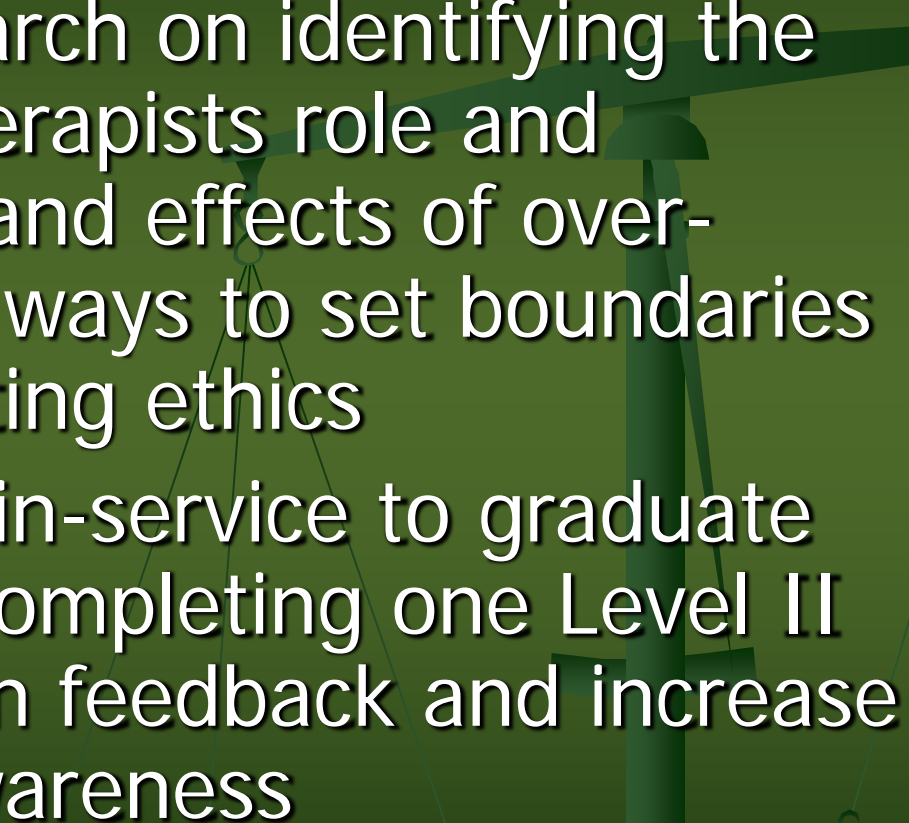


Summary: O.T. Application

- The in-service is flexible and subjective making easy to use in a variety of settings.
- This in-service is beneficial to the therapists through:
 - Providing coping strategies to deal with stress and burnout
 - Providing a supportive and open environment to help increase personal awareness of strengths and weaknesses in the field.
- It benefits the profession of occupational therapy through:
 - Increasing familiarity of ethics and core values
 - Providing ways to determine if role delineation is occurring.

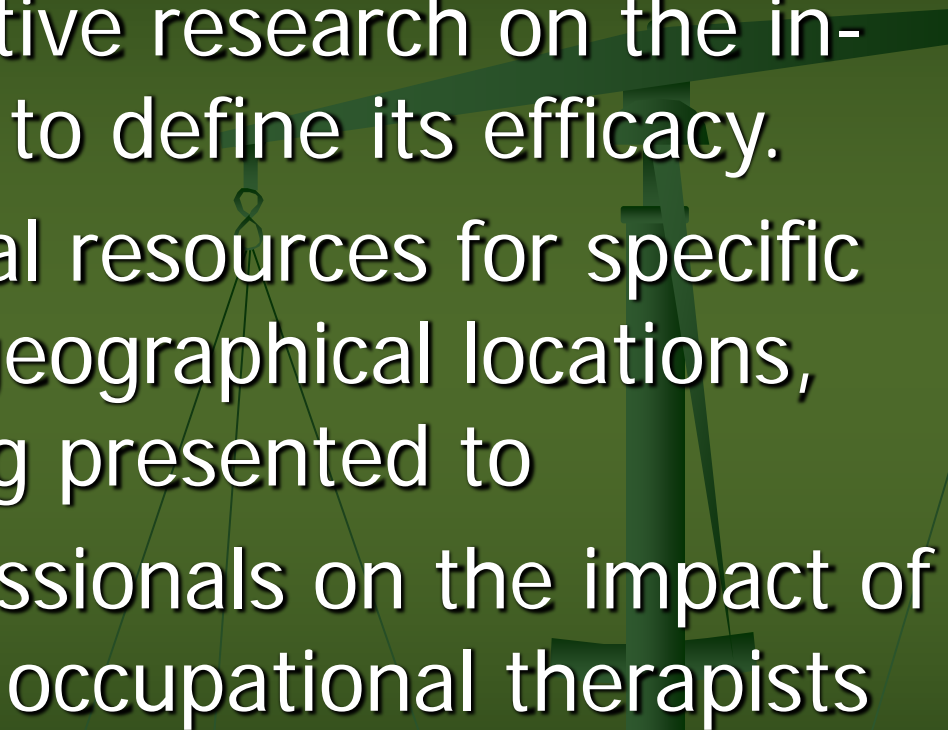


Recommendations

- Continued research on identifying the occupational therapists role and responsibilities and effects of over-involvement on ways to set boundaries while incorporating ethics
 - Develop a pilot in-service to graduate students after completing one Level II fieldwork to gain feedback and increase the students awareness
- 



Recommendations

- Conduct qualitative research on the in-service in order to define its efficacy.
 - Obtain additional resources for specific work settings, geographical locations, population being presented to
 - Educating professionals on the impact of these issues on occupational therapists
- 

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Module 1

Code of Ethics

Therapeutic Relationships

Over-involvement

Boundaries

The Real Issue

- “Providing care can be an emotionally complicated process. It requires the ability to be meaningful related to a patient and family yet separate enough to distinguish one’s own needs.”- Holly Moss and Laura Gaynard

Retrieved from: <http://www.cookchildrens.org/ContentStore/Boundaries.pdf>

The Code of Ethics and Professional Practice

1. Introduction
2. Client Autonomy and Welfare
3. Services to Clients
4. Personal and Professional Integrity
5. Professional Competence and Standards

AOTA, 2005

Client Autonomy and Welfare

Respecting the autonomy of the client

2.1 Occupational therapists shall at all times recognize, respect and uphold the autonomy of the clients and their role in the therapeutic process including the need for client choice and the benefits of working the partnership. Occupational therapists shall promote the dignity, privacy and safety of all clients with whom they come into contact. (AOTA, 2005, p. 639)

Client Scenario

- A competent client who had just received a total knee replacement did not feel ready to be back in her home due to perceived lack of balance. She had reached all of her goals set by the team and was modified independent in all ADLs and was ready for discharge according to the outcome measure. The team did not feel she was at risk for falls.

Client Autonomy and Welfare

Duty of care to the client

2.2 Occupational therapists have a duty to take reasonable care for clients whom they accept for treatment/intervention. (AOTA, 2005, p. 639)

Client Autonomy and Welfare

Confidentiality

2.3 Occupational therapists are ethically and legally obliged to safeguard confidential information relating to clients. (AOTA, 2005, p. 639).

Client Autonomy and Welfare

Cruelty and abuse

2.4 Occupational therapists must not engage in or condone behavior that causes mental or physical distress. Such behavior includes neglect, intentional acts, indifference to the pain or misery of others and other malpractice. (AOTA, 2005, p. 639)

Client Autonomy and Welfare

Property

2.5 Occupational therapists shall take all reasonable precautions to avoid damage to clients property. (AOTA, 2005, p. 640)

Services to Clients

Referral of clients

3.1 Occupational therapists shall accept referrals which they deem to be appropriate and for which they have the resources.
(AOTA, 2005, p. 640)

Services to Clients

Equity of service provision

3.2 Occupational therapists shall provide services to all clients in a fair and just manner. (AOTA, 2005, p. 640)

Services to Clients

Provision of services to clients

3.3 Services should be client centered and needs met. (AOTA, 2005, p. 640)

Services to Clients

Occupational therapy records

3.4 Occupational therapists shall accurately record all information related to professional activities. (AOTA, 2005, p. 640)

Client Scenarios

- Read this therapy session scenario and state what parts you would put into your daily note.

Personal and Professional Integrity

Personal integrity

4.1 The highest standards of personal integrity are expected of occupational therapists. They must not engage in any criminal, unprofessional or other unlawful activity or behavior. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Personal relationships with clients

4.2 Occupational therapists shall not enter into relationships that exploit clients sexually, physically, emotionally, financially, socially or in any other manner. The college considers it unethical for occupational therapists to indulge in relationships which may impair the professional judgment and objectivity and/or may give rise to advantageous/disadvantageous treatment of the client. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Professional integrity

4.3 Any reference to the quality of service rendered by, or the integrity of, a professional colleague will be expressed with due care to protect the reputation of that person. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Professional demeanor

4.4 Occupational therapists must conduct themselves in a professional manner appropriate to the setting. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Substance misuse

4.5 Occupational therapists must not be under the influence of any toxic substance with is likely to impair the performance of their duties. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Personal profit/gain

4.6 Occupational therapists must not accept tokens such as favors, gifts or hospitality from clients and their families or commercial organizations when this might be construed as seeking to obtain preferential treatment. (AOTA, 2005, p. 641)

Personal and Professional Integrity

Advertising

4.7 Occupational therapists may make direct contact with potential referring agencies to promote their services. (AOTA, 2005, p. 642)

Personal and Professional Integrity

Information/Representation

4.8 Occupational therapists shall accurately represent their qualifications, education, experience, training and competence and information about services they provide.
(AOTA, 2005, p. 642)

Professional Competence and Standards

Clinical competence

5.1 Occupational therapists shall achieve and continuously maintain high standards of competence. (AOTA, 2005, p. 642)

Professional Competence and Standards

Delegation

5.2 Occupational therapists who delegate treatment or other procedures must be satisfied that the person to whom these are delegated is competent to carry them out. Such persons may include students, support workers or volunteers. In these circumstances, the occupational therapist will retain ultimate responsibility for the client. (AOTA, 2005, p. 642)

Professional Competence and Standards

Collaborative practice

5.3 Occupational therapists shall respect the needs, practices, special competencies and responsibilities of other professions, institutions and statutory and voluntary agencies that constitute their working environment. (AOTA, 2005, p. 642)

Professional Scenario

- Situation: You are working in a rehabilitation facility with PT, OT, SLP, and RT. One of the client's main goals at this facility is community reintegration, and preparing and making a meal is your client's area of deficit. The recreation therapist takes the client out to a local grocery store and helps them with organization and money management. You feel as an OT that this is under your area of practice, what do you do?

Professional Competence and Standards

Continuing professional development

5.4 Occupational therapists shall be personally responsible for actively maintaining and developing their personal professional competence, and shall base service delivery on accurate and current information in the interests of high quality care. (AOTA, 2005, p. 643)

Professional Competence and Standards

Occupational therapy student education

5.5 Occupational therapists have a professional responsibility to participate in the education of occupational therapy students, particularly in the area of fieldwork education. (AOTA, 2005, p. 643)

Professional Competence and Standards

Development of the profession

5.6 Occupational therapists shall promote an understanding of, and contribute to, development of occupational therapy. (AOTA, 2005, p. 643)

Discussion of Ethics

- Can anyone give any specific examples of someone becoming too over-involved during therapy in regards to ethics? (ie. Gifts, outside visits or personal relationships)
- Has anyone found themselves between two ethical dilemmas in the same situation?

CELIBATE Resource

- Article: Denend, T., and Finlayson, M. (2007) Ethical decision making in clinical research: Application of celibate. American Journal of Occupational Therapy, 61(1), 92-96.

10 Steps of CELIBATE

1. Identifying the problem
2. Identifying the facts
3. Identifying the interested parties
4. Identifying the nature of their interest
5. Examining the potential ethical dilemmas
6. Examining the potential legal dilemmas
7. Asking whether more information is needed
8. Brainstorming possible action steps
9. Analyzing the steps
10. Choosing a course of action

Solving an Ethical Dilemma

Suggested Process

1. Gather all facts
2. Decide which ethical principles are involved
3. Clarify your professional duties in this situation
4. Describe the general nature of the outcome desired or the consequences
5. Describe pertinent practical features of this situation (Davis, 1994, p. 72)

Therapeutic Relationship

Questions to think about...

- How do you define the therapeutic relationship?
- What is involved with this relationship?
- How do you set personal/professional boundaries?

Definition of Therapeutic Relationship

- Tickel-Dengen (2002) refers to the therapeutic relationship as the therapeutic alliance which involves two types of relationship bonding:
 - Rapport
 - Working Alliance
- What do these two terms mean to you?

Therapeutic Relationship

- What qualities are needed as a therapist to develop a positive therapeutic relationship?
- Provide a list of key elements you feel are involved with the therapeutic relationship?

Darragh, Sample, and Krieger (2001) list these qualities when working with people who have sustained a TBI:

- An active listener
- Understanding and empathetic
- Competent
- Caring
- An open communicator
- Holistic

Therapeutic Use of Self

- Therapeutic use of self plays a strong role in the therapeutic relationship
- How you view yourself affects your communication with your client
- “Self-concept acts as a screen through which we view the world” (Davis, 1994, p. 87)
 - How do you interpret this?

Factors of Professional Relationships

- Paid
- Time-limited
- Location defined
- Goal-directed
- Unequal power
- Clinician responsible for the relationship
- Formal training

Factors of Personal Relationships

- Non-paid
- May last a lifetime
- Location unlimited
- Pleasure directed
- Equal power
- All parties responsible for the relationship
- No formal training

Warning Signs of Over-involvement

- Thinking of patient or family away from work
- Planning other patients' care around a particular patient's needs
- Spending free time with patient or family/sharing home phone number
- Sharing personal information or work concerns with a patient or family
- Being defensive about care
- Secretive behavior
- Gift giving to individual

Warning Signs of Over-involvement Continued

- Inappropriate physical touch
- Loaning or sharing personal items
- Feeling so strongly about situation that can't hear feedback from team/not remaining neutral
- Feeling responsible if patient's progress is limited
- Feeling possessive about a patient or family

What to do if becoming over-involved?

- Accept the things you can't fix
- Practice relaxation
 - restorative breathing
 - Repetitive exercise
 - Meditation
 - total absorption in pleasant activity
- Use Humor
- Social support
- Healthy choices
 - moderation (eating, alcohol, spending etc.)
 - exercise
 - good nutrition
 - adequate sleep

Setting Boundaries

- What would you do to “leave it at the door?”
- Other options:
 - Refer patient to another therapist
 - Request less involved patients
 - Talk to supervisor about issues
 - Find outside support
 - Journal

- Over-involvement for an extended period of time or taking on extra responsibilities can lead to stress and burnout in the area of occupational therapy

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Module 2

Stress

Burnout

Desensitization

General Questions

Have you experienced stress at work?

Have you experienced burnout at work?

What is the difference between the two?

Stress

- Bassett and Lloyd (2001) describe stress as, **“the psychological, physiological, and/or spiritual discomfort that is experienced when environmental stimuli are too demanding or exceed a person’s coping strategies”** (p. 406).

Burnout

- In the article by Basset and Lloyd (2001) it is stated that the term burnout was coined by Freudenberger in 1974 and it is describing, **“a state of emotional exhaustion brought about by overwork and resulting in a progressive inability to carry-out the responsibilities of ones job”** (p. 406).

Side Effects of Stress

HANDOUT: “How vulnerable are you?”



Cognitive:

- Memory problems
- Indecisiveness
- Inability to concentrate
- Trouble thinking clearly
- Poor judgment
- Seeing only the negative
- Anxious or racing thoughts
- Constant worrying
- Loss of objectivity
- Fearful anticipation

Emotional :

- Moodiness
- Agitation
- Restlessness
- Short temper
- Impatient
- Inability to relax
- Feeling tense
- Feeling overwhelmed
- Sense of loneliness and isolation
- Depression or general unhappiness

Physical:

- Headaches/
backaches
- Muscle tension and
stiffness
- Diarrhea or
constipation
- Nausea/dizziness
- Insomnia
- Chest pain
- Weigh loss/gain
- Skin breakout
- Loss of sex drive
- Frequent colds

Behavioral:

- Eating more/less
- Sleeping more/less
- Isolating from others
- Procrastination
- Using alcohol
cigarettes or drugs
to relax
- Nervous habits
- Teeth grinding
- Overdoing activities
- Overreacting
- Picking fights

Factors Leading to Stress

- New job
- Difficult boss or co-workers
- Difficult client scenarios
- Complicated family/client situations
- Being overworked
- Lack of supervision
- Job dissatisfaction
- Office politics
- Insufficient pay – Financial stress

How Does Burnout Develop

- “High levels of job stress experienced over time, as well as personal frustration and inadequate coping skills, could lead to the syndrome known as burnout.”
 - Bassett and Lloyd (2001, p. 406)
- “Burnout, viewed as the exhaustion of physical or emotional strength as a result of prolonged stress or frustration.”
 - Felton (1998, p. 237)

3 Components of Burnout

- Emotional Exhaustion
- Depersonalization
- Lack of Personal Accomplishment

Basset and Lloyd, 2001, p. 406

Factors Contributing to Burnout

- Nature of clients
- Lack of resources
- Lack of supervision/training
- Lack of rewards/career structure
- Lack of professional identity
- Mismatch of values

Basset and Lloyd, 2001, pp. 407-408

Signs of Burnout

- Withdrawing from the client
- Apathy
- Cynicism
- Rigidity
- Loss of concern

- Basset and Lloyd, 2001, p. 407

Signs of Burnout Cont.

- Rise in absenteeism
- Higher healthcare costs
- Higher turnover rate
- Change in quality of care
- Decrease in self-esteem
- Loss of empathy
- Decreased productivity

- Felton, 1998, p.238

Preventing Stress and Burnout

- Early identification is needed to prevent the depersonalization of the provider patient relationship.

- Felton, 1998, p. 237

Preventing Stress and Burnout

- Elements to avoid burnout:
 - Identifying the problem as soon as possible
 - Being familiar with the signs and symptoms
 - Educating the supervisor about the signs and symptoms
 - Review of records for repeated absenteeism or tardiness

Elements to Avoid Burnout cont.

- Increasing control in the employees individual job
- Making options available to staff members such as:
 - Group meetings
 - Open communication among workers
 - Vocational Counseling
 - One-on-one meetings with supervisor

Coping Skills for Stress

- **Look for humor in the situation**
- **Learn to forgive not only others but yourself**
- **Find a listening ear to vent frustrations.**
- **Exercise your mind and your body**
- **Be aware of limitations, but focus on abilities.**
- **Practice relaxation techniques**

-Retrieved from <http://www.njc.org/disease-info/wellness/stress/Stress-Relief-Cpng-Strtgs-Pstv-Attds.aspx>

Coping Skills for Burnout

- Identify what you are feeling and why
- Set realistic goals for yourself
- Recognize the symptoms of burnout
- Ask for help when needed
- Develop a personal support system
- Retain hope
- Develop a detached concern for recipients of your efforts

-Retrieved from <http://www.joe.org/1986spring/at.html>

Coping Skills cont.

- Take timeouts
- Maintain proper nutrition and physical exercise
- Develop a sense of organizational involvement
- Be willing to accept counseling when needed
- Accentuate the positive
- Maintain an active personal social life outside of work

“A Stressful Situation”

- Please read the following situation and answer the questions provided.
- Share your results with the people around you.
 - What did you have in common?
 - What was different?
 - Was this situation similar to any other experiences you’ve had?

Managerial Strategies

- Managers benefit from learning about stress and burnout and by incorporating preventions strategies into the work environment.
- Managers have a role to create a supportive, creative, and positive organizational climate.
- There should be well defined practice guidelines, performance feedback, and annual performance appraisals for staff.

-Basset and Lloyd, 2001, pp. 409-410

Desensitization

- The issue of becoming desensitized or developing a lack of compassion or empathy for patients is a long-term result of stress and burnout
- Desensitization can also result from the business aspect of the healthcare industry

Client-Centered Practice

- What are some of the issues or barriers in preventing us from performing client-centered practice?
 - Productivity (Units)
 - Time
 - Institutional Procedures
 - Reimbursement
 - Variety of insurances
 - Environmental constraints
 - Distinguishing the “true” client
 - Ex: Family, caregiver, physician, patient, company

Client-Centered Practice

- Client-centered practice is an on-going battle in occupational therapy practice
- Desensitization can influence therapists not to use client-centered practice

Transition

- Stress, burnout, and desensitization are difficult to deal with. Finding the balance between becoming overly involved and lacking compassion and empathy is a complicated process. Resources are necessary for extra support when establishing this balance.

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Module 3

Establishing a Balance



What is Occupational Therapy?

- What is your own personal definition of occupational therapy?
- What do you feel are the responsibilities of the occupational therapist?
- What makes us different from other professions?

Holistic Perspective

- What exactly does holistic practice mean?
- Can other health-care professions be holistic?
- Why do we as O.T's focus on holism so greatly?

Framework of Holism

SCALE	Intention	Attention	Creation
Individual	Spirit	Mind	Body
Group	Mission	Integration	Connection
Organization	Purpose	People	Place
Society	Community	Ecology	Economy

Retrieved from: <http://www.neverendingpaths.org/whatisholism.htm>

Occupational Therapy Core Values

- The document of our “core values” was formed in 1993 by the American Occupational Therapy Association.
- In 2005, Eleanor Clarke Slagle produced an article found in the Nov-Dec AOTA issue entitled “Embracing Our Ethos, Reclaiming Our Heart.”

Reference

- The article entitled “A Reconsideration of Occupational Therapy’s Core Values” written by Suzanne Peloquin (2007) provides the following information on core values:

7 Core Values

1. Altruism
2. Equality
3. Freedom
4. Justice
5. Dignity
6. Truth
7. Prudence

Suggested Additional Core Values

1. Courage
 2. Imagination
 3. Resilience
 4. Integrity
 5. Mindfulness (Peloquin, 2007)
- Do you feel these core values should be added to our original core values?
 - Do they support our ethical standards?

The Balance

- Sticking to our core values and code of ethics can help in establishing the balance in therapy provided to clients.
- Maintaining sight of what occupational therapy means to us personally and professionally will also help define the balance.

Ask yourself questions?

- Why did I choose this profession?
- Why do I choose to stay in this profession?
- How does it affect my life in a positive way?

How do I get Help?

- Develop your coping strategies
- Talk to your supervisor or manager
- Develop a support group
- Visit the Ethics Board Commission through AOTA
- Maintain high job satisfaction

Using Coping Strategies

- Review signs and symptoms of stress and burnout
- Develop your support system
- Trial and error with strategies that work for you
- Maintain open communication and be supportive to fellow co-workers

How do I approach my manager?

- Select a place and time where you can discuss personal issues
- Don't focus on complaining, but look for ways to approach the difficult situations at hand
- Don't be afraid to inform your manager about your feelings.
- Share information and new strategies to be implemented in your department.

Develop a Support Group

- Find out if there is a need or want among co-workers for a support group
- Gather information on what are the main issues or problems within the work environment
- Go to your manager for information
- If smaller facility, locate outside support within your community

Ethics Commission

- www.aota.org/practioners/ethics/ec.aspx
- This commission is responsible for education and enforcement of ethical dilemmas in the field of occupational therapy. It is responsible for developing the ethics standards for the profession.

How do I Maintain Job Satisfaction?

- List the positive and negatives of your job
- Decipher what you have the power to change and what you don't
- Can the negatives get better through time?
- If you can't change the things you don't like, consider why you choose to stay in that job
- Consider what would make you happy in your current job and take action.

In Conclusion

- Where are you currently at?
 - Over-involved
 - Under-involved
 - Balanced
- Do you feel the topics discussed are issues at your facility that need to be dealt with?

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