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# The Planning Process in Occupational Therapy: Perceptions of Adult Rehabilitation Patients

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Key Words: outcome and process assessment (health care) • patient care planning

*Objectives.* The purpose of this study was to learn about (a) adult physical rehabilitation patients' perceptions of their involvement in the treatment planning process (goal setting, treatment planning, outcome evaluation), (b) their valuation of occupational therapy, and (c) how they would describe their interpersonal relationships with their occupational therapists.

*Method.* Fifteen subjects who had received occupational therapy were interviewed. The transcripts were independently and jointly reviewed by the authors to answer five research questions.

*Results.* Most of the subjects indicated that they had been involved in occupational therapy goal setting; treatment planning; and outcome evaluation, albeit this indication was weak. They also valued the occupational therapy services they received. Eight described positive interpersonal interactions with their therapists, and seven provided no information.

*Conclusion.* Patients receiving occupational therapy services are involved in goal setting, treatment planning, and outcome evaluation; however, their involvement varies and can be difficult for them to identify and describe. Because of increasing societal emphasis on patient rights and participation (e.g., consumerism, health professions standards, health care accreditation criteria, health care legislation) and the likelihood that health care funding will be used for services linked to patient goals, occupational therapy practitioners could become more overt and systematic in involving patients in the planning process. Increasing patient involvement in planning may result in more individualized treatment and more effective use of health care dollars.

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Patient involvement in planning rehabilitation is the ideal standard shared by the occupational therapy profession, standards organizations (Commission on Accreditation of Rehabilitation Facilities [CARF], 1988; Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 1992; World Health Organization, 1979), legislative bodies, and health care recipients (Smith, Smith, King, Frieden, & Richards, 1993). But to what extent do occupational therapists measure up to this ideal in practice?

Two important events in the 1970s indicated a shift in patient role in health care and rehabilitation: the creation of *A Patient's Bill of Rights* by the American Hospital Association (Countryman & Gekas, 1980) and the Independent Living Movement (ILM) (DeJong, 1979; Frieden & Cole, 1985; Schlaff, 1993). A desire to improve communication between patients and health care

staff members was one of the key reasons for the development of *A Patient's Bill of Rights*. The American Hospital Association recognized that such communication was becoming a more important facet of care because of advances in medicine and the corresponding increase in the number of health care professionals involved. Persons with disabilities began the ILM during the late 1960s and early 1970s (Frieden & Cole, 1985) while seeking alternatives to traditional physical and vocational rehabilitation services (DeJong, 1979). DeJong's (1979) analysis of the ILM included commentary on persons with disabilities being consumers, and with this increase in consumerism, "professional dominance in disability policy and rehabilitation [was] being challenged" (p. 439).

Since the creation of *A Patient's Bill of Rights* and the ILM and its legislative victories (e.g., Rehabilitation Act of 1973 [Public Law 93-112]; Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978 [Public Law 95-602]), rehabilitation patients are expected to participate in setting goals (CARF, 1988; JCAHO, 1992). Have these events influenced the actual participation of adult patients with physical disabilities in planning and evaluating their rehabilitation and, more specifically, their occupational therapy? Do patients perceive that they have had a participatory role in their care?

Occupational therapists and other rehabilitation professionals have made efforts to involve patients in planning their care. Neistadt (1995) summarized many of these efforts. In addition, Payton, Nelson, and Ozer (1990) developed a process to be used by occupational therapists and physical therapists to maximally involve patients in problem identification, goal setting, outcome evaluation, and means evaluation. This process involves therapists using open-ended questions with patients to help with ensuring patient individuality in planning versus introducing therapist bias. Gage (1994) and colleagues have designed and implemented a patient-driven interdisciplinary care plan at their facility. Their care plan included eliciting concerns, outcomes, and ratings of outcomes from patients as well as analyzing patient participation levels as described by Payton et al. (1990). Use of this care plan process on a pilot unit for patients with pain resulted in multiple benefits for patients and the other team members. A study group interested in consumer choice in the vocational rehabilitation process thoroughly examined this topic (Fry, 1995). The outcome of its work was a format to be used by counselors that incorporated consumer choice. The timing of consumer involvement, problem solving, cultural diversity, and documentation are some of the topics addressed in the format.

Although there has been some impetus to involve patients in planning and evaluating their care, there are

other indications that much progress is still needed. In written correspondence submitted for public hearings before the National Center for Medical Rehabilitation Research (National Advisory Board on Medical Rehabilitation Research, 1993), one patient wrote, "In rehab I was evaluated, dissected, tested, and judged by everyone on the staff. Nobody ever asked me how I experienced what they were doing" (p. 51). Clark (1993) described a friend's similar experience during rehabilitation after a stroke: "Her previous identity was not taken into account, except very superficially; she was stripped of her history; and she remained suspended in limbo until she was discharged and on her own" (p. 1072). Northen, Rust, Nelson, and Watts (1995) found variability in their study that examined the extent of occupational therapists' efforts during the initial evaluation to involve rehabilitation patients in planning. However, each of the 30 therapists in the study had attempted at least one of 23 criteria for patient participation. The authors concluded that demographic factors, such as diagnosis, therapists' years of experience, or educational background, did not demonstrate an influence on the therapist's promotion of patient involvement in therapy. In another study, Neistadt (1995) surveyed 269 directors of occupational therapy departments serving adults with physical disabilities and found "that occupational therapists...are not effectively collaborating with their clients regarding goal setting and treatment planning" (p. 435).

However, Pope and Kennedy (1993) found that when patients discharged from occupational therapy were surveyed about their participation in planning their care, 92% of 37 respondents strongly agreed or agreed that they had helped to determine goals, and 79% strongly agreed or agreed that they had helped to determine activities that would be used in therapy. A slightly different picture of these patients' participation emerged when they were asked to select one of three scenarios that best described their situation in occupational therapy. Fifty-seven percent selected a scenario that described the therapist setting the goals and determining treatment activities, and only 13% selected the scenario indicating, "I played a major role in setting my own goals and choosing the activities that I used in therapy" (p. 24).

To further clarify the state of patient involvement in the planning of therapy, our study explored how occupational therapy patients perceive and articulate their role in therapy, particularly in goal setting, treatment planning, and evaluation of outcomes. Questions about how patients value their occupational therapy experience and their perceived interpersonal relationships with their therapists were also studied. This study paralleled one conducted with physical therapy patients (Payton & Nelson, 1996). The questions that guided the present study were:

1. Do occupational therapy patients believe that they have effective input in setting therapeutic goals?
2. Do these patients believe that their input is sought and accepted in planning treatment?
3. Do these patients believe that they provide useful information to the therapist relating to the evaluation of therapeutic outcomes?
4. Do these patients value occupational therapy; why or how is it important to them?
5. How do patients describe their interpersonal relationships with their therapists?

## Method

The study was conducted in three institutions: a large urban university health care facility in Richmond, Virginia, and two large suburban community hospitals located in Northern Virginia. These sites were ones of convenience in that the authors were academic faculty members at the university affiliated with the urban health care facility, and the Northern Virginia sites had clinical affiliation agreements with the authors' school. Occupational therapists at each facility were asked to identify patients who had received a minimum of 2 weeks of occupational therapy and could communicate during an interview. Fifteen subjects (5 women, 10 men) between the ages of 23 and 78 years ( $M = 50.7$  years,  $SD = 19.3$ ) were recruited for the study and signed an approved informed consent document (see Table 1). Their time in occupational therapy ranged from 2 to 26 weeks ( $M = 7.6$  weeks,  $SD = 7.0$ ); some subjects may have received services from the same occupational therapist.

Semistructured interviews were used to gather data to answer the five research questions. The interview started with a broad opening question (e.g., "Tell me about you and what you do in occupational therapy") and then addressed Questions 1 through 3 in a nonstandard way if the subjects did not discuss them in their opening re-

marks. Questions 4 and 5 were not explicitly asked, but answers were inferred through review of transcribed interviews.

Twelve subjects were interviewed one on one, one was interviewed with his wife present, one was interviewed with her father present, and one interview was conducted with both authors and a research assistant present. Interview length ranged from 10 to 40 min ( $M = 22.5$  min,  $SD = 8.5$ ). All interviews were audiotaped and transcribed verbatim.

All transcripts were independently read and scored by the authors. Scoring involved underlining subject responses that related to each guiding question and noting whether the response was positive or negative. The researchers then met to compare their independent scores. Differences in scores were discussed until agreement was reached regarding relevance. Each transcript was given a final rating for each question on the basis of a total of subject responses. Possible ratings were (a) strong negative, (b) moderate negative, (c) weak negative, (d) no data, (e) weak positive, (f) moderate positive, or (g) strong positive. Transcripts were rated weak (positive or negative) if one or two statements were made about the question but no examples were given; they were rated moderate if only one statement was made and an example provided; and they were rated strong if two or more statements were made with examples or if one statement was made and a very detailed example provided. If a transcript with a final positive score contained both positive and negative data, it was ranked one step lower than it would have been marked without negative statements.

## Results

### *Effective Patient Input in Goal Setting*

Eight subjects indicated having effective input in setting therapeutic goals in occupational therapy, five of which were weak indications (see Table 2). For example, Subject

**Table 1**  
**Demographic Information**

Subject	Gender	Age	Approximate Weeks of Occupational Therapy	Diagnosis
1	F	26	2	SCI with paraplegia
2	M	76	3.5	CVA
3	M	71	5	CVA
4	F	78	2	Multiple sclerosis-accelerated
5	F	48	2	CVA
6	M	62	5	CVA
7	M	30	18	TBI and multiple upper-extremity fractures
8	M	42	7	Multiple musculoskeletal injuries
9	F	25	4	TBI
10	F	51	13	Wrist fracture with complications
11	M	72	4	CVA
12	M	51	26	SCI
13	M	41	4	CVA
14	M	23	14	SCI with tetraplegia
15	M	65	5	Spinal cord tumor with paraplegia

Note. CVA = cerebrovascular accident; SCI = spinal cord injury; TBI = traumatic brain injury.

**Table 2**  
**Subjects' Perceptions of Certain Aspects of Occupational Therapy**

Aspect	Perceptions						
	Negative			No or Conflicting Information	Positive		
	Strong	Moderate	Weak		Weak	Moderate	Strong
1. Had effective input into setting therapeutic goals <i>n</i> Subjects	1 (15)	0	3 (1,9,12)	3 (3,7,11)	5 (2,4,5,6,8)	2 (10,13)	1 (14)
2. Input was sought and accepted in planning treatment <i>n</i> Subjects	2 (6,7)	1 (15)	2 (3,5)	1 (11)	5 (1,2,4,9,14)	3 (8,10,12)	1 (13)
3. Provided useful information to therapist regarding evaluation of therapeutic outcomes <i>n</i> Subjects	0	0	1 (9)	4 (2,3,5,15)	8 (1,4,6,7,10,11,13,14)	1 (12)	1 (8)
4. Values occupational therapy <i>n</i> Subjects	0	0	0	1 (6)	2 (3,5)	3 (1,13,14)	9 (2,4,7,8,9,10,11,12,15)
5. Interpersonal relationships with occupational therapists <i>n</i> Subjects	0	0	0	7 (1,4,5,6,8,12,15)	7 (3,7,9,10,11,13,14)	1 (2)	0

Note. *N* = 15.

5 indicated that her long-term goal was “to dress myself and [do] my personal grooming, without help,” but when asked how that goal was set, she responded:

It's the only one I can think of that makes much sense. I don't want to spend my life with somebody having to bathe me and dress me, go with me every time I have to go to the bathroom, so that had to be my number one goal.

Throughout the interview, Subject 5 did not provide information on how she participated in setting her goals.

Subject 8 also provided weak positive support for Question 1. In addressing a question about the relationship of his therapy to his short-term and long-term status, he stated:

It has been difficult to do all that I need to do [in] dealing with the injury and keep up with my work schedule at the same time. I mean, I have had to make some compromises there. With my line of work [as a college professor], I need to spend a lot of time at the computer...and that takes away time that I can devote to exercising and keeping my left arm in a splint...that's a problem....If therapy were organized around the very specific details of what people have to do in their work and so forth, it would be even better.

When probed further, the subject noted that he had discussed his goals for work and his therapy regime with his therapist, but there was no clear indication that he was successful in having his therapist tailor therapy around his goals. His last comment in this quote reflects a likely gap between his therapy and his goals.

Subject 14 spoke most positively about his involvement in setting therapy goals, with his transcript containing seven such statements, and many of which were coupled with examples. Early in the interview, the sub-

ject stated that his therapist does not “really give me anything to do, she ask[s] me, you know, what do I want to do.” Later he described:

She watched me to see...the things that I [am] trying to do, and then when I might come in another day, she'll say, “Well, do you want to work on balancing yourself when you pick things up?” She [would] just be watching me...She [doesn't] really want to stand over my back, and she'll come up to me and ask me, “Do you want to work on that?”

According to the following transcript data, Subject 15 had no input in goal setting:

Interviewer: How do you decide on what you do in occupational therapy?

Subject 15: It's a set program that's decided on by the individual that runs the program. She [the occupational therapist] has an evaluation...of the injury or your condition, and she takes it from there. She's working on your strengths rather than your weaknesses.

Interviewer: Now the goals that you have, how did you arrive at those?

Subject 15: I don't think that there was any independent decision to arrive at goals.

Interviewer: Have you had a chance to individualize your goals at all?

Subject 15: No, not at this time.

### *Patient Input Sought and Accepted*

In planning treatment, nine subjects indicated that their input was sought and accepted, but five of these subjects provided weak support (see Table 2). Subject 2's statement illustrates a weak response:

Interviewer: Did you ever have any thoughts or ideas about what you were doing in occupational therapy?

Subject 2: Not other than, "Are we going to do that again today?" [laughs]. We had a very nice association, and I was very fond of her, and we got along really well—it was just one of those things that we never had any great conversations about it.

Subject 9's statements illustrate both positive and negative treatment input. When asked how it was decided what she did in therapy, she stated:

I think she [the occupational therapist] decides, I don't decide. She tells me, do I feel like doing a puzzle, and I'll say yes or no. And she'll ask me, "Do you want to do these work sheets," and I'll say yes or no.

When asked whether she ever said to her therapist that she would like to try doing this or try doing that, she responded affirmatively. When asked for some examples of when she had done that, she responded:

Subject 9: I did it last week. She had a work sheet for me to read and do, and I wanted to do a puzzle with the little pegs, so she showed me a picture of that and I did that instead.

Interviewer: So she showed you one thing to do, and you said you'd rather do something else?

Subject 9: Yeah. So she helped me do it, let me do it.

Subject 13 was the most positive about his ideas being sought for treatment. His transcript revealed four positive statements. One example occurred after a lengthy description of his arm exercises:

Interviewer: Who decides what you're going to do?

Subject 13: Well, when I come in...he [the occupational therapist] would play with my arm a little, and he would play with my hand a little, and then from there we'll figure out what exercises are needed for that day...that I would want for that day for my arm. Some days I would come in, and I would tell him can we do this exercise, my arm exercise first, rather than weight bearing first...he goes for it.

Interviewer: Do you ever say to him that you would like to try a different exercise?

Subject 13: Oh, yes. Yes, I've said that a few times.

Interviewer: These exercises you've come up with yourself, can you give me an example?

Subject 13: Okay...I came in here one day, and I asked him can we do an elbow exercise, which is trying to put my hand in a motion to go in my pants pocket...we did that, and I also came in one day and asked him can we do an exercise whereas I would put my hand behind my back.

Subjects 6 and 7 were most negative about their treatment ideas being sought. When asked whether he ever suggests things to his therapist that he would like to do or whether he tries to personalize his therapy activities, Subject 6 responded no. When asked about his discussions with his therapist during therapy, he stated, "She [the occupational therapist] just tells me how to walk, how to do exercise. I do what she tell[s] me to do. That's all we talk about." Subject 7's transcript contained 11 statements indicating that all treatment activities came from his therapist without any input from him.

For example, when asked how treatment activities were decided, he noted, "Well, it's really not my decision," and about possible changes he shared with his therapist, he said, "I just do what she tells me to do whether she is there or not." In spite of his many comments negating that he had had any input into his therapeutic activities, he did not doubt that if he wanted to do something, his therapist would assist him.

#### *Patient Provided Useful Information About Outcomes*

Ten subjects indicated that they had provided useful information about evaluation of therapy outcomes to the therapist, eight of whom provided weak indications (see Table 2). Six of the eight transcripts included just one brief statement about this item. For example, when Subject 14 was asked whether he ever provided feedback to his therapist about what was and was not working in his therapy program, he responded yes. When asked for an example, he stated:

When I first got on my dressing program...I'd tell her this thing worked, so she said we're going to try it this way [using the patient's method]. It just seemed like it was better for me 'cause I felt much better getting my clothes on.

The remaining two transcripts of weak positive evidence provided five references each about evaluating therapeutic outcomes. Subject 1 was not clear, however, about whether she provided this information to her therapist. When asked about sharing with her therapist, she said, "I just kind of do them, I mean, she sees them, yeah." When pressed, Subject 7 could not give an example of when he had told his therapist about therapeutic outcomes. His attempt at an example included a description of his shoulder tightening up when he had not complied with doing his stretching exercises. He realized the value of the exercises and stated, "She can tell if I've been doing it because if I don't do it, then it's just going to tighten up." Later he said, "If it's not doing me any good, I'll let her know. But if it is, then I...say nothing."

Subject 8 gave the strongest evidence of discussing therapeutic outcomes with his therapist, for example:

Interviewer: How does the alteration of the program come around, if there is one?

Subject 8: Well, you know we typically handle that in a flexible way. I tell her what's going on in experiences I've had, and she responds to that. She suggests things that we can do.

No subjects provided strong negative evidence with regard to Question 3.

#### *Patient Validation of Occupational Therapy*

Without being asked, 14 subjects provided a positive view of occupational therapy, with 9 of them providing strong evidence. For example, when asked a general question

about himself and occupational therapy, Subject 8 stated:

Well, I feel very positively about the experience I've had here, and that this is part of the overall therapy or the attention that I've received since injury. This has been a critical part of the process. It fits with the philosophy of the surgeon who worked on me; his attitude about my injury was that the bones had to be fixed rigidly and followed up with aggressive therapy, and that makes a lot of sense to me. My progress has been pretty dramatic.... That seems to be directly attributable to the occupational therapy component of my care.

Subject 4 concluded her interview with comments about occupational therapists, such as "they are so helpful and encouraging and don't let you give up." Subject 15 described his occupational therapy as "practical and following the instructions that I've been given, very successful." He noted that his therapists "were also instrumental in setting up a home visit and looking at my home" and "they've been helpful in that sense." Subject 12 indicated real satisfaction with occupational therapy goals by saying that "even next week, I'll come back 3 days a week, and I wanted to go back to occupational therapy, it will be in outpatient occupational therapy now, but I still want it because it helps."

#### *Therapist–Patient Interpersonal Relationships*

About half of the subjects provided weak evidence about positive interpersonal relationships with their occupational therapists, and about half provided no information (see Table 2). Subject 2 made the clearest and strongest statements, noting, "She was fun to be with; she was very businesslike; and she was pretty strict about everything, which is fine"; "I was fond of her, and we got along really well"; and "Like I said, we were good buddies."

#### *Miscellaneous Comments*

Some subjects' comments about their experiences were outside the framework of the five guiding questions. The following comments seem worth noting because they provide additional information on the therapeutic process from a patient's perspective.

Subject 1 seemed to be describing an "all-knowing" therapist when she admitted not giving her therapist "too many ideas" but saying that her therapist knew what "I'll need for my job" and "what I need to do when I go home." Subject 14 referred to a dynamic process as has been described in the literature (Prugh & Eckhardt, 1980; Shontz, 1975) when he noted that "at first I used to refuse, you know, going to therapy 'cause I [thought] it can't help me." Additionally, near the end of his interview he explained how he wanted to be able to take care of his 4-month-old daughter. When asked whether he had shared this goal with his occupational therapist, he responded that he had told his physical therapist and

thought that by telling one, the other will find out. He described wanting to avoid having to depend on equipment but was reluctant to raise this issue in some cases. Subject 15, although very satisfied with occupational therapy, described a very regimented helping relationship—"an educational process" and "learning experience." He, more than any other subject, drew parallels between occupational therapy and education, using language such as "learning," "training," "very practical course," "instruction," and "taught."

#### **Discussion**

The results indicate that the practice of occupational therapy may be minimally meeting the expressed belief of the profession and the expectations of others that patients participate in planning and evaluating their care. Although the majority of subjects indicated that they participated in planning therapy, many described what we considered to be weak involvement. This mixed finding is consistent with that of other researchers (Neistadt, 1995; Northen et al., 1995; Pope & Kennedy, 1993). That is, whether only therapists are studied (Neistadt, 1995; Northen et al., 1995) or only patients as in our study and Pope and Kennedy's (1993), patients are not always being clearly involved in key aspects of planning. Thus, there appears to be some discrepancy between intent and practice.

Of the five research questions examined, Question 4 (valuation of occupational therapy) received the strongest support, and no subject was asked a specific question about it. This high valuation existed despite the weak-positive indicators of subjects' involvement in the planning process. One must be cautious about this finding for a number of reasons. First, even though informed consent and confidentiality were assured, subjects may have been worried about their future care had they not been outwardly positive about occupational therapy. Additionally, subjects may have been unsure about the research purpose and may have feared therapists' loss of a job, even though the study's purpose was explained verbally and in writing. Finally, Thorne (1993) described the relationship between patients with chronic illness and their health care providers as evolving through the stages of naive trust, disenchantment, and guarded alliance. Because of the relative acuteness of their medical conditions, the subjects in our study may have been in the stage of naive trust and, thus, valued occupational therapy highly. If Thorne's stages are correct, one could assume that when the acute conditions shift to chronic, these subjects would move to the disenchantment stage of the health care relationship and have a corresponding decrease in their valuation of occupational therapy.

Subjects did not provide much information about

their interpersonal relationships with their therapists probably because they were not asked a specific question about this. They had, however, offered much on their valuation of occupational therapy without being asked. Perhaps valuation content is more easily offered than that of interpersonal relationships.

Several comments indicate the complexity and variability of patient participation in planning. For example, Subject 1 had not communicated her anticipated future needs to her therapist. On the basis of our interpretation of the subject's transcript, it was evident that the therapist was attempting to direct her care, assuming that she knew what a young woman with paraplegia would want to do and have to do at home and work. With this approach, the therapist would likely be correct in addressing some of the subject's concerns and needs and miss others. The likely areas of concern to be missed are those that make patients unique and that serve as their motivation.

Subject 14 raised a number of interesting issues. One was his reliance on effective communication between team members with regard to his goals. This communication seems to be an appropriate patient expectation. However, given that Neistadt (1995) found that most occupational therapy departments use informal methods for evaluating patient priorities, one may wonder how many facilities have a formal, effective mechanism in place for transmitting patient goals between disciplines. Another issue Subject 14 raised is that therapists should expect to take the time to probe for concerns, goals, treatment planning ideas, and outcomes. This exploration may be difficult in today's fast-paced health care system, but asking one question about goals on an initial evaluation is probably not adequate. Near the end of his half-hour interview, Subject 14 announced that he had a 4-month-old daughter and described his problems with taking care of her. However, he had neither directly mentioned these problems to his occupational therapist nor stated that one of his goals was to take care of his daughter. This information could have provided meaning to his occupational therapy goals. We have observed this phenomenon in using the system described in Payton et al. (1990) when patients are asked to state three functional concerns as a result of their medical condition and then select their chief concern. Frequently, the chief concern is listed third, or later in the interview when discussing other questions, patients identify an even more important concern than the three originally listed. Subject 15 reminded us how important teaching or imparting information is in therapy. When teaching is part of the occupational therapy role, it need not be so structured that individual needs are not addressed. Subject 15 did not object to the lack of individualization at this point in his rehabilitation, but he may eventually because of the evol-

ing aspects of rehabilitation relationships (Thorne, 1993).

### *Implications*

When reviewing the similarities and differences in these 15 subjects, we are somewhat overwhelmed by the thought that at any one time therapists are carrying case-loads of patients whose views on therapy and health care vary widely. Patients' views vary at a particular moment and as they move through the various stages of recovery (Prugh & Eckhardt, 1980; Shontz, 1975) and are confronted with new challenges. The most constant factors in this situation are the health care professionals and the team members who need to be knowledgeable and skilled in helping others. Perhaps a valuable addition to the initial evaluation and reevaluation phases of therapy would be to query patients about their perceptions of their own roles; the roles of therapists and other staff members; and the meaning of help, therapy, rehabilitation, goals, and outcomes. This information would yield baseline information about and possibly change a patient's beliefs or understanding.

Increasing patient participation in planning and establishing goals will involve more patient instruction. Some patients will have to learn to assume the role of coplanner or planner versus that of passive recipient of care. In cases where patients attempt to describe functional problems in terms of impairment-level information (e.g., "I'm too weak"), they will have to be taught to think in terms of disability-level information (e.g., "I cannot raise a glass of milk to my mouth"). Patients who attempt to describe functional problems too broadly (e.g., "I want to do what I did before I got injured") will have to be taught to evaluate, analyze, and communicate more specifically about what they did premorbidly and what they want to do in the future. Similar instruction will have to be given in order to change some patients' attitudes about their roles in planning treatment and in communicating positive and negative treatment outcomes.

If therapists in our study were involving patients in planning, then their patients should be as aware of those planning efforts and able to articulate them as they are about other activities done by therapists. For example, it is not unusual for patients to know the names of impairment assessment tools (e.g., dynamometer, goniometer) and to be able to quote their own range of motion measurements and muscle testing grades. This degree of awareness of participating in the planning process was not demonstrated by the subjects as illustrated by the few moderate or strong positive perceptions for Questions 1 through 3.

### *Limitations*

This study had several limitations. The small sample from

a limited geographic area does not permit generalizability of findings. Additionally, subjects may not have been forthright in answering questions because of their concern about therapists learning of negative comments. Subjects 8 and 9 had a family member present during the interview, which may have affected their participation. However, Subject 8 was very verbal and did not seem to be influenced by his wife's few comments, and Subject 9 knew her father was in the room but responded promptly to all questions.

## Conclusion

Of the first three questions about the helping process, patient participation in evaluating outcomes received the strongest support; patient participation in the evaluation of treatment planning received somewhat less support; and patient involvement in goal setting received the weakest support. The subjects volunteered high valuation of occupational therapy in their lives, and about half described a sense of personal relationship with their therapists.

With every indication that the consumerism movement in health care will continue, it would behoove occupational therapists to examine carefully whether and how they are involving patients in planning, especially in goal setting. Including patients superficially or not at all in planning will not bode well for practice. Limited health care dollars will more likely continue to flow to services that can demonstrate a relationship to patient goals. ▲

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