Volitional Narratives and the Meaning of Therapy

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Objectives. Occupational therapy literature has long recognized meaning as central to therapy. By focusing almost exclusively on how the therapy process influences the experience of meaning, the literature has neglected to examine how the patient’s experiences before therapy influence the creation of meaning in therapy.

Method. Building on a previous study of how patients discover and recount the meaning of their own lives in volitional narratives, we investigated the effect of those narratives on the experience of therapy.

Results and Conclusion. Our examination of the therapeutic experiences of two patients enrolled in a psychiatric day hospital program reveals how they assigned meaning to therapy as an episode within their larger volitional narrative.

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More than 35 years ago, Bateson (1956) observed that occupational therapy’s ability to transform patients’ lives depended on the meaning they experienced when engaged in action. A decade later, Yerxa (1967) argued that meaning was a central determinant of therapeutic outcome. More recently, Engelhardt (1977) proposed that occupational therapists were custodians of meaning, adding the idea that the therapeutic process had implications for and required attention to the meaning experienced by the patient. Despite such recurring calls for attention to the problem of understanding meaning in occupational therapy, the field’s research on meaning is still fledgling.

Most of the discussions of meaning in occupational therapy have focused on understanding how the media or the occupational form (Nelson, 1988) used in therapy creates meaning for the patient. Such discussions have argued that occupations have socially and culturally defined meanings that participants naturally experience. Cynkin (1979), Kielhofner (1985), and Nelson (1988) have argued that the experience of meaning is greatly affected by the way in which an activity is framed by the socially ascribed significance of occupation undertaken.

A number of studies have demonstrated that variation in activity content influences the experience of meaning. The measures of meaning used in such studies are somewhat variable, ranging from self-reports of experienced meaning to standardized measures of affective response to the occupation undertaken. Studies have demonstrated that subjects who used real life materials or tools have reported them to be more meaningful than either rote exercises (Miller & Nelson, 1987; Yoder, Nelson, & Smith, 1989) or imagery-based activities (Lang, Nelson, & Bush, 1992). Some studies have shown that manipulating the circumstances of treatment, such as incorporating life review or keeping the product made in therapy, alter the affective response of participants (Froehlich & Nelson, 1986; Hatter & Nelson, 1987; Kircher, 1984; Rocker & Nelson, 1987; Thibodeaux & Ludwig, 1988). Kremer, Nelson, and Duncombe (1984) found differences in the affective meaning experienced by psychiatric patients in different occupational therapy treatment activities. In a study of psychiatric patients’ responses to participating in activities, Boyer, Colman, Levy, and Manoly (1989) found that affective responses to structured repetitive activity differed from responses to unstructured and nondirected activity. Adelstein and Nelson (1985) found significant differences in subjects’ affective responses to sharing and to not sharing of supplies and products in a collage activity. However, still other studies failed to show differences in affective responses to similar manipulations of activity conditions (Bloch, Smith, & Nelson, 1989; Steffan & Nelson, 1987).

These studies are characterized by manipulation of single factors in task performance when multiple influences on the meaning experienced may have been at
work. Not surprisingly, they provide mixed evidence concerning the effect of task variation on affective meaning. Indeed, many of the authors raised the possibility that meaning could have been influenced by many factors. In particular the characteristics or life situations of the persons studied (Adelstein & Nelson, 1985; Nelson, Peterson, Smith, Boughton, & Whalen, 1988; Nelson, Thompson, & Moore, 1982; Riccio, Nelson, & Bush, 1990; Rocker & Nelson, 1987; Steffan & Nelson, 1987; Thibodeaux & Ludwig, 1988). Other writers have emphasized that meaning is a function of the personal perspective the patient brings to therapy (Andberg, 1983; Kielhofner, 1992; Nelson, 1988; Sharrott, 1980; Yerxa, 1967).

Despite the recognition that patients' life perspectives may influence meaning in therapy, there is almost no research in occupational therapy that examines this issue. One exception is Crepeau's (1991) examination of an occupational therapist's treatment session with a patient learning to live with a spinal cord injury. This study is a first step in understanding therapy from the life perspective of patients.

The disproportionate emphasis on meaning as a feature of either therapeutic media or therapeutic process reflects a view implicit to the occupational therapy research—a view that the patient is coming into therapy. An alternative way of viewing how meaning is experienced in therapy is to consider therapy as an event coming into the life of the patient (Dreier, 1992). From this perspective, it is important to know how the patient experiences his life and, therefore, how the patient is disposed to experience meaning in therapy.

A paper published in this issue of AJOT (Helfrich, Kielhofner, & Mattingly, 1994) argued that persons interpret and anticipate their lives in volitional narratives that organize their sense of personal causation, interests, and values into a coherent schema. These volitional narratives also relate an array of past, present, and potential life events into systematic wholes. Moreover, persons remember past experiences and anticipate an imagined future from the perspective of these narratives.

The concept of volitional narratives builds the interdisciplinary argument that persons organize their self-knowledge and choices through narratives, that is, the stories they tell themselves and others (Geertz, 1986; Gergen & Gergen, 1988; Mattingly, 1991b; Mattingly & Fleming, 1993; Schafer, 1981; Spence, 1982; Taylor, 1989). Thus, the paper argued that through volitional narratives, persons locate themselves within an unfolding story—a story through which the self is known. As unfolding events become part of the life story that the person is experiencing, they take on particular meaning for the person from the perspective of that narrative. Because it is from the perspective of the volitional narrative that persons assign meaning to their everyday experiences, we might expect the same to be true of the experience of therapy.

### Study Purpose and Method

Helfrich et al. (1994) illustrated how two persons employed volitional narratives, placing themselves in an unfolding life story. Moreover, the article showed how their lives, and the events within them, took on meaning within these stories. The present article explores the experiences of these two persons in therapy, focusing on how their volitional narratives influenced the meaning they found in the therapeutic process. In pursuing this line of investigation, we have purposefully shifted emphasis away from understanding how the process of therapy influences meaning. Instead, we explored how these patients came to ascribe meaning to the therapeutic experience, given that they come to therapy with lives already in progress—lives with meanings told in volitional narratives. The two persons we studied both experienced a number of hospitalizations and, in that context, have received occupational therapy several times. At the time of this investigation they were enrolled in a partial hospital program receiving occupational therapy.

Several sources of data were generated and used. Detailed interviews were conducted with both persons; these interviews concerned their perceptions of themselves and of occupational therapy. Observation and fieldnotes from therapy and reports from their occupational therapists were also used. These two subjects were previously described in detail (Helfrich et al., 1994); they are briefly reintroduced here.

#### Tom

Tom is a 28-year-old journalist whose aspirations to a career in journalism began when he was a star student and editor of his high school newspaper. He is an honors graduate in journalism from a prestigious private university and has held jobs in investigative journalism for city newspapers. After repeated episodes of manic depressive illness that have interrupted his career and made the usual climb up the journalistic career ladder impossible, Tom has remade his story. After his most recent hospitalization, he accepted a less demanding and less prestigious position on a trade publication. This career move belongs to a personal narrative in which he is struggling against a chronic disease. By lowering his sights in light of his chronic illness, he avoids becoming embittered and envious of peers who have gone on to pursue successful careers. Tom most wants to continue to function as a worker in an area related to his original love of journalistic writing, to have his own home, and to be self-sufficient. This is the story he struggles to make of his life.

Tom related his experience of occupational therapy during his first hospitalization as follows:

> I was never very enthusiastic about [occupational therapy]. I would usually just color, you know, just try to pick the simplest...
[activities]. I didn’t want to concentrate. I didn’t want to devote any effort. I thought it was all just dumb. I was in there and I didn’t want to be in there and I hated it. It just seemed very annoying to me, to be asked to create little projects as if I was in grade school so I probably gave them a hard time. When you’re in the hospital you have very heavy issues on your mind like “How am I gonna stop the world from being destroyed?” or “Is my life ever gonna be the same and am I ever gonna be employed again and are my friends ever gonna talk to me again?” The last thing you want to do is just devote your attention to tempera paints!

For Tom, most of occupational therapy was largely irrelevant to his struggle to get over the episode and the hospitalization experience and to get on with life. In his words, “I wanted to pack as much serious therapy as I could into each day” cause somehow I figured that could help me resolve things faster” (emphasis added).

Thus, while he was highly motivated to return to work and equally motivated to participate in serious therapy that would help him achieve this goal, he did not perceive occupational therapy as serious. Rather, it was for him an irritating and irrelevant detour:

There’s a real impatience that comes along with being in a group like that where you know you are out of the hospital but for some reason can’t quite get back into the real world. The working world and you don’t want to be in the group for any longer than you have to be . . . at least that’s the way it was for me. And it seemed like those kinds of activities took up a lot of time, but maybe weren’t all that helpful, you know, it’s the way I felt.

Tom provided a telling example of why he perceived occupational therapy as less than helpful in achieving his goal of getting back to his career. He participated in an occupational therapy group that focused on increasing patients’ awareness of motivation. In this group, patients worked together to create a motivation tree. As he described it,

we were forced to think of things that motivate us and then she [the occupational therapist] declared that we were going to copy these ideas on to leaves and paste them on to this tree that she drew on a large piece of paper . . . we all humored her and did it, but we were looking at each other like this was a really silly way . . . she should have just let us brainstorm about what motivates us and then discuss it . . . it went a little too far to ask us to paste leaves on to a tree like we were in kindergarten.

Reflecting on how he experienced the group, Tom concluded that a more appropriate label for the exercise was “the anxiety bush.” Although it may be tempting to suggest that he failed to see such therapy as meaningful because of the activity used in the group, it is more to the point to consider how his volitional narrative led to this interpretation of therapy.

Indeed, Tom told many more stories like this one. They all illustrated his difficulty with engaging in a range of activities that he perceived as irrelevant. At first, it seemed that he was making a distinction between talking and doing, that he preferred therapy to consist of talk. Further exploration of this issue revealed that he was making a more subtle distinction between therapy that he perceived as relevant to the volitional narrative, in which he was struggling to return to work, and activities that he saw as belonging to the story of being a psychiatric patient.

For example, in contrast to the anxiety bush activity, he reacted positively to an exercise in which patients simulated a job interview:

To me a classic example of what was most useful for me was doing a mock job interview. You had to come in and pretend that you were a job applicant and try to answer questions about your history. It just addresses a very practical, immediate concern that I had at the time.

Tom’s volitional narrative involved his struggle to return to outside life with a paying job in journalism. Real therapy, to him, was that which achieved a place in this narrative. He saw cutting and pasting paper leaves, along with other occupational therapy activities, as humiliating detours because they seemed to him more appropriate to the experience of being a mental patient than to the experience of returning to his life outside. They were part of the story in which he was a patient—an episode that he was trying to bring to a close. He derided the activities that he perceived as maintaining his role as a patient rather than helping him move into the story in which he was an ex-patient and a paid journalist. In contrast, what most characterized the therapeutic sessions Tom valued was that he could readily fit them inside the volitional narrative he was creating to begin. The following description of what he considered a relevant therapeutic event illustrates this point:

When we went to Chinatown and ate lunch and just walked around Chinatown, it was nice, because it was the first time in many months that I felt like I was part of a group again. You know, here I was eating good food with about 10 other people that nobody knew we were from the hospital. We were just ordinary people and it was really good. It felt like I was returning to some semblance of reality. After being in and out of psychiatric wards for four or five months it felt like a nice, normal activity. I enjoyed all the community re-entry trips for the same reason.

Tom experienced these community trips as part of the journey back to the life he wanted. Because Tom’s volitional narrative defined relevance for him, rationales for therapy (learning motivation through an activity, for example) seemed foreign when he could not readily place them inside his narrative. Tom was in a story in which his life, and in particular his career, had been interrupted—yet again—by an exacerbation of bipolar disorder and consequent hospitalization. He was looking during his treatment for whatever could give him a foothold on the journey back into his life and his career. Thus, therapeutic episodes could belong either to the class of stories that made up his detour from life, which he characterized as “let’s play mental patient,” or to the volitional story of his return to everyday life and to being a journalist. In fact, Tom doggedly insisted that the therapy be a part of his life—he’s in his life story. And that was the defining characteristic of the meaning of therapy for him. If an activity could connect with his life by being a real episode in the

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chapter about his return to work, it worked for him; it was real therapy.

Thelma

Thelma began with similarly outstanding prospects as a high school honors student and student council member with aspirations of being a translator for the United Nations. Her volitional narrative is that bipolar disorder—beginning with her first episode in college which led to her dropping out—has ruined her life. It has wiped out her career hopes and negated her dreams of family life. Nineteen years and innumerable hospitalizations later, she is unemployed and subsists on Social Security disability income. She feels rejected by others as a “nutcake” and lives an isolated life in unsafe subsidized housing in a dangerous neighborhood. Thelma’s story is one in which efforts to make a good life do not pay off and could make matters worse. To venture outside her apartment is to risk robbery or harm, so she barricades herself inside “for months at a time.” Getting to know other people means facing rejection as someone who is crazy. Trying to return to work raises the specter of later losing the job and then being unable to get back on the same level of disability income:

Do you think it’s worth your Social Security disability to go out there and try to get a job for about a year or so until your next episode and then you go and lose it, you know? What would I do then? Cause I think it’s twice as bad trying to get on Social Security Disability now than it was when I got on 15, 20 something years ago.

Thus, Thelma lives a fundamentally ruined life in which the most one can hope for is an occasional and fortuitous pleasure. Hers is a story of tragedy with no sense of progression or betterment.

Thelma, according to her own account, has experienced so many hospitalizations that she cannot count them. In fact, future hospitalizations are one of the most predictable features of her life. Existence within the confines of a subsidized public housing apartment reduces Thelma to a guarded, isolated and withdrawn “unattractive woman.” The respite she experiences during her stay in the hospital creates the freedom to associate with others, express feelings, and do things that she cannot do in the outside world. And she knows how to make hospitalization “worth the trip.”

In the context of her narrative, Thelma experiences occupational therapy as a time when opportunities for pleasure become available:

The therapy groups also make a hospital good. . . . and they have to have good recreation. Trips and stuff like that. Museums and stuff, to the show or bowling, or anything like that . . . I don’t like being there, but once you’re there you have to do something. It’s nice to construct your time so you don’t get bored, you talk to your . . . OT person, whatever, they think of fun things to do to keep you busy while you’re there . . . It’s nice to get in the kitchen and cook a delightful meal or a snack. It’s nice to keep in the spirit of cooking so you don’t lose your strength when you get home.

In Thelma’s life, which is mostly the “same old, same old thing,” therapy is a pleasant diversion and, for one who sees her life as already ruined, therapy is not a means to an end. Consequently, good therapy should “keep you busy and interested. [the occupational therapist] has to know what he or she is doing craft wise or it’s not any fun.” For Thelma, fun is the whole point of therapy; thus, her discussions of therapy all center on the quality of the experience. For example, good therapy requires a therapist who will “treat you like a person” and who is conscientious and thoughtful, who doesn’t rush you when it’s time to clean up, you have a few minutes left, wash out your brushes, pick up your stuff, just kind of finish up whatever you’re doing ‘cause we’re gonna have to clean up soon.

Moreover, therapy is also Thelma’s opportunity to garner some resources for her otherwise impoverished life. The products of therapy do matter to Thelma, who noted that the “little rug I made with the geese on it and stuff” has a place of honor in her living room. “No one is allowed to step on it; it’s too cute for that. I want to hang it up on the wall.”

Therapy is also one of the true opportunities for Thelma to participate in a common activity with others:

It was real nice to see what other people came up with to work on too. . . . And then you try to finish your project and this person would be rushing to get out and be the first to get our project done, you know. It was real nice. Like a sharing and caring experience, you know. You tell me what you did and I’ll tell you what I did, like that, it was real nice.

Thelma’s view of good therapy is something for the here and now, a few minutes of enjoyment, warmth, and sharing. It has nothing to do with any future. Consequently, it makes no sense to Thelma that the goals of therapy should be to change her life. She brushes off any such suggestions as unrealistic. Like Tom, Thelma wanted to make therapeutic activities into real life experiences, not therapy per se. As with Tom, the meaning that therapy took on for Thelma was dependent on her volitional narrative. From the perspective of her story, of a miserable life that is basically ruined, Thelma readily ascribed to therapy the significance of respite or temporary escape.

For Thelma, therapy was an oasis of fun in an otherwise monotonous, isolated, and impoverished existence, and it was an opportunity to make otherwise unobtainable decorations for her apartment. This was the meaning of therapy that she was prepared, by virtue of her personal narrative, to accept.

Discontinuities of Patients’ and Occupational Therapists’ Narratives

As Schafer (1981) noted, therapists come to their patients with a therapeutic story that frames how they make sense of the patient and the course of therapy. Mattingly (1991a) added to this that, when occupational therapists
engage in clinical reasoning, they construct stories through which they seek to grasp both what their patient's circumstances are and where therapy might take them.

Occupational therapists typically employ a type of progressive narrative—a story in which things get better over time (Gergen & Gergen, 1983). In the manner of progressive narratives, the therapeutic story typically involves patients coming into therapy and participating in a series of activities designed to enable them to progress toward better functioning in their life occupations. This was certainly the case for the occupational therapists working with Tom and Thelma during their stay at the day hospital. Working from such progressive narratives, the occupational therapists encountered two very different characters from the highly motivated Tom and the resigned and hopeless Thelma whom we have described.

Thelma appeared as a model patient in occupational therapy. She took a leadership role among the patients in the partial hospital program that she attended daily. She arrived early, often before staff members, and warmly greeted everyone. She was careful to note any absences among members and frequently reminded staff members and others as to the whereabouts of missing members with planned absences. In occupational therapy groups, Thelma willingly completed any task requested by the occupational therapist.

Tom was considered a problem patient. He was non-compliant with treatment protocols, challenged and chastised occupational therapists, and was highly critical of all aspects of the partial hospital program. He resisted identification as a patient and strove to maintain an identity with the treatment staff members, as he frequently reminded them of his status as an alumnus from a prestigious private university. Tom missed treatment so often that he jeopardized his participation in the program and teetered on the edge of being terminated from treatment by his case manager.

Tom publicly devalued nearly every occupational therapy session that he attended. In one such case, after an occupational therapy assessment, the therapist recommended and Tom agreed that he needed to become more involved in leisure activities. After the interview, Tom told his case manager, a psychiatrist, that he had to start watching a wider array of television programs because “the occupational therapist thinks I need to broaden my horizons from Andy Griffith.” This attitude made Tom a difficult patient who tried occupational therapists' patience with his constant belittling of their work. Moreover, from the perspective of the occupational therapist, Tom appeared to be unwilling to collaborate and engage in the therapeutic processes that were designed to help him return to community function.

From the vantage point of their occupational therapists, Thelma seemed to be in agreement with the progressive narrative, whereas Tom did not. As we know, the opposite was true. Tom's personal narrative was a progressive narrative, but he often found occupational therapy irrelevant to it. For Tom, occupational therapy often had little to do with his story of struggling against his disability to return to work and independent living. Thelma rejected, even feared, any progressive narrative. However, she knew how to go along with occupational therapists' view of her in order to get what she really wanted. Predictably, she did not reach the goal of obtaining volunteer work (which she had agreed to in therapy because she had long since learned that therapy is more pleasant if one goes along with therapists' ideas of improving one's life, however misguided they might seem from one's own perspective).

Without knowing the meaning therapy took on from inside Tom and Thelma's stories, the occupational therapists could only see Thelma as struggling to make the most of therapy and Tom as unwilling to participate in those activities designed to help him improve. Moreover, because Tom and Thelma did not find therapy to be automatically relevant or integrated into their personal narratives, each had to find ways to partition irrelevant parts of therapy and subvert other parts to their own purposes. Consequently, the occupational therapists never completely entered into Tom and Thelma's reality nor Tom and Thelma into the occupational therapists' reality.

Although it was not our purpose to investigate what occurred in communication between the patients and their occupational therapists, it is worth noting that the therapists did make sincere efforts to understand Tom and Thelma. Indeed, the therapists, working from the perspective of the Model of Human Occupation (Kielhofner, 1985) considered it important to know about their patients' volition. But the therapists perceived this task as gathering data to formulate an objective understanding of their patients' volitional status, not as a means of entering into their realities. The therapists' approach to assessment and evaluation implies the view of the patient coming into therapy that we mentioned earlier.

Moreover, Thelma saw the need to go along with the occupational therapists' expressed goals of therapy and actively concealed (by what she did not say to her therapist) her true volitional narrative. It seems that this concealment was something she had learned was the path of least resistance over many years and many experiences in therapy. On the other hand, Tom's critical demeanor toward what he considered as irrelevant therapy was readily interpretable in a psychiatric setting as acting out and resistance. Such behaviors are typically considered antithetical to the therapeutic progressive narrative.

Discussion

The current investigation focused on the therapeutic experiences of two patients. This study demonstrates how the patients' volitional narratives influenced the meaning
The volitional narratives of Tom and Thelma were powerful influences on how they saw therapy. First, we observed that Tom and Thelma were strongly predisposed to see therapy as something in their lives. They did not want therapy to be something outside their experiences affecting them, nor did they wish to have the therapeutic experience defined for them from some perspective foreign to their volitional narratives. This attitude was apparent in the ways in which they aggressively made therapy into something that took on meaning in terms of their unfolding lives. Although this study did not compare the relative influences of the therapeutic process and the volitional narratives of Tom and Thelma on how they experienced therapy, it suggests that the latter may have a much more powerful influence on the meaning of therapy. Because we wanted to highlight the role of volitional narratives in patients’ ascribing meaning to therapy, we did not examine how the occupational therapist’s efforts, the therapeutic process, or the activities themselves influenced the patients’ ascription of meaning to therapy. The interaction between the volitional narrative and the various processes involved in therapy obviously need detailed examination in future studies.

The miscommunication that existed between occupational therapist and patient is not adequately explained as a failure of the therapist to adequately communicate, or of the patients to make their needs known. Rather, it must be understood as linked to an incompatibility of perspectives embedded in the occupational therapist’s view of patients as entering the world of therapy and in the patients’ learned cynicism about the desire or ability of therapy to consistently connect with the lives they experienced. Thus, it appears that the misunderstanding cannot be remedied by more effort, but rather by a fundamental change in perspective. The required perspective reverses our view of therapy and makes the therapy an event in the life of a patient.

When such a perspective is taken, it redefines what we mean by assessment and evaluation. The existing purposes of collecting data to make professional judgments about a person’s status must, at least, be augmented with the purpose of gaining entry into the patient’s volitional narrative. This means that part of the purpose of assessment must be to gain sufficient understanding of the life story the patient is telling and living to begin to know how therapy might enter into it. It also means that the process of therapy and the patient’s behavior when in therapy must be recognized as information about how therapy is entering into the patient’s life. Finally, the present study suggests that occupational therapists should be cautious lest they oversubscribe to the notion that the meaning created in therapy is influenced by the processes the therapist seeks to manipulate. A more balanced view would suspect that a range of meanings are being created. Moreover, these meanings could provide important insight into the patient’s volitional narrative. Said another way, the patient’s reactions to therapy provide important information about the story in which the therapy has become an event.

When we consider the potentially powerful role of volitional narratives in determining the meaning of therapy, the question emerges: What role should the volitional narrative have in therapy? The answer does not appear to lie in allowing the volitional narrative to completely determine the nature, direction, and content of therapy. After all, if the patient’s personal narrative were not somehow challenged or troubled, there would be no need for therapy. It might be said, instead, that the patient seeks and will benefit by finding ways to reconstruct, reaffirm, redirect, or otherwise profitably continue his or her life story into the future. For therapy to provide this kind of help to the patient, therapeutic narratives must incorporate an understanding of and an interweaving with the patient’s story.

This will often require more than simply communicating or collaborating better with the patient. It goes well beyond just finding a more suitable therapeutic media for the patient. For example, Thelma’s volitional narrative tells the story of a ruined life. Within it, therapy is mainly something to be enjoyed, and does not signify progression to a different life. Indeed, Thelma’s narratives require that we pause to ask, what should therapy be for Thelma? Should it cajole her into exploring vocational options and possibly risk making her life even worse than now? Should Thelma get out of her apartment more, when getting out means risking her life by walking in a neighborhood where people get killed? Such questions are complex and not easily answered. Indeed, there is something downright uncomfortable about facing such dilemmas. Therapeutic progressive narratives may allow occupational therapists to put on blinders and avoid some of these more perplexing questions. However, these are the kinds of moral dilemmas with which patients struggle in their own volitional narratives, and it appears that these are the very issues with which the occupational therapist and patient should struggle in therapy. Unless they are confronted, therapy may be stalemated. For example, no amount of occupational therapy is likely to alter Thelma or her life greatly unless the deepest issues in her narrative are addressed in some way.

As occupational therapists understand the life story of patients, they can begin to comprehend the patients’ worlds — worlds into which they must insert therapy. Occupational therapy can only transform lives if patients see meaning and relevance to their own unfolding life stories. The task of occupational therapy is to become an episode in the patient’s narrative. As Clark (1993) noted, meaningful therapy helps patients to create and continue their life stories into the future. Within such a context, it becomes obvious that the problem of influencing what meaning
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References


