Achieving Intersubjective Understanding: Examples From an Occupational Therapy Treatment Session

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Occupational therapists, like other health care professionals, must balance their application of treatment techniques with an understanding of their patients' life experiences. This paper reviews the literature from interpretive and medical sociology regarding the interplay between professional power and the achievement of an understanding of another person. It analyzes how an occupational therapist, during a single treatment session, enters into her patient’s life-world and simultaneously controls and manages the treatment process. The concepts of knowledge schemata (the expectations and beliefs people bring to a situation) and footings (the shifts in alignment, or focus, that occur during interaction) are central to this analysis. The process of achieving a balance between professional power and an understanding of the patient’s experience may be fostered in education and in clinical supervision through increased emphasis on the importance of understanding the values and beliefs of patients and on the development and refinement of interactive skills.

Communication is an essential aspect of health care provision. Treatment effectiveness is partially determined by the degree to which health care providers listen to and understand their patients’ problems (Paget, 1983). To gear their approach to the specific needs of patients with chronic illness or disability, health care professionals must attend to the details of daily management and to how patients balance or attempt to balance self-care and the ongoing life of their families (Strauss & Corbin, 1988). This attention to others’ experience is referred to as intersubjectivity, or entering the life-world of another person (Schutz & Luckmann, 1973). This idealistic view is countered by the observation that professional power in the form of professional socialization and social control undermines the attainment of intersubjective understanding in medical encounters (Freidson, 1986; Treichler, Frankel, Kramarae, Zoppi, & Beckman, 1984; Waitzkin, 1989). Asymmetrical interaction caused by professional power or social control demonstrates the inequities produced by social structure, which lead to barriers in the achievement of intersubjective understanding (Habermas, 1970).

This paper examines the communication process that occurred in one occupational therapy treatment session to provide an understanding of how the occupational therapist balanced intersubjectivity with control. Because the patient came to the therapist for help, some asymmetry in the interaction should be expected. However, because the therapist had to engage the patient in a collaborative process, the asymmetry should not have been too great. Two aspects of the communication process are explored—knowledge schemata and footings.

Knowledge schemata are the expectations and beliefs that people bring to a situation (Tannen & Wallat, 1987). The degree to which the therapist and patient share knowledge schemata is an important indication of the communication process. Because knowledge schemata are tacit, therapists must use questions to understand their patients’ interpretations of situations and use teaching to impart their understanding to their patients. This approach requires that therapists listen and respond to patients in order to gain an understanding of their knowledge schemata and to enter into their life-worlds.

Footings are alignments within interactions and are marked by an apparent “change of gears” in the interaction (Goffman, 1981, p. 126). For example, the informal interaction at the beginning of a treatment session represents one footing; the initiation of treatment represents a second footing; and the closure, a third. Many shifts in alignment can occur within a treatment session. The footings dictate the agenda and mood of a session. Who controls the footings or changes them may be one indication of the power structure within the treatment session.
Taking the Patient's Perspective

Health care professionals, in achieving intersubjective understanding, are challenged to transcend the constraints of social structure to enter into the meaningful world of their patients. This requires the ability to understand the life-world of another person (Schutz & Luckmann, 1973), take a reflective stance, and understand the speaker's intended meaning (Schutz, 1967). The term life-world connotes a person's physical and social reality. The life-world has a highly individualistic cultural and physical reality. The essential aspect of the life-world is that things within it are taken for granted and therefore are not questioned. Thus, the life-world becomes part of the background assumptions from which people act. According to Schutz and Luckmann, people operate on the belief that others share their life-world, which implies shared assumptions and meanings. Because of the tacit nature of the life-world, these differences may not be recognized, thus leading to difficulty in the achievement of intersubjective understanding.

Even if the differences in life-worlds are recognized, a full understanding of others is difficult, because the differences in life-worlds lead to differences in streams of consciousness (Schutz, 1967). Observations of the behavior of others and of their actions and artifacts are made from our own perspective and experience, not the experience of those we observe. To enter into another's life-world, we must take a reflective stance in which we consciously interpret and make meaning from our interactions. These interactions are always filtered through our own experience (Schutz, 1967).

This interpretation of meaning occurs over a period of time during which our personal knowledge of the speaker is used to determine the intended meaning. When the meaning is clear, this interpretive process is suspended (Schutz, 1967). However, this subjective meaning is only an approximation of the speaker's intended meaning, never the meaning itself. Thus, our interpretation of another person's intended meaning may fall short. Schutz explained this discrepancy in interpretation as the inability to understand fully another person's perspective, because we have not experienced directly the other person's life; we have experienced it only through our own experience. Because interpretation of many interactions is routinely suspended, our knowledge of and communication with the world around us becomes tacit. This tacit nature of communication may be understood through the concept of knowledge schemata.

Tannen and Wallat (1987) defined knowledge schemata as "participants' expectations about people, objects, events, and settings in the world" (p. 207). Knowledge schemata are part of the contextual understanding that persons bring to social interaction. Knowledge schemata may be shared through language or may remain tacit. Shared knowledge schemata, or shared definitions of a situation, contribute to intersubjective understanding. Although this understanding may be viewed as dynamic and responsive to the social situation (Garfinkel, 1972) or experience (Tannen & Wallat, 1987), some knowledge schemata may be resistive to change (Tannen & Wallat, 1986). The experience of the persons involved may contribute to a different interpretation of the same situation. These definitions may be so much a part of the context for these persons that they remain implicit and are never questioned or discussed. Even if they are discussed, the language used may be a further barrier to understanding. Wittgenstein (1958) believed that language categorizes and describes experience. Different experiences, therefore, may lead to different linguistic descriptions of the same situation. The study of language and its structure is essential to an understanding of social life (Cicourel, 1980). Through such study, the congruence or lack thereof in knowledge schemata may be explored.

Tannen and Wallat (1987) demonstrated the mismatch of knowledge schemata and the resistance of these schemata to change in their study of an encounter between the mother of a child with cerebral palsy and a pediatrician. One aspect of this encounter was a discussion of the child's noisy breathing. The mother viewed this noisy breathing as difficulty in breathing, which is part of an illness schema rather than part of the normal problem for a child with cerebral palsy, as seen by the pediatrician. The mother's knowledge schema about the child's noisy breathing was quite resistive to change, despite the pediatrician's repeated explanations that this type of breathing was normal for a child with cerebral palsy. The mother's inability to change was possibly caused by the experience of hearing her child's noisy breathing, which was not acknowledged or changed by the pediatrician's medically oriented explanations. This mismatch in knowledge schemata led to repeated explanations on the pediatrician's part, without improved understanding on the mother's. The reader is left with a sense of frustration that these people are "talking by" each other despite apparent efforts to understand.

Another explanation of the problem of a mismatch in knowledge schemata is that the medical interpretation of the problem relies only on "the biological reality and that the meaning of the symptoms lies only in their relationship to that biological reality" (Mattingly, 1988, p. 1-85). This problem stems from the assumptions inherent in the biomedical model, which treats illness as a biological fact and ignores its inherent social aspects (Foucault, 1975; Mishler, 1981). Thus, the pediatrician's failure to hear the breathing through the mother's experience led the pediatrician to fail to understand what it was like for the mother to hear her child breathing noisily and the anxiety that this experience evoked. Had the pediatrician questioned the mother's definition of the problem, she may have talked with the mother long enough to discover that she...
constructed the problem from an illness perspective. This mismatch in knowledge schemata led to a loss of understanding and communication between the physician and mother. In this example, the mother will continue to be worried and anxious about the child’s breathing, even though from a medical perspective such breathing is considered normal.

Barriers to Taking the Patient’s Perspective

Ideally, the communication process between the patient and the health care professional should be an open interchange that enables the health care professional, before making any recommendations or plans, to understand all factors in the patient’s life. Unfortunately, the medical literature is replete with examples of the failure of physicians to listen and respond to their patients (Paget, 1983; Tannen & Wallat, 1987; Treichler et al., 1984). Occupational therapy practice, like medical care in general, is not immune to this problem. Yerxa (1986) spoke movingly about her brother-in-law’s occupational therapy experience, which focused on his arm and not on the long-term effects of a massive stroke on his daily life. Murphy (1990), an anthropologist, recalled his rehabilitation as adequate for his physical needs but inadequate for his social and psychological reentry into the world and for his inevitable deterioration. He said about occupational therapy,

I was doing well in occupational therapy, although I thought some of the exercises ridiculous. Nonetheless, visitors to our house still scrape their feet on the doormat that I made in [occupational therapy]. Yolanda is the only person who knows its origins, a sign of the care I have taken to keep secret the indignities visited upon me in my disability. (p. 55)

As discussed previously, one source of the problem is the biomedical model, because it separates the illness from the patient’s experience (Foucault, 1975). This separation leads to the tendency for health care professionals to focus on technical rather than social problems.

Mishler (1984) described two voices that compete with each other in physician-patient communication. The voice of medicine includes the biomedical topics of physiology, psychology, and pharmacology. These topics concern physicians in their professional work of diagnosis and treatment. The voice of the life-world comprises the everyday, mainly nontechnical problems that the patient carries into the medical encounter. In the examples used by Murphy (1990) and Yerxa (1986), the biomedical aspects of care gained precedence over the patients’ everyday experience and needs.

In the medical encounter, physicians have more power than do patients, some of which is derived from the upper-middle-class standing of most physicians (Waitzkin, 1989). Formal knowledge is another source of power expressed in the expert-layman relationship between physician and patient (Freidson, 1975). The patient goes to the physician because the physician is perceived as having the knowledge and skills to identify a cure for the patient’s problems (Freidson, 1975).

Because physicians have greater power than patients, they control the interaction and decision-making process (Freidson, 1986). For example, Treichler et al. (1984) demonstrated the inadequacy of a physician-patient encounter in uncovering the problem that was really disturbing the patient. In this encounter, the physician focused on biomedical issues and excluded problems that the patient raised about disability and loss of income. Treichler et al. attributed the physician’s lack of verbal responses to the patient’s information to power and control. They concluded that the physician’s attention to the biomedical issues as well as his interaction methods and note taking prevented him from fully understanding the patient’s concerns.

This power is not limitless. The medical literature discusses problems with patient compliance, which for the physician means an unsuccessful use of power to influence the patient’s behavior (Freidson, 1986). Nonetheless, the power discrepancy between physicians and their patients may mean that patients are unable to fully express their needs so that the physician never fully understands their perspectives. This occurs because physicians control the interchange by asking questions and interrupting. Both of these techniques are identified as mechanisms of domination (Waitzkin, 1989).

Habermas (1970) provided connecting concepts to explain the relationship between intersubjectivity and the influence of social structure on communications. He proposed that communicative competence is necessary for interaction to occur. Communicative competence consists of “linguistic competence, basic qualifications of speech, and symbolic interaction (role behaviour)” (p. 367). He further stated that intersubjectivity is characterized by a symmetrical relationship between the dialogue roles of the persons who are interacting. Habermas believed that social structure changes dialogue rules and may undermine intersubjective understanding. From this perspective, the study of the dialogue provides insights regarding the social structure that may not be readily apparent through casual observation.

Occupational Therapy

Mattingly (1990b) described occupational therapy as a two-body practice in which the therapist attends to the biomedical aspects of the disability as well as the illness experience. Because occupational therapists deal with everyday activity, an understanding of the experience of living in a disabled body is central to their understanding of their patients. Thus, therapy must be highly individualized, because each patient has a different life-world and experiences disability from a unique perspective. The di-
agnosis itself, therefore, should be only one small aspect of the occupational therapist's domain of concern. Occupational therapy values state that therapists should focus on the achievement of goals established by a collaborative process between themselves and their patients. These goals center on either the resumption of previous life roles and activities or the adaptation of roles and activities. Murphy's (1990) assessment of occupational therapy exercises as ridiculous and his carefully kept secret of the origin of the doormat reflect a lack of understanding between therapist and patient. The occupational therapy treatment he wrote of seemed to miss the individuality of his needs and his image of himself as an anthropologist, university professor, husband, and father.

In rehabilitation hospitals, patients may receive 1 to 2 hr of occupational therapy daily for a period of 2 weeks to several months. Occupational therapists must form alliances with their patients so that the patients will "do with" the therapist in order to ultimately become independent and "do for" themselves (Mattingly, 1990b, p. 1). As Peloquin (1990) stated, "This singular distinction ought never to be forgotten, occupational therapy's vision of 'being with' is essentially a vision of 'doing with'" (p. 16). Because occupational therapists must "do with" for treatment to be successful, their achievement of intersubjective understanding is critical. This differs from the role of other health care professionals within the hospital setting, who "do for" or "do to" their patients. The latter approach requires less involvement and investment in the treatment process from the patient's perspective (Mattingly, 1990a). When occupational therapists "do to" patients, that is, do not allow them to experience success, the lack of intersubjective understanding seems clear and painful (Peloquin, 1990).

Occupational therapy is not a powerful profession. In many hospitals, it is one of the newest and smallest departments. The reliance on everyday activity in the midst of the technical wonders of the medical world further reinforces the ordinariness of occupational therapy practice. Furthermore, occupational therapists tend to be middle class and are thus more likely to be closer to the social class of their patients than are physicians, who tend to be from the upper middle class. These factors make it more likely that the occupational therapist will have to engage the patient in therapy rather than impose therapy goals from a position of power.

This relative lack of power reinforces the view that the therapy process is one in which patients must actively engage in order to gain autonomy and independence. The strength of this position is that it enables the therapist to enter the patient's life-world more easily. Once entered, the therapist has an essential perspective from which to understand the patient. The power of this understanding is reflected in Peloquin's (1990) accounts of patients talking about therapists as their friends. Friendship implies equivalent status and mutual understanding, which are concepts central to Schutz's (1967) notions of intersubjectivity.

Provided below is an exploration of the concepts of knowledge schemata and footings in order to make possible a fuller understanding of the communication process and how intersubjective understanding is achieved. The therapist may gain this understanding by continually questioning the tacit nature of the communication process. To remain in this state of inquiry requires that the therapist examine his or her assumptions and respond to the patient's verbal and nonverbal cues. This constant interpretation of meaning contributes to the intersubjective understanding so essential to successful practice.

Methodology

Rheinharz (1988) and Yerxa (1991) contended that the research process is one in which we actively seek to derive meaning from our observations. In qualitative approaches, the analysis of data is filtered through the researcher's experience (Glaser & Strauss, 1967). Description and lengthy analysis enable the reader to judge the adequacy and usefulness of this process (Hasselkus, 1988). The use of videotapes or audiotapes and transcriptions is a typical approach in sociolinguistic research (Cicourel, 1987). It enables a contextual understanding of the interaction and a deeper study of the interaction process that occurred (Tannen & Wallat, 1987). The present paper presents a close study of the interaction in one occupational therapy treatment session. Its goal was to explicate aspects of the communication process that occurred during this treatment session and to foster a greater understanding of the implications of this communication process on the shared understanding between therapist and patient.

This analysis was based on a videotape obtained from the American Occupational Therapy Association (AOTA)/American Occupational Therapy Foundation (AOTF) Clinical Reasoning Study, conducted at University Hospital in Boston, Massachusetts. The videotape analyzed here involves a 38-min treatment session in the spinal cord unit. This tape was transcribed verbatim with procedures modified from the original work established by Schenkein (as cited by Craig & Tracy, 1983). The process of transcription includes indications of pauses, prolongation of syllables, and intonation marks. Because this is a transcription of a videotape, as much nonverbal communication as possible was included in the transcript but is not necessarily shown here for reasons of clarity. To the extent possible, the transcript reflects a verbatim record of the treatment session. Consequently, it includes colloquial speech and errors in English syntax. To transcribe the interactions on videotape, I listened to and watched segments of the tape, wrote down the dialogue and action, and then checked it against the tape. This process
was repeated until the entire tape was transcribed and as many of the ambiguous sections as possible were clarified.

After this step was completed, I coded the transcript to identify strips of dialogue that reflected the concepts of knowledge schemata and footings. These strips were further sorted into specific categories of knowledge schemata and footings. The knowledge schemata and footings were identified by terms that emerged from the coding process. This is an inductive process that uses data as the source for categories and is derived from the concepts of grounded theory developed by Glaser and Strauss (1967).

The patient, Frank, is a 38-year-old fireman. Three months before the taping, he was working on his boat, which was in dry dock. For some still undiscovered reason, he lost consciousness and fell from the boat to the dock, causing a fracture of the seventh cervical vertebra. This fracture resulted in quadriplegia. Frank's upper extremity function is limited to some shoulder, wrist, and thumb movement. He has greater remaining skill in the left upper extremity than in the right. The injury occurred 2 weeks before the date of his second marriage. Because of the accident, the wedding was delayed until early summer. Frank has three children from a previous marriage.

At the time of the taping, the patient had been at University Hospital for approximately 8 weeks. He had been treated by the same occupational therapist for this entire time, first in the intensive care unit, then in the spinal cord unit. He received approximately 1 hr of occupational therapy treatment daily. The occupational therapist, Louise, has 7 years of experience. In an interview immediately following the session, Louise identified the major theme of the session as, "Use your right hand, Frank." The primary activity was a backgammon game. To the casual observer seeing only a small portion of the session, the interaction would seem quite relaxed and social, with little or no apparent work being conducted. However, beneath the surface were lessons in sitting balance, upper extremity use, persistence, the experience of quadriplegia, and management at home. The shifts between game playing and the goals of the session were frequent and fluid. The therapist was able to use the more relaxed atmosphere of the game as a way to ask questions, which in a more formal situation would have been difficult.

### Knowledge Schemata in an Occupational Therapy Treatment Setting

As stated earlier, knowledge schemata are the expectations and beliefs that people bring to a situation. They are the way in which one defines the context within which interactions occur. A match of knowledge schemata means that the interacting persons share a common understanding of the situation at hand. Achievement of this common understanding is an essential component of occupational therapy practice. The therapist can achieve a common understanding in one of two ways—by teaching or instructing the patient so that he or she is informed of the therapist's knowledge schema or by asking questions and listening carefully so as to understand the patient's knowledge schema. Both approaches occurred repeatedly during the treatment session. This interaction can be viewed from the therapist's perspective as teaching the patient how to function with quadriplegia and from the patient's perspective as teaching the therapist about the experience of being a quadriplegic.

#### Teaching the Patient How to Function With Quadriplegia

Frank, the patient, is a quadriplegic and must learn new information about the way his body functions. Louise, the therapist, intersperses the therapy session with short lessons to be sure that Frank has a more complete understanding of his body. At the beginning of the session, the therapist manipulates the patient's hand and asks him to move it, especially to see if she can improve the tenodesis action. While working with his hand, she verbalizes what she is thinking and in the process teaches the patient about his hand function. (See the Appendix for an explanation of the symbols used.)

Therapist: Bring your hand up and down. < Patient drops his hand down and moves it up > Bring it all the way up < therapist observes patient >. You know, it's funny where your thumb comes in. That's a hard place. < Therapist models with her hand; patient and therapist look at their respective hands >. Can you try to (have any motion)? < Therapist holds patient's hand > To do that = < both move their thumbs > yeah, you do < watching thumb > You have a little of that = 'cause if we could/m think part of what happens is because the muscle you have in your thumb is that part that pulls in this way = < therapist demonstrates > that naturally if you had no active motion in your thumb your thumb would come out a little more possibly < therapist demonstrates > but because this is where it is strong it wants to (pull in) right there < therapist demonstrates > .

Patient: Yeah, well, I can get down there < patient demonstrates >

Therapist: Yeah, but what happens when you want to come up/ Patient: The pressure on it (pause) on it falls off (pause). < Both look at thumb, therapist points to part >. The pressure (is) up here, not down there.

Therapist: Yeah, that's why it's hard to pull things up. Try to pick these keys up.

During this lesson, the therapist engages the patient by having him demonstrate movements, comparing her hand to his, and, finally, trying to pick up some keys. During this brief interchange, the therapist and patient develop a shared understanding of how the patient's hand functions. The therapist problem-solves to understand how the patient's hand differs from the hands of other persons with quadriplegia. The patient learns how his hand differs from before it was injured and how it works now. A key element of this interchange is that the information is flowing between the two persons. The therapist does not lecture the patient, but rather, draws
him into a mutual problem-solving process in which they discover together the way in which his hand functions.

Teaching the Occupational Therapist About the Experience of Being a Quadriplegic

To listen to and learn from patients means that the therapist must relinquish authority as the expert. It also means that the therapist must set the stage so that the patient is willing to share his or her knowledge and experience. In the previous example, although the therapist was clearly teaching, she did so in a way that drew the patient into the process, thereby establishing an atmosphere of mutual problem solving. This enabled the patient to take on the role of teaching the therapist about the experience of being a quadriplegic.

Therapist: Remember when you were saying to me the other day about (pause) that-being married is, er-is tougher for you at this point than = you would think someone who is single- < patient moves backgammon pieces with his right hand > -who they don't have all those hassles.

Patient: Yeah =

Therapist: Do you think it's true?

Patient: I don't know. Every case is different. < Both look at each other and laugh. > Where did I get that from?

Therapist: Yeah. I was thinking a lot about that cause I had never had that perspective on it. O-h, o-h.

Patient: Doubles. [There is a break in the topic, as the patient and therapist return to focusing on the game and the patient's ability to move the pieces with his right hand.]

Therapist: That's the breaks—wrong hand, Frank (pause). Um, it was interesting, because I had-usually get it from the people who are single.

Patient: Um,

Therapist: Who worry too much about that.

Patient: Yea (pause). < Patient throws the dice. >

Therapist: But it makes sense. < Patient reaches across the board with his right hand. > You're not going to give me any more than a one-word answer < patient is still moving pieces >

Patient: Well I < both laugh briefly >. Pretty deep subject, we may not have enough time. < Patient leans back in his chair, therapist laughs and shakes the dice. >

This segment of dialogue is interesting, because although it was the patient's comment from a previous session that initiated the therapist's thinking, the therapist reopened the topic so that the patient could expand on it. The therapist said afterward that she believed that the videotaping caused the patient to be less forthcoming than he would have been under normal circumstances. She also spoke of the insight she gained from the patient. The therapist's previous knowledge schema about quadriplegia included the notion that after a spinal cord injury, the establishment of intimacy is more difficult than the maintenance of intimacy in an existing relationship. The patient's comments and the therapist's willingness to listen to them gave her a new appreciation of the dilemmas of maintaining intimacy after such a devastating injury. Had the therapist approached these comments as an expert on quadriplegia, she may have tried to point out difficulties from a single person's perspective. She would have denied the legitimacy of the patient's concerns and missed an opportunity for increased understanding of the patient's life-world.

The therapist provides multiple opportunities for the patient to teach her about the experience of being a quadriplegic. Sitting balance is a problem for this patient. When he moves his arms, he loses stability in his trunk and must catch himself. During the entire session, improvement in sitting balance is emphasized.

Therapist: Your balance is good (pause) your elbow. < Patient picks up one die with his right hand. > That's much better.

Therapist: Does that make you a little insecure when I do that?

Patient: Ah (pause) a-h. < Patient grasps die, leans back in chair >

Therapist: Have you ever gone face down into something?

Patient: With the halo on < therapist shakes dice >.

Therapist: Did you really?

Patient: When I had the halo on < therapist throws dice > (pause). Dropped it < therapist hums, taps fingers, and looks at the board >.

Therapist: Did you think you wouldn't have that trouble now?

Patient: Yeah (pause). I thought-I'd get my balance back-but =

Therapist: Did you have fantasies about what it would be like when other than that-when you got the halo off, like all of a sudden things would move on.

Patient: No, I figured I'd get my balance back anyways. < Patient throws dice, therapist looks at patient, shakes head in assent >

Doubles, doubles—can't use them. < Patient leans back in his chair, smiles, leans forward, and reaches with his right hand to pick up the pieces. >

Therapist: I would imagine people think a lot about, like, what it will be like when the halo comes off, but that's pretty [therapist makes expression of relief]. < Patient picks up the dice with his right hand > I'm going to get you a deck of cards, Frank.

During the above interchange, the therapist controls the agenda by asking the patient to share his experiences and teach her what it feels like to be a quadriplegic. In both of these examples, if the therapist had not taken the initiative either to follow up a statement from an earlier treatment session or to ask questions about the patient's experience, the lesson would not likely have occurred. Thus, the therapist's willingness to create an opportunity for the patient to teach her about his experience is crucial for this understanding to occur. This control, however, has its limits. The therapist broke off the discussion about sexuality because it was clear that the patient did not want to discuss it further. Furthermore, she did not impose her definition of the problem on him, but rather, she listened to his interpretation, thereby entering more completely into his life-world. Cicourel (1985), drawing on Max Weber's work, discussed the special knowledge and control of knowledge that physicians can use to dominate the medical encounter. Few patients are able to challenge this medical authority. In contrast, this therapist's encounter with the patient is notable for its lack of authority and control over the patient's thoughts and concerns and the openness with which the therapist seeks to understand the patient's perspective.

The fluidity of this teaching-learning process is dem-
In the above interchange, the patient and therapist are teaching each other about sensory changes. The therapist is teaching the patient from a scientific, or medical, perspective; the patient is teaching the therapist from his experience. At one point, the therapist catches herself telling the patient what he is feeling: "But, it's a different kind of pain—nah—what do I know, I'm not inside your skin." She quickly shifts the focus back to the patient's interpretation of the pain.

This occupational therapy session is remarkable for the degree to which the therapist and patient consistently seek to test and revise their knowledge schemata. It is also remarkable for the lack of tension caused by disparate knowledge schemata, as described by Tannen and Wallat (1986) and Paget (1983). The degree of understanding that the therapist achieves in this session demonstrates her appreciation for the validity of the patient's experience and perspective.

**Interactive Frames in an Occupational Therapy Treatment Session**

Interactive frames enable people to understand the context of human interaction. Footings, or stances, are particular aspects of this communication process that describe the change in subject or alignment between persons (Goffman 1981). This change in alignment may be signaled by changes in posture or other nonlinguistic cues, tone of voice, or a shift in language itself (Goffman, 1981). These footings within the treatment session can be divided into work and social components. Within these broad categories, additional footings occur. Generally, the therapist verbally initiated the change in stance, thus demonstrating her control of the treatment session. However, many of the changes in footing were in response to subtle cues in the situation. For example, a change in Frank's body posture, a sigh, or the extended period of time it takes him to place the backgammon pieces were cues that the therapist used to change the focus of the session. Questions, diversion to social chat, and the use of humor were primary linguistic cues to mark a change in footing. The timing of these changes reflected the therapist's attention to Frank's nonverbal communication as well as her control over the pace and tone of the session.

The shift from work to social footings often occurred at points of tension and frustration. The social footing gave the patient the time to relax and regroup for additional work. It is clear throughout the session that the patient is severely disabled, and even the simple act of picking up a backgammon piece is difficult. The frequent changes in footing provide respite from this frustration and confirmation of the patient as a human being capable of enjoying ordinary conversation. For example, at the beginning of the game Frank struggles to set up his backgammon pieces. The pieces seem to slip easily from his grasp. The therapist pauses to watch, then says,

Therapist: We can do it that way = <points in one direction on the board>. No, this is you can start here if you want to end on that side.
Patient: No.
Therapist: You want to end on that side. <Sets up pieces. Frank struggles with some.> (Pause.) Come on ... now you are confusing me (pause). <Frank continues to struggle.> You know, Oscar absolutely killed me in checkers yesterday. <Therapist finishes setting up her backgammon pieces, looks up at the patient.>
Patient: Is that so?
Therapist: Uh, huh. He did it with his own hand in a splint. But he really (pause). I lost miserably. Oh, this goes here. I'm sorry (pause). <Patient continues to set up his pieces. Therapist finishes setting them up for him.>

The story about Oscar, a social diversion, deflects Frank from his frustration with the pieces and enables the thera-
pist to share the success of another patient with him, a
dual success in that Oscar could physically play the game
and also "kill" the therapist. Additionally, perhaps sensing
the patient's frustration, the therapist finished setting up
the last of his pieces.

Within the actual game of backgammon there were
at least four footings: (a) playing backgammon, (b) use
your right hand, (c) don't eat the pieces, and (d) what it is
like to be a quadriplegic. The rest of this paper addresses
each of these footings, with a focus on who initiates the
change in footing and how this change is achieved.

Playing Backgammon

This is the social component of the game and is charac­
terized by teasing, joking, and conversation about the game
itself. Attention is on the game, and eye gaze is on the
board itself or briefly on each other. This footing is used
during lulls in the game when Frank is moving pieces as a
way to fill time or reduce tension. The previous segment
is an example of this footing, in which Louise uses a story
to fill the time needed for Frank to finish placing his
pieces. In the following segment, the therapist has
stopped the patient from using his left hand to move the
pieces and is explaining why.

Therapist: But, part of what I'm (pause) my goal to do with you is
to get your hand as strong and functional as possible so that it
does become more automatic for you to use it or have it help you.
Patient: Right.
Therapist: I don't want you to think that I'm purposely (pause)
making your life difficult.
Patient: Right, right = it's only an hour a day.
Therapist: Your best hour of your day (pause) isn't it?
Patient: Best hour of my life < both laugh >.
Therapist: Do I detect a note of sarcasm?

The teasing tone of these interchanges provides a release
for the increasing tension that the patient felt in his effort
to use his right hand, and it interrupted the therapist's
explanation. The phrase, "It's only an hour a day" seems
to be an inside joke, something they use to help maintain
their efforts when treatment is difficult. The patient inter­
rupted the therapist's defense of her "making your life
difficult" with the joke.

Use Your Right Hand, Frank

This is one of the work components of the game and is
the most explicit one. In fact, the therapist identified this
footing as a major theme of the session. It is repeated
throughout the session in various ways. In one segment,
the therapist asks the patient to pick up a particular play­
ing piece so as to give him practice with the grasp he is
perfecting.

Therapist: Do you see if you could pick that one up for me?
Patient: Tha't one there? < Indicates piece and reaches for it, mak­
ing several attempts.>

Therapist: That's it. < Patient continues to try, then leans back.>
Patient: It's slippery < knocks piece off center board >. Oh, [ex­
pletive deleted]. < Therapist picks it up and patient tries again,
finally moving it into the palm of his hand. He moves his hand
toward himself and the piece slides out of his hand. He shakes his
head, slides the piece toward the divider. > Up and under. < Both
laugh and smile >.
Therapist: It's a move.
Patient: Won't go out the window <smiling >.
Therapist: All right/That was good. That was better than I thought
you would be able to do that.

At the end of this footing, the therapist acknowledges that
the patient did better than she had expected. She pro­
vided the patient with feedback for both his performance
and his effort. Much of the "Use your right hand" footing
is spent with the patient trying to pick up the pieces. It is
intense. In many of these segments, both the therapist
and the patient are absorbed by the patient's efforts. This
alignment ends with praise, as in the previous segment,
or humor, to deflect from the hard work Frank is doing.
Louise generally initiates the use of praise or humor.

Don't Eat the Pieces

The name for this footing comes from one comment by
the therapist, "Are you going to eat the pieces?" She said
this when the patient was bent over, almost touching his
face to the playing board. This footing addresses the pa­
tient's balance and his difficulty maintaining an upright
sitting position, especially when he is using his arms.
Consequently, in moving the backgammon pieces, he
frequently loses his balance. In the following segment, the
therapist suggests a way in which the patient can practice
improving his balance while also playing the game. She
immediately backs off from this effort to control the situa­
tion when the patient says, "Oh, yeah."

Therapist: This will help you with your balance too, if you pick
them off from here < indicates a spot on the board on patient's
right > and you put them over here < indicates well on the left
side of the board > with your right hand.
Patient: Oh, yeah < holding the dice with left hand and shaking
them >.
Therapist: Am I pushing my luck?
Patient: I think so.

The therapist responds to the "Oh, yeah" comment with a
question that changes the alignment from balance to rec­
ognition that this is hard work for the patient and that she
should not push too hard. This rapid response to the
patient's tone of voice reflects the therapist's ability to
use small cues to change the focus of the session.

Don't Eat the Pieces

What it is Like to be a Quadriplegic

This footing is used during lulls in the game in which the
patient is handling the pieces more easily or to explore
the patient's feelings. For example, at this point in the
session, Louise explored Frank's feelings as she held her
hand up to protect him from losing his balance while
attempting to move a playing piece far away from himself.
In the above footing, the therapist explores the patient’s feelings about being a quadriplegic so that she can understand his experience more fully. This footing is related to knowledge schemata mentioned earlier in the paper, because it provides the alignment with which to discuss these issues. In addition, although the preceding dialogue is reported as one footing, there are several shifts of footing, from “Playing backgammon” to “What it is like to be a quadriplegic.” These rapid shifts between the two footings seem to enable continuation of a subject that, if pursued directly, would be too difficult or would increase tension. Thus the backdrop of the game enables more active exploration in another footing. The elegance with which the therapist responds to the patient (the patient’s sigh initiates her response of asking about his feelings) is an example of expert practice with the use of small cues to shift the focus of the session, even momentarily.

Implications for Occupational Therapy Education and Clinical Supervision

This paper demonstrates the importance of balancing professional power with intersubjective understanding of the patient’s life-world. This process is complex and relies on the therapist’s ability to read the patient’s verbal and nonverbal cues and to refocus the session in response to these cues. Occupational therapy education and clinical supervision can play a central role in the development of intersubjective understanding by emphasizing the importance of the patient’s values and beliefs and interaction skills as much as the development of specific evaluation and treatment techniques. The imposition of occupational therapy techniques and the use of professional power results in inappropriate treatment activities and alienated patients (Parham, 1986; Pelouquin, 1989; Yerxa, 1986).

Both actual and fictional accounts of medical care and disability can enhance students’ understanding of the recipient’s health care experience. Miller’s (1990) novel, Family Pictures, and Murphy’s (1990) personal ethnography of disability, The Body Silent, enhance our understanding of the effects of disability on persons and their families. Journals and reflective papers enable students to explore their own feelings in relation to these accounts. Through this type of learning experience, students gain an appreciation of the relationship between treatment techniques and an understanding of the patient’s life-world and of the importance of each in occupational therapy practice.

Cohn (1989) discussed methods with which to enhance the clinical reasoning of fieldwork students through the use of clinical stories and videotapes. Videotapes are valuable tools with which to explore the patient–therapist interaction. A single treatment session, as this paper demonstrates, yields valuable insights into the communication process. The study of exemplars, or ideal models, therefore, as well as our own treatment interactions will help us understand the communication process more fully and explore ways to enhance this process in our practice. These methods are applicable for practicing occupational therapists and could be adopted as part of continuing education activities within an occupational therapy department.

Conclusion

Competent occupational therapy practice requires that therapists have a firm understanding of the techniques they can use to bring about change in their patients. These techniques, or the formal knowledge of the profession, are only one aspect of competence. The other aspect is the ability to enter into the patient’s life-world so that the techniques are tailored to meet the patient’s needs. The AOTA/AOTF Clinical Reasoning Study demonstrates that this tailoring is an ongoing process within each treatment session. This paper adds further to this understanding by identifying several specific mechanisms used by one therapist to control and adapt the treatment session to meet her evolving understanding of the patient’s immediate and future needs.

Appendix

Symbols Used in the Transcription Process

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>=</td>
<td>Indicates that the speech of one speaker to another was heard as a continuous stream of speech. In other words, there was no break between utterances.</td>
</tr>
<tr>
<td>(pause)</td>
<td>Indicates a longer than usual pause between turns.</td>
</tr>
<tr>
<td>(pause)</td>
<td>Indicates a pause within turn.</td>
</tr>
<tr>
<td>:</td>
<td>Indicates a brief pause within turn.</td>
</tr>
<tr>
<td>---</td>
<td>Indicates prolongation of the preceding syllable.</td>
</tr>
<tr>
<td>hh</td>
<td>Indicates a noticeable exhalation, the number of letters indicating the length.</td>
</tr>
<tr>
<td>?</td>
<td>Indicates either the possessive case or a contraction.</td>
</tr>
<tr>
<td>/</td>
<td>Indicates a full stop falling intonation.</td>
</tr>
<tr>
<td>/</td>
<td>Indicates a standard question intonation.</td>
</tr>
<tr>
<td>!</td>
<td>Indicates a terminal rising or falling intonation with a lower pitched utterance than a standard question.</td>
</tr>
</tbody>
</table>

An exclamation; an animated delivery.
Note. Dialogue that was unclear is enclosed in parentheses. When the conversation was not understandable, this break is indicated by empty parentheses (Craig & Tracy, 1983). Because this is a transcript of a videotape, significant movements, eye contact, and positioning cues are enclosed in angled brackets.

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None of this work would have been accomplished without the patient’s and occupational therapist’s willingness to be videotaped. I also wish to thank Nedra Gillette, Cheryl Mattingly, and Maureen Fleming for permission to use this tape from the AOTA/AOTF Clinical Reasoning Study. I also thank Ellen Cohn, Bud Khleif, and Stephan Fuchs, who read early versions of this paper and provided criticism and support, which contributed greatly to the development of the ideas presented here.

References


