Upper Extremity and Hand Therapy-Module 3: Professionalism

Course Description:
This course is derived from the textbook by Cynthia Cooper “Fundamentals of Hand Therapy: Clinical Reasoning and Treatment Guidelines for Common Diagnoses of the Upper Extremity” © 2007. This illustrated text and reference emphasizes the fundamentals of hand therapy – for both specialists and non-specialists who encounter clients with hand issues. It provides a consistent format with tips and guidelines for hand therapy treatment. Coverage includes hand anatomy, key terms and concepts, and the evaluation process. A focus on professional issues includes clients with functional somatic syndromes and challenging behavior, client-therapist rapport, and the roles of therapy assistants. Providing many case studies, this text helps therapists think critically about clients' individual needs.

Module 3: Professionalism covers chapters 7 through 9.

Chapter 7: Clients with Functional Somatic Syndromes or Challenging Behavior
Chapter 8: Fundamentals of Client-Therapist Rapport
Chapter 9: Roles of Therapy Assistants in Hand Therapy
Appendix to Part 2: Some Thoughts on Professionalism

Methods of Instruction:
Online course available via internet

Target Audience:
Physical Therapists, Physical Therapy Assistants, Occupational Therapists, and Occupational Therapy Assistants

Educational Level:
Intermediate

Prerequisites:
None

Course Goals and Objectives:
At the completion of this course, participants should be able to:
1. Recognize clients with functional somatic syndromes and challenging behaviors
2. Identify the importance of the therapeutic relationship
3. Recognize a successful therapeutic relationship
4. Identify Watson’s Theory of Human Caring
5. Recognize nonverbal aspects of communication
6. Identify how to terminate the therapeutic relationship
7. Identify the hand therapy experience matrix
8. Determine why professionalism is important in hand therapy
9. Identify skills related to professionalism and examples of professional and non-professional behavior

Criteria for Obtaining Continuing Education Credits:
A score of 70% or greater on the written post-test
DIRECTIONS FOR COMPLETING

THE COURSE:

1. This course is offered in conjunction with and with written permission of Elsevier Science Publishing.
2. Review the goals and objectives for the module.
3. Review the course material.
4. We strongly suggest printing out a hard copy of the test. Mark your answers as you go along and then transfer them to the actual test. A printable test can be found when clicking on “View/Take Test” in your “My Account”.
5. After reading the course material, when you are ready to take the test, go back to your “My Account” and click on “View/Take Test”.
6. A grade of 70% or higher on the test is considered passing. If you have not scored 70% or higher, this indicates that the material was not fully comprehended. To obtain your completion certificate, please re-read the material and take the test again.
7. After passing the test, you will be required to fill out a short survey. After the survey, your certificate of completion will immediately appear. We suggest that you save a copy of your certificate to your computer and print a hard copy for your records.
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Part Two

Professionalism
Clients with Functional Somatic Syndromes or Challenging Behavior
JOEL F. MOORHEAD AND CYNTHIA COOPER

KEY TERMS
Body dysmorphic disorder
Chronic fatigue and immune dysfunction syndrome (CFIDS)
Chronic fatigue syndrome (CFS)
Clenched fist syndrome
Conditioned responses
Conversion disorder
Disease
Dissimulation
Factitious disorders
Fibromyalgia
Functional somatic syndrome (FSS)
Hypochondriasis
Idiopathic environmental intolerance (IEI)
Illness
Malingering
Mankopf’s test
Multiple chemical sensitivity (MCS) syndrome
Munchausen’s syndrome
O’Donoghue’s maneuver
Psychogenic tremors

Somatization disorders
Time-dependent sensitization (TDS)

CLIENTS WITH FUNCTIONAL SOMATIC SYNDROMES

A functional somatic syndrome (FSS) is defined as a physical illness that cannot be explained by an organic disease and that involves no demonstrable structural lesion or established biochemical change.¹ The distinction between disease and illness is particularly important. A disease is an anatomic or physiologic impairment of function in a structure or biochemical process. An illness is the client’s personal experience of poor health. Clients frequently have illnesses that are not fully explained by available medical evidence of disease. Functional somatic syndromes can be classified as undifferentiated somatoform disorders, somatization disorders, factitious disorders, or malingering, depending on whether the client’s actions are intentional or unintentional and whether motivation is conscious or subconscious.

The goal of giving clients satisfying and health-promoting rehabilitation care is particularly challenging for therapists treating clients with FSS. When the client’s distress is disproportionate to the medical evidence of impairment, reducing the degree of impairment may not reduce the client’s distress. The goal of this chapter is to
help therapists become familiar with the types of FSS seen in clinical practice so that they can build a therapeutic relationship with even the most challenging client.

**Undifferentiated Somatoform Disorders**  
Clients with symptoms that are out of proportion to impairments most often manifest one of the somatoform disorders, in which symptom magnification is subconscious and unintentional (Table 7-1).

**Hypochondriasis**  
Clients with hypochondriasis show excessive concern about minor health disturbances or intense worry over the possibility of future ill health.

**Body Dysmorphic Disorder**  
Clients with body dysmorphic disorder become preoccupied with imagined or innocent variations in appearance.

**Conversion Disorder**  
Clients with conversion disorder have a bodily event (e.g., paralysis or seizure) that is psychologic in origin. Clients with psychogenic pain and unspecified psychophysologic dysfunction have persistent symptoms without apparent organic origin and without other distinctive classifying features. Clients with medically unexplained pain may have other diagnostic features as well, which could lead to a diagnosis of one of the somatization disorders below.

**Psychogenic Pain**  
Clients with psychogenic pain have persistent symptoms without apparent organic origin and without other distinctive classifying features.

**Unspecified Psychophysologic Dysfunction**  
Clients with unspecified psychophysologic dysfunction have persistent symptoms without apparent organic origin and without other distinctive classifying features.

**Undifferentiated Somatoform Disorders**  
Clients with undifferentiated somatoform disorders show symptoms that are out of proportion to impairments.

**Somatization Disorders**  
More controversial are the somatization disorders, in which clients experience persistent or recurrent symptoms without objective or measurable medical evidence of impairment. Although these disorders occur frequently, general agreement is lacking on the cause and the treatment, and even on the status of some of them as legitimate diagnoses. However, questioning the validity of the diagnosis does little to help the client become more functional and may do irreparable harm to the therapeutic relationship. This chapter makes no judgment on the diagnostic legitimacy of the somatization disorders, but it recognizes the high level of distress in many clients diagnosed with these conditions.

**Fibromyalgia**  
Fibromyalgia is perhaps the most common somatization disorder. The criteria for a diagnosis of fibromyalgia, established in 1990 by the American College of Rheumatology, include pain on both sides of the body, above and below the waist, accompanied by tenderness at 11 or more of 18 specific tender point sites. Fibromyalgia affects approximately 2% of the population, although clients with fibromyalgia may account for 10% to 20% of visits to rheumatology clinics. The prevalence is inversely related to income and level of education, and females are affected more frequently than males at a ratio of up to 6:1. Fifty-nine percent of clients with a diagnosis of fibromyalgia rate their health as fair or poor. Clients with this diagnosis commonly have other, associated symptoms, including nonrestorative sleep, fatigue, headaches, diarrhea or constipation, numbness, tingling, stiffness, a sensation of swelling, anxiety, and depression. Clients with rheumatoid arthritis and osteoarthritis report similar levels of distress, according to one measurement tool, the Rheumatology Distress Index; however, clients with fibromyalgia report higher levels of distress.

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**TABLE 7-1**  
Diagnostic Classification of Functional Somatic Syndromes

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>ICD-9 CODE</th>
<th>ICD-10 CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undifferentiated somatoform disorders</td>
<td>300.82</td>
<td>F45.1</td>
</tr>
<tr>
<td>Hypochondriasis</td>
<td>300.7</td>
<td>F45.2</td>
</tr>
<tr>
<td>Body dysmorphic disorder</td>
<td>300.7</td>
<td>F45.1</td>
</tr>
<tr>
<td>Conversion disorder</td>
<td>300.11</td>
<td>F44.9</td>
</tr>
<tr>
<td>Psychogenic pain</td>
<td>307.8</td>
<td>F45.4</td>
</tr>
<tr>
<td>Unspecified psychophysologic malfunction</td>
<td>306.9</td>
<td>F59</td>
</tr>
<tr>
<td>Somatization disorders</td>
<td>300.81</td>
<td>F45.0</td>
</tr>
<tr>
<td>Fibromyalgia</td>
<td>729.1</td>
<td>M79.0</td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td>780.81</td>
<td>F48.8</td>
</tr>
<tr>
<td>Multiple chemical sensitivities</td>
<td>955.2</td>
<td>T88.7</td>
</tr>
<tr>
<td>Psychogenic tremor</td>
<td>306</td>
<td>F44.4</td>
</tr>
<tr>
<td>Factitious disorders</td>
<td>300.19</td>
<td>F68.1</td>
</tr>
<tr>
<td>Munchausen’s syndrome</td>
<td>301.51</td>
<td>F68.11</td>
</tr>
<tr>
<td>Clenched fist syndrome</td>
<td>300.19</td>
<td>F68.1</td>
</tr>
<tr>
<td>Secretan’s syndrome</td>
<td>300.19</td>
<td>F68.1</td>
</tr>
<tr>
<td>Malingering</td>
<td>V65.2</td>
<td>Z76.5</td>
</tr>
</tbody>
</table>

*ICD*, International Classification of Diseases.
distress in the areas of anxiety, depression, sleep disturbance, global severity, and fatigue. Fatigue is also prominent in another disorder in this classification, chronic fatigue syndrome.

Chronic Fatigue Syndrome

The case definition of chronic fatigue syndrome (CFS), or chronic fatigue and immune dysfunction syndrome (CFIDS), includes several important criteria: (1) the fatigue cannot be explained by other diagnoses; (2) it must persist for longer than 6 months; (3) it must have a definite time of onset; (4) it must result in decreased activity level not due to ongoing exertion; and (5) it must not be substantially relieved by rest. This case definition, like that for fibromyalgia, was established primarily to identify subjects for clinical research. Salit notes that these criteria “are not suitable for the determination of the presence and severity of illness, either in general medical settings or for medicolegal or insurance purposes” and that “clinical management should be based on an assessment of the client” (Box 7-1).

The case definitions for fibromyalgia and CFS overlap substantially. About 70% of clients with CFS meet the case definition for fibromyalgia, and 70% of clients with fibromyalgia meet the case definition for CFS. Both disorders result in a high prevalence of work disability. Bombardier and Buchwald found that 37% of clients with a diagnosis of CFS were unemployed. The prevalence of unemployment rose to 52% for clients diagnosed with CFS and fibromyalgia.

Multiple Chemical Sensitivity Syndrome

A third somatization disorder that can affect perceived ability to work is multiple chemical sensitivity (MCS) syndrome. Clients with multiple chemical sensitivities, or idiopathic environmental intolerance (IEI), experience medically unexplained symptoms in response to low-level, identifiable environmental exposures. Among the postulated mechanisms for MCS syndrome are time-dependent sensitization (TDS) and the development of conditioned responses. In TDS, repeated stressful episodes make an individual increasingly sensitive to low-level environmental stimuli. With conditioned responses, cardiovascular, respiratory, gastrointestinal, or immunologic responses are triggered by heightened perception of environmental stimuli.

Psychogenic Tremors

As with MCS syndrome, stress can be a factor in the development of psychogenic tremors. Psychogenic tremors of the hands and arms can manifest in unusual ways and have variable clinical characteristics. The severity of the tremor may be task specific, with the tremor often improving when the client is distracted. Shaking of the limbs or body can appear exaggerated, whereas finger tremors often are absent. A twisting or ballistic component to the tremor can create the appearance of chorea. Psychogenic tremor as a somatization disorder appears unintentionally and without conscious client awareness of motivation.

Factitious Disorders

Factitious disorders result from intentional client action, but without conscious client awareness of motivation. They more often arise from a psychologic need to be sick than from a conscious effort for material gain. Clients with factitious disorders knowingly cause their own disease but are unaware of the underlying reason or reasons for their behavior. Several factitious disorders can affect clients’ hands.

Munchausen’s syndrome derives its name from Baron Karl Friedrich Hieronymous von Munchhausen, an eighteenth century nobleman known for telling vivid but untrue stories. Clients with Munchausen’s syndrome may cut, bruise, bite, or inject their hands and then give an untruthful history to the medical professionals who care for the resulting injuries. Clients with clenched fist syndrome have stiff, tightly curled fingers that resist extension. The thumb and index fingers often are spared, enabling the client to maintain a level of function with the involved hand. Nerve block of the affected upper extremity or examination under anesthesia produces some relaxation of the hand, but often not full extension of the involved fingers.
Some edema of the hand may be present, but it is not as great as in a hand that is repeatedly traumatized. (See Case 7-1.)

Clients who repeatedly strike their hands on a wall or other hard surface eventually develop chronic dorsal hand edema, a condition that has been called secretan’s syndrome. The fibrotic changes that develop in a repeatedly traumatized hand eventually create an appearance similar to the brawny edema that develops in the lower legs of clients with chronic vascular insufficiency.

Malingering

Malingering can be defined as the intentional presentation of false or misleading health information for personal gain. This personal gain is described as secondary gain, distinct from the primary gain of recovery from illness. Some malingering clients are seeking financial gain, whereas others are consciously seeking social or interpersonal benefits. Although malingering generally is recognized as an uncommon condition (prevalence 5% or less), Mittenberg and colleagues estimate that 29% of personal injury cases, 30% of disability cases, 19% of criminal cases, and 8% of medical cases probably involve malingering and symptom exaggeration.

Evaluation Tips: Findings Suggestive of Simulated or Exaggerated Upper Extremity Deficits

Inconsistent Force Generation

Manual muscle testing provides information to the examiner in several ways. First, normal strength through a joint’s functional range of motion (ROM) reassures the examiner that no abnormalities have been identified on this screening test. Second, examination of a client with organic weakness, such as that caused by neuropathy or myopathy, will disclose a smooth, consistent inability to resist the examiner’s opposition. For example, the examiner will be able to flex the client’s extended wrist smoothly despite the client’s full effort to maintain wrist extension. An experienced examiner takes into account the client’s age, muscle mass, and overall medical condition when assessing the significance of such a finding. Third, a client with disease or injury may be unable to maintain consistent force generation because of pain or structural instability. This results in a sudden release of resistance to the examiner’s opposition. The client can be expected to describe the reason for this release of resistance clearly, providing information that is helpful for diagnosis and management. Fourth, the client may release resistance inconsistently, without other organic signs of impairment and without reporting incapaci-
Tips from the Field: Treatment of Clients with Functional Somatic Syndromes

As mentioned previously, the distinction between disease and illness is very important in the treatment of clients with FSS. To recap, disease is a demonstrable alteration in anatomy or physiology with unfavorable consequences for the client; illness is the client’s perception and experience of poor health. Both disease and illness are valid and important concerns for clients and the health care professionals who treat them.

Clients with a conversion disorder are unaware that their physical symptoms have a psychologic origin. Clients with somatization disorders feel unwell and can become truly convinced that they have a life-threatening or incapacitating disease or injury; this phenomenon has been called dissimulation. Clients with factitious disorders have diseases or injuries that require treatment; in addition, to prevent future disease or injury, attention must be paid to the factors that caused these clients to harm themselves. As Hippocrates observed, “It is more important to know the person who has the disease, than the disease the person has.”

CLIENTS WITH CHALLENGING BEHAVIORS

Reaching Agreement on a Treatment Plan at Every Stage of Treatment

Treatment of clients with FSS requires attention to the biologic, psychologic, and social factors that influence a client’s illness; that is, a biopsychosocial approach. Kleinman observes that clinicians tend to evaluate treatment success by improvement in signs of disease, whereas clients view success as healing of illness. The five-step strategy recommended by Kleinman recognizes the importance of the clinician and client finding enough common ground to reach agreement on a treatment plan (Box 7-2).

Not every client requires or wants the type of negotiated understanding produced by this five-step process. This is fortunate for the busy clinician, because the discussion can take a bit longer than the 10 to 15 minutes estimated by Kleinman. This is especially true when the client’s and the clinician’s models for explaining illness have little in common. The therapist often has the luxury of being able to work through these five steps gradually over two or three therapy visits, taking advantage of the natural rhythm and growing trust that develop between client and therapist over time. The experienced clinician is alert for opportune moments to explore psychologic or social factors that may contribute to a client’s illness.

Windows of Opportunity

In their study on client interaction with five experienced physicians, Branch and Malik described “windows of opportunity” as unique moments in which clients briefly discuss personal, family, or emotional issues with clinicians. Based on the findings from their study, they suggested the following four ways clinicians can explore important issues efficiently:

- Listen attentively.
- Ask open-ended questions, such as, “Is there anything else I can do for you today?”
- Listen for and recognize changes in the client’s emotions, appearance, posture, or voice. These windows of opportunity often occur in the middle of the visit. Ask a second question in a softer, gentler tone. Use silence, nods, and small comments to encourage the client to talk while you listen.
- Know when to end the conversation. Summarize the discussion and convey understanding and empathy.

Other authors have offered additional suggestions for establishing therapeutic relationships with challenging clients; these are presented in Box 7-3.

BOX 7-2

Five-Step Strategy for Reaching Agreement on a Treatment Plan

| Step 1: The clinician develops an understanding of the client’s explanatory model of his or her illness and the meaning of the illness to the client. |
| Step 2: The clinician presents his or her explanatory model for the client’s illness in nontechnical terms. |
| Step 3: Clinician and client compare models. |
| Step 4: Clinician and client discuss illness problems. |
| Step 5: Clinician and client develop and agree upon specific interventions and elements of a plan for treating the client’s illness. |

complaints we’re ignored. 25 Physician traits associated
with these complaints include being aloof, lack of a
ready answer, and the desire for the patient to be
too tired or busy.

Participatory Decision Making

Clients who have been encouraged to participate in deci-
sion making demonstrate better follow through on their
decisions than those who have not been encouraged
to participate. Clients with the best health outcomes are
those who express their opinions, who indicate their
preferences about their treatment during appointments,
and who ask questions. Physicians who regularly include
their patients in treatment decisions are those who offer
options and ask for input about patient preferences, and
who pursue mutual agreement about treatment plans. These
physicians demonstrate a participatory style. They elicit
greater patient cooperation and better health outcomes
than physicians who have more controlling styles of decision making. 27 This probably is also true for hand therapi-
ists.

**BOX 7-3**

**Establishing Therapeutic Relationships with Challenging Clients**

- Build trust. Positive client-therapist interactions
  require trust. Actions foster trust as much as
  words do. For example, return the client’s phone
calls and provide materials as promised.
- Provide good instructions. Focus on the client’s
  agenda whenever possible. Clear instructions that
  fit with the client’s agenda result in better client
  satisfaction and improved outcomes.
- Let the client talk without interruption at the
  beginning of the appointment. Identify which
  problems can be covered in the time available and
  which problems can be addressed at subsequent
  visits.
- Stay attuned to your sense of frustration, because
  this may be a sign that you find the client to be
  “difficult” (see Case 7-2).
- Be client centered. Use simple explanatory models
  that are easily understood. Avoid blaming the
  client; the therapeutic relationship can be harmed
  by the client’s perception that he or she is being
  blamed (see Case 7-3).
- If a consensus cannot be reached with a
  challenging client despite compassionate listening,
  it may be best to refer the client elsewhere.
  Barriers to reaching a consensus include
  unexpected resistance from the client and
  communication mismatch. Noncompliance or
  oppositionality from a client is exemplified by
  denial of disease, conscious or unconscious
  sabotaging of the treatment, or a need to control
  every detail (see Case 7-4).
- Try to develop and convey unconditional positive
  regard for the client, family, and caregiver. Respect
  the client’s autonomy and individuality and be
  willing to learn from clients’ various backgrounds
  (see Case 7-5).
- Give your undivided attention to complaining
  clients. Dissatisfied clients tell 20 people, and
  satisfied clients tell three.
- Avoid dealing with difficult clients when you are
  too tired or busy.
- Don’t downplay the client’s perception of the
  seriousness of the complaints. Give each client
time to describe his or her illness in its entirety.
  Listen responsively, but avoid interrupting.
- Make a statement that is empathetic. Work to
  establish a good rapport with the client and do
  not be defensive. Convey that you are working
  with, not against, the client.
- Ask additional questions and take control of the
  situation. Ask what clients would like to be done
  or how they believe the problem can be solved.
  Create an action plan and describe that plan in
  positive terms.
- Explain changes in treatment ahead of time. Fewer
  problems arise when there are fewer surprises.
- Follow up in a timely fashion and document the
  situation.

Modified from Levinson W, Siles WB, Invis TS, et al: Physician frustration in communicating with patients, Med Care 31:285-295, 1993; Lin EHB,
Katon W, Vo Korf M et al: Frustrating patients: physician and patient perspectives among distressed high users of medical services, J Gen Intern
Kaplan CB, Siegel B, Madill JM et al: Communication and the medical interview: strategies for learning and teaching, J Gen Intern Med 12(suppl
styles. They found that physicians who demonstrate participatory decision making are willing to spend extra time with patients and have lower volume practices.

Participatory physicians reported greater satisfaction with the autonomy they experienced in their personal lives. Short office visits in busier practices have demonstrated poorer outcomes. Medical office visits shorter than 18 minutes are associated with poor quality of information. Patients who had more time with their physicians rated the physicians more favorably. Physicians whose communication styles are less dominant receive higher satisfaction ratings than physicians who communicate in a more dominant manner.\(^\text{27}\) In current practice, unfortunately, fiscal demands and business issues may challenge the ability of some physicians and hand therapists to provide participatory care.

**Partnerships in Client Care**

Quill\(^\text{28}\) makes the following observations and recommendations:

- The relationship between the therapist and client is not obligatory, it is consensual. The therapist may speak with authority but should not be authoritarian. The client may ask questions, present alternatives, seek other opinions, or choose a different caregiver.
- The two parties must respect and trust each other.
- The client gets healed, cured, and/or relieved of pain. The provider derives enjoyment from being able to help, experiences personal or intellectual satisfaction from solving a problem, and receives financial compensation.
- The client's request may be incompatible with what the health care professional feels is the client's best interest, or it may conflict with the professional's personal beliefs. The caregiver should not compromise ethical, medical, or personal standards because of a client's request.
- Not all clients participate equally in their care. Caregivers may need to encourage clients to participate. It may be helpful, when appropriate, to request that clients participate more actively in their own treatment.

**Case Studies**

**CASE 7-1**

**Factitious Disorders**

A 58-year-old woman had tightly clenched long, ring, and small fingers on her nondominant left hand. This posture had persisted for 2 years and had been refractory to treatment by medications for dystonia and muscle relaxation. The client was able to use the thumb and index fingers to some degree. A diagnosis of clenched fist syndrome was made. Further discussion revealed that the condition began at the time of a stressful change at her workplace.

**Treatment approach**

Make sure the client understands that she has a condition that requires treatment and that the likelihood of improvement with treatment is excellent. Perform an examination under regional anesthetic block and fit the client for a custom wrist-hand orthosis while the arm is still under the effects of anesthesia. See the client daily for at least 2 weeks to reinforce wearing of the wrist-hand orthosis to preserve the ROM gained by the procedure. Perform and teach passive, active-assisted and active ROM exercises with the goal of restoring full ROM. Consider a custom dynamic wrist-hand orthosis to speed restoration of full ROM. Consider the timing of recommending psychologic counseling. Often the time to suggest counseling is when the client reports feeling sad or anxious, as many clients naturally will do as they become more comfortable with the therapist. Work closely with the referring physician to achieve the best outcome from a mental health referral.

**CASE 7-2**

**Windows of Opportunity**

A female executive was seen after excision of a recurrent glomus tumor of the nondominant left small finger. She experienced a Code Blue that was narcotics induced. She stated at her next visit that her hand therapist had caused the code by upsetting her with a discussion of her therapy authorization status.

**Treatment approach**

Validate the client's concerns. Tell her that you recognize that discussions about therapy authorization can be upsetting and that you are sorry she was upset. Ask how she would like to be kept informed about authorization status in the future. Recommend that the client discuss the factors that led up to the Code Blue with her physician. Call the physician so that he or she is prepared to discuss the Code Blue with the client. Coordinate all care as a medical team and document the situation carefully.

**CASE 7-3**

**Participatory Decision Making**

A 60-year-old, right-dominant retired male executive suffered a radial collateral ligament injury to the small finger
of his right hand while bicycling. He was shocked to learn that it would take longer than 2 weeks to recover from this injury. He could not accept this and demanded that he recover normal ROM and resolution of edema in 2 weeks’ time.

**Treatment approach**
Supervise the client’s home program closely. Provide good explanations of the typical recovery timeline at every visit and include the physician in this explanation. Offer encouragement and enthusiasm for the client’s progress and explore ways he can pass the recovery time meaningfully.

**CASE 7-4**

**Partnerships in Client Care**
An elderly female underwent open reduction and internal fixation with volar plating for a left nondominant distal radius fracture. At follow-up, she had shoved long black strings from her holiday ham into her postoperative dressing; she claimed that these were her sutures, which had “fallen apart.”

**Treatment approach**
Make sure to notify the physician, who can explain to the client that the black threads are not her sutures. Also, document the situation carefully. Focus therapy on functional needs and positive aspects of the client’s recovery.

**CASE 7-5**

**Partnerships in Client Care**
An elderly right-dominant female underwent excision for recurrent sarcoma of the right forearm, with radiation and multiple tendon transfers. She had had 11 previous surgeries on the involved extremity and was a well-informed client who had realistic expectations of her functional prospects. She followed her home program very well and often suggested appropriate upgrades. She and her therapist had a seemingly compatible and effective relationship. Near the end of one therapy session, she voiced an ethnic slur that was personally hurtful and offensive to the therapist.

**Treatment approach**
Try to strike a balance between sincerity and professionalism. Focus on the client’s clinical picture and use the situation as an opportunity to practice professionalism.

**CASE 7-6**

**Partnerships in Client Care**
An operating room nurse was treated nonoperatively for a boutonniere deformity of the dominant long finger. She refused to make appointments and frequently arrived at hand therapy unscheduled. She was unwilling to wait to be seen even though she had no scheduled appointment. She called and interrupted the department director to complain, wrote letters of complaint, and also complained to the hand surgeon about being told she needed to make appointments to be seen in hand therapy.

**Treatment approach**
Provide a nonemotional, factual explanation to the department director and the physician and be consistent in requiring all clients to have appointments for therapy. Offer the client the option of seeking care elsewhere if she prefers to do that.

**SUMMARY**
Ideally, the hand therapy client and the hand therapist will have similar goals. Also ideally, the client will attend therapy as scheduled, describe his or her illness honestly and accurately, make clinically appropriate requests, participate actively in treatment, and follow the treatment plan. When the therapist-client relationship does not benefit from these positive attributes, the relationship can deteriorate.

Through their recognition of the various patterns of FSS and the characteristics of challenging clients, hand therapists can more effectively shape rewarding therapeutic relationships. These positive relationships can favorably affect the clinical outcome for even the most challenging clients. Challenging client situations are opportunities for professional growth and can bring out the best care we have to offer.

**References**

Fundamentals of Client-Therapist Rapport

TERI BRITT PIPE

Client-therapist relationship then can serve as the foundation for assessment, prioritization, mutual goal setting and shared decision making.

Creating and maintaining rapport are essential first steps in coming to know and understand the client. Much more than simply being nice or acting respectful, truly knowing the client is part of effective clinical care and has important implications for client outcomes. Knowing the client means comprehending the client’s physical, emotional, cognitive, spiritual, and social sense of personhood and connecting to it as one human being to another within the boundaries of a professional therapeutic relationship.

Research and theory provide evidence that knowing the client is crucial to one of the most important yet basic aspects of clinical care: ensuring the client’s safety. Learning more about clients, understanding their unique perspectives, listening to what is and is not said, and accurately reading behaviors to formulate a correct clinical impression are all vital steps in keeping clients aligned with their therapeutic program and keeping them from harm. For instance, research indicates that the clinical behaviors of knowing and connecting with clients provide protection against untoward events and promote early recognition of client problems. Serving as a client advocate and guarding clients’ best interests are professional responsibilities that are deeply rooted in the therapeutic relationship.

KEY TERMS

Authenticity
Caring moment
Caritas
Ego self
Empathy
Equanimity
Hope
Interactional synchrony
Knowing the client
Mindfulness
Spiritual
Transpersonal caring
Transpersonal self

IMPORTANCE OF THE THERAPEUTIC RELATIONSHIP

Holistic, client-focused care is a unifying goal among client care professionals. Holistic care involves viewing clients as complex, dynamic beings with evolving, developing personas, needs, and strengths. Developing and nurturing the therapeutic relationship are the keys to understanding clients from a holistic perspective. The client-therapist relationship then can serve as the foundation for assessment, prioritization, mutual goal setting and shared decision making.

Creating and maintaining rapport are essential first steps in coming to know and understand the client. Much more than simply being nice or acting respectful, truly knowing the client is part of effective clinical care and has important implications for client outcomes. Knowing the client means comprehending the client’s physical, emotional, cognitive, spiritual, and social sense of personhood and connecting to it as one human being to another within the boundaries of a professional therapeutic relationship.

Research and theory provide evidence that knowing the client is crucial to one of the most important yet basic aspects of clinical care: ensuring the client’s safety. Learning more about clients, understanding their unique perspectives, listening to what is and is not said, and accurately reading behaviors to formulate a correct clinical impression are all vital steps in keeping clients aligned with their therapeutic program and keeping them from harm. For instance, research indicates that the clinical behaviors of knowing and connecting with clients provide protection against untoward events and promote early recognition of client problems. Serving as a client advocate and guarding clients’ best interests are professional responsibilities that are deeply rooted in the therapeutic relationship.
In addition to having implications for the client’s safety and well-being, meaningful therapeutic relationships also have implications for professionals. At times therapists may not be fully aware of the impact on clients of “simple” interventions, such as listening, being present, and offering encouragement. Behaviors such as these lead to knowing the client. Perhaps if therapists understand the depth of caring that can be conveyed by a simple gesture or by listening to clients talk about their experiences, they themselves can find renewal and healing in their practice.

**DEVELOPING A SUCCESSFUL THERAPEUTIC RELATIONSHIP**

Developing a therapeutic relationship is fundamental to working well with clients. The most effective approach is guided by a theoretical context, so that thoughts and behaviors can be seen in a broader, systematic perspective of caring for the client as a comprehensive whole. A theoretical perspective helps the therapist perceive, recognize, and process clinical information in a systematic way and can help bring order out of chaotic clinical data. The theoretical perspective that provides a framework for this part of the chapter is Watson’s theory of human caring. This model is not simply “applied to” a situation; rather, it lends itself to being experienced, so that the elements of the model come alive for the participants in caring relationships and encounters.

**WATSON’S THEORY OF HUMAN CARING**

Watson’s model has gained international recognition and has been used by a variety of disciplines since its origin in nursing. For the purposes of this chapter, the therapist is the “self,” and the client is the “one being cared for.” The theory of human caring is also sensitive to the changing realities of society and health care. (http://www2.uchsc.edu/son/caring/content/jwbio.asp) This chapter presents an overview of some of the theory’s major concepts, as well as examples based on clinical experience. The three major components used to frame the discussion are caritas, transpersonal caring healing relationships, and the caring moment.

**Caritas**

Caritas derives from the Greek word meaning “to cherish, appreciate, and give special attention, if not loving attention, to; it connotes that something is very fine, that indeed it is precious.” Caritas characterizes how hard therapists may choose to approach their clients.

**CLINICAL Pearl**

A positive, respectful regard for the client is the very first step in the therapeutic relationship.

Whether they meet clients in the home, hospital room, office, or other setting, therapists’ extension of a positive caritas regard for clients and their personal environment sets the stage for the development of therapeutic rapport. The ideal way to begin is to spend a moment or two mentally settling down and reaching a clear state of mind before meeting the client. This centering approach need not take a great deal of time; it requires merely the time it takes to inhale and intentionally clear one’s focus in preparation for the client encounter. It is a way of cultivating mindfulness about one’s practice.

Mindfulness is simple but not easy; it requires effort and discipline to “pay attention in a particular way: on purpose, in the present moment and nonjudgmentally.” The purposes of this centering moment are (1) to bring therapists awareness and understanding of their own minds; (2) to teach them how this can influence perceptions and actions; and (3) to show them how perceptions and actions influence the clinical environment, the client-therapist relationship, and the clinical encounter. The essence of mindfulness is to cultivate self-awareness through self-observation, self-inquiry, and mindful action. The overall attitude is one of gentleness, gratitude, and nurturing. From this point of inward clarity, the therapist can progress to the therapeutic relationship with the client. Again, this practice of focused attention need not take a great deal of time; it can be done in a moment. Yet the effects can be quite powerful because of the intention and focus this approach brings to the clinical encounter.

Watson’s theory of human caring delineated 10 caritas processes, which are used to explore the development of the therapeutic relationship. The discussion of each process includes common pitfalls and ways the therapist can avoid them.

**Caritas Process 1: “Practice of Loving-Kindness and Equanimity within Context of a Caring Consciousness”**

The word practice in the definition of caritas process 1 is a reminder that the attitude of loving-kindness and equanimity is not something that can be accomplished quickly or permanently; therapists practice it not with the goal of achievement, but rather with the objective of becoming more conscious of how they approach clients. Equanimity is the quality of being calm and even tempered. It is an evenness of mind characterized by calm temper
or firmness of mind, reflected as patience, composure, and steadiness of mind under stress. For the hand therapist, cultivation of this mindful, caring approach to the therapist-client relationship translates into reflections such as, “Who is this person? Am I open to participating in his or her personal story? How ought I be in this situation? What are the client's priorities?” The client’s response is also affected and may include the person’s perceptions of how the interaction and relationship will be part of the healing process and how the client will choose to participate in the therapist-client relationship.

Common Pitfalls and How to Avoid Them

1. Allowing yourself to be distracted: When you find yourself thinking about something other than the client in the present moment, gently refocus your attention. Try not to scold or reprimand yourself, because this is a fairly common occurrence, particularly early on in the development of a reflective practice.
2. Forgetting to take a moment to focus: Generally, once you notice how much more productive your focused encounters are, the reward will reinforce the practice of taking the small amount of time required.
3. Letting your mind say, “This client is just like that other client I had last week . . .”. Remember that just as you are different from any other person and your reactions are unique, so is this client different from any other, and his or her reactions are unique.

Caritas Process 2: “Being Authentically Present and Enabling and Sustaining the Deep Belief System and Subjective Life World View of Self and One Being Cared for”

Authenticity requires that hand therapists know who they are and how they can contribute to their clients’ care. Although authenticity sounds very simple, it can be counterintuitive in the context of modern standardized health care practice to remember that each therapist and each client brings something unique to the therapeutic relationship; unless therapists know their individual talents and gifts, those talents and gifts can’t be shared. Discovering one’s unique sense of authenticity involves taking the time to reflect on how experiences, clinical learning, personal knowledge, culture, belief system, aspects of personality, and a vast array of other factors unique to each individual can be cultivated to help in the current clinical situation. During this phase of the therapist-client relationship, the therapist is using his or her sense of self to be intentionally present with the client. This means being able to focus on only the client for this time. It means turning attention to what it is the client is experiencing in order to support the client in his or her belief system and discovering the things that will sustain and inspire hope or faith for that client.

In this phase of rapport building, helpful questions therapists might ask themselves include, “What information is needed to care for this person? Can I imagine what this experience is like for this client and what it means in his (or her) life?” Likewise, the client can contribute to the clinical relationship by sharing stories of his or her past as it relates to the person’s current health status, exploring sources of strength and meaning that can be used in the work of hand therapy.

Common Pitfalls and How to Avoid Them

1. Thinking that a diagnosis (e.g., a fractured wrist) has the same meaning to every client: Remember that this client will formulate a personal meaning from this condition and about the therapy.
2. Failing to assess or understand the client’s sources of strength and meaning: It is refreshing for clients to be reminded that they have overcome challenges in the past and that they have a reservoir of strengths to use in the present and future.

CLINICAL Pearl

Clients often are pleased and relieved to be asked about the strengths they bring to a situation, because health care providers generally ask instead about weaknesses or problems.

Caritas Process 3: “Cultivation of One’s Own Spiritual Practices and Transpersonal Self, Going Beyond Ego Self”

This element of caring requires a delicate balance. Caring involves tapping into one’s own source of strength according to a personal belief system while taking care not to assume that the client shares those values. In order to use the transpersonal self, the therapist must sustain healthy personal boundaries and put aside personal concerns, worries, and needs to care for the client. This part of the rapport-building process involves supporting the client in his or her spiritual beliefs and source or sources of strength and meaning, even when those differ from the therapist’s own beliefs. Going beyond the ego self means acknowledging the uniqueness of each individual while recognizing that the connections between individuals can be used for healing.

In this phase, the therapist may reflect on a question such as, “How am I attending to this person’s spiritual needs and soul care?” The client can assist in building this part of the relationship by identifying the aspects of his or her life style that the client feels “feed my spirit.”
Common Pitfalls and How to Avoid Them

1. Assuming the client shares the therapist’s belief system: Ask the client; don’t presume to know, even if seemingly obvious signs are present (e.g., religious symbols).

2. Failing to clarify and uphold professional boundaries: Clients can feel vulnerable and may say things to please the therapist. Always keep in mind the influence of the healer on the client and use it responsibly.

3. Neglecting to call in resources: The trust between client and therapist is strengthened if limitations are communicated and arrangements or referrals are initiated for social workers, community providers, and other sources of help.

4. Neglecting to devote the time and energy to “feed one’s own soul,” leading to a professional sense of eroded spirit and diminished effectiveness: This is perhaps the most common pitfall among health care professionals. The remedy is to cultivate activities and recreational pursuits that strengthen the sense of self. Find a source of restoration and recreation that builds your self-confidence and self-respect. Your clients will benefit, because you will be much more effective in your professional role.

Precaution. Remember to use your own personal sources of strength but not to overstep professional standards regarding relationship boundaries.

Caritas Process 4: “Developing and Sustaining a Helping-Trust Authentic Relationship”

Participating with a client in a caring, healing relationship is a choice. The therapist can “go through the motions” and still deliver safe, effective care; however, a much higher standard is set when the therapist deliberately creates the potential for the development of a healing relationship. Within this framework, the professional must cultivate a caring consciousness that is integral to the healing process, requiring self-development and ongoing personal growth.

The therapist’s thinking about the therapeutic relationship should include questions such as, “What significance does this illness or injury have for this client and how can I honor that meaning? What are the specific forms of caring and hand therapy that will best acknowledge, affirm, and sustain this client?”

From the client’s perspective, this phase of the relationship means choosing and showing a degree of trust and openness with the hand therapist. The client may show signs of willingness to relate to the therapist by sharing experiences and deeper meanings, past occurrences, and validating the therapist’s understanding of concerns, needs, and priorities.

Common Pitfalls and How to Avoid Them

1. Getting caught in the routine and distracted by time constraints and schedules. Keep your attention and focus on what is happening with this client, in this moment. Verbally set realistic and positive expectations about time with your client by saying something such as, “Mr. Smith, we have 15 minutes together to accomplish our work. This will be ample time, so let’s get started.”

2. Rushing into a client’s space before considering the best approach: Try to imagine what it would be like to have to ask for help from someone and then having that person disrespect your sense of privacy and your need for personal space.

3. Overlooking the significance that illness, injury, and therapy have for clients: The hand therapist represents a significant source of hope, repair, and return to function for the client.

4. Failing to recognize that trust is a changing characteristic: Be patient and allow the trusting relationship to develop. Once it does, diligently guard that trust.

CLINICAL Pearl

Keep in mind that your time will be better spent if you slow down and focus.

Caritas Process 5: “Being Present to and Supportive of the Expression of Positive and Negative Feelings as a Connection with a Deeper Spirit of Self and the One Being Cared for”

The hand therapist recognizes that within a trusting relationship, the client will feel more comfortable if he or she can share negative as well as positive aspects and can voice disagreements and deeper feelings than might not otherwise be exchanged. The hand therapist’s role is to listen to what is said and to understand what is left unsaid (i.e., read between the lines). It is a good idea to confirm or validate verbally what you understand from the client’s expression. This is crucial with expressions of pain or discomfort, which is highly subjective and open to interpretation.

What is perceived becomes reality. However, two realities, the client’s and the therapist’s, operate within the relationship. Clients may be trying to assimilate what their injury, disease, symptoms, diagnosis, or treatment means within their culture or personal relationships. Clients also are often trying to get a clear picture of what the current health situation means for their life and future.

Common Pitfalls and How to Avoid Them

1. Feeling offended when the client expresses negative emotions or behaviors: Remember that if the client
didn't trust you, he or she would not reveal these feelings to you. Demonstrating that you accept the negative as well as the positive is one way of showing a caring attitude.

2. Forgetting to validate meanings: Verbally acknowledge the behavior or expression and verify the meaning of what you observed. For example, “You are crying and seem upset right now. I wonder if you are physically tired or maybe you are frustrated that you aren’t completing this activity as well as you’d like, or maybe it is something else. Can you help me understand?”

3. Dismissing the client’s stories as irrelevant to the current clinical situation: Remember that for the client, the story may be connected to the client’s view of his or her health condition and therapy.

Caritas Process 6: “Creative Use of Self and All Ways of Knowing as Part of the Caring Process; to Engage in Artistry of Caring-Healing Practices”

In many cases, standardized methods of structuring client care serve as guidelines for a certain diagnosis or treatment approach. The art of caring involves a spirit of willingness to explore and discover other approaches to care that build on the unique aspects of the particular client and on situations that might lend themselves to creative or artistic healing methods.

The hand therapist might choose to address the following reflections to support the artistry of caring: “What are the unique attributes of this client and this situation? How can I use the environment to support healing for this client?”

Clients’ perspectives included determining the degree to which they feel comfortable disclosing their uniqueness as individuals and their ways of expressing themselves. Clients may also be coming to new levels of understanding about their pattern of response to the health situation, changes in roles and responsibilities, and how their life style may change.

Creative innovations can be very simple, and many hand therapists incorporate artful insight into their practice with each client. Such innovation could involve simply finding out the kind of food the client likes to cook or eat and then facilitating some aspect of that food preparation as part of hand therapy, or finding out the kind of music the client enjoys and incorporating that into the practice environment. If the client enjoys writing, the hand therapist may ask the client to keep a journal of what the recovery process means to him or her, describing important milestones and setbacks along the way.

Common Pitfalls and How to Avoid Them

1. Failing to consult the client regarding preferences about artful ways of caring: Remember that some clients are more willing than others to incorporate nontraditional approaches. The client’s comfort level is always the guide.

2. Becoming disappointed or discouraged if an artful approach does not work: Role model the qualities of persistence and optimism for the client.

3. Forgetting to ask about role changes and significant issues: Take the time to figure out what this illness or injury means to the client as you go about designing an artful approach. For example, if a pianist is working to recover from a hand injury, the significance of using music in the therapy will rest on whether the client finds this approach motivating or if it is a source of despair.

4. Moving too quickly into the artful approach without building a sense of rapport: Wait until you can gauge the types of approaches to which the client might respond and then share the ideas with the client at the appropriate time.

Caritas Process 7: “Engaging in a Genuine Teaching-Learning Experience That Attends to Unity of Being and Meaning, Attempting to Stay within the Other’s Frame of Reference”

Teaching and learning are key activities in the hand therapist-client relationship. The hand therapist’s role is to create a teaching-learning environment that supports the client’s progression through healing.

CLINICAL Pearl

Although the primary outward activities of hand therapy involve the body, a significant part of treatment also involves the client’s mind and spirit.

Teaching requires attending to the client’s ways of learning and preferences for information exchange and decision making. The hand therapist may ask, “Is this person able to understand what he or she is experiencing? How can I share knowledge and expertise with this client in a way that is relevant and meaningful for facilitating self-healing?”

It is very important to ascertain the client’s definition of health, healing, and wholeness so that the therapist can incorporate this into the teaching-learning plan. The hand therapist also must assess the client’s understanding of self-care needs, limitations, resources, and strengths.

Common Pitfalls and How to Avoid Them

1. Focusing only on the physical aspects of treatment and overlooking the cognitive, emotional, and spiritual impact hand therapy can have. Bring an intentional awareness to how the treatment may be influenced by the client’s thoughts, attitudes, beliefs, and experiences. It may be beneficial to ask the client
to help you understand what questions or concerns he or she is having about therapy and what it means for the healing process.

2. Failing to use the client’s strongest learning style: People usually find it easiest to teach in the style in which they learn best; take care that you don’t always choose the teaching approach that best suits you. Some clients prefer multiple approaches (e.g., visual, auditory, kinesthetic), therefore offer a variety of activities.

**Caritas Process 8: “Creating a Healing Environment at All Levels, Physical as Well as Nonphysical, a Subtle Environment of Energy and Consciousness Wherewith Wholeness, Beauty and Comfort, Dignity, and Peace Are Potentiated”**

The hand therapist can work with the client to create the best environment, physical and nonphysical, to promote healing. Manipulation of the environment can range from basic methods to more complex approaches. The treatment environment should be well lighted, ventilated, and clean. Beyond that, the hand therapist can incorporate elements of beauty, including sources of color, movement, texture, and form, to enhance the healing environment. When possible, a view of the outdoors, a change in surroundings, paintings, flowers, plants, and music can also be included. It is important to eliminate or reduce unnecessary noise, clutter, and other distractions from the environment during the clinical interaction.

The hand therapist can focus on questions such as, “What is important to this person to make his or her experience comfortable? How can healing art be incorporated into this space and time? How can I use creativity in managing institutional imperfections, constraints, contingencies, and scheduling issues while sustaining the context of a healing environment?” The client’s role is to participate with the therapist in the creation of an environment that is most suitable. It is very important that the client is honest and forthcoming in discussions of how the environment can be adapted to be more pleasing to the senses.

**Common Pitfalls and How to Avoid Them**

1. Trying to do everything yourself: Hand therapists are probably more aware of the environmental aspect of care than many of their professional counterparts. Ask for help from the client or family in creating a healing environment, or talk with others on the healthcare team to share ideas and insights. This type of collaborative work will enhance the client-therapist relationship and can promote teamwork among members of the interdisciplinary team.

2. Neglecting the physical and psychologic environment: Remember that a link exists between the physical environment and how a person feels emotionally and physically. Change the physical environment as much as possible to support the healing process; when this is impossible, do your utmost to create a positive psychologic environment.

**CLINICAL Pearl**

A positive attitude conveyed by the hand therapist can make a significant difference in the client’s immediate surroundings.

**Caritas Process 9: “Assisting with Basic Needs, with an Intentional Caring Consciousness, Administering Human Care Essentials That Potentiate Alignment of Mind/Body/Spirit Wholeness and Unity of Being in All Aspects of Care, Tending to Both Embodied Spirit and Evolving Spiritual Emergence”**

It is essential to the building of a therapeutic relationship that the therapist take care to notice the client’s very basic needs for safety, comfort, nutrition, clothing, cleanliness, privacy, and the need for relationships with others. Until these basic needs are attended to, the goals of hand therapy cannot be fully addressed. These facts seem self-evident, but many clients start hand therapy when they are hungry, weak, in pain, or not fully clothed (e.g., hospital gowns), or they are experiencing alterations in their normal patterns of personal hygiene. All these factors can leave clients feeling eroded in spirit and “less” than they could be. By putting the client in the best condition possible for therapy and acknowledging the impact of basic human needs, the therapist can more effectively accomplish the goals of the therapeutic session, and the client probably will be more confident about trying new approaches. As a result, the client-therapist relationship operates on a higher level.

The hand therapist can reflect on questions such as, “Am I process focused or outcome focused? Can I let go of the need to fix things? Am I honoring this person in my actions? What is the practice I can use now that will honor caring as a moral ideal?” The client’s role is to provide honest and timely information about his/her own experience of how well basic needs are met. For instance, the client can be as prepared as possible for the therapy experience by having toileting needs met prior, eating a small meal or snack prior as appropriate, and being open about telling the therapist when needs are unmet. Also, the client can share with the therapist the approaches that will help the client feel most cared for. The therapist can work to set this expectation with the client in the initial meeting.
Common Pitfalls and How to Avoid Them

1. Overlooking basic needs: To the extent that you can, make sure the client comes to the clinical encounter with basic needs met.
2. Forgetting to honor the process: Remember that outcomes are very important, but the journey is, too.
3. Focusing only on the “broken” body part: Remember and remind clients that they are more than this part of their body and that many aspects of the body and spirit remain strong, even in times of illness or injury. Avoid using terminology such as “the bad arm”; instead use “the affected arm.” A small semantic difference may help the client reframe the injury and see the body as an integrated whole rather than made up of “good” and “bad” parts.

CLINICAL Pearl

Bring honor to the process of your work with clients by developing an unhurried presence, one that reassures clients that their individual treatment journey is an essential part of arriving at the outcome.

Caritas Process 10: “Opening and Attending to Spiritual-Mysterious and Existential Dimensions of One’s Own Life-Death; Soul Care for Self and the One Being Cared for”

During times of illness or injury, clients often have questions about their future and what the health event means for them personally. At this juncture, clients often confront issues of loss and mortality, even if the injury or illness is not considered life-threatening. Clients may experience heightened emotions as they consider these existential questions.

In this phase the hand therapist focuses on how the client views the future for himself or herself and others, how the client can find meaning in the current experience, and how he or she can make good decisions about life and death. Therapists may ask themselves, “What are the life lessons in this situation for the client and for me? What soul care is useful for this client at this time?”

The client can consider his or her openness to deeper self-exploration and soul care and what that means in relation to healing. Key existential questions may arise during this time of illness or injury. The hand therapist’s role is not to provide answers to these questions, but rather to support clients as they ask the questions and then realize that they simply may have to live with uncertainties. Clients may be facing critical life decisions that require deep reflection, and this may affect their physical stamina and motivation.

Common Pitfalls and How to Avoid Them

1. Feeling fearful or uncomfortable about bringing up difficult issues: Remember that your role is to walk along with this client through a difficult time in the person’s life. Sometimes the most helpful thing you can do for clients is not to do anything, but simply to “be”; that is, be present with them, listen to them and, if they ask questions or express deep spiritual needs beyond your comfort level or professional preparation, ask them for permission to arrange a referral to others trained in these areas.

2. Failing to recognize the limitations of hand therapy: Work within the scope of professional practice and consult others for assistance and referral as needed.

CLINICAL Pearl

You are not charged with meeting all the client’s needs, but you can be instrumental in arranging the right combination of resources to do so.

Transpersonal Caring Healing Relationships

The second major element of Watson’s theory of human caring is transpersonal caring healing relationships. Transpersonal caring “conveys a concern for the inner life world of another . . . seeking to connect with and embrace the soul of the other through the processes of caring and healing and being in authentic relation, in the moment.” (http://www2.uchsc.edu/son/caring/content/transpersonal.asp) A transpersonal caring relationship connotes the sharing of authentic self between individuals and within groups in a reflective frame. All parties are changed within the relationship.

Care is founded on transpersonal caring relationships and is built on moral commitment, intentionality, and caritas consciousness. It is a vehicle for healing through the auspices of the relationship. The hand therapist recognizes and connects with the inner aspect of the other through presence, being centered in the caring moment, and through actions, words, intuition, body language, cognition, thoughts, senses, and other ways of interacting and connecting with others. (http://www2.uchsc.edu/son/caring/content/transpersonal.asp)

An assumption of transpersonal relationships is that “ongoing personal and professional development and spiritual growth, and personal spiritual practice assist the [therapist] in entering into this deeper level of professional healing practice.” (http://www2.uchsc.edu/son/caring/content/transpersonal.asp) The hand therapist learns how to build and expand transpersonal caring relationships based on his or her own life history and previous experiences or conditions or by having imagined others’ feelings in various circumstances.

The Caring Moment

The third component of Watson’s theory of human caring is the caring moment or occasion. The caring
moment happens when the therapist and the client come together with their unique life histories and enter into the human-to-human transaction in a given focal point in space and time. (http://www2.uchsc.edu/son/caring/content/transpersonal.asp)

There is awareness that the moment in time is transient; one makes choices about how to spend the time, occasion, or opportunities that transcend the moment itself. If the caring moment is characterized by transpersonal relationship and caritas consciousness, a connection develops between the therapist and the client at a spiritual level, transcending time and space and creating the potential for healing and human unity at deeper levels. (http://www2.uchsc.edu/son/caring/content/transpersonal.asp) On a more global plane, “We learn from one another how to be human by identifying ourselves with others, finding their dilemmas in ourselves. What we all learn from it is self-knowledge. The self we learn about . . . is every self. It is universal—the human self. We learn to recognize ourselves in others, [it] keeps alive our common humanity and avoids reducing self or other to the moral status of object.”

NONVERBAL ASPECTS OF COMMUNICATION
Personal Space, Body Language, and Gestures

The first impression a client gets is often the nonverbal communication that begins before the conversation ever starts. Hand therapists’ posture and use of personal space often are clues to how they feel about themselves and their practice. Personal space can be thought of as an invisible bubble or zone that varies from person to person and depends on the circumstances. Studies of personal space generally describe four zones: intimate distance, for embracing or whispering (6 to 18 inches); personal distance, for conversations among good friends (1 1/2 to 4 feet); social distance, for conversations among acquaintances (4 to 12 feet); and public distance, for public speaking (12 feet or more). With most clients, the personal zone becomes the territory of the health care team for the purposes of assessments, treatments, and therapies. However, by always maintaining an awareness of personal space and its influence on client comfort, therapists can more easily comply with the client’s preferences and take care not to compromise communication by violating this space.

The position and posture of clients (and of hand therapists, too) can convey relevant information about physical and emotional health, comfort with communication strategies, and general attitude. Clearly, nonverbal communication can be an important source of clinical information for the hand therapist, but it is a subjective means and can be misinterpreted. Therefore a very important part of therapy is validating the meanings of nonverbal communication with the client.

Therapists also must take special note of how they use space, body language, speech tone, and volume when engaging in activities with clients. Much of the work of hand therapy is performed within personal boundaries that would be considered socially uncomfortable in another context.

Studies of physician nonverbal behaviors have indicated that behaviors such as increased facial expression, frequent eye contact, smiling, leaning forward, open body posture, and nodding correlate with client satisfaction in a variety of clinical scenarios. Also, in the most favorably rated clinical encounters, the clinician’s behaviors often mirror or are patterned after the client’s behaviors. The study of conversation usually tends toward mutual behavior when they are on good terms and relating well. This is interactional synchrony, a term used to describe the extent to which behaviors in an interpersonal interaction are patterned or synchronized. The pattern can take place in the way movements and behaviors are timed or in the actual behaviors themselves, such as scratching one’s nose or leaning forward. This model of rapport includes three elements: mutual attentiveness, positivity, and coordination. Although the hand therapist may not consciously try to match the client’s behavioral conversational responses, the natural unfolding of this mutual conversational pattern may positively affect the sense of rapport reported by the client.

Nonverbal communication can provide valuable clinical information and can serve as a tool for enhancing the therapeutic relationship. However, the therapist must always use caution in interpreting nonverbal cues. Culture, health issues, context, and the social situation are just a few of the many variables that can alter the meaning of nonverbal communication. Therapists should always confirm their understanding of nonverbal behaviors with the client.

Reading Between the Lines

Sometimes the hand therapist must call attention to something that is not said or a gesture that is not made. At times the verbal message conflicts with the nonverbal message. Some clients are very reluctant to open up to the health care team, even about health-related issues such as pain or functional status. Pain is one of the most difficult factors to assess because of its subjective nature;
some people have a very high tolerance, whereas others have a very low threshold. An effective approach to dealing with this is to continue to ask verbal questions while assessing nonverbal cues until the client verifies that the therapist understands what the client means. For example, you might say, “You are rating your pain as a 3, yet we aren’t seeing the movement in your finger that we did yesterday. Can you tell me more about your discomfort or stiffness so that I can understand it better?”

**Empathy** is a strong component of an ability to understand what might be missing from a conversation. By truly trying to put oneself in the client’s place, the hand therapist may gain further insight into what is not part of the conversation. For example, if the hand therapist is working with a young farmer who recently had an upper extremity amputation, yet the subject of farming and role change has not yet been introduced, the hand therapist may surmise that the client might like to talk about this issue but does not know how to begin—it is the proverbial pink elephant in the middle of the room. Unspoken concerns such as this one require a sensitive approach because they usually represent very difficult issues. In most cases, giving the client the chance to express concerns opens up new possibilities. The energy that was spent worrying about the issue now can be spent addressing it.

The ability to figure out what is left unspoken or unexpressed is a high-level clinical skill that therapists develop after experiencing several similar client care scenarios. Patterns of expected behaviors and issues usually begin to make sense after the therapist sees clients in similar circumstances. Then, when a client’s specific communication does not fit with the basic pattern, the therapist may conclude that something unspoken warrants attention.

**Listening**

In our fast-paced culture of information overload, people often are forced to triage information rather than truly listen. Paying attention can mean skimming through the bulk of the material present to pick out what is really useful. “Sound bites,” text messaging, digital images, and executive summaries are the norm. Listening is more difficult and takes longer.

Listening means perceiving the words and creating meanings or interpretations for them. Listening also means mentally capturing the concrete message the client is sending while at the same time exploring deeper meanings that might be part of the message. For example, if a client says, “My hand is killing me,” it probably means the client is in physical pain. The deeper meaning may also be true; this statement may also send a message of loss and grief that would not be discerned if the listener only hears the text of the concrete message.

For therapists, listening requires more than sorting through information to decipher which data are clinically meaningful. It means incorporating what the client is saying into the therapist’s perception of that person as a whole. For instance, if a client starts talking about the quilt she hoped to make for her new grandson and this expression is dismissed as irrelevant to the clinical encounter, the hand therapist might miss an important opportunity, such as the chance to learn what is meaningful to the client and to work with the client on skills that would allow her to regain this function and restore her sense of role competency.

Listening takes time. Listening with the focused intention of caring and concern is a therapeutic technique in its own right. Often when clients are asked which interventions they find most meaningful, they report that when therapists listen to their concerns, they feel understood and cared for. Listening can be a means to the desired result of a productive therapist-client relationship, and it can also be an outcome in and of itself. Listening provides a chance to connect with the client in a meaningful way, and it also can be very rewarding for the therapist.

Even when the client cannot communicate verbally, listening is still an important skill. Listening can be accomplished with more than the ears and through means other than sound. Consider how attention might be turned to the client in a meaningful, silent way, supporting and accepting the person’s sense of being without words.

**CLINICAL Pearl**

Some of the most stunning listening takes place in silence.

**HOPE**

Hope is a positive attitude or orientation toward the future. It has cognitive aspects (such as when the client thinks about how treatment will affect outcomes) and affective components (such as the emotional excitement a client feels when thinking about regaining abilities).
Scientists also are investigating the physiologic aspects of hope, such as how hope may affect neurologic and immunologic function.

**CLINICAL Pearl**

Hope can be present even in the most desperate circumstances.

Individuals can simultaneously feel hopeful about one thing and hopeless about another. Sometimes hope extends beyond the constraints of the physical world; that is, sometimes, in the face of impending death, clients express hope for a future beyond death or describe hope in the people or things they will leave behind. Hope can be vested not so much in extending the quantity of life, but rather the quality. Clients look for signs of hope in the faces of those who care for them. The simple words, “The body has an amazing capacity for healing,” can provide clients with a foundation for believing hand therapy can and will work for them.

Hope plays an important role in health and healing and in adjusting to serious injury, illness, and death.

**CLINICAL Pearl**

Providing realistic hope is a crucial aspect of care.

Taking away hope can have devastating effects. Hope can be viewed conceptually as requiring four critical attributes: a time-focused future orientation, energized action, the existence of a goal or desired outcome, and a feeling of uncertainty. Hope is both a universally important construct and a very individualized experience.

Statements that clients can rate to indicate their level of hope are found in Herth’s Hope Index, an instrument used to measure hope in research settings (Box 8-1).

Hope is an attitude that can be affected by clinical interventions; to some degree, an outlook of hope can be taught. Important work is emerging that focuses on specific, scientifically based interventions designed to inspire hope and to teach people thought patterns and behavioral competencies that enhance personal happiness and meaning.

How should clinicians approach the issue of supporting realistic hope while not making unwarranted positive predictions or statements? In his book, The Anatomy of Hope, Jerome Groopman addresses this question from the point of view of a medical oncologist caring for clients with life-threatening illness. He explores the dangers of taking away psychologic hope by providing only survival statistics and factual summaries, as well as the perils of giving too much hope or unrealistic hope. The approach he finds most therapeutic is to balance a straightforward appraisal of the worst-case scenario with realistic optimism. He finds that clients are very appreciative when practitioners show an awareness of their diagnosis and predicted course and that these clients make the most beneficial personal strides in building a sense of meaning and hope when they have a realistic picture combined with emotional support and reinforcement of hope.

The hand therapist can assume an important role in assessing hope and providing clients with realistic hope for the progress and outcomes of hand therapy. Hope can be conveyed in words, through encouraging remarks or by reminding clients how far they have progressed. Helping clients to identify their individualized sources of support and to build on past successes are two approaches that go a long way in sustaining hope. Clients are much more likely to reach the physical and functional goals of hand therapy when they participate with a sense of hope intact.

**CREATING A MOTIVATING ENVIRONMENT**

One function of the therapeutic relationship is to create an environment in which the client can reach the very best possible clinical outcome. Motivation plays a key role in how much effort, dedication, and resilience a client will have in the therapeutic regimen. Naturally motivating factors and ways the therapist can enhance that motivation include the following:

1. Significant contributions: Identify the efforts clients are making; help them see the work they are accomplishing.
2. Goal participation: Take the time and effort to achieve mutual goal setting.
3. Positive dissatisfaction: When clients are not comfortable with their current status, help them use this dissatisfaction as a positive motivator for change.
4. Recognition: Create ways of acknowledging progress.
5. Clear expectations: Clarify reasonable goals, strategies, and regimens with the client; be a leader, encouraging and inspiring the client to reach beyond current abilities.

Clients often need help learning how to be successful in their treatment; they must realize that knowledge alone does not necessarily get them to the goal. The most effective rewards usually are those that are positive, valued by the individual client, and intermittent.

Clients become motivated when therapists help them find meaning in their therapeutic regimen. Point out the link between the activities or exercises and the way they will help the client about daily life, especially the activities most important to the client. Share your observations with the client, such as, “Your range of motion is much better today.” Even the simplest observation conveys to the client that you are paying attention to the person’s progress (or lack thereof), and this feedback itself provides motivation. Also use any available nonverbal means of feedback (e.g., chart, graph, or journal for keeping track of progress) for motivation.

Certain strategies do not work as motivational tools and can even set back motivational success. These include belittling clients, treating them in childlike ways, drawing attention to weaknesses or calling clients lacy, showing insensitivity to cultural or age-related norms, and in general behaving disrespectfully. Negative reinforcement should not be used. Sometimes confronting people about their negative behaviors or lack of focused effort is a reasonable tactic, but it should be done with care and respect.

**CLINICAL Pearl**

Clients find it easier to be motivated if the hand therapist also is motivated or energized.

Clients are keenly aware of the authenticity of encouragement. Therefore the therapist must find ways to maintain a personal sense of energized optimism. Clearly this is tied to self-care strategies; for example, taking good care of your own health and well-being has some of its clearest implications for professional success when it comes to providing motivation. A tired, depleted, “burned out” hand therapist finds it very difficult to support clients in the motivational domain. Find and engage in personal strategies that provide opportunities for healthy growth and development so that these strengths can be shared with your clients.

Working with clients who have little motivation can be particularly frustrating for the therapist. Clients have differing levels of readiness for adopting the changes required by hand therapy. Patience, gentle persistence, and time generally are the most effective strategies for managing weak motivation.

A motivating hand therapist provides the client with clear direction about goals, how therapy will progress, what to expect along the way, how long it will take, and the results. Providing honest, constructive feedback during each session and about the whole course of therapy is the most effective way to maintain motivation for most clients. Reinforcing a client’s “can do” spirit and conveying an attitude of “I knew you could do it” are excellent ways to boost motivation. Such encouragement leaves clients better prepared to draw from this motivation as a resource in the future, when they are discharged from therapy. The hand therapist can make the impossible become possible and can give the client the courage to turn a possibility into a reality.

**TERMINATING THE THERAPEUTIC RELATIONSHIP**

It is important that the therapist take the time and opportunity to acknowledge the end of the therapeutic relationship, if at all possible. The client may be discharged from the hand therapy program for a variety of reasons. At this juncture, the therapist should note the progress that was made, not only in terms of functionality, but also in terms of the process of therapy. The therapist may want to share some thoughts with the client about the goals accomplished, the strengths or characteristics that most obviously helped on the journey, and any reflections about humorous, meaningful, or important moments the therapist and client shared.

Clients often feel a great deal of gratitude to the hand therapist for the work that has been accomplished, and they may have difficulty expressing this gratitude in a way that is fitting within the professional culture of the therapist. For instance, clients may offer gifts or tokens of appreciation. As a rule, it is best to thank the client and explain that you really can’t accept personal gifts. Maintaining professional boundaries is very important, even as the therapist-client relationship is coming to a close.

Some of the most difficult good-byes can arise when a client enters a phase in treatment in which hand therapy is no longer relevant because of the client’s declining condition or impending death. It is important not to ignore the transition. Instead, tell the client good-bye. You might take the chance to say how much you enjoyed working with the client and spending time together.
Other situations also can create difficulty in maintaining social and professional roles. For instance, in a large health care organization, some of the hand therapist’s clients may be fellow employees. In rural settings, clients may also be neighbors. In these situations it is helpful to acknowledge that the professional therapeutic relationship is ending but that the social role will continue. If this transition in roles is acknowledged verbally, the former client is far less likely to ask a therapy question in the hospital elevator or request advice in the grocery store.

The end of the therapeutic relationship sometimes can cause emotions the client may be feeling about the hand therapist to bubble up. These can range from gratitude for reaching a therapy goal to frustration that goals were not accomplished. A client may even have just stopped therapy abruptly without giving notice. Most health care professionals develop a personal method of managing these thoughts and emotions, such as talking to colleagues, journaling (using no client names or identifiers), and finding ways to “let go” of clients when they leave. After you have been in practice for a while, you will have many client stories, some of them good memories, some not. Your expertise will be deepened by the complicated parade of clients that comprise an active clinical practice.

Suggested Approach

The physician’s notes make it clear that this will be a psychosocially complex case. The initial priority is to establish a trusting professional relationship with the client and her son. The clinical priority is safety for the client, followed by the formulation of clear working relationship roles and responsibilities that support the physical work of therapy.

Before initiating the client encounter, the hand therapist might take a moment to clear his or her mind of other distracting thoughts and to bring into focus a “fresh start” perspective for this client/family visit. A first step here might be to request and arrange for separate time with the client and the son and to arrange a physical setting that is conducive to privacy. Reassure both that they will have an adequate opportunity to voice concerns and questions. Recognizing that the son may have a lot of emotional investment in his caregiving role, since he is otherwise unemployed, the therapist may find it beneficial to comment on his strengths in this area. It will be important to draw clear lines about how the hand therapist will treat the family as a unit, but the primary therapeutic recommendations and work will be focused on the client’s priorities. Building a positive rapport with the son will facilitate the care of the client. The hand therapist might ask what the son’s priorities are, if he feels that his priorities match the client’s goals, and what the barriers have been up to this point. When talk turns to complaints about the physician, the hand therapist could refocus the son, saying, “Let’s focus on what we can accomplish for your mother here today.” After rapport is established, it will be more feasible to discuss therapeutic recommendations with the son. If he continues to suggest things that are clinically contraindicated, the therapist can explain the reasons for the contraindication. If rapport is not well established, the son is likely to dismiss the therapist’s recommendations.

In the client encounter, it is important for the therapist to notice nonverbal communication and to do an unobtrusive assessment for possible elder abuse. In scenarios in which the caregiver expresses a lot of anger and blame, the elderly individual sometimes is at risk for verbal, physical, or financial abuse. If signs of abuse are present and the client seems comfortable talking with the therapist, the therapist can assess the situation verbally to discern whether the client feels vulnerable. If so, a referral to social services and/or the elder abuse hotline is in order. If no signs of abuse are noted, the therapist proceeds with assessing the client’s goals for therapy and her readiness to begin.

The private consultation with the client focuses on gaining trust, establishing priorities, and clarifying everyone’s roles: client, son, hand therapist, and physician. Once

CASE Studies

CASE 8-1

An 80-year-old, right-dominant woman arrives for hand therapy accompanied by her 54-year-old son, who recently lost his job and now lives with his mother, “working” as her caregiver. The client was referred with a diagnosis of stiff fingers of both hands secondary to disuse after right shoulder surgery to repair the rotator cuff. The physician’s notes explicitly state that the son aggressively debated the issue of surgery with the physician and that he had been argumentative at office visits. He also had “pestered” the physician to the extent that the physician suggested that the client and son find another doctor with whom they might be happier. The client and son have decided to stay with this physician, saying, “Let’s focus on what we can accomplish for your mother here today.” After rapport is established, it will be more feasible to discuss therapeutic recommendations with the son. If he continues to suggest things that are clinically contraindicated, the therapist can explain the reasons for the contraindication. If rapport is not well established, the son is likely to dismiss the therapist’s recommendations.

1. What is your first client/family relationship priority?
2. What is your clinical priority?
3. How do you plan the therapeutic interventions so that they will have the greatest effect?
the part each person plays in the client's therapy is clearly understood, realistic goals can be established. In this situation, establishing trust and rapport may take longer, but without these elements hand therapy probably will be unsuccessful. The time spent "up front" in establishing a positive working relationship will pay benefits by fostering a more productive therapeutic progression.

The hand therapist must be very careful to document the findings in this case thoroughly because of the son's issues with anger and hostility. It also is important for the therapist to have an opportunity to debrief and reflect about his or her time with this client and son. Progress probably will take time, and this case has the potential to be discouraging if the therapist focuses only on physical gains. The first major accomplishment in this case will be creating rapport with and establishing realistic expectations for all those involved; these outcomes are more difficult to see. After each visit, the therapist should take a few moments to reflect on the strategies that did and did not work in this particular situation and to envision how things might be more successful in future encounters.

CASE 8-2
A precocious 9-year-old arrives for hand therapy with her mother, a pediatric nurse. The child has been referred with a diagnosis of bilateral wrist tendonitis. She is in gifted classes at school and is an avid reader. She is quite active and has trouble sitting in one place for longer than 5 minutes. She does not make eye contact with her mother or the therapist unless the mother specifically commands her to do so; she then makes eye contact for less than 30 seconds. Her hand therapy examination does not reveal any isolated structures that fit the criteria for tendonitis. She is hypermobile in numerous joints, including her wrists, and she has a habitual practice of forcefully passively stretching her wrists into extremes of flexion and extension. She does this often and states that it both "hurts and feels good." The mother is concerned that the physical problem causing the child's painful wrists has not been properly diagnosed, and she hopes that therapy will correct the condition.

1. How can rapport be gained?
2. What are the competing clinical priorities?
3. What referrals would be appropriate?

Suggested Approach
Presenting a focused, calm, accepting demeanor will be particularly helpful in this case, therefore the hand therapist might want to spend a few moments getting focused and clearing the mind of distractions before initiating this encounter. This client will be particularly sensitive to anxiety carried by the therapist. Maintaining a calm presence will be challenging, given the client's many movements and lack of eye contact, as well as the mother's presence. A very simple, yet effective, way therapists can remain focused and serene is to be aware of their own breathing, focusing on making the exhalation longer than the inhalation. This means of slowing down can have a positive effect on the client, who typically will slow her own breathing in response. Getting the client to slow down and focus is a critical first step in establishing rapport.

The hand therapist probably suspects that this child is experiencing anxiety or attention deficit characteristics. Further assessment of these suspicions warrants a complete history and may involve referrals to other professionals and perhaps school personnel. Competing clinical priorities include clarification of the behavioral issues that seem to be exacerbating the tendonitis, discerning medical versus psychologic etiologies for the behaviors, and identifying social or academic issues that might be compounding the condition. The fact that the child is academically precocious may mask her other developmental needs, which may be more in line with those of the average 9-year-old. Although there may be interventions the hand therapist can recommend for the tendonitis, the picture is complicated by the child's repeated behaviors. Treating the underlying psychosocial conditions extends the effectiveness of hand therapy. Referrals to developmental specialists, social workers, psychologic and medical care providers, and the school counselor may also be appropriate. Again, the referral process can be facilitated if the therapist develops a sound, trusting relationship with the client and her mother, particularly if this is their first encounter with the health care system regarding this constellation of issues.

As in the first case study, the hand therapist should evaluate the client out of the mother's presence, if at all possible. The mother's presence may be interfering with the daughter's ability to focus. Also, the girl may have goals for therapy that are different from those of her mother, which will be important to discern. The therapist can capitalize on the client's love of reading by giving her age-appropriate books or pamphlets about her tendonitis and its treatment. The therapist also should work with the client to identify ways of creating a soothing environment for her treatment, techniques that may extend to her living and academic activities. For example, the therapist might help the client identify music she finds relaxing or activities that help her unwind before therapy.

The hand therapist must work to gain an understanding of the significance of the client's repeated flexion and extension of her wrists. Is this action symbolic of a desire
for flexibility? Is the client’s “hurts and feels good” statement symbolic of what it is like for her to be academically gifted, given the social realities of her school setting. These symbolic meanings can greatly influence the client’s desire to quit the behaviors if the movements themselves are comforting psychologically.

Working separately with the mother, the hand therapist must first establish rapport and then gauge the mother’s understanding of her daughter’s underlying anxiety or attention-related condition. If no workup has been done on these issues, it is important that the therapist address the possibility of referrals. It is essential that the therapist make no assumptions about the mother’s cognitive understanding of her daughter’s condition; just because the mother is a pediatric nurse does not mean that she can objectively identify issues in her own family. The hand therapist must verify the mother’s understanding and her concerns verbally, in addition to assessing her nonverbal communication. Working with the mother to identify priorities for diagnosis and treatment comes after this basic assessment of her understanding the larger picture of her daughter’s condition. Supporting the mother and helping her accept the possible psychosocial diagnoses for her daughter also strengthens the therapeutic rapport and places the client in a better environment for improvement in overall well-being.

CASE 8-3

A 61-year-old, right-dominant teacher is referred for hand therapy after repair of a fracture of the right distal radius with plating. The referral is for pain management, edema, and stiffness that limit functional use of her hand. She tells the therapist that she is an overachiever and is highly motivated to recover. The therapist provides the woman with written instructions for gentle exercises; she also instructs her to stop or modify the exercises if they cause pain or do not feel good. When the client arrives for the next therapy session, the pain, swelling, and stiffness are all worse. She states that she had tripled the recommended exercise regimen, although she realized immediately that it increased her pain, swelling, and stiffness. She explains that she did this because she was eager to recover. The client is developing a highly guarded posture of the painful right upper extremity that is contributing to the worsening of all symptoms, and she is at risk for complex regional pain syndrome (CRPS).

1. How can you sustain this client’s high level of motivation, yet convince her that she has overdone her exercises?
2. How can you best approach this client about the worsening symptoms and pain?

Suggested Approach

The hand therapist can draw on the client’s many strengths to optimize treatment. First, the woman is highly motivated to get better. Second, she clearly understands the link between treatment and outcomes. Third, she must have a high level of trust in the hand therapist, as evidenced by her wanting to follow the recommendations, if not the level of gentleness, recommended by the therapist.

The therapist’s first step is to capitalize on the rapport already established. The therapist should acknowledge the client’s hard work and then gently but firmly remind her that in her case, “less is more.” The link between exercise and rest should be explained, as well as how pain affects mobility. The therapist is highly motivated to learn and likely will respond to logical, clear, multifaceted explanations of why vigorous or repeated exercise is causing her pain. In this case it probably will be beneficial to give the physiologic explanations of overuse, edema, and pain. These explanations will appeal to the client’s sense of reason, and this is likely to increase her motivation to be slower and gentler in her approach.

The hand therapist should not scold the client or trivialize the time and work she has already invested in her recovery. Shaming this client would be very detrimental to her overall well-being and to her progress in therapy. However, the hand therapist might want to gently inquire about other reasons the client overdid her therapy. Are there underlying reasons for her not to want to regain function, or was the overexertion truly related to wanting to get better faster? Such questions may help the client come to a better understanding of herself and her motives. If her sole motive is a speedy recovery, helping her discover that the most beneficial method is a gently paced approach that respects tissue tolerances may give her a deeper insight into other areas of her life.

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Roles of Therapy Assistants in Hand Therapy

CYNTHIA COOPER

The managed care system affects all health care fields, including hand therapy. One result of this change in the approach to health care is the increasing amount of treatment provided by occupational therapy assistants (OTAs) or physical therapy assistants (PTAs). This trend is likely to persist, and higher caseloads, shorter treatment times, and budget constraints will mean staffing patterns in which more assistants perform therapy. A knowledgeable, well-trained assistant can improve the care provided in a hand therapy program. This chapter discusses the roles of therapy assistants and suggests ways to develop and maximize an effective team. For clarity, the chapter uses the term assistant to mean an OTA or a PTA and the term therapist to mean an occupational therapist (OT) or a physical therapist (PT). It is understood that all are professionals who are therapy practitioners, and that semantics vary.

In some states, therapy assistants need a license to practice. The fields of occupational therapy and physical therapy have separate practice acts and different licensing agencies, which can affect the staffing options of hand therapy programs. Typically, OTAs must work under the supervision of OTs and follow an OT plan of care, and PTAs must work under the supervision of PTs and follow a PT plan of care. A PTA with hand experience can be added to a hand therapy program only if the assistant reports to a PT. However, more OTs practice hand therapy than do PTs. These types of considerations affect staffing decisions.

The therapist sets the standard of care for the program. The assistant is responsible for adhering to these standards. Ideally, therapists and assistants work collaboratively. The term collaboration has more than one definition; in this sense, it means “working together, especially in a joint intellectual effort.” By definition, collaboration implies a hierarchy, with the assistant reporting to the therapist. The hand therapist is responsible for the care the client receives; the therapist also determines the level of supervision an assistant requires. The assistant aids in the client’s goal setting and contributes ideas for the client’s program. Assistants’ responsibilities are increased as appropriate, depending on their clinical skills. All therapists and assistants are responsible for learning about and following their state laws concerning supervision and scope of practice.

HAND THERAPY EXPERIENCE MATRIX

The hand therapy experience matrix (Fig. 9-1) is a model of collaborative roles for therapists and assistants. The x axis represents the therapist’s level of experience in hand therapy. The y axis represents the assistant’s level of experience in hand therapy. The hand therapy team’s goal is to move to a higher quadrant through supervision and training, with competencies demonstrated in a manner consistent with state and facility guidelines.
In quadrant I, both the therapist and the assistant are inexperienced in hand therapy. In such cases, you, as the therapist, should study as much as possible about the diagnosis and arrange for mentoring from and close communication with experienced hand therapists. If you have hand therapy colleagues in the area, phone calls may be helpful. Also, keep in close touch with the physician’s office about the client’s status. Be honest with the referring physician and communicate well; this style of interaction can build trust and lead to a close working relationship, with a strong likelihood of future referrals.

In quadrant II, an inexperienced therapist is paired with an experienced assistant. The therapist must supervise the assistant but may not even know what is clinically wrong with the client. The assistant cannot fully evaluate the client and cannot and should not supervise the therapist. In this case, the therapist and the assistant, working as a team, should pool their knowledge, read as much as possible about the diagnosis, and follow the suggestions for a quadrant I situation. Special care must be taken in these cases to avoid any role reversal of therapist and assistant.

In quadrant III, an experienced therapist is working with an inexperienced assistant. The therapist can help train the assistant, and competencies can be achieved in accordance with the facility’s guidelines, maximizing the assistant’s potential to broaden clinical skills. In this team, it is important for the therapist to supervise the assistant closely. The therapist should create a structured learning program with the assistant’s assistance, identifying reading assignments, reviewing cases, and sharing resources from conferences and journals. This enrichment is more meaningful if it is shaped to match existing clients. For example, if a client has just been referred to you and your assistant for therapy after repair of the flexor pollicis longus, try to make that diagnosis your topic of study, so that it is relevant to your case. If you have a client with adhesions, study scar management with your assistant and ask the OTA or PTA how the knowledge gained can be applied to the client’s treatment. Box 9-1 presents a tool that can help assistants develop their clinical reasoning capabilities in reviewing hand therapy cases.

Quadrant IV is the best of both worlds. In this situation, both the therapist and the assistant are experienced in hand therapy. This team can continue to grow professionally and clinically by discussing cases, studying review articles, and keeping up with professional journals.

In all quadrants, it is very important that the assistant know when to ask the therapist for input about the client; this comes closest to a truly collaborative relationship.

An inexperienced therapist practicing hand therapy faces increased risk and a reduced likelihood of a favor-
able outcome. Inexperienced therapists should always use extra caution and should keep striving to learn. They should seek out all possible avenues for obtaining mentoring from other hand therapists and physicians. It strengthens, rather than weakens, your credibility and authority as a therapist if you are willing to ask questions and admit you do not know something, rather than pretending to be more knowledgeable than you are. Most professionals will respect you more for this approach. Even the most experienced therapists do not know everything; there is always more to learn in hand therapy. The knowledge will come if you apply yourself, follow the suggestions made previously, and stay committed to reading and studying. The knowledge base for hand therapy is very broad; in fact, it can be overwhelming. It takes time to learn all this material and to see all these clients, who will continually teach you more. Pacing yourself through this learning process is far better than overdoing it, which can result in burn-out.

Diagnoses that ideally should be referred to more experienced hand therapists include the following:

- Flexor tendon injury
- Extensor tendon injury
- Rheumatoid reconstruction
- Replantation/revascularization
- Complicated crush injury
- Nerve injury
- Complex regional pain syndrome (CRPS, also RSD)
- Dupuytren’s release
- Significant or infected wound

DEVELOPING A RESPECTFUL AND EFFECTIVE TEAM RELATIONSHIP

Clients are sensitive to the subtleties of communication among coworkers, and they often comment on their perception of a team’s work relationships. In a professional environment, the therapist explicitly shows respect for and appreciation of the assistant’s work in front of clients. If the assistant reciprocates, all the better. Clients may remark on the friendly flow they notice among team members; this type of collaborative arrangement is very favorable to a successful clinical experience. Conversely, clients can tell if tension exists among coworkers; this situation affects the quality of care and reduces clients’ comfort and satisfaction with the program.

Promoting a Learning Experience for Assistants

When all team members have a high level of clinical skills, the result is a better program. Supervising therapists should serve as role models and foster continual learning for the entire staff. For example, the staff could hold a journal club meeting once a month at lunch, sharing information from conferences that team members have attended and encouraging assistants to attend courses and read about hand therapy.

An awkward situation can arise if a team member feels that a therapist or an assistant is using outmoded treatment techniques. Some such techniques might include treating subacute hand edema with string wrap or retrograde massage instead of manual edema mobilization (MEM); failing to recognize or ignoring obvious and objective clinical signs of tissue intolerances (flare reaction); or performing hands-on treatment (e.g., passive range of motion [PROM]) that is painful, aggressive, and/or injurious. In such cases it may help to challenge that practitioner to bring in evidence from the literature supporting that choice of treatment. At the same time, recommend and provide reading that supports MEM or explains flare reactions.

What to Say to Clients

Hand therapists and assistants should explain their roles when they introduce themselves to clients. This should be done in a way that conveys both the concept of teamwork and the fact that the assistant’s contributions are a valued component of therapy. Team members must have a thorough understanding of their different roles if they are to explain them well to clients.

The hand therapist and OTA or PTA might introduce themselves to a client as follows:

Hand therapist: “Hello, my name is Jane. I will be your hand therapist, and today I will evaluate you. This is Sam, who is an [occupational or physical] therapy assistant. We will be your hand therapy team, and both of us will be working with you.”

OTA or PTA: “Hello, my name is Sam. I will be working with you today. I am an [occupational or physical] therapy assistant. Jane is your hand therapist. We are your hand therapy team, and we both will be involved with your care.”

TIPS FROM THE FIELD

- When a physician calls about a client, the therapist should take the call if available. If the assistant handles the call, the assistant should inform the therapist. Also, if the therapist is not available and the assistant takes the call, the assistant should ask the physician if he or she would like to discuss the case further with the hand therapist. If so, this should be arranged.
Therapists should show respect for assistants' knowledge and their desire to learn. Hand therapy assistants with good experience can be more knowledgeable in some areas than relatively new hand therapists. Assistants who have just attended a conference have educational material to share; they should be allowed to do so without awkwardness, because this will help to improve client care.

Team members should have as much clinical and philosophic compatibility as possible.

• The therapist should know about tissue tolerances. If the assistant is being too aggressive on a client, this must be corrected with instruction and hands-on practice. Conversely, if a therapist is not well versed in tissue tolerances, the assistant should not be overly aggressive just because the therapist orders it.

• The therapist makes the final decisions about treatment, including modalities. The assistant can provide input and suggestions, but the therapist is responsible for the decision.

• The therapist and assistant should meet regularly to review their client cases, including cases in which the clinical needs seem to be minor. The therapist is responsible for ensuring that clients' therapy programs are appropriate and are upgraded regularly. For this and other reasons, the hand therapist should see each client approximately every third or fourth visit if possible. Some state licensing agencies stipulate how often the therapist must be directly involved with care that is provided by an assistant.

• Assistants should always feel that they can question or ask about the treatment a therapist prescribes. However, any discussions should take place in private.

• The therapist should try to avoid correcting or reprimanding an assistant in front of a client. Instead, the therapist and assistant should use an agreed-upon set of signals that convey specific messages that may mean, for example:
  • Stop doing that immediately. What you are doing is not safe or appropriate for the client.
  • We need to go down the hall immediately to discuss what you are doing before continuing treatment.
  • This client needs both of us now to reinforce an instruction or a precaution.
  • Please come help with this splint or dressing.

CASE Studies

CASE 9-1
An assistant was trained by a relatively new, inexperienced hand therapist. The assistant was not taught to instruct clients with wrist fractures to isolate the wrist extensors when they performed wrist active range of motion (AROM) exercises during the home exercise program. The assistant had more years of experience than the new therapist had.

An experienced hand therapist subsequently was hired, and he identified wrist extensor isolation as an important clinical priority. This therapist began his discussion with the assistant by complimenting her for her hard work and acknowledging her clinical strengths. The therapist then said, "I know you have many years of clinical experience. As we develop our work relationship, I will be identifying things I want us to do more similarly. Feel free to ask me more about these topics. I will be happy to recommend reading on these subjects. It is very important to teach clients how to isolate the wrist extensors when they are learning AROM after wrist fracture so that they do not substitute this motion using the extensor digitorum communis [EDC]. Let's practice this together, and I will tell you what I like to say to clients so that they learn this motion well. Clients find it much harder to learn this motion if they have already learned to extend the wrist with the EDC; that is why I prioritize this technique and want you to practice it with clients quite a bit, so that they learn it thoroughly."

CASE 9-2
An inexperienced hand therapist worked on a team with an experienced assistant who was excellent at making splints. The therapist acknowledged her need for more practice making splints. The assistant shared her expertise, and they practiced together. The assistant made it clear that she enjoyed splinting and did not want to lose the opportunity to be involved in that work. The therapist improved her splinting skills and made sure that the assistant continued to have rewarding opportunities to make splints.

SUMMARY

Much of hand therapy probably falls into quadrants I and II of the hand therapy matrix. Be careful with this; a well-intended but inexperienced therapist or assistant can do permanent harm to a hand client. For this reason, it is critical that the hand therapy team recognize clinical limitations and improve competencies. Therapists and assistants who are inexperienced in hand therapy but are treating these clients should consult or network with more experienced hand therapists while advancing their clinical skills through reading, workshops and conferences, professional networks, and self-study. The rewards are well worth the effort. At the same time, therapists
and assistants should work to maximize their team effectiveness, because this enhances personal satisfaction and improves client care.

**Acknowledgments**

I wish to thank Michelle Robin Abrams, MS, OTR/L, CEAS; and John L. Evarts for their thoughtful reviews of this chapter and valuable suggestions.

**References**


APPENDIX TO PART TWO

Some Thoughts on Professionalism

CYNTHIA COOPER

“Sincerity is the most important thing . . . learn to fake that, and you’ve got it made”. From

WHAT IS PROFESSIONALISM?

Professionalism is a combination of maturity and effectiveness. In the workplace, professional behavior is demonstrated by being the best you can be and doing the best you can, even if you are not in the mood to do so. Professionalism has been described as being a “class act,” with emotionality being replaced by focus and responsibility. Instead of making decisions based on emotion, the professional relies on intellect and experience. Although professionalism implies treating others with respect, it does not imply elimination of empathy. While behaving professionally, we should still wonder what it is like to be in the client’s shoes. In other words, we should try to understand our clients’ subjective experiences.

WHY IS PROFESSIONALISM IMPORTANT IN HAND THERAPY?

Lack of professionalism contributes to low morale, which reduces our job satisfaction and also negatively affects our clients’ experiences. Professional behaviors foster teamwork, which is advantageous for meeting clients’ needs. Opportunities for advancement and success are associated with being perceived as a professional. Additional benefits of professional behavior include receiving the trust of clients and the admiration of colleagues and co-workers.

COMMUNICATION SKILLS RELATED TO PROFESSIONALISM

Professionalism is exemplified by polite and respectful styles of communication, efficient use of time, punctuality, and integrity. These behaviors help convey the message that the client comes first. Minimizing interruptions, answering questions, smiling, having a friendly or open facial expression, and providing eye contact are examples of effective communication. Projecting a sense of confidence and staying calm during difficult situations are additional examples of professionalism.

EXAMPLES OF NON-PROFESSIONAL BEHAVIOR

Example One

AA is an attractive female hand therapist who is single. She would like to meet a doctor at work. She wears low-cut tops and skimpy clothes to work, eliciting the attention of male clients and physicians. She has conversations in front of clients about her dates from previous nights. She is asked by doctors in front of clients if she would like to be fixed up with their single friends.

Questions: How does AA’s behavior affect the professionalism of the clinic? What can be done to help correct this situation?

Example Two

BB is a hand therapist who feels she has excellent splinting skills. When a co-worker’s client returns to clinic after not showing for appointments for 3 weeks, BB assesses the client’s splint and notices that it no longer fits well due to clinical changes in the client’s forearm and hand over the 3-week absence. BB states to the client: “This splint was made poorly and does not fit well. In fact, it is causing damage to your tissues. I will fix it for you and will make sure the other therapist is informed of the poor quality of her splint.”

Questions: How could she have worded this more professionally?

Example Three

DD is a therapist who believes that hand therapy should be painful. She imposes painful forces on delicate finger joints during PROM and tells clients that this will help them. Her clients frequently have flare responses with pain, edema, and stiffness. She yells at her clients to “Relax” while she performs painful PROM on their digits.

Questions: Is this an issue of professionalism or is it a lack of clinical understanding? What type of commu-
communication skills would be more effective in helping a client relax? For example, before removing sutures, what could you say to your client and how would you say it?

**Example Four**
EE is a hand therapist who is hoping to find a new career. She treats a client who is self-employed. She begins a business relationship with the client, exploring prospects to start a business together while still treating him. She uses the work computer on this project while her scheduled clients wait to be seen late by her.

*Questions:* What problems in professionalism do you see here? What solutions do you suggest?

**Example Five**
FF is an experienced hand therapist who has a very busy home life. She talks to her clients more about her own home life than about their lives or their hand therapy. She often receives presents from clients.

*Questions:* What changes in behavior would improve FF’s professionalism with her clients?

**Characteristics of Professional Behavior**
- Arrive at work on time and start your first clients on time.
- Notify clients who are waiting if you are running late.
- Listen to your clients.
- Take pride in your work.
- Take initiative by identifying and implementing changes that improve efficiency and clinical care.
- Be open to constructive feedback.
- Ask for help if you need it.
- Admit it if you do not know something.
- Be trustworthy.
- Be pleasant.
- Be aware of your facility’s policy about receiving gifts from clients.

**TIPS FROM THE FIELD**
- Start the day with a pleasant expression on your face, even if you are not feeling that way. Doing so may actually make you feel better.
- Be hopeful with clients and pleasant with colleagues.
- Present a harmonious team front to clients, even if there are differences to be ironed out in private. Be as professional as possible.
- Do not discuss politics or religion with clients.
- Do not have any business activity with clients.
- Be open to suggestions from colleagues and give positive feedback for good suggestions.
- Do not feel obliged to become friends with or socialize with team members. Prioritize a good working relationship that focuses on clients’ needs. If your clients feel well-cared for, you will become close with your team members on a professional level.
- If the workload is skewed, try to help each other as appropriate.

**Summary**
Our profession is hurt by therapists who are competent in hand therapy if they are incompetent in professionalism. We probably all recognize acquaintances or colleagues in the examples sited above. In truth, we may even recognize ourselves there a little bit. These thoughts and case examples remind readers that therapists and clients alike can benefit from ongoing efforts to improve our professionalism.