Personal–Professional Connections in Palliative Care Occupational Therapy

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This qualitative study examined the experiences of occupational therapists working in palliative care. Multiple qualitative interviews were conducted with each of eight occupational therapists working with people who are terminally ill. The interviews were transcribed verbatim and analyzed for recurring and unique themes. Five themes emerged: satisfaction, hardship, coping, spirituality, and growth. Common themes, while resonating through all participants’ stories, were experienced in a uniquely personal way by each participant. The result was the discovery of an individualized “personal–professional connection” for each participant. The exploration of personal–professional connections can contribute to the understanding of occupational therapy practice in palliative care. Furthermore, these individual stories may resonate for other occupational therapists and inspire personal and professional reflection; validation of feelings and issues can arise from parallel comparisons. Therapists may in turn gain insight into the relationship between their own personal and professional experiences.


Palliative care programs are dedicated to maximizing quality of life while providing support when there is little hope for cure (World Health Organization [WHO], 1990). The relief of suffering and the provision of comfort are assumed to be what each client hopes for in his or her final days. As suggested by the World Health Organization (2002):

Palliative care provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient’s illness and in their own bereavement; uses a team approach…will enhance quality of life…(and) is applicable early in the course of illness…to better understand and manage distressing clinical complications. (Definition of Palliative Care, para. 1)

Although palliative care is commonly discussed in relation to cancer care, the philosophies of palliative care apply to any client who is facing a terminal illness. A typical palliative care team is multidisciplinary with an occupational therapist as a member of this team (American Occupational Therapy Association [AOTA], 1987; Penfold, 1996; Rahman, 2000; Tigges & Marcil, 1988). Professionals help clients who are dying by comforting, supporting, and connecting (Hasselkus, 1993; Rosa & Hasselkus, 1996). An occupational therapist can assist a terminally ill person through his or her final journey by helping a client redefine life roles, achieve relaxation, conserve energy, manage pain and anxiety, and by helping a client be comfortable through proper positioning and mobility (AOTA, 1987; Bye, 1998; Doyle, 1998; Gammage, McMahon, & Shanahan, 1976; Penfold, 1996; Picard & Magno, 1982; Pizzi, 1984; Rahman, 2000; Tigges, 1998; Tigges &
Marcil, 1988). An occupational therapist can also help a client address embarrassment associated with physical changes, social isolation, boredom, and emotional pain that can accompany terminal illness (Doyle, 1998). An occupational therapist is committed to making a positive difference in clients’ lives (Bye, 1998; Hasselkus & Dickie, 1990; Rahman, 2000), even in the face of impending death. Frequent changes in the client’s physical, mental, and emotional condition direct the occupational therapist’s ongoing modifications to a personalized treatment plan.

Although little has been written about occupational therapists working in palliative care, much can be learned from the experiences of other health professionals. Rasmussen, Norberg, and Sandman (1995) reported that nurses hope and expect to grow personally from close relationships established with dying clients and family members. For health service providers, one of the most rewarding aspects of working with people who are terminally ill is to receive expressions of appreciation and gratitude from clients and their families (Cohen, Haberman, Steeves, & Deatrick, 1994; Rasmussen et al., 1995; Scanlon, 1989). Honesty, attentiveness, and giving of oneself have been recognized as fundamental personal qualities in people who work in palliative care (Davies & Oberle, 1990; Rasmussen et al., 1995).

Despite the personal rewards, professionals working with people who are dying experience many challenges. When death occurs, a professional may have difficulty letting go of one relationship, characterized by rapport and friendship (Rasmussen et al., 1995; Scanlon, 1989), only to enter another destined to end in the same way (Beszterczey, 1977; Feldstein & Gemma, 1995; Kiger, 1994; Martin & Berchulc, 1988). The sadness and grief associated with the death of one client may compound as unresolved grief from the constant and often unacknowledged loss of many clients (Davies & Oberle, 1990; Petrosino, 1984; Vachon, 1983). Such grief can deplete energy levels, leaving the health professional feeling fatigued, professionally ineffective or even incompetent, disinterested in life outside of work, and perceiving a lack of control in his or her life (Alexander & Ritchie, 1990; Martin & Berchulc, 1988; Vachon, 1983). Professionals may not only feel sadness, but also “frustration at having invested large amounts of energy in caring for people who then die, taking this investment with them” (Vachon, 1983, p. 241). Uncertainty can accompany a client’s death, especially if the death was sudden and treatment goals were unmet. It may not be clear “whether the lack of accomplished goals is related to one’s own limits regarding knowledge, skills, understanding, and courage or to the nature of dying itself” (Rasmussen et al., 1995, p. 352).

Professionals may be preoccupied with thoughts of what they could have done differently for a particular client who dies (Beszterczey, 1977; Martin & Berchulc, 1988). Bennett (1991) and Bye (1998) have said that occupational therapists working with dying clients need to reevaluate the criteria for successful therapy. Self-esteem and self-confidence of professional caregivers may be fostered only when expectations become congruent with the limitations inherent in caring for people who are dying (Beszterczey, 1977).

Health professionals working in palliative care commonly experience anxiety. Their clients may have extreme pain or psychological distress. The caregiving setting can also provoke anxiety. For example, anxiety of care providers has been associated with the carers having to make decisions under time constraints without available consultation, and without adequate preparation for communicating with and caring for people who are terminally ill (Martin & Berchulc, 1988; Petrosino, 1984).

According to Petrosino (1984), self-realization and a realistic awareness of personal abilities and limitations are essential for setting manageable goals and minimizing feelings of frustration. Even so, sadness and grief in palliative care may remind the health professional of his or her own personal losses. As an occupational therapist facing a family member’s dying and subsequent death, Thibeault (1997) recognized her own personal vulnerability and limits of coping. DeHennezel (1997), a psychologist devoted to palliative care, recognized how being so close to the suffering and death of others taught her to “live differently, with greater awareness and greater intensity” (p. 48) providing “moments of incomparable humanity and depth” (p. 69).

The personal and professional connections acknowledged by Thibeault (1997) and DeHennezel (1997) from their own testimonials are clear. A similar theme emerged in a phenomenological study by Rasmussen et al. (1995) in which the impact of palliative care on nurses was examined. Palliative care occupational therapists have never been the focus of such examination. One author (CP), an occupational therapist who has practiced in palliative care for 7 years, was curious about the experiences of other palliative care occupational therapists. The initial personal entry from her research journal, written before the participant interview process began, reflected this curiosity and thirst for the stories of others:

Working in palliative care has changed my life. I have had rewarding experiences, frustrating experiences, and experiences I can only begin to describe….Knowing I have helped someone in a time of great need can be very satisfying. The gentle touch from a client is a wonderful thank you….Not having time to see all clients in short order can leave me feeling guilty….Many clients leave me
filled with grief and sadness when they pass on...I have learned not to put off until tomorrow what I can do today...I have become a better listener...Silence can be very therapeutic...My social relationships have changed, grown in so many ways...Personally, I have grown and become more tolerant of life’s small problems, because they are just that...I anticipate this research study will demonstrate that my feelings and experiences are similar to other therapists...Perhaps I will note commonalities, but it is possible I will hear several, unique stories.

This study was designed to describe the nature of the connection between the personal and professional lives of palliative care occupational therapists. The personal effects of professional practice in palliative care deserve illumination and validation for practicing therapists and future therapists. The identification of occupational therapists’ connections may lead to new understandings and support, both personally and professionally.

Method

Qualitative research methods are particularly useful for examining a phenomenon about which little is known and which necessarily starts from the perspective of the person experiencing it (Morse & Field, 1995). For this reason, we used a method of qualitative inquiry in which the participants’ experiences represented the richest data available. We targeted occupational therapists from hospices, acute care facilities, and community-based settings whose primary practice was providing services to clients who were terminally ill. To recruit participants, we used purposeful sampling by telephoning occupational therapists who practiced palliative care within a large urban city in western Canada. Eight occupational therapists agreed to participate in the study. All participants had a minimum university baccalaureate degree in occupational therapy. Of the one male and seven female participants, three were married with children and five were single with no children. With a mean age of 35 years, their experience in occupational therapy practice ranged from less than 1 year to 25 years. Their average time in palliative care practice was 3.5 years, ranging from less than 6 months to 10 years.

The first author conducted private, repeated in-depth interviews at a time and in a space convenient for each participant over a 3-month period. Each of the initial unstructured interviews began with the broad, open-ended question: What is it like to work with people who are dying? Participants were able to “move freely in his or her descriptions” (Streubert & Carpenter, 1999, p. 25) during interviews which lasted 45 minutes to 2 hours. Thus, the participants gave direction to the interviews as the interviewer responded to what they said by encouraging them to go on as one point led to another. Each interview was audiotaped, transcribed, and reviewed by both the interviewer and the participant prior to their next interview. This gave each participant the opportunity to verify what had already been said and allowed the interviewer to ask for further clarification and elaboration of their experiences. After seven participants were interviewed three times and the eighth participant was interviewed twice, “repetition and confirmation of previously collected data” (Morse, 1994a, p. 230), was apparent and we assumed that theoretical saturation was achieved.

In addition to the audiotaped and transcribed in-depth interviews, triangulation of data collection was achieved by the interviewer keeping a research journal, an introspective record of her pre-understandings and feelings that may have influenced the interviewing and interpretive processes. As well, she kept field notes on the circumstances and events that surrounded each interview to serve as prompts, reminders, and organizers for her thought processes.

Thematic analysis was carried out as an inductive process concurrent with data collection so that interviews could focus on qualities of the experience as they were identified (Marshall & Rossman, 1995; van Manen, 1990). The data were analyzed by what Morse (1994b) describes as a process of sifting “insignificant noise from the aggregate stories, leaving only the common but important features” (p. 31). After each interview the interviewer identified, highlighted, and categorically labelled key words, sentences, passages, paraphrases, and quotes that described a significant aspect of the experience. The interviewer continually verified the analysis through participant member checks during subsequent interviews. Themes discovered in each participant’s interview transcripts were further synthesized to form themes generic to all participants in the study. The thematic analysis process continued until each participant indicated that a rich, coherent, complete, and detailed description of his or her unique experience had been captured within the generic themes.

Findings

Five themes emerged from the data analysis: satisfaction, hardships and difficulties, coping, spirituality, and growth (see Figure 1). Although each of these themes was a separate entity, they were all closely linked and interconnected as dimensions of personal–professional connections.

Satisfaction

Satisfaction from working in palliative care was a strong sentiment expressed by participants. During the course of
A final source of satisfaction was described as managing the clinical and emotional challenges of clients while facing the urgency of palliative care. For instance, one participant described developing innovative solutions to new and unique problems as a creative experience that, when successful, was extremely satisfying:

You have to meet a [client’s] demands quickly….I like that….You can’t be taking 5 weeks to carry out a treatment intervention. Usually, the client’s needs were 2 days ago…they need it now. [Palliative care] keeps you on your toes, makes you think quickly.

Hardships and Difficulties

Along with the satisfactions of palliative care practice, participants discussed being able to endure hardships and difficulties. While strong, individual relationships are not developed with every client, the death of any one client is experienced with some level of sadness and sorrow. When a large number of deaths occur in a short time span, participants explained that these feelings of sadness and sorrow can accumulate: “Some days you can feel pretty devastated [when] you lose a couple of people fairly close together in time, where you have been quite involved. You feel like the bottom is dropping out on you.”

One participant described a type of grief that she defined as “unnecessary grief.” This kind of grief consumed her energy and prevented her from taking constructive actions in her personal life. For instance, as a client was added to her caseload, she would sometimes personalize the experience. She would imagine herself in the position of the client’s family and as a result found herself grieving for the imaginary loss of her own loved one, a loved one who was in reality strong and healthy. Similarly, another participant described being preoccupied with the demise of her own health and wellness, and with the possibility that she might herself be diagnosed with cancer: “Sometimes I think about [dying] too much….It is grief that I don’t need. I’m grieving for something that hasn’t even happened.”

Coping

Participants described a sense of urgency in palliative care stemming from the rapid deterioration in health and fragile condition of palliative clients. Participants expressed feelings of impatience, anger, and frustration related to this urgency. Some participants spoke about feeling guilty when interventions were not promptly delivered: “I start getting more and more impatient, because I think everything has to happen now.”
late feelings, particularly the grief experienced by partici-
pants when clients died, was described as an important cop-
ing method for each study participant. One participant, 
however, acknowledged the importance of finding a bal-
ance. For her, talking too much about the challenges of pal-
liative care consumed a lot of energy causing her to feel that 
she focussed too much on the negative aspects of her work. 
In some cases, participants described the cathartic benefits 
of speaking about their feelings and experiences during 
team meetings and group situations. At other times, partic-
ipants explained that it was more helpful to speak about 
their feelings and experiences privately, with someone close 
to them. Two participants explained that self-expression is 
not simply a conversation with a colleague, but rather a 
deep examination of feelings that included humour as well 
as sadness. To them, humor could put situations into per-
spective and lighten things up. Black humour and sarcasm 
might be used when they felt particularly challenged with a 
situation. Realizing how callous such humour could appear 
to clients and their families, one participant explained how 
she was careful to use black humour only with her col-
leagues. Writing in a journal or a diary or sending cards 
were other ways participants conveyed their emotions. 
Journals and diaries were perceived as ways for releasing 
emotions in a personal, private way without necessarily hav-
ing to share them with others:

All of the team members talk about their experience. That 
is really therapeutic to do that. The debriefing part of it is 
helpful. If [a death] happens when we are not having a 
team meeting, I will often just talk it over with one of the 
team members….We kind of reminisce about things and 
that helps.

Self-nurturance was the second coping strategy 
described by the study participants. Self-nurturance strate-
gies that helped to relieve work-related stress included using 
physical exercise as a time for reflection and self-expression 
when words would not suffice, pursuing leisure activities 
not only for pleasure but distraction from the challenges of pal-
liative care, and practicing relaxation techniques.

Another coping strategy described by the study partic-
ipants involved finding ways to bring a sense of closure to their 
experiences with death. This included attending funerals 
and wakes, lighting candles in memory of their clients, and 
meeting with the client’s family one last time. One partici-
pant described a very personal way of terminating a rela-
tionship whenever a client died. In a private moment of 
quiet reflection, she would deliberately bring a distinctive 
characteristic of the person to mind, what might be called 
the final image. In so reflecting on her experience with that 
partial client, she was able let go of that relationship so 
that new ones could flourish:

For everybody that passes on I have a final thought about 
them….If [the client] was a lady who loved flowers, I might 
just think of a flower [resembling] her. Then, chapter 
closed and someone else can go into the room….I remem-
ber something about everybody…no matter how much I 
worked with them.

The participants described a fourth coping strategy as 
control-taking behaviours such as establishing clear personal-
–professional boundaries and withdrawing or distancing 
themselves. Some described putting limits on how much 
they would talk, cry, or reflect with others about their work. 
Others talked about the importance of placing limits on how much they invested in their relationships with their 
clients.

A final coping strategy identified by the study partici-
pants was the act of rationalizing. By seeking explanations 
from their past experiences or those of others, they were 
able to justify behaviors encountered in practice. One par-
ticipant used a rational thought process and described how 
she could consciously choose to not feel guilt about the 
complex and unfortunate circumstances that sometimes 
surrounded clients’ deaths. This participant would rational-
ize the need to complete the concrete tasks of her job such 
as collecting equipment which had been provided to clients 
who then died: “I lend [clients] equipment….We want to 
get that equipment back….We have to look at the practical 
things to be able to continue to be able to do our jobs.”

Spirituality

Participants believed that spirituality became more mean-
ingful as a result of their experiences in palliative care prac-
tice. Many participants acknowledged how their thoughts 
about death and fears of the unknown had been altered. 
Their experiences seemed to have given them insight into 
what was important in life. While Urbanowski and Vargo 
(1994) have described spirituality as “the experience of 
meaning in everyday life” (p. 89), its many forms can 
include finding the good in life, clarifying religious faith, 
and discovering hope. To one participant, spirituality was 
defined as the awakening of her belief in the goodness of the 
human spirit. While she had always believed that people 
were basically good, her palliative care experiences not only 
affirmed this but strengthened her religious beliefs and 
strong sense of “God” as well: “Working in palliative care 
makes me think, ‘What is it that I do believe in?’”

All but one participant described how they were ini-
tially apprehensive about working in palliative care. Not 
knowing what they would encounter in such a setting 
evoked a sense of fear. However, most of this fear was al-
leviated after time once they developed a sense of their pro-
fessional self. While one participant spoke about her con-
Continuing fear of death as a personal issue, others talked about death with a sense of wonder and rationality. For example, one participant wondered how she might react if she were diagnosed with a terminal illness, while two others not only pondered their own mortality but had already made plans in the event of their death and discussed those with their families. Others recognized how their palliative care experiences reminded them of the finiteness and uncertainty of life’s course. One participant described how she now thought about the importance of balancing her present realities with her future plans. Another spoke about how she had come to realize the importance of living her life according to her own aspirations and dreams and encouraged others to do the same. One participant reflected that her palliative care experiences had reinforced how each day is a gift to savor. Another participant said that working with people who are terminally ill put the trivial matters of her own life in perspective:

Life is very brief. We’re here to live it.
It hits me when I’m with somebody who doesn’t have a long time to live….When you are working with people in palliative care, you realize that you never know what can happen and what life can bring.

**Growth**

All participants identified ways in which their personal lives had been enriched by their palliative care practice. For example, one participant described how she was not only more aware of her personal strengths now but more confident in trusting that she could act on them. Two others explained how their work in palliative care helped them to confront their own personal losses, some that had occurred many years ago, and to still learn from them. One participant described how her historical fascination with funerals and cultural differences related to death merged with her attending the funerals of clients for whom she had cared. In doing so, she developed a unique awareness of herself and an awareness of her own needs when it came to planning a funeral for her own death. She felt that, while developing in her professional practice, she also grew in a personal way: “[Working in palliative care] has made me aware of what is inside me, my own criticisms, the struggles that are really inside me.”

Palliative care experiences also influenced the relationship between several participants and their families. Following her scare with a possible diagnosis of cancer and knowing intellectually the possible disease progression which could follow, it became extremely clear to one participant how much more important her husband and family were to her than her work. Another participant developed the courage to challenge the self-defeating thoughts of a loved one. A third participant came to terms with previous personal losses by discussing them openly with those closest to her, in turn enhancing the quality of those relationships: “[I am] more sensitive to the needs of friends and family, especially [during] the time of a family member’s death. Extending a supportive word or extending myself in some other way to acknowledge their situation.”

**Discussion**

The themes that emerged from this study were: satisfaction, hardships and difficulties, coping, spirituality, and growth. It might be argued that these themes reflect the experiences of occupational therapists in general. However, the experiences of the participants in this study suggest that these themes are experienced more intensely by occupational therapists working in palliative care than in other areas of occupational therapy practice.

Integral to the five themes are the personal and professional connections experienced by palliative care occupational therapists. The boundary between one’s personal and professional life can be a permeable one that allows for interplay between personal life experiences and professional practice. In fact, in their study with occupational therapists, Rosa and Hasselkus (1996) determined that the “therapists personal identities seemed to combine with their professional identities” (p. 256).

**Personal–Professional Connections for Occupational Therapists in Palliative Care**

The *satisfaction* and rewards to occupational therapists evolving from the experience of working in palliative care can be due to the appreciation and gratitude shown by the terminally ill clients, their families, and colleagues (Cohen et al., 1994; Rasmussen et al., 1995; Scanlon, 1989). For the occupational therapists in this study, the relationship between the client and the therapist was a reciprocal one. They talked about how their “giving” was in turn met by the “giving” of others. This type of reciprocity in a patient–therapist relationship has been shown to not only provide satisfaction, but to foster connectedness (Rosa & Hasselkus, 1996). Although satisfaction from a reciprocal relationship can exist in other work settings, this type of relationship may be more intense and common in palliative care due to the sense of urgency brought on by a client’s dying experience. As Hasselkus and Dickie (1990) discovered, a sense of being valued and appreciated by clients and colleagues can be professionally rewarding for an occupational therapist.

The *hardships and difficulties* described by the participants in this study arose largely out of the numerous deaths...
that occur in palliative care settings. Depending upon the strength of their relationships with the clients, the participants explained how some deaths had a greater emotional impact than others. However, even in the absence of strong relationships, the experience of death in the palliative care setting brings a sense of loss, sadness, and grief to the unit. In their study with intensive care nurses, Rashotte, Fothergill-Bouffonais, and Chamberlain (1997) described how with the death of a patient, nurses hurt and felt a “cluster of emotions” (p. 377) that included sadness, grief, and loss. Such grief, if unresolved, can have a cumulative effect on the caregiver and can be further heightened by the caregiver observing the grief of the patient’s family (Petrosino, 1984). Much like how the frequent exposure to death precipitated anxiety nurses had about their own health (Gray-Toft & Anderson, 1986), a similar sentiment was expressed by a participant in this study when she became concerned about dying of cancer. Though this individual did not have cancer, her daily confrontation with death proved so difficult that she took this hardship in a personal way. Another participant talked about experiencing the “unnecessary grief” of grieving the imaginary loss of her own loved ones when observing families losing a terminally ill client. In these examples the palliative care experiences of their professional work affected how they experienced certain aspects of their personal lives.

As found by others (Alexander & Ritchie, 1990; Bye, 1998; Martin & Berchulc; 1988; Vachon, 1978), participants expressed feeling a loss of control and uncertainty about their level of competence in working with clients who are dying. Although a palliative care occupational therapist may do his or her best to meet the needs of a dying client, three participants wondered what could have been done differently and whether they indeed could have done more. It would not be surprising if prolonged and unresolved professional doubts eventually affect personal confidence as well.

The sense of urgency of palliative care practice described by participants has also been described by Bye (1998). Occupational therapists who work with terminally ill clients appear to view time as more precious than therapists who work with clients who are not terminally ill (Bye, 1998).

The coping strategies commonly used by participants in this study included some form of self-expression, self-nurturance strategies, actions to bring closure to relationships when clients die, control-taking behaviors and rationalization. While all of these strategies were stimulated by work-related stresses, each found its way into both the participants’ personal and professional worlds. The journal writing for instance, would occur at home, as would their pursuit of relaxation techniques and physical activities. Bringing closure to their experiences with death occurred during both personal and professional times. Going to funerals might involve taking time away from work whereas lighting a candle in memory and bringing forth the final image of a client who had died might be done both as a personal and professional experience. Contrary to previous findings (Beszterczey, 1997; Feldstein & Gemma, 1995; Kiger, 1994; Martin & Berchulc; 1988), participants in this study did not seem to have difficulty letting go of client relationships. Indeed, successful termination strategies appeared to relieve stress associated with the challenges of palliative care occupational therapy. Though it is recognized that caring, empathy, and understanding are valued in occupational therapy practice (Peloquin, 1990, 1993a, 1995), participants appeared to impose personal and professional limits through control-taking behaviours such as establishing boundaries and distancing. As Peloquin (1993b) described in her studies of professional–patient relations, these control-taking behaviours seemed to safeguard participants against the hardships and difficulties of their palliative care practice.

The rational thought processes that participants used to cope with the difficulties and hardships of palliative care practice were reminiscent of the reconceptualizing and reframing of practice described by Bye (1998). Occupational therapists may alter their manner of thinking to suit the unique needs of terminally ill clients and to take control of their personal feelings.

When spirituality is defined as a reflection on what is important in one’s life (Davies & Oberle, 1990), it becomes an integral aspect of participants’ personal–professional connections. Each participant clearly articulated how his or her experience in palliative care practice had taught him or her to appreciate life and to live for the moment. Working with people who are dying made them more comfortable with death as a “natural part of life.” A similar finding has been reported about nurses who work with people who are dying (Rasmussen et al., 1995). As a professional facing death on a regular basis, one confronts one’s own personal thoughts on death and dying (Petrosino, 1984; Robbins & Moscrop, 1995).

Within the last theme, growth, palliative care occupational therapy experiences made it possible for the participants to develop deeper understandings of themselves. They talked about becoming more acutely aware of not only their own strengths and weaknesses, but also those of others. As Kubler-Ross (1969) has stated, “being a therapist to a dying patient makes us aware of the uniqueness of each individual in this vast sea of humanity” (p. 276). Through their observation of what suffering entailed, two participants...
experienced a depth of empathy they had not known before. According to Twycross and Lichter (1998) this experience is essential for effective palliative care practice.

In this study, participants described how their professional experience enhanced their personal growth in terms of being more aware of one’s own needs and strengths, dealing with personal losses, and appreciating relationships with one’s own family. The boundary between their personal and professional lives was permeable with the experiences of one affecting the other. As participants described their palliative care experiences, it became clear to the interviewer that the occupational therapists’ personal and professional lives were so intensely intertwined that any attempt to separate them seemed forced and artificial. As Rosa and Hasselkus (1996) describe, “therapists were personally engaged in their professional work” (p. 256). Furthermore, it became clear to the first author that as a palliative care occupational therapist, her experience fit into the common themes while including unique aspects. In fact, she discovered her own personal–professional connection in palliative care occupational therapy.

Recommendations for Future Research

This qualitative study has demonstrated the nature of the connections between the personal and professional lives of palliative care occupational therapists. Practicing occupational therapists, future occupational therapists, and other palliative care professionals who read this study may see similarities in their experiences to the personal–professional connections of the participants. Differences are also expected as each professional creates his or her own personal–professional connection. It is hoped that through exploration of connections, we will better understand occupational therapy practice in palliative care.

Participants often referred to the context of palliative care—the intensity, the urgency, the continual exposure to death and grief. Each of these characteristics of palliative care is worthy of examination as one might assume that each affects the personal–professional connection of a therapist. What might influence the occupational therapist’s intensity and duration of grief and his or her ability to cope and manage it? The answer to such a question may increase our understanding about how to best provide occupational therapy in a palliative care setting.

Though this study was conducted with palliative care occupational therapists it is reasonable to assume that other palliative care providers experience personal–professional connections. What might the nature of these connections be? A comparison of personal–professional connections may illuminate common as well as unique connections within and between disciplines. Are any findings unique to a particular discipline? Moreover, are findings applicable to other practice settings?

This study consisted of an in-depth exploration of five themes. With this exploration came the realization that the themes relate in an interconnecting manner, that which we have called personal–professional connections. These connections require further exploration as a phenomenon. How do these connections come to be? How do they influence practice?

Furthermore, the findings of this study speak to the complexity of personal and professional areas of life and how they interrelate. Future examinations are needed to more fully understand the meaning of professional and its integral relationship with what is personal.

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the dying teach us to live. Shambhala Sun, 45–49, 66–69.