CLIENT-THERAPIST PERCEPTIONS OF HELPING IN PSYCHIATRIC OCCUPATIONAL THERAPY: A QUALITATIVE STUDY

By

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A thesis submitted in conformity with the requirements for the degree of Master of Arts
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Ontario Institute for Studies in Education of the University of Toronto

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Master of Arts 1999
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Abstract
Using an exploratory qualitative approach, data were collected on the perceptions of helping from six psychiatric occupational therapists and two clients of each therapist. Adopting an empowerment theoretical perspective, this study explored the experiences in occupational therapy that clients and their therapists perceive as helpful. In addition, barriers to helping were also examined. Clients and therapists shared many perceptions regarding benefits of the supportive relationship and of valued group dynamics. However, differences emerged with regard to the issues clients named as barriers to helping. These included the concrete problems of poverty, unemployment, social isolation, harmful effects of institutionalization, and stigma. Therapists did acknowledge the sick role as a major barrier but tended to assume a clinical perspective consistent with their training and focused on individual functional skill deficits as areas of concern. This study demonstrated the relevance of an empowerment analysis for helping psychiatric occupational therapy clients.
Acknowledgements

I would like to thank the clients and occupational therapists who shared their perceptions and gave their time to enable me to complete this study. I am particularly indebted to Sara Aharon who helped me crystallize my ideas from the very beginning. Through her concrete assistance with reading and commenting on drafts and her tireless support and encouragement, I was able to see this project to completion. I would like to express my deepest gratitude to my husband, Dave, for his confidence and encouragement through all of my endeavors. Finally, I would like to thank my thesis supervisor, Dr. Margaret Schneider for all her support throughout this project.
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CHAPTER 1

PSYCHIATRY: PAST AND PRESENT

Purpose and Objectives of the Study

Several years ago, working at a residential psychiatric rehabilitation program in the occupational therapy department of a large psychiatric hospital, I was asked by a frustrated co-worker: "How do we get the patients to stop feeling that we [staff] are their enemies? How can we convince them that we are on their side; that we are trying to help them?". His entreaty is quite instructive for both the genuine desire of many mental health workers to help their clients and for the feelings of anger and alienation experienced by psychiatric patients. At the time I had already begun to note the powerlessness of the psychiatric patients with whom I was working. I felt that if my co-workers believe (for others had expressed similar sentiments) that patients do not perceive their mental health care as help then obviously we must be doing something terribly wrong. I felt that this clearly demonstrated our lack of understanding of the nature of "help" and of the needs and feelings of the people whom we were trying to help. I became acutely aware that if we are going to increase our understanding of the best way to help our clients then we need to understand the experience of mental health services and what the clients themselves perceive as important and meaningful.

It is from my direct experience working in the field of psychiatric occupational therapy that my interest in exploring the perceptions and subjective experiences of both occupational therapists and their clients and my concern for client empowerment has evolved and hence serves as the primary catalyst for the subject of this study.
Writing about the dehumanization and "spirit breaking" of mental health services, Patricia E. Deegan (1990), a mental health clinician and a former recipient of mental health services, strongly advocates for the self-expression of users of psychiatric services. She insists that clinical language must be rejected in order for clients to validate their experiences by describing them in their own words. She writes: "We use our own language and discover our own words in order to reclaim our experiences and validate them."

(p.306). She cites Paulo Freire (1989) who writes that overcoming the effects of dehumanization and oppression means "each man [sic] wins back his [sic] right to say his [sic] own word, to name the world" (p.13). She adds: "Indeed, the first step in overcoming oppression is expression. That is why it is so important to listen to people and allow them to find their own words in order to name their own world" (p.306) (italics added).

Noting the pervasive abuse and powerlessness of psychiatric patients historically and coming to learn from my own experience as an occupational therapy assistant in institutional psychiatry that what we think we are doing in the name of "help" may not always be perceived as help by the clients of occupational therapy, I wanted to discover how and where the perceptions of helping are different and similar between occupational therapists and their clients. However, I wanted to ask them in a way in which they would really be heard. Therefore, the qualitative "Interview Guide Approach" (Patton, 1980) was employed to allow participants to express themselves using their own words-- encouraging an in-depth, open-ended exploration of subjective experiences and perceptions. This was critical in order to ensure that I would not reify relations of powerlessness through the present study. Part of an empowerment
ideology means giving people a voice and respecting that voice and self-expression is a critical step towards empowerment as noted by Deegan above.

This paper, then, is a qualitative exploration of the experience of helping in psychiatric occupational therapy services from both client and therapist perspectives. Establishing a dialogue with both groups can lead to a clearer understanding of what constitutes "help" as perceived by those whom we are trying to help and by those who are trying to do the helping thus elucidating the interrelationship between helpers and helpees, help and helping in psychiatric occupational therapy.

Historically, institutionalized individuals have had very little power or control over their treatment and over their lives. My own experience working in occupational therapy revealed that little has changed in terms of clients having equal control or decision-making power with regard to their psychiatric OT treatment and more importantly their lives. During my work experience, I felt that we were ignoring the perceptions and experiences of the clients whom we were supposed to be helping and felt, as do many psychiatric survivors, that the process of "helping" is dominated by the providers of services and the mental health system, in general. This domination has created a basic conflict between participatory democracy for clients and patients and the professional expertise ideal.

The tendency of mental health professionals to dominate the process of helping and a lack of true dialogue between client and worker are fundamental barriers to the process of helping. In Chapters One and Two, I discuss how, in spite of the movement towards an empowerment ideology in mental health, there are still
many barriers to a true dialogue and thus a truly egalitarian relationship -- such as the persistence of stereotypic ideas about individuals labelled "mentally ill", a lack of time for rapport to develop, and the internalization of the sick role by both clients and workers.

The purpose the present study is to explore, by establishing a dialogue with both clients and therapists, what clients and therapists perceive as "helpful" in psychiatric occupational therapy (OT). How are their perceptions similar; how are they different? In what ways are perceptions of helping activities, experiences, interpersonal dynamics, and so on the same and different among the two groups. I wanted to explore with the clients what aspects of OT they find helpful and what aspects they find not so helpful and what they think they would find more helpful. Similarly, I wanted to hear from the OT's what kinds of things they are doing that they think are helpful to their clients, and what kinds of things would they like to be doing but cannot for various personal and institutional reasons. Most importantly, often what we perceive to be help or helpful is not perceived by clients as help thus I wanted to be open to new ideas, feelings, thoughts, and experiences of the participants of which had not been previously conceived. Therefore it was important that both clients and OT's voice their perceptions, opinions, feelings, thoughts, ideas, experiences, and visions of helping in their own words without the constraints of forced choice questions.

I chose a qualitative methodology which would allow a dialogue with the participants and allow them to explain, clarify, reflect, and speak about their feelings, opinions, and ideas in their own words. I was interested in discovering reality as constructed by the
participants. As such, I needed to utilize a methodology which would not only allow but also encourage the participants to speak freely. Utilizing a questionnaire with pre-determined set responses which come from my own or others' frames of reference as opposed to the participants' would severely inhibit such freedom and openness. For as Berger (1975), writes: "To try to understand the experience of another it is necessary to dismantle the world as seen from one's own place within it, and to reassemble it as seen from [sic] his (p. 7)". Thus, I adopted a semi-structured interview to enable an attempt to gain an understanding of the participants' world.

Furthermore, my literature review will show that very few phenomenological studies which attempt to explore the subjective experience of users of psychiatric services utilize qualitative methodologies. Thus, this study fills a gap in previous research and the kinds of knowledge obtained. There are even fewer studies which explore the subjective experience of providers of mental health services utilizing a qualitative methodology. To my knowledge, there are no qualitative studies that examine psychiatric occupational therapists' perceptions of their helping. Most studies focus on general psychiatric services or psychotherapy and are not specific to the discipline of psychiatric occupational therapy. And finally, most of the research, that focuses on the experience of psychiatric services whether from the point of view of the client/patient or mental health worker/therapist, employs a quantitative methodology and tends to be limited to survey research. The limitation of most studies in this area is that they typically focus on measuring consumer satisfaction with specific modalities or interventions (Davidson et al. 1996). As Davidson et al. (1996) point out: "Providers continue for the most part to define the major policy
directions of mental health systems, and only then solicit feedback from consumers about specific elements of care" (p.50).

Though this is beginning to change and qualitative methodologies are being employed more and more to explore the subjective experience of users of psychiatric services, sometimes in combination with quantitative and sometimes alone. In fact, the significance of client/patient perspectives has been recognized as early as the 1950's though typical methodologies for these studies have been quantitative and such research has not become widespread until recently. Similarly, the use of qualitative methodology to attempt to understand in depth the phenomenological experience of the psychiatric patient can be traced back to 1961 with Goffman's participant research on the world of the institutionalized psychiatric patient in his book, Asylums: Essays on the social situations of mental patients and other inmates.

Qualitative methodologies are based on the assumption:

...that the study of human beings is very different from the study of physical phenomena; that it is important to understand the meanings which underlie human experience; and that to understand human beings and the meanings of their experiences, one must also understand the social context in which human interaction unfolds (Kraemer Tebes & Tebes Kraemer, 1991). (p.747)

Another very important rationale for choosing a qualitative methodology for the present study is that qualitative ways of knowing are much more consistent with an empowerment approach to the delivery of human services and to research because the researchers do not decontextualize and objectify the participants. It is empowering and validating for participants (particularly psychiatric patients whose opinions and perceptions have historically been invalidated due to the label of "crazy" or "mentally ill") to be allowed to express themselves freely, to engage in a dialogue about
what is important and meaningful to them, and to participate in the research by regularly sharing their perceptions and being informed about the data. In this study, as is typical for qualitative methodologies, debriefing sessions were provided and evolving data was reviewed with the participants.

In fact, throughout the interviewing, particularly with the clients, I had the sense that such undivided attention and such interested attentiveness was a rare experience for them (this is understandable considering the high caseloads assigned to a mental health worker) but one which made them feel important and validated their perceptions. I believe that partly due to this attentiveness and to the open-ended and extensive nature of the interviewing process, it was readily apparent to participants that I was indeed interested in their perceptions, opinions, feelings, thoughts; that I respected their perceptions, and that I felt these perceptions were very important. In addition, during the focus group a few clients expressed interest in continuing such meetings and seemed visibly disappointed, when I explained that this would be the last one. Furthermore, the clients were aware that this information would be presented to the OT department. While it is not certain that participants' suggestions and perceptions, will be transformed into actual service delivery implementations, I do believe that the experience itself has the potential of contributing to a psychological sense of importance and validation which while insufficient in itself, is a significant component of empowerment.

The objective of the study is to identify what elements of the client-therapist interactions/work are helpful to the client, to explore what might be more helpful, and to identify the barriers to helping. In particular, I was interested in identifying areas of
convergence and points of conflict or disagreement between clients and therapists with the goal of making suggestions regarding “helping” which will empower clients.

Overview

Throughout history, people who were believed to have suffered from mental illness were subjected to treatments which were more punitive than helpful/therapeutic. Bloodletting, applying leeches on the head and anus of inmates, pouring as many as 50 buckets of cold water at a time on an inmate’s head, and inducing vomiting, encompassed some of the interventions employed in the “insane asylums” of 1700 and 1800 Europe and North America, forerunners of today’s mental health institutions. The rationale for such “therapies”, writes Kraepelin (1962), was that they somehow restored the equilibrium of those individuals confined to asylums. Reported cures conceivably refer to the consequent obedience and docility of the patient. Not surprisingly, at this period in history the efficacy of these treatments was uncertain and the curative process unknown (Kraepelin, 1962).

Were these interventions perceived by patients as helpful? It is doubtful that they were as many of the patients who were able to free themselves from the various restraints committed suicide (Ackernecht, 1968).

Even since the early twentieth century, physicians, psychiatrists, and other mental health professionals have been vested the authority and power to employ interventions for which the efficacy is highly variable and uncertain and for which the curative process is unknown in order to treat individuals labelled with a variety of mental illnesses. Such interventions have included lobotomy or psychosurgery (surgically cutting, destroying, or
removing brain tissue), electro-convulsive therapy (ECT) and, more recently, drug therapy (Simmons, 1990).

Since implementation of these more physical interventions, a variety of treatment approaches and disciplines with a psychosocial focus, have emerged. One of these is occupational therapy (OT) which focuses on occupational functioning in the areas of productivity (i.e. work, school), leisure and self-care.

While today's methods of "treatment" or "help" have become increasingly more humane and the mental patient or mental health "consumer" has gradually gained more rights, a hegemony of the mental health system prevails. In fact, many consumers criticize the delivery of mental health services as overcontrolling, oppressive and even abusive (Burstow & Weitz, 1990; Chamberlin, 1978; Deegan, 1990). The paternalism of the mental health system extends from medical drug treatment to all forms of treatment in which psychiatric patients' perceptions regarding their treatment as well as their values, needs, feelings, opinions, and goals have largely been ignored by the helping professions (Hendrickson-Gracie, Staley, and Neufeld-Morton, 1996). This has been identified by psychiatric patients and psychiatric survivors, in addition to clinicians and theorists, as one of the most pervasive problems for users of mental health services (Burstow & Weitz, 1990; Chamberlin, 1978; Deegan, 1990; Hutchinson et al., 1985; Trainor & Church, 1984; Walsh, 1988; Walsh-Bowers & Nelson, 1994). Indeed, due to a lack of equal participation and decision-making power in the treatment process, a dissatisfaction with the current mental health system has become widespread among users of mental health services. This dissatisfaction is characterized by the rise of the self-help movement which seeks an empowering alternative (Chamberlin, 1978;
Chamberlin et al., 1996; Deegan, 1990; Hutchinson et al., 1985; Walsh-Bowers & Nelson, in press). In view of such widespread dissatisfaction among consumers we need to know more about their perceptions of help in terms of mental health care and how mental health care providers' perceptions of helping are similar and different from their clients.

"Help is whatever the person perceives as help," writes Tamara Dembo (1964); but how shall we know what a person perceives as help unless we ask them? Dembo makes a case not only for the significance of the subjective experience of the rehabilitation client but also for a dialogue, for a reciprocal relationship between professional and client. In this sense, "dialogue" implies an openness to learning about and a basic respect for and trust in the perceptions of the client.

This study is an attempt to explore and understand, via dialogue, what it is that psychiatric occupational therapy clients and their therapists perceive to be "help". ['Therapist' will be used in this paper interchangeably with 'occupational therapist' (OT) and 'OT'].

In order to understand the experiences of the user and provider of psychiatric occupational therapy services it is important to understand the social/political/historical context. As psychiatric occupational therapy practice takes place within the psychiatric system and the two are intimately intertwined, no analysis of psychiatric OT would be complete without an analysis of institutional psychiatry. Therefore, if we are to fully understand the experience of the OT client and therapist, it is crucial to examine the current and historical nature of that setting. This topic will be discussed in the next chapter. At the end of this
section I will present an explanation regarding the various terms used to describe the population studied.

The next section presents an overview of psychiatry beginning with the Middle Ages and concluding with current approaches to mental health care delivery of which psychiatric occupational therapy is a major field. Chapter Two presents a discussion of the barriers to helping in mental health delivery in general. In Chapter Three, I discuss the theoretical conceptualization for the present study-- the theory of empowerment as applied to mental health care delivery. In Chapter Four I review the relevant literature on empowerment and consumer perceptions of treatment and mental health delivery as well as outline prior research in this area. Chapter Five is a discussion of the methodology employed for the study where I describe, in more detail, my rationale for utilizing a qualitative methodology and for employing a semi-structured interview approach. Chapter Six reports the results of client and therapist perceptions of the process of goal-setting and individual contact with clients. Client-therapist perceptions of helpful components in Occupational Therapy groups are reported in Chapter Seven. The results of two focus groups--one comprised of the client participants and the other of the therapists, are reported in Chapter Eight and reveal the interweaving of several key themes which arose in the individual interviews. The final chapter provides a summary and discussion of the findings and the implications for future research.

Terms used to describe the population studied: Clients, Consumers, and Psychiatric Survivors

The use of the term "consumer" is currently in vogue replacing "patient" and "client" as it "...has the advantage of being psychiatrically neutral and anticipates a significant restructuring
of the service system through user purchasing power” (Church &
Reville, 1993, p.1). Some individuals, particularly former
psychiatric patients, prefer the term “psychiatric survivor” as it
makes a stronger political statement than the term “consumer”
through the connotation that individuals “survive” a basically
destructive and oppressive system. Moreover, the term “consumer” is
somewhat misleading as it implies that users of mental health
services choose the services they receive and as well incorrectly
suggests that they have “purchasing power”. As many users of
psychiatric services are either institutionalized, unemployed and/or
live in poverty, they have little or no power to choose services and
must submit to the very limited existing services nor do they have
any “purchasing power” to pay for alternative services. For these
reasons the term “client” is also misleading.

Rose & Black (1986) identify another problem with the term
“consumer” for promoting an empowerment perspective of users of
psychiatric services:

Consuming mental health or social services, however adeptly,
communicates an entirely different outcome than engagement in a
process of participation as a producer. There is a striking
parallel between consumers of services and consumers of
commodities: both are out of control of what they consume; both
stand outside the determinants of the process of production;
both act in response to a definition of their needs outside
their conscious control; and both are passive recipients of the
interaction which reproduces existing power relations. (Italics
added, p. 37).

In this paper I have decided to use all the terms
interchangeably as they are currently being used in the field
however, thus noting the severe limitations of the above terms.

A Brief History of Psychiatry

The ways in which individuals are perceived by a society
influence the ways in which they are “treated” by that society and
conversely the ways in which individuals are “treated” by a society influence the ways in which they are perceived and the ways individuals [both patients and mental health professionals] perceive themselves. In this chapter we examine how those individuals labelled “mentally ill” have historically been oppressed, segregated, abused, and devalued and how this has affected the current delivery of mental health services and the status of helper and helpee.

Unless we understand the phenomena of disempowerment we are neither able to understand nor able to facilitate empowerment. Thus an examination of the history of psychiatry and the oppression of the psychiatric patient is relevant to understanding the current disempowerment of people involved in the psychiatric system. Beginning with the Middle Ages the varying perspectives of individuals deemed “mad” and the “treatment” methods employed will be briefly outlined.

**Madness as Evil**

During the Middle Ages, the early Christian churches were the institutions given absolute power to “treat” and control disenfranchised and marginalized individuals, (i.e. the poor, the disabled, and women). This authority was exercised by labelling troublesome individuals believed to be mad—“evil” or “possessed by the devil” or “witches” (most of whom so labelled were women [Achterberg, 1991]) (Hardie, 1975; Renner, 1975). “Treatment” was carried out by the clergy who tortured innocent victims until they confessed to being witches. It has been estimated that millions were executed by the Church in Europe from the 14th to the 17th century with 85% of those executed being women—old women, young women and children (Ehrenreich & English, 1998).
Renner (1975) also draws parallels between those accused of witchcraft and those considered mentally ill today. For example, he compares the legal system for conviction of witchcraft with involuntary hospitalization. The process for voluntary hospitalization is such that if a person agrees to be admitted to the hospital his/her status is voluntary and s/he has the right to leave the hospital without medical approval. Paradoxically, if the individual refuses hospitalization against the advice of a physician, the individual's status becomes involuntary. S/he is then admitted involuntarily and does not have the right to leave the hospital without medical approval.

The absolute authority and power of the physician or psychiatrist to incarcerate an individual against his or her will can be compared to the authority and power of the clergy in the Middle Ages. In both cases the individual’s testimony is regarded only as valid if it is consistent with the verdict of the authority figure. Inconsistency with authority only serves to provide further evidence of an individual's lack of credibility.

During this era when the etiology of madness was believed to be evil, there was no cause to analyze the behaviour of the "mad" nor any cause to locate a "cure" (Hardie, 1975). As Hardie (1975) notes: "The mad were put to death with legality and certainty" (p.91).

**Madness as Animality**

A major development in the history of "madness" occurred with the rise of the modern city. "This era witnessed the institutionalization of madness" (Hardie, 1975, p.97). Due to the cyclic economic dislocation of the majority of the population, increasing numbers of beggars, vagrants, prostitutes, physically
disabled, and mentally ill were homeless. Some of the more violent or aggressive were chained up and flogged, surviving only on handouts (Ackernecth, 1968). Others who were more fortunate were cared for by their families, protected by wealth, or provided for by charities and religious orders (Ackernecth, 1968).

Hardie (1975) in her doctoral dissertation has researched extensively the history of psychiatry. She writes, "with mercantilism a bourgeois conscience embraced a moral definition of work resulting in the confinement of these ‘immoral idlers’" (p.98). Their incarceration, a desperate attempt by the current absolutist governments to solve the social crisis, was the structural precursor of today’s mental institutions (Hardie, 1975).

In Paris in 1656, the Hospital General opened and the Bicetre and La Salpetriere, as well as other small hospitals were reassigned to meet the needs of the poor. Eventually, throughout Europe, workhouses, reformatories and “madhouses” were opened to deal with the crisis (Hardie, 1975). These houses of confinement were operated by both religious and municipal bodies and incarceration of individuals was made by judicial order. There was no form of appeal for the “inmate” and his/her legal status was never made clear (Hardie, 1975). Hardie (1975) writes of the perceptions of the authorities of those individuals deemed “mad”:

[The] mad among the confined were seen as a monstrous, degraded manifestation of the animality of absolute freedom of the ‘passion’ that was believed to threaten all humankind. The evilness of such unrestrained behaviour must be consigned to oblivion by brutal discipline and force. (p.100)

According to Hardie (1975), to protect the criminals and the poor from this corrupt “animality” and because their behaviour disrupted the workhouses, the mad were segregated into separate
cells and dungeons. The image of the "mad" as beasts was reflected in the conditions of their confinement. They were locked-up or caged, chained, often in cold, dark dungeons with stone floors and beds of straw (Hardie, 1975). It was reasoned that simply because individuals endured these horrible conditions they must be insensitive to them, and this endurance provided still further evidence of their "solid animality". Foucault (1965) quotes Pinel, the legendary reformer who: "...would always admire the constancy and the ease with which certain of the insane of both sexes bear the most rigorous and prolonged cold" (p. 74).

With industrialization and the need for cheap labour, only the criminal and the "mad" were kept confined (Hardie, 1975). All others were freed from confinement only to be subjected to long hours of hard work in order to survive (Hardie, 1975). This forced employment was a crude form of welfare and regulation of unemployment. As Hardie (1975) writes: "The mad were to be the scapegoats of a socio-political system which could not adequately care for all members of society...The mad were further devalued; they were weak, base, and immoral because they could not contribute to the productivity of an industrialized society." (p. 100)

**From Sinner to Patient: Madness as Disease**

In France, after the Revolution it was decided that the mad were to be temporarily detained in the prisons with the criminals (Hardie, 1975). Hardie (1975) indicates that the mad were then to be segregated in facilities of their own "in order not to degrade and defiled the houses of correction" (p. 101). At this time hospitals in France were then designated as centres for the care of the insane.

Eventually a more physical perspective of madness was adopted and the physician entered these centres (Hardie, 1975). According
to Hardie (1975), growing out of the discoveries of seventeenth century medicine, a mechanistic philosophy led to the disease model conceptualization of madness.

Similarly in the United States there was some change in public attitudes toward those individuals deemed mad. Their status was changing from that of sinner to that of patient. With the advocacy of Dorethea Dix, a retired school teacher from Boston, public hospitals began to house the mentally ill (Renner, 1975). Prior to this, as they were in Europe, the mentally ill were abandoned in foul local jails and poorhouses where they were confined in filthy pens, caged, chained and beaten with rods. However, because the new hospitals soon became overcrowded and many of the old abuses recurred (Renner, 1975).

The change in confinement of the mentally ill from jails to hospitals led to the unquestioned absolute power and authority of the physician. Even though medical knowledge was not brought into the hospital, the physician was given powers of granting admission and discharge in the legal form of the "certificate" (Hardie, 1975). According to Hardie (1975), the authority of the physician was not based on scientific competence or on a well founded body of medical knowledge concerning mental illness. She points out: "What was introduced, in fact was, rather, a 'personality' whose professional status and prestige granted him a 'quasi-miraculous' stance vis-a-vis the patient". (p.21).

To be sure, the most bizarre and gruesome forms of "treatment" were legitimated by the presence of the physician in the asylum. For example: "[In the Darwin Chair] the insane were rotated until blood oozed from their mouths, ears, and noses, and for years most
successful cures were reported as a result of its use. Castration and starvation cures were also employed..." (Ackernecht, 1968, p.38).

To recall from the introduction, bloodletting, applying leeches on the "inmate's" head and anus, pouring as many as 50 buckets of cold water at a time on an "inmate's" head, and induced vomiting were some of the "treatments" which were described by Kraepelin (1962) as: "...as varied and perverse as the imaginations of their perpetrators". (p.38). These "shock treatments" were employed with the rationale that they somehow restored equilibrium (Kraepelin, 1962).

Benjamin Rush, sometimes referred to as the father of American psychiatry, believed in the "efficacy of fright": "...terror acts powerfully on the body through the medium of the mind and should be employed in the cure of madness." (Kraepelin, 1962, p.8). He introduced the "tranquilizer chair", a restraining chair equipped with supports to which the entire body was strapped in a most painful position; one in which the individual was unable to even scratch or drive away flies. The tranquilizer chair was reported to make the "most stubborn and irascible patient gentle and submissive." (Kraepelin, 1962, p. 17). Kraepelin (1962) writes: "Similar success was reported with the straitjacket, a common form of restraint used up to the mid-twentieth century". (p.17). Because of the horrible conditions of the asylum and the abusive treatments, many of the patients who succeeded in freeing themselves committed suicide (Ackernecht, 1968).

Curiously, even with the increasing medicalization of madness, those who "cared" for the inmates, aside from the physician, were non-medical and not that different from the guards and goalers of the almshouses and prisons, writes Hardie (1975). The attendants
were generally described as “uncouth, unsympathetic, rude, and untidy” (Kraepelin, 1962, p.17). In fact, in some institutions, such as the Sommelstein, the policy was to employ ex-convicts (Kraepelin, 1962).

Clearly, the forms of treatment described above were punitive in nature and those subjected to them were at best, devalued and at worst, considered subhuman. Kraepelin (1962) explains the widespread abuses of the mad in terms of two major false assumptions accepted by the public at large as well as by physicians. One, mental illness was believed to be incurable and two, the mental patient was believed to be intrinsically weak and base.

**Moral Treatment**

The nineteenth century saw some reforms in the treatment of the mentally ill with the entrenchment of the medical model application to madness and with the advent of Moral Treatment (Hardie, 1975).

With the Quaker movement at the turn of the nineteenth century, moral treatment would be provided at Quaker establishments which operated for mentally ill individuals. Eventually, moral treatment would spread to North America but was provided only at Quaker establishments (Hardie, 1975).

In England, the Tukes, wealthy tea and coffee merchants, founded the Retreat in which the Quaker principles of moral treatment were practiced. This approach emphasized the significance of Quaker religious beliefs in treating the mad and therefore members for the Quaker faith were segregated from non-members.

Work was also an essential part of moral treatment. However, it was important not for any productive value but rather as a moral rule--it was a way of teaching the mad self-control and
responsibility (Hardie, 1975). Implicit in moral treatment was an insidious form of social conditioning. Inmates of the retreat were judged morally and were continually reminded of the transgression of their madness. Guilt was a form of punishment which would lead to atonement of sins. However, it was more than that, guilt served to create a form of self-restraint for the madman. Perpetual observation and recrimination by the inmate's keepers would replace physical restraints to a large degree. Hardie (1975) writes of this powerful form of social control: "Reason was no longer threatened by unreason, no longer fearful as of old, but rather now unreason was controlled by the absolute authority of reason" (p150).

The absolute authority of reason, namely the physician, would become a patriarchal authority as madness was to be perceived as a return to a form of childhood (Hardie, 1975).

It was believed that organizing the Retreat as a prototype of the institution of Family would create a beneficial milieu for the patient. However, Foucault (1965) points out that rather than benefiting the patient, this milieu further alienated the patient by placing him/her in the inferior role of child. Moreover, being forced into this role of child precluded a reciprocal staff-patient relationship wherein the patient was a self-determining agent. There would be no dialogue; only the observation and classification of the mad by their keepers which would serve as the method for describing madness (Hardie, 1975). Hardie (1975) writes: "Out of this world of observation a psychology of madness grew up; in this world madness is only what is seen, no intentions are ascribed, no secrets explicated, no reciprocity entailed" (p. 154). She further writes of this tautological reasoning: "Madness was madness and this had to explain all." (p. 155). We can see the vestiges of the tendency to
locate pathology within the individual as opposed to examining the environment for sources of behaviour even today (Goffman, 1961; Rosenhan, 1973; Szasz, 1976). The paternalism of this era is also ever present in today’s asylums and mental health programs (Trainor and Church, 1984; Hutchinson et al., 1986; Rose and Black, 1986).

Over the decades, as with the United States and Europe, asylums in Canada became overcrowded with an increasing number of chronically mentally ill (Hardie, 1975).

Recovery rates, now being calculated more accurately, revealed successful treatment of mental illness had occurred in very few cases. (Hardie, 1975). This discovery contradicted the exaggerated and often unfounded claims of cures with the initial practice of moral treatment and dampened the public optimism of a cure for mental illness. It also served to further devalue the mentally ill (Hardie, 1975). The terms used to name the institutions and those who housed them clearly reflect the negative images of the mad held by society. For example, the Queen Street Mental Health Centre, in Toronto, Canada was called The Upper Canada "Lunatic" Asylum, when it first opened its doors in 1844. An asylum in Orillia was opened in 1876 to care for the "Idiots and Feeble Minded" (Hardie, 1975). Furthermore, the daily care of the inmates in these institutions was carried out by untrained, very low paid aides and attendants.

**Institutional Psychiatry**

As institutional psychiatry applied the medical model to mental illness it would increasingly grasp treatment techniques which imitated those of medicine. Since it was agreed among institutional psychiatrists, that mental illness was a disease similar to physical illness, it appeared logical that treatment should be primarily physical in nature. But it was the zealousness
of psychiatry to be accepted as a bona-fide science, that led to the adoption of the medical model and its subsequent physical treatment. Unfortunately, as Simmons (1990) writes: “In their [psychiatrists] eagerness to apply the new therapies, they overlooked the fact that these treatments were painful, physically or mentally injurious, and in the end, mostly ineffective” (p.IX).

**Labelling and the DSM.** It is this same eagerness to be accepted as a scientific field, that has also led to labelling individuals with arbitrary diagnoses (Rosenhan, 1973; Szasz, 1976). According to Lewis (1994), the Diagnostic and Statistical Manual of Mental disorders (DSM), a manual which provides names or labels for a variety of problems in human behaviour, is being widely used in North America by many mental health professionals as a diagnostic tool. Through my work experience I have observed many a client having been labelled at different times with 10 or more different diagnoses within only a few years time span. The diagnosis varies with each particular psychiatrist with which that person is involved. This extreme variation underlines the arbitrary nature of the diagnostic procedure which suggests its unreliability.

Illich (1976) has pointed out in his critique of the medical profession and medical model, that physicians faced with many uncertainties, would rather err on the side of caution and diagnose illness before health. So too with psychiatrists as Rosenhan (1973) has revealed in his classic study: *On Being Sane in Insane Places* where eight pseudopatients gained admission to various psychiatric institutions across the United States. All eight pseudopatients were admitted and all, save one, were diagnosed as "schizophrenic". As with Illich, Rosenhan (1973) observed: "Failure to detect sanity during the course of hospitalization may be due to the fact
that...physicians are more inclined to call a healthy person sick...than a sick person healthy...” (p.255). However, unlike most medical illnesses, psychiatric labels are pejorative and the stigma associated with them are personally, socially, and legally detrimental.

Rosenhan’s study has also convincingly demonstrated the power, permanence, and fallibility of the psychiatric label. The eight pseudopatients in the study came from varying backgrounds, such as a psychology graduate student, a painter, and a homemaker. These individuals gained secret admission to 12 hospitals located in five different states. With exception of alleging names, occupational backgrounds, and symptoms (i.e. hearing voices), no other personal information was falsified. None of the pseudopatients had histories of psychiatric problems. All pseudopatients were admitted and all, except one, received the diagnosis of schizophrenia and eventually were discharged with the diagnosis of schizophrenia “in remission”. Length of their hospitalization ranged from 7 to 52 days, with an average of 19 days. This study has shown how once a person is labelled, the label overshadows all other behaviours, characteristics, and roles of that person. Rosenhan (1973) has shown how the label has a life of its own. Many of the pseudopatient’s normal behaviours either went unnoticed or were profoundly misinterpreted. Rosenhan (1973) concludes:

One tacit characteristic of psychiatric diagnosis is that it locates the sources of aberration within the individual and only rarely within the complex of stimuli that surrounds him [sic]. Consequently, behaviors that are stimulated by the environment are commonly misattributed to the patient’s disorder. (p. 157)
**Status of the Mentally Ill**

While the status of the inmates had certainly improved since the Middle Ages--there was a shift in the perspective of mental illness from sin to disease--it nonetheless remained very low. Hardie (1975) notes that: "Sharing the public prejudice against the mentally ill, those who cared for them had little of the commitment and humanitarianism of previous lay reformers, such as Dorothea Dix" (p.234). The current medical belief in scientific practice and somatic concepts of mental illness served further to alienate these workers from patient care and treatment. Increasingly, treatment consisted of drugs, seclusion rooms, mechanical restraints or agitators, and various forms of hydrotherapy, all applied explicitly for the "benefit" of the patient and implicitly for management of overcrowded hospitals (Hardie, 1975). Understandably, few patients would perceive these treatments as helpful.

In the nineteenth century, psychiatry in North America became narrowly concerned with hospital administration unlike in Europe, where schools of psychiatry and medicine were producing new theories of mental illness from scientific research based upon strong intellectual and scholarly traditions (Hardie, 1975).

During the first half of the 1920’s the asylum would remain largely custodial in nature despite being named “hospitals.” Few patients were involved in any sort of constructive work or therapy and it was primarily untrained attendant staff who carried out treatment programs.

The fact that these staff were untrained and poorly paid reflects the public prejudice and devaluation of individuals considered mentally ill. Such devaluation is also evident by the fact that responsibility for mental health was not transformed from
the Provincial Inspector of Prisons and Public Charities to the Provincial Department of Health until the 1930's (Simmons, 1990). The cavalier use of radical treatments such as insulin coma therapy, metrazol, shock treatment, electroshock therapy or lobotomy (surgical removal of part of the brain), further suggests the low priorities for quality care for the mentally ill (Simmons, 1990).

**The Status of the Client**

After the Second World War, a variety of reforms were gradually introduced into mental hospitals which would supplement the physical therapies of the 1930's with group therapies.

The status of the psychiatric patient would be elevated with such therapies as Jones' Therapeutic Community, and the Cummings' Milieu Therapy. Typically, these therapies emphasized patient governments, power-sharing or decision-making group therapies, and attempts to involve the patients in the ward "community" (Hardie, 1975).

With the evolution of the field of occupational therapy and psychiatric rehabilitation, the emphasis would be on health induction as opposed to symptom reduction (Anthony, 1979). Moreover, with the emphasis on developing patients' strengths, on skill development, and ultimately on facilitating optimum independent functioning, it was conceivable that some psychiatric patients could eventually return to the community in a supportive environment. Wolfensberger's concept of normalization and the integration movement of the late 1960s and early 1970s also contributed to the deinstitutionalization in the 1970s and 1980s (Hutchinson, Lord, & Osborne-Way, 1986).

Thus, a shift in thinking about mental illness occurred. It was believed that though rehabilitation, the psychiatric patient
could once again become a productive member of society. Soon occupational therapy departments and rehabilitation units opened in psychiatric institutions and a more active role for the psychiatric patient in his/her treatment program was advocated (Anthony, 1979). However, as was indicated in the introduction, while there seems to be recognition of the significance of patient participation in their treatment, actual implementation of this philosophy is not yet widespread.

**Occupational Therapy**

A task force convened by the Canadian Association of Occupational Therapists, the Health Services Directorate, and the Health Services and Promotion Branch (1985) prepared the *Guidelines for the Client-Centred Practice of Occupational Therapy* in which they define occupational therapy as:

...the art and science which utilizes the analysis and application of activities specifically related to occupational performance in the areas of self-care, productivity, and leisure. Through assessment, interpretation, and intervention, occupational therapists address problems impeding functional or adaptive behaviour in persons whose occupational performance is impaired by illness or injury, emotional disorder, developmental disorder, social disadvantage, or the aging process. The purpose is to prevent disability; and to promote, maintain or restore occupational performance, health and spiritual well-being...(p.xvi).

"Occupation" refers to the activities or tasks which utilize a person’s resources of time and energy when engaging in self-care, productivity, and leisure (Reed & Sanderson, 1980). "Occupational performance" is the performance of daily activities of living (such as dressing, making a bed, taking a shower, typing, taking a bus) which encompass self-care i.e. grooming and hygiene, lifeskills such as money management, cooking, shopping, and housecleaning, leisure and recreation, and vocational activities such as study or work.
"Productivity" refers to those activities or tasks which are carried out to enable the person to provide support to the self, family, and society through the production of goods and services (DNHW and CPA, 1980). School work, paid work, volunteer work, and/or homemaking are examples of productive activities. Thus, the approach to practice in occupational therapy is holistic and it is these ordinary activities of everyday living and their meaningfulness to clients which become the therapist’s focus in performing functional assessments and in carrying out treatment.

The role of the occupational therapist, as defined by The Task Force (1985), is:

...to facilitate the individual’s engagement with his [sic] environment. An essential component of the therapeutic relationship is the therapist/client interaction and the exchange which occurs throughout the learning situation created by the occupational therapist. Purposeful activity is used to develop and refine task skills, to explore alternative roles and to promote positive change in areas of occupational performance. (p. 10)

Individual supportive counselling, individual and group skills-teaching, and group dynamics sessions/activities, are the modes through which occupational therapy practice is achieved. The wide variety of the kinds of "purposive activity" used by therapists could include activities such as woodworking, crafts, art, assertiveness training or other social skills training sessions, computer skills training, stress-management groups, cooking, menu-planning and food-shopping for cooking groups, and other community outings to introduce clients to community resources and/or leisure facilities. Often these activities have a didactic component.

The conceptual frame of reference adopted by The Task Force (1985) integrates a number of theoretical and philosophical concepts adhered to by occupational therapists. Holistic concepts and a
humanistic view of the individual as a whole person fundamental to the beginnings of occupational therapy practice originated with therapeutic activities provided to soldiers who returned from World War I. Identifying the mind, body, and spirit as the interacting elements, these therapeutic activities were provided to assist soldiers in returning to work by the "ward aides", the first Canadian occupational therapists (The Task Force, 1985). The delivery of occupational therapy, is described by The Task Force (1985) as a "client-centred process" based on a systems approach in which clients are seen as part of their environment and in which "...the occupational therapy process is based not only on the personal experience of the client but also on his [sic] social reality" (p.14).

The occupational therapy process typically begins with a referral from the multidisciplinary team or from some outside mental health or community health agency. If the therapist determines that the client is not suitable for occupational therapy services s/he will refer the person to a more appropriate resource. Once the therapist determines the suitability of the person for occupational services, the Task Force (1985) stipulates that a global assessment and evaluation of the individual’s abilities and deficits in the following areas be completed:

occupational performance
a) self-care
b) productivity
c) leisure

performance components
d) mental
e) physical
f) sociocultural
g) spiritual
environment

h) physical
i) social
j) cultural

Following the global assessment, the therapist should work collaboratively with the client to determine the goals of the occupational therapy treatment. Together the therapist and the client explore and clarify the client’s valued or desired life roles, goals, and make a plan. Such program planning is developed in consultation with the multidisciplinary team (The Task Force, 1985).

This process suggests occupational therapy is one of the leading fields in recognizing the significance of clients’ perceptions about their treatment and in regarding the client as partner. According to Clark et al. (1993), “The involvement of consumers in occupational therapy services is central to the core values of occupational therapy” (p.193). Kielhofner (1980) suggests that in order to provide a meaningful service to our clients and in order for rehabilitation to be successful we must seek to understand the client’s “inner symbolic model of the self as actor in the world” what he has termed “volitional subsystem” (p.575).

Similarly, one of the seven principles of Anthony’s (1980) model of psychiatric rehabilitation, a model commonly applied in occupational therapy, states: “The involvement of the psychiatric client is necessary in all phases of the rehabilitation process” (p.72). Here “involvement” is defined as the active participation of the client whereby her/his experiences, values, feelings, ideas, opinions, thoughts, interests, and goals are facilitated and incorporated throughout all phases of the rehabilitation process. However, my experience working in the field of psychiatric occupational therapy
has revealed some contradictions to these espoused goals and for a variety of reasons active and equal participation of the client is infrequent.

From my experience working in OT, it seemed to me that one of the barriers to equal participation of clients is the fact that clarifying and exploring client values, roles and goals is often a very long, arduous, and time-consuming process. Furthermore, most mental health clients, particularly those who have been involved with institutional psychiatry for an extended period, are not accustomed to having their opinions, values, and perceptions sought out by mental health professionals and find the increased responsibility of being a partner in their mental health care difficult. Needless to say, many people are in crisis when first admitted to a mental hospital or mental health facility and are not in the best frame of mind to start making decisions and plans. Unfortunately, for several reasons often there is institutional pressure on the therapist to complete an assessment and provide treatment within a limited time frame.

Occupational therapy practice is holistic and deals with many facets of the individual’s life. As well, its fundamental values of client involvement and equal participation in treatment differentiate it from more traditional health care relationships. Yet through my experience working in psychiatric OT, I found that barriers to the realization of these values exist. Through the current study, I hoped to gain some insight into the nature of these barriers. Due to these factors and due to the fact that my experience is in psychiatric occupational therapy, I chose to focus on the perceptions of helping of psychiatric occupational therapy clients and their therapists for this study.
Hierarchies in Mental Health-The OT Setting

Due to the predominance of hierarchical relations in work settings and psychiatric services in particular (Walsh-Bowers & Nelson, 1994), the power differential between mental health providers and users of services notwithstanding, mental health workers, too, are in ways powerless. Typically in most psychiatric institutions, a multidisciplinary team approach is adopted. Each ward or unit has its own team which usually consists of a psychiatrist as the team director, a physician, a head nurse, a social worker, a psychologist, an occupational therapist, a nursing representative, and perhaps a recreationist. In my experience, workers may make suggestions about individual treatment and/or service delivery attempting to advocate for clients but in the end they may be powerless to implement these changes as it is the team director or psychiatrist who is esteemed the highest status and holds the most power of all the team members to either approve or disapprove proposals. And as Scheff (1976) points out, it is the psychiatrist or medical doctor who is invested authority by law.

Although the status of mental disorder as a bona-fide disease is uncertain from a scientific standpoint, Scheff (1976) indicates that this status is awarded psychiatrists based on the consensus among the public-at-large and policy makers that mental disorder is in fact a disease and therefore psychiatrists are required to control treatment. Ultimately, though, while perhaps guided by unit clinical directors, it is management who make the institutional-wide decisions based primarily on cost containment and “cost-effectiveness”. Due to rising costs for mental health care and growing inflation, an economic paradigm has been adopted and business management personnel occupy top level positions in
governmental mental health departments and institutions (Rose & Black, 1986). As such, the occupational therapist is accountable to these higher level personnel who are invested with the power to approve or prohibit any treatment or program decisions made by clinical staff.

So, while the ideal of client involvement in occupational therapy services are extolled, occupational therapy, (usually) practiced within the mental institution and descended from the medical model, places professionals in a patriarchal position vis-a-vis the patient/client. Moreover, as pointed out above, the psychiatrist is usually placed at the top of the hierarchy of clinicians and as such is in a patriarchal position vis-a-vis other clinical staff. Even though the values of OT support the client taking control and making choices (Clark et al., 1993), it is indeed challenging to implement these ideals within such a restrictive environment. Thus, it would be valuable to discover if there are things that the therapists would like to be doing to help their clients but, due to these institutional, bureaucratic, and economic constraints, feel powerless to implement.

**Occupational Therapy and Empowerment**

During the last two decades (Glenn, 1978), with the rise of the self-help and consumer/survivor movements, there has been a gradual shift from traditional medical models of mental health treatment to an empowerment model (Walsh-Bowers & Nelson, 1994). "A fundamental assumption of an empowerment model for social action and community development is that one of the most critical needs of human beings is the need to be a creative and effective participant in one's environment" (p.21). This assumption is also fundamental to the practice of occupational therapy, albeit in a microenvironment.
The primary goals of occupational therapy are to foster the person’s independence and enhance self-care, productivity and leisure. Adolf Meyer (1921) one of the leading founders of Occupational Therapy wrote: “Our role consists in giving opportunities rather than prescriptions. There must be opportunities to work, opportunities to do and to plan and create, and to learn to use material” (p.84). And more recently, in elaborating their Model of Human Occupation, Kielhofner & Burke (1980) write: “The model is based on the assumption that occupation is a central aspect of the human experience (p.573).” In this sense occupation refers to human activity and productivity—creating and doing and encompasses both work and play. It is this focus on the individual’s active relationship with her/his social, cultural, physical, and spiritual environment which differentiates occupational therapy from the field of medicine. As Kielhofner & Burke (1980) write:

Recent trends in medicine have focused too narrowly on the inner workings of the human organism so that occupation has become misunderstood and devalued. Work and play are not merely by-products of the human essence: they are the essence of human existence...Occupational therapy clinics tap the deepest and most powerful adaptive response—the ability to find challenge and meaning in one’s daily undertakings, one’s occupation. (p. 573)

Inherent in the philosophy of occupational therapy is the significance of the individual’s effective, creative, and meaningful participation in her/his environment. However, unlike explicitly defined empowerment models of helping, within the practice of occupational therapy there is no formal theory or theories which acknowledge the social world and little or no focus on the political, socio-economic context of the individual. The importance of developing a clear and coherent framework for creating and maintaining a positive practice in mental health delivery which
addresses the social reality of individuals is emphasized by Rose & Black (1986) and is an integral part of their advocacy/empowerment model.

The severe marginalization and disenfranchisement of psychiatric patients and ex-patients tend to be ignored or minimized in direct practice. The role of the therapist is decidedly apolitical and there is no formal acknowledgement of the need to help individuals obtain access to concrete resources and to social power. Working toward institutional support and social change which are the foundation of empowerment (Walsh, 1988) are also not included in the domain of occupational therapy practice. The assumption in occupational therapy as with psychosocial rehabilitation and psychiatry in general which originate from the medical model is that the macro-environment, i.e. political, social, cultural, economic world does not need to be changed in order to enable a healthier person-environment fit. With these paradigms the focus is on the individual who needs to change.

**Summary**

Through historical examination we have seen how the varying conceptualizations of mental illness have influenced the kinds of treatment utilized and how the kinds of treatment have shaped the perceptions of status and roles of practitioners and patients. A common theme emerges, however, which involves the devaluation and oppression of the individuals labelled "mentally ill". This phenomenon has led to the unmitigated authority and power of the provider of mental health care to administer highly uncertain and often harmful (iatrogenic) treatments to mental health patients.

While ancient fears and superstitions of the mentally ill have more or less diminished, the power imbalance of provider and user of
mental health services prevails. Negative stereotypes persist and interplay among the different structures of service delivery for the mentally ill. Despite the gradual recognition of the significance of empowerment models which emphasize consumer participation, even in the more recent approaches to mental health care such as occupational therapy major barriers to helping continue to exist.

The historical misconceptions and fears have resulted in devaluation, abuse, segregation, and denial of basic human rights of users of mental health services. Under these conditions it has been very difficult for psychiatric patients to be seen as valued, contributing members of society but it has been even more difficult for patients to see themselves as valued, deserving members of society. In the next chapter barriers to helping in mental health care delivery are examined in more detail.
While negative stereotypes of the mentally ill persist and interplay among the different structures of mental health service delivery, many professionals in the helping fields increasingly, are attempting to "move beyond the disability" and see and hear the person as a valued human being (Hutchinson et al., 1985). In terms of mental health policy, support for consumer participation in the planning and development of mental health services is steadily building as evidenced by the Graham Report's recommendation that Ontario's mental health system provide for: "...a partnership between consumers, their families, service providers, and government in the planning, development, and delivery of services..." (The Provincial Community Mental Health Committee, 1988, p. 6). However, many barriers to equal participation of consumers persist and one of the major criticisms of psychiatric clients regarding mental health services is, as stated previously, a lack of participation in their treatment and a lack of respect for their perceptions on the part of service providers. Institutional structures are slow to change and some critics argue that much of the participation by users of services is still only token while the decision-making power lies in the hands of others (Hutchinson et al., 1985; Walsh-Bowers & Nelson, 1994). Further, in the Graham Report there is no mention of collaboration with consumers in evaluation of mental health services.

A clear example of this power imbalance can be seen in Church and Reville's (1993) analysis of the community mental health services legislation consultation undertaken by the Ontario Ministry
of Health in 1990. They found that even though there was an explicit mandate to involve people who are "popularly referred to as mentally ill" in the consultation there were many barriers to this involvement. Lack of time and lack of awareness of the intention to involve consumers in a significant way as well as organizational barriers and stereotypical beliefs about psychiatric survivors on the part of staff who were in a position to organize consumer involvement effectively blocked their participation.

Walsh-Bowers and Nelson (1994) criticize traditional approaches to the professional-consumer relationship as minimizing opportunity for ex-patients to exercise voice and choice in their own services. Many factors are related to the lingering tendency for hierarchical relationships between helpers and helpees and stereotypical beliefs about users of mental health services; one of which, as noted in Chapter One, is the historical misconceptions of mental illness and treatment of individuals labelled mentally ill which sustain their devaluation (Trainor & Church, 1984).

In my experience as a volunteer for a psychiatric self-help group and my 10 years' as a mental health worker in psychiatric occupational therapy, I have observed that many users of psychiatric services have had few opportunities for a real dialogue with mental health workers and have seen few instances of a truly egalitarian relationship between worker and client. Moreover, not only do the helping professions control and maintain power over people's treatment but also over fundamental life decisions which are included in the domain of psychiatric treatment and/or rehabilitation. Decisions about where to live, work and/or seek vocational training, and kind of accommodation, for example, are often not in the hands of patients themselves. This section will
discuss some of the barriers to helping which I have observed from my own experience working in the mental health field as well those outlined in the literature.

**Locating Problems Within the Individual**

Chamberlin (1978) criticizes the tendency of mental health professionals to minimize or ignore the objective reality of everyday difficulties of clients in favor of an illness-focused or individual defect-focused approach. This tendency toward an illness-focus by mental health workers has been noted by researchers as well (Hendrickson-Gracie et al., 1996; Murphy and Solomone, 1983). Chamberlin (1978) does assert that many former mental patients may need many special kinds of help, but she explains that this help is required "...not because they are sick but because in addition to experiencing personal crises, they have been through the often debilitating experience of psychiatric institutionalization" (p. 328).

**Decontextualizing**

One of the major problems with psychiatric care in general has been the neglect in considering the social objective world of the individual and an almost obsessive tendency to focus very insularly on the internal "defects" or psychopathology of the individual. Other very important factors which affect one's well-being and influence behaviour are often ignored. Specifically, professional staff working in psychiatric facilities tend to "...minimize or ignore the concrete realities of ex-patients' marginalization and oppression" (p. 3, Walsh-Bowers & Nelson, 1994). For Canadian ex-patients these are:

... substandard income, housing, clothing, health, while many continue to struggle with the side effects of psychotropic medications and perhaps ECT. Socially, ex-patients are not
only isolated from networks of support, but they are also stigmatized as 'mentally ill' by mainstream society. (Walsh-Bowers & Nelson, 1990, p.3)

Similarly, in America, Rose and Black (1986) also criticize the tendency of the psychiatric system to ignore the social objective conditions of life for the user of psychiatric services:

Supplementary services in the community, from day hospital programs to vocational rehabilitation agencies, rarely acknowledge the world of poverty, inadequate housing, landlord domination, inaccessible health services, irresponsible polypharmacy, SSI [social security income], decertifications, and related problems that comprise the daily life of former patients. (p. 16)

The tendency of staff to neglect the social world of the patient is what Rose and Black (1986) refer to as decontextualization which has been identified as a problem inherent in the institutional-sickness-treatment model (Chamberlin, 1978; Goffman 1961; Rose & Black, 1986; Scheff, 1976; Szasz, 1976; Walsh-Bowers & Nelson 1990) and remains the dominant paradigm in mental health for explaining and treating problems (Rose & Black, 1986; Walsh-Bowers & Nelson 1990).

The tendency to neglect the objective social realities of a person involved with the psychiatric system or "decontextualization" creates a false consciousness in both providers of mental health and their clients. "False consciousness" refers to the fact that when the focus favors the intra-psychic over the environmental, the individual's problems in living are seen as inherent defects or pathology and the person becomes utterly objectified. This process in turn often facilitates "blaming the victim" by helpers and self-blaming in helpees.

A situation from my work experience powerfully reveals the tendency of staff to decontextualize clients. A young man of 32
years, who was a resident of a 24-hour rehabilitation program, expressed the desire for a girlfriend and in fact had taken it upon himself to seek the assistance of a dating service. He stated that he had yet no sexual experience and longed for a long-term love relationship. He was understandably "preoccupied" with the desire to have a sexual relationship and had confided in several staff that he found some of the female workers attractive but made no comments of the desire to initiate any intimate relationship with them nor did he make any behavioural overtures. He was considered a rather shy person with a low self-esteem lacking in confidence. The reaction of the co-coordinator of the program, a psychiatric nurse, was to recommend that he be given a psychotropic medication which would lower his sex drive! I suggested that his "preoccupation" with developing a sexual relationship was quite normal and healthy and that perhaps it might be more helpful if he participated in a social skills group in which he learned assertiveness skills. This might increase his confidence and help him achieve his desired goal and avoid the need to be given a drug which would repress a normal healthy desire. In response, the nurse teasingly suggested perhaps I had an unusually high sex-drive and in the end my suggestion was ignored. What I found particularly peculiar about this nurse’s reaction is that he, who himself often made many sexual jokes and innuendoes directly to female staff, pathologized a very normal human desire and distorted the man’s expression of finding some of the female staff attractive (something that was only told in utmost confidence to a staff person) as abnormal.

Never was there any reason to be concerned that this young man would ever harm an individual or act upon his attractions. In addition, his quite self-directing behaviour of joining a dating
service was also pathologized and criticized as being “too preoccupied with getting a girlfriend.” He was advised by many staff to forget about doing that and focus on himself. Clearly this is an example of decontextualization-- i.e. the tendency to ignore this young man’s objective social situation--hospitalized and not working at his former job as a grocery store clerk--he was unemployed and socially isolated. In this instance this man was not understood as a person in the social world but merely as a mental patient in a rehabilitation program.

In this circumstance the mental patient identity and the essence of a person are presumed to be the same. However, it is not only the mental patient who is socialized into a role, the psychiatric worker is also socialized into a very rigid role of omniscient expert. And these roles are believed to be fixed, permanent. Rose & Black (1985) write:

Taking the mental patient to be the same as the person disassociates mental health and other social service workers from their responsibility for their own activity. Accountable to both a profession and to an agency which employs people socialized into professional roles and thought structures, the workers become as disconnected from their real activities-consciously understood and chosen-as are their products, the ex-patients. (p.36)

Later they add:

...both the person involved and the workers become one-dimensional or flattened out. There is no room for creativity, for development, for change. The world of the possible becomes reduced to the situation at hand: stasis, paralysis, and demoralization occur (p.38).

**Blaming the Victim**

As a mental health worker within the psychiatric occupational therapy department at two different psychiatric institutions--one in rural Manitoba and one in Toronto-- I was continually astounded at just how often staff seemed oblivious to the environmental
influences in general and in particular the affects of the
institution on individuals confined there. This is what Rose and
Black (1986) refer to as staff being "disassociated" from their own
responsibility for their own activity which serves as a defense
mechanism.

A situation from my own experience working within the
occupational therapy department on an psychogeriatric ward can
illuminate this process of staff disassociation or detachment. A
female patient was not allowed to leave or enter the ward freely on
her own and had to be escorted everywhere. Often she would try to
"sneak" off the ward whenever she had a chance. Considering her
confinement and the total control over her life in the institution,
to me it only made sense that she would be compelled to try to
escape the ward so she could enjoy a cup of coffee or a cigarette
when she felt like it. However, some nurses and nursing assistants
interpreted her behaviour as if she was inherently deficient, "bad"
or morally "flawed" somehow for disobeying hospital rules. In my
mind, her behaviour was that of a healthy person who feels trapped.
In this case we can clearly see how in the eyes of the staff this
woman lost her humanity and was not seen as a trapped human acting
out of desperation to be free but as a mental patient breaking
hospital rules. In fact, I could see myself doing exactly the same
thing were I in her situation. Staff persons rarely seem to try to
imagine what they would do, or how they would feel were they in the
patient’s situation. This again shows just how extreme is their
sense of separateness and detachment from the people confined to
institutions, how removed they feel from the patients, ultimately
leading to the objectification of the people with whom they work on
a daily basis.
Furthermore, according to one of my colleagues, particularly those staff working on the ward, constantly witness dehumanizing rules, practices and procedures, which often they must enforce or carry out themselves; in order to protect themselves from despair they blame the victim. This is an example of how the staff as well as patients of mental institutions, are socialized—staff through educational training and on-the-job training and patients through media, family, and the institutionalization, into the hierarchical roles of professional—expert and patient—dependent.

With objectification and detachment comes the process of "blaming the victim" which is apparent in the above instance and is pervasive in the mental health system. Tyler, Pargament, and Gatz (1983) cite Ryan (1971) who argues that this identification of others as deficient in relation to ourselves creates the process of "blaming the victim". They write: "Once the individual is defined as deficient, programs focus on changing the victim rather than the conditions associated with victimization" (p. 390, emphasis added). They also cite Zwerling et al. (1976) and Rappaport (1981) who have noted this process of blaming the victim as inherent in unidirectional influence models.

Pathologizing

This leads us to another problem with disempowering environments inherent in psychiatric services which is related to the tendency of psychiatric workers to sever the interactional relationship between objective conditions and subjective experience and thus minimize or ignore the very oppressive concrete realities of patients. Due to training in the medical model and other factors the focus is on the intrapsychic and patients' problems, behaviour, and life events in general are often interpreted psychiatrically. In
such an environment, patients, internalizing the sick label, as well as staff come to doubt all the perceptions of individuals labelled "mentally ill". The label of "sick" or "crazy" becomes so entrenched in the minds of staff and patients that it overshadows all other roles of the patient and discredits valid ideas and actions of the patient (Scheff, 1976). In fact, if a client disagrees with a psychiatric staff or treatment team's selection of treatment goals, the disagreement may be defined as part of the client's illness. Chamberlin (1978) adds:

The reliance on medical expertise leads to passive patients submitting to 'treatments' such as the heavy use of psychotropic drugs, which is often perceived by the patient as torture. But the patients cannot object to treatment without bringing on more treatment. Only agreeing that one is indeed ill and in need of help brings the possibility of ending the treatment. Mental patients are caught in a vicious circle, where their own feelings are discredited (unless they are in agreement with the psychiatric viewpoint) (p.111).

As Kotin and Schur (1969) have pointed out, there "...is constant danger that valid complaints of patients may be interpreted by staff as pathology" (p.413). And as Chamberlin (1978) points out above, sometimes valid complaints by patients result in increased treatment responses designed to attain manageability or control. Thus obedience, dependence, passivity, and powerlessness on the part of the patient are reinforced. We can see this passive obedience reflected in what Stanton and Schwartz (1954) have called "submissive decisions" which refer to decisions made by patients under implicit coercion that may be real or perceived. These decisions are not volitional as the patient is aware of the staff's perception of the "correct" decision and may fear disapproval, retribution, or further treatment, for example an increase in medication.
In addition, as a result of decontextualization often value judgements on the part of staff are interpreted as "clinical recommendations" and when patients do not agree with these recommendations it is seen as pathology. For example, I have seen many instances of staff trying to persuade residents to initiate friendships with other residents and when they did not they were labelled "withdrawn and unsociable". These staff seemed to believe that simply because the patients were living together they should develop friendships regardless of age differences, like-mindedness, compatibility or whether they liked each other. Sometimes there was the danger of when a staff person's recommendation was not heeded by a resident, that person would suffer reprisals in the form of an overly exaggerated negative weekly "progress report" written by that particular staff. I have read many a progress report, designed to "help" the client improve their "skills" and gain "insight". These reports had one section for "strengths" and one for "limitations or areas to improve", with perhaps only 1 or 2 comments written under "strengths" and as many as 10 under "limitations or areas to improve". These reports would be discussed with each resident weekly, creating a patronizing atmosphere. This was a form of abuse of power albeit perhaps unconscious on the part of the frustrated staff.

Again the above situation underlines the danger of decontextualizing the person and pathologizing behaviour which conflicts with staff values. Definitions of "appropriate" behaviour become very narrow for 'mental patients' when social realities are obliterated by mental patient-hood. In addition, the power differential between staff and patient make it all too easy to confuse clinical judgments with personal value judgments.
Confusing Clinical with Value Judgments

An institutionalized individual lacks control over the exposure of her/his private self. Highly personal histories are available to almost any level of staff (Rosenhan, 1973). Of course this process of exposure is not reciprocal; the patient knows very little if anything about the personal life and circumstances of the staff and thus the power differential is apparent. In addition a patient's current behaviour is open to the constant surveillance of staff. The continual scrutiny of past and present behaviour and the moral judgements made by the staff based on this information which other people may keep private is damaging to the individual's self esteem. Decontextualization of the person and the tendency to "blame the victim helps encourage this judgmental stance of staff.

Goffman (1961) has written about the tendency of psychiatric workers to confuse moral judgements with "clinical" judgements and indeed perhaps it is sometimes even impossible to distinguish between the two. In his seminal work Asylums which he wrote based on participatory research in a mental hospital, Goffman (1961) noted: "The low position of inmates relative to their station on the outside...creates a milieu of personal failure in which one's fall from grace is continuously pressed home." (p.67).

Non-Collaboration

Typically, mental health professionals' role relationship to people has been one-sided and hierarchical where the so-called "expert" controls most of the interactions specifically between helper and helpee as well as more broadly between helpee and other agencies and social institutions. In these interactions, the decision-making power rests with the helper who characteristically defines the goals and objectives of the treatment or help often
neglecting to communicate them to the helpee. Rappaport (1977), commenting on the status of psychotherapy, notes:

...the bias of the system is toward a middle-class professional ideology which suggests that experts are not only technically competent, but also have the right, by virtue of their technical skills, to select the values and goals appropriate for their clients, and to decide on the basis of their own desires, what services to offer whom. (p.303)

This pattern of interaction is typical of traditional medical models of treatment from which much of service-oriented psychology (Tyler et al., 1983), psychiatry (Szasz, 1976) and occupational therapy (Meyer, 1921) are descended. Further, as Walsh-Bowers & Nelson (1994) point out, such a "...pattern of non-reciprocity of social support exchanges may foster dependency and lower self-esteem" (p.13). These are the precise behaviours which rehabilitative treatments are adopted to ameliorate. Rappaport (1981) writes that the aim of empowerment should be: "...to enhance the possibilities for people to control their own lives. If this is our aim then we will necessarily find ourselves questioning both our public policy and our role relationship to dependent people" (p.15).

**Internalization and Powerlessness**

"Psychiatric patients through their historical experience have internalized the content of their oppression and the reality of their oppressors as part of their identities" (Rose & Black, 1986; p.23). While the individual may enter the mental institution with a positive, non-deviant self-conception, during admission procedures and thereafter, the person "comes to the realization that it is virtually impossible to maintain a positive conception of self" (Herman, 1985). Herman (1985) further notes:

While the patient may initially attempt to reject such a label and status [i.e. mental patient], previous studies indicate
that, through the consistent reactions of the psychiatric staff, combined with the processing of the institutional system, the patient is ultimately forced to accept this redefinition of self—a deviant identity and status affecting the person's future participation in society. (p. 191)

At best clients feel angry and resentful at being coerced into following treatment plans that are not decided upon in an egalitarian fashion and at being subjected to constant monitoring, supervision, and intrusions which sometimes (Walsh-Bowers & Nelson, 1994) result in a loss of civil liberties. And at worst, clients as well as providers of services internalize the negative beliefs and stereotypes about the illness and skill-deficits of "mental patients" (Walsh-Bowers & Nelson, 1994).

Rose & Black (1986) write extensively about the psychiatric system's objectification and decontextualization of patients, the tendency to define all behaviour psychiatrically, the adverse effects of labelling, and how these all lead to the person's internalization of the psychiatric viewpoint:

...the capacity for autonomy, responsibility and self-direction was removed, particularly for those people having spent many years incarcerated in state institutions. In fact, a careful reading of the critiques of institutionalizing practices in state hospitals suggests that their overall, unintended by-product was to decontextualize the person, to contour their lives as patients in such a way as to remove or restrict their capacities for daily living in the community. It is our belief that even the contemporary meanings attached to the term mental illness, or chronic mental illness, have this same impact. Once part of the mental hospital system, the person's capacity for self-confident assessment of real world variables becomes substantially undermined. In large part this comes about through the omnipresent insistence that the person remain on medication and continue to go to a clinic where daily life events and experiences are all too often registered by staff as responses to medication. (p.16) (italics added).

Coming to doubt all one's perceptions and ideas is one of the most oppressive effects of institutionalization. The tendency of
psychiatric staff to ignore and/or invalidate the individual’s subjective experience and perceptions leads to patients doubting their own perceptions. The effects of such invalidation combined with the objectification of a person as mental patient or crazy causes patients to internalize the attitudes and beliefs of the ‘authority figures’, the people who have control over their lives.

Rose & Black (1986) write:

People’s views of their own perception generally correspond to their own sense of their validity as observers. The process of becoming a mental patient and remaining a former patient has stripped most people of their sense of validity. The objective context, coupled with medical language and thought structures, has reduced and distorted people’s validity and legitimacy as participants in perceiving and acting in their own behalf. They are coerced into consuming the social reality of domination in much the same way they consume medication - as passive receptacles, relatively powerless to resist in a confrontation with their situation. (p. 49)

Judi Chamberlin (1978), a former psychiatric patient and currently a patient rights activist, in her book, On Our Own, describes the feelings of helplessness and powerlessness resulting from the internalization of the sick label: “When I was defined as ‘ill’, I felt ‘ill’, and I remained ‘ill’ for years, convinced of my own helplessness” (p. 111).

Ultimately, the negative affects of institutionalization combine with the internalization of the “deviant” label or label of “sick” or “mentally ill” and work to condition self-blame and self-contempt in the psychiatric patient. What results from this loss of “self” is loss of control, lack of initiative, apathy, dependency, and feelings of worthlessness. These characteristics, often defined by staff as symptomatology of psychiatric illness, are well known as “institutionalism” by researchers (Rose & Black, 1986; Wallace & Anderson, 1978; Rosenhan, 1973; Goffman, 1961; and Stanton &
Schwartz, 1954). This conditioning process, aptly referred to as "mortification" or "self-curtailment" by Goffman (1961), is defined as a process of self-debasement, alienation, loss of identity, dependency, and internally-directed hostility. We can see similar characteristics in the condition known as "learned helplessness" or in what Michel Lerner (1987) has termed "surplus powerlessness".

**Surplus Powerlessness**

Lerner (1987) defines surplus powerlessness as "...the ways that we see ourselves as lacking the real power, limited though it is, that we really do have" (p.21) He explains that it is our encounters with real powerlessness that often make us think of ourselves as even more powerless than we really are. But the condition does result from real powerlessness as the opportunity for the psychiatric patient to actualize, what Lerner (1987) refers to as, the "human essence" is thwarted. He writes:

Human beings have a need to actualize their capacities for loving, creativity, freedom, solidarity, and understanding. When these needs are not being met, human beings have physical and emotional health problems...People are powerless to the extent that they are prevented, either on an individual or social basis from actualizing their human capacities. Real powerlessness refers to the fact that economic, political, and social arrangements prevent this actualization from occurring. Surplus powerlessness refers to the fact that human beings contribute to this powerlessness to the extent that their own emotional, intellectual, and spiritual makeup prevents them from actualizing possibilities that do exist within the context of real powerlessness...(p. 23)

The condition of helplessness or surplus powerlessness, while resulting from a belief in one's own inefficacy, originates from an initial experience of uncontrollability which according to Seligman (1975) may lead one to passivity and helplessness even in new situations that are controllable. Institutionalized individuals have...
very little control over their environment and over their lives particularly if they are involuntary patients. And as Lerner explains the opportunity for actualizing the human essence is indeed limited in these situations.

Consequently, this sense of powerlessness serves as a major barrier to full participation not only in clients' treatment but also in their lives. This is one of the most insidious and oppressive of the iatrogenic effects caused by the mental health service system.

Patricia E. Deegan (1990), a mental health clinician and former recipient of mental health services, says that many people with disabilities refer to this dehumanization and depersonalization as "spirit breaking" (p.302). She describes the relationship between the power differential between clinicians and clients the spirit breaking of users of human services. She writes:

Spirit breaking can and does happen in any environment in which there are people who have power and people who have been stripped of their power to direct their own lives and make their own choices. It can happen in any environment in which there are those in a position of dominance and those who are deemed to be subordinate. It can happen in environments where there are people who are considered by implication to be superior, because they are surrounded by people who are labeled as inferior. Simply put, it occurs when we relate to people as if they are disabilities, as if their person-hood is disabled, and as if somehow, they are not real people at all. (p. 307)

The Vicious Cycle

Rose & Black (1986) explain how this process of internalization or "spirit breaking" of the sick-role of users of psychiatric services creates a cycle in which the consumers presentation of self reproduces the cycle of domination, pathologizing and oppression:
...the self-concept of the persons involved in the exigencies of daily life contours the way people participate in it. When one’s self-concept is ridden with externally imposed contempt, when a person incorporates the devalued perception of his or her oppressors, and acts through that self-concept in the social world, the result will inevitably be the reproduction of the objective conditions dominated by oppressive interests. We believe this to be the common shared experience of daily life for most former psychiatric patients. (p. 58)

So a cycle exists in which the psychiatric system “decontextualizes” (i.e. to dictate a reality which is based on the severing of knowledge of the objective conditions of reality)" the person. Decontextualization in combination with labelling and other iatrogenic effects of institutionalization lead to internalization, surplus powerlessness, and alienation and the person presents as “crazy”. Presentation of the self as “crazy” or “sick” causes the whole cycle to begin again--decontextualization-pathologizing-blaming the victim—by staff leads to the patient’s internalization of the sick role—leads to decontextualization. Rose and Black (1986) describe this process:

The pervasive influence of these objective factors reinforces the demoralized self, expressed pragmatically by the ex-patient. It is exactly this demoralized self, communicated as mental patient identity/self-expression, that becomes the focus of treatment by most after-care provider systems. In the implementation of programs which, either overtly or subtly, are founded upon a medical/therapeutic definition of reality, providers reinforce the decontextualization of hospital life. (p.3)

Summary

In this chapter I have discussed the ways in which institutional psychiatry presents barriers to helping for users and providers of psychiatric services. I have described how the psychiatric system oppresses and objectifies individuals through involuntary confinement, labelling, drug therapy, punitive and rigid hospital controls and rules. The tendency for mental health workers
to “decontextualize” clients, to blame the victim, to pathologize problems in living, and to confuse clinical and value judgements was discussed. I explained how these lead to the powerlessness of individuals involved in the psychiatric system and how the internalization of the sick-role creates a prevailing sense of hopelessness and uncertainty ("surplus powerlessness"), alienation, self-blame, and self-hatred in the individuals who are the clients of psychiatric occupational therapy. It is within this context that psychiatric occupational therapy practice is carried out. An empowerment model can provide a corrective to the paternalism and domination of traditional models of mental health care.

I am informed by my experience as an occupational therapy assistant as well as, the empowerment ideology. In the next chapter I will discuss the empowerment ideology in detail as it forms the theoretical foundation of this thesis. I explain how adopting an empowerment approach to psychiatric occupational therapy can increase our understanding of the experience of recipients and providers of psychiatric services in order to provide practice/help which is meaningful to psychiatric consumers and which respects their dignity.
CHAPTER 3

THE THEORY OF EMPOWERMENT

What IS Empowerment?

The essence of empowerment, an idea which has come out of the "social action" ideology of the 1960's and the "self-help" movements of the 1970's (Kieffer, 1984), is related to power and lack of power (Pinderhughes, 1983). Julian Rappaport (1987) describes empowerment as encompassing two dimensions: 1) a subjective level--a psychological sense of personal control or influence/power and 2) a concern with objective conditions--actual social influence, political power, and legal rights. Similarly, as mentioned elsewhere in this paper, Rose & Black (1986) have stated that fundamental to an empowerment model for social action and community development is the assumption that one of the most critical needs of a human being is the need to be a creative and effective participant in one's environment. In order for an individual to participate in their environment the above two dimensions of empowerment are necessary.

"Coping skills," "mutual support," "natural support systems," "community organization," "neighborhood participation", "personal efficacy", "competence", "self-sufficiency", and "self-esteem" are all concepts popularly thought of as synonymous with empowerment (Kieffer, 1984). Finding a paucity of research on the dynamics and developmental processes involved in individual empowerment, Kieffer (1984) studied the patterns and processes of the transition from powerlessness to socio-political empowerment. He found that the most meaningful definition of empowerment encompasses the area in which the above varied concepts intersect. Other key concepts of empowerment that have been identified by various
theorists/clinicians/mental health consumers are hope, choice, self-respect and dignity, self-confidence, interdependence, solidarity, consciousness-raising, critical inquiry and knowledge (Deegan, 1990; Deegan, 1992; Rappaport, 1987; Rose & Black, 1986; Szasz, 1970; Walsh, 1988; Walsh-Bowers & Nelson, 1994; Weitz, 1983).

Three major dimensions of empowerment or “participatory competence” were identified by Kieffer’s (1984) study on the developmental processes of empowerment. They are as follows:

(a) development of more positive self-concept, or sense of self-competence, (b) construction of more critical or analytical understanding of the surrounding social and political environment, and (c) cultivation of individual and collective resources of social and political action. (p. 31)

Recognition of the subjective and objective dimensions described earlier by Rappaport (1987) i.e. a psychological sense of power and competency (subjective) as well as actual political and social power (objective) and support are also identified by Kieffer. In addition, his study also points to the significance of the process of critical inquiry into the objective conditions of oppression which would potentially lead the individual to a “commitment” toward action or changing the oppressive conditions.

Empowerment Models of Helping in Mental Health

An Oppressed Class

Users of psychiatric services, as outlined in Chapters One and Two, have historically been subject to terrible abuses and human rights violations. In a context of poverty, social isolation, stigmatization, and unemployment, psychiatric patients and ex-patients must struggle with a psychiatric system that also marginalizes and disenfranchises them (Rose and Black, 1986). Facing systemic and pervasive marginalization, psychiatric patients and ex-
patients are, in effect, an oppressed class. Rose and Black (1986) write:

When we examine the ideological and organizational bases from and in which typical mental health theory and practice emerge, we can see the larger context of social control, oppression and domination of both workers, confined to medical model paradigms, and their products—the institutionalized or chronic ex-patients. Because the ideology and organizational environments are similar across states...the conditions of life for former patients discharged into communities across the country are quite similar. The ex-patients, then, while existing as individuals, simultaneously are essential members of a class. (p. 33) (italics added).

In addition to a critical inquiry into the psychiatric history with its often intrusive medical care, lack of control over one's body, professional monitoring and control, and lack of voice and choice; the impoverished living conditions psychiatric clients must endure are also addressed by empowerment models of helping (Deegan, 1990, Rose & Black, 1986; Walsh-Bowers & Nelson, 1993).

The daily living realities of poverty or substandard income, poor quality housing, social deprivation/isolation are recognized as sources of many problems psychiatric patients experience. In an empowerment ideology, human behaviour is conceptualized as a function of “resources available” to people and groups and paradigms of individual deficit are explicitly rejected (Rappaport, 1977). In other words, recognition that the concrete conditions of daily life are central to well being is paramount. Thus, an empowerment model emphasizes individuals’ capacities instead of deficits (as with medical models) and locates many of the problems facing patients and ex-patients in the social environment (Walsh-Bowers & Nelson, 1994).

Rappaport (1981) writes that empowerment models imply:

... many competencies are already present or at least possible, given niches and opportunities. Prevention implies experts fixing the independent variables to make the dependent variables come out right. Empowerment implies that what you
Legitimization of the individual’s right to equal access to resources is a fundamental component of this model.

Empowerment models of helping in mental health services attempt to validate the “mental patient” as a person and elaborate the socio-political world of that person. Validation of the individual also involves developing opportunities for the experience of human dignity and for the opportunity to engage in human as opposed to mental patient activity. Rose and Black (1986) write: “It is clear that humanizing activity relates their [psychiatric clients] experience as objects to the objective world through a dignifying process which we describe as empowerment.” (p. 20).

Applying the Theory of Empowerment to Mental Health Care Delivery

Paolo Freire’s (1968) distinction between people as “subjects” and people as “objects” is relevant for psychiatric patients and has important implications for their empowerment. Rose & Black’s (1986) empowerment/advocacy scheme is informed by Freire’s work with the oppressed Brazilian poor and they see parallels between the oppression and submerged existence of the Brazilian poor and psychiatric patients. Freire says that objects are known and acted upon; subjects know and act. In other words, consistent with the theory of empowerment, responsible subjects continue to know their social world and act to transform it; they are dynamic participants, creators, producers. Conversely, objects are commodities, manufactured to maintain and reproduce social reality in its present form.
Psychiatric patients are not dynamic participants, creators, or producers in their mental health care nor in their lives as once they are labelled and defined as "crazy" or "mentally ill" they are objectified and lose all entitlements. Daily life in an environment where the most basic rituals from when to eat, sleep, or bathe are not in one’s control and where the opportunity to leave the ward or to go outside and breath fresh air, to see friends and family and to participate in recreational activities can become "privileges"--we can readily see how a person’s capacity for autonomy, responsibility, and self-direction are easily removed. Hospital language reinforces “mental patient-hood” by framing everyday life for the incarcerated person. For example, the basic right to go outdoors of the hospital building is termed “outdoor privileges” and to leave the hospital grounds as “downtown privileges”.

The omnipresent insistence that the person is “sick”, “crazy”, “defective” and “deviant” reinforces the emphasis on medical treatment which legitimates the prevalent use of psychotropic medications [many of which cause severe and debilitating side effects as noted previously--for example, memory impairment, liver and kidney damage, restlessness, agitation, anxiety, sedation, lethargy, loss of spontaneity, reduced libido, hallucinations and so on (Szasz, 1976)] which further incapacitate the individual. Being labelled “crazy” by virtue of a person’s mere presence in a psychiatric hospital (Rosenhan, 1973) may also legitimate that person’s incarceration against his or her will, although this is changing to some extent with tighter committal criteria (Czukar, 1988).

Of course there are those who argue that the individual is “sick” or mentally ill and therefore the subjectivity of the patient
and his/her perceptions are suspect. However, health and illness occur on a continuum and as Buck (1990) points out:

...it is possible to conceptualize abnormality, normality and health as segments along a continuum of increasing capacity for managing the essential issues of living: autonomy, identity, work, creativity, propagation, aging and death. Most individuals, however, will not exhibit uniformity in their competence. (p. 187).

Thus individuals who are labelled schizophrenic, for example, and experience psychotic episodes in which they hallucinate will obviously at such times have impaired functioning but they are not always impaired and are not always incapable of appraisal of real-world variables. Mental health is not a static condition or state and illness and/or functioning are not static; there are different degrees and levels of health and functioning at different times and as such do not preclude the capacity to participate in one’s environment as a “subject”. Moreover, respecting an individual’s perceptions does not mean all perceptions must be accepted non-critically.

In order to respect the oppressed, we must seek to understand the reality they perceive so that, as Paolo Freire (1968) has said, “...knowing it better, [one] can better transform it. [One] is not afraid to confront, to listen, to see the world unveiled” (p.24).

Through this critical inquiry, empowerment models of helping elucidate the objective social, cultural, political, and economic structural conditions in society that prevent an individual’s active participation in her/his life and potentially lead to action. Rose and Black’s (1986) model rejects medicalized models of treatment because they sever the interactional relation between objective reality (economic, social, political, legal, and ideological structures) and subjective reality (self-concept, perception,
emotional life). They are critical of medicalized forms of practice because they effectively bar or deny patients' participation in the construction of their own lives (as subjects rather than as objects) and reduce them to consumers of the lives determined for them by others.

Validation of the disenfranchisement and powerlessness of psychiatric clients and social action that promotes effective participation in their environment is central to an empowerment model of helping in mental health. Rose and Black's (1986) "advocacy/empowerment scheme" attempts to: "...produce change or movement of the deinstitutionalized former patient from a position of passive powerlessness and self-destructive alienation to one of increased self-conscious autonomy through implementation of a series of action phrases" (p.60). While the focus of their advocacy/empowerment model is former institutionalized clients, it is also applicable for work with clients who are currently institutionalized.

Their scheme involves a mutual interaction process between client and worker in which the experiences and subjective reality of the client are validated, explicated, and broken down into workable problems. These "workable problems" are analysed for potential action or "action phrases". Mutuality of the interaction between worker and client is based on the recognition of the significance of collaboration and of a reciprocal relationship between professionals and consumers. Reciprocity in this context refers to the fact that it is not only the helpee who is influenced or changed by the helper; the helper, too is affected by the relationship. For example, the helpee may teach the helper about her/his world of experience; about the impact of the worker as well as other
professionals/mental health agencies on the helpee, for example.

This new learning by a professional may be quite substantial and could also involve gaining insight into the helpee’s life dealing with stigma due to being a member, as a patient, of the psychiatric system, dealing with poverty as many individuals involved with the psychiatric system for an extended period of time live in poverty, or if the client is a person from a different cultural or ethnic background, learning about her/his life in that context.

The purpose of the advocacy/empowerment scheme is to facilitate transformation of the psychiatric client from object (i.e. passive consumer of services) to subject, creator, or participant first by promoting critical intervention into her/his reality leading to a series of problem-focused activities arising from the person’s life which cannot be successfully negotiated through direct service provision (“action phrases”). This work, which often involves the provision of information regarding the client’s legal rights and entitlements as well as negotiating with agencies, forms the “advocacy” part of Rose and Black’s approach. Part of the critical inquiry involves demythologizing the psychiatric label and critically examining concrete daily life of the person which encompasses the social/political/historical/economic conditions in addition to those of incarceration in a mental institution. The interplay of these conditions among the individual’s subjective reality and how they contribute to the person’s problems is examined with a view to changing those conditions which are oppressive and/or problematic. Thus the person moves from object to subject or actor through conscious attempts to change oppressive conditions in her/his world.
Another very important aspect of this process is respecting the patient's subjectivity and encouraging the person to describe their world of experience and when some aspect of this description may initially seem "irrational" or nonsensical the workers listen carefully, negotiate for meaning and attempt to extrapolate the essence of the subjective meanings of the patient and/or the real issue with a "conscious strategy for action; not an acquiescence to dictates" (Rose & Black, 1986, p.37). "Whining" or complaining about food or living conditions or doctors is transformed into serious criticisms of housing and medical care with an exploration of the individual's legal rights and options to improve those conditions or find another doctor, for example. Sometimes this work might even involve taking the issue outside to an appeal process, a fair hearing, or a courtroom or even legislative arenas. Rose and Black (1986) point out that the process of empowerment occurs to the extent that the person is fully informed of what is occurring, what the implications are for each step of advocacy taken, and is authorizing each step and participating in it to her/his fullest capacity. In other words, it is a collaborative process.

The initial step in facilitating this transformation is coming to understand the patient's subjective experience, their views of their own needs, goals, or aspirations as well as frustrations, and pain. Dialogue, as discussed earlier, is the medium of exchange for this mutual learning process for as Rose and Black (1986) point out:

...as the worker learns from the patient what s/he needs to know about the patient, and the world of patient-centred perception and experience, the patient is simultaneously learning about a different type of mental health worker, about a person who wants to know and learn rather than instruct or coerce, or neglect. (p.16)
This mutual learning or reciprocity is what Rappaport (1981) is referring to when he writes: "Prevention suggests professional experts; empowerment suggests collaborators" (p.16).

The theory of empowerment provides the framework for this study as psychiatric patients, clients and ex-patients are an oppressed group. A fundamental part of empowerment is giving people a voice; being open to and learning from the users of psychiatric services. As Rose & Black (1986) write:

Being open to learning from clients is unfamiliar. Often being open to hearing information outside the boundaries of one's training is unknown since a major aspect of professional indoctrination involves categorizing what one hears, especially if one hears it from those identified as clients. For those clients having had extensive experience with workers, a similar situation may pertain. The challenge to us, as workers, is a difficult one--to continue to encourage people to elaborate on their perceptions and the causes for their perceptions, without making clinical judgements and without reacting defensively...And finally, one has to confront a most difficult perception: The social world of the people we work with is indeed objectively characterized by oppression, domination, and manipulation. (p.55)

This dialogue with clients is part of the critical inquiry process which demystifies the psychosocial version of reality, links objective conditions to subjective experience, helps to legitimate and validate the client as person in the social world and ultimately may lead to action. For a true dialogue to occur the relationship between helper and helpee must be a collaborative one where both helper and helpee can learn from one another.

**Collaboration**

Proponents of empowerment models of helping emphasize collaboration and egalitarian relationships in which both helpers and helpees define the terms and goals of the relationship/treatment. This type of relationship is characterized by a process of mutual influence and exchange wherein both helper
and helpee possess equal status and influence each other.
Conversely, traditional models of helping which have what Tyler et al. (1983) refer to as a "unidirectional influence" where the professional is regarded as omniscient expert. The term "unidirectional" refers to the one-sided quality of the helper-helpee relationship in which the helper controls much of the decision-making and there is little or no awareness or acceptance of a reciprocal influence. The inherent assumption of the proponents of traditional models such as the institutional-disease model is that the helper is expert and the helpee dependent (Rappaport, 1988; Rose & Black, 1986). Most occupational therapy models of helping fall somewhere in between.

The resource collaborator role, an alternative role for helping professionals, proposed by Tyler et al. (1983) is consistent with an empowerment approach. This role aims to avoid the paradox of traditional helping approaches where the helper's presentation of self as expert and the helpee's as dependent is incongruous with the goal of independence for the helpee.

**Summary**

An empowerment ideology is related to power and lack of power. As such, integral to empowerment models of helping in mental health is the application of empowerment theory which through a critical inquiry process which demystifies the psychosocial version of reality by linking objective conditions to subjective experience. This process, which is collaborative and reciprocal, helps to legitimate and validate the client as person in the social world and ultimately may lead to action.
As there is a paucity of research on clients' and therapists' perceptions of helping specifically with regard to occupational therapy practice, this chapter includes studies dealing with mental health care in general. In this section we look at research about perceptions of goal-setting and collaboration, perceptions of helping in vocational services, helpful processes in OT groups, and what clients would find more helpful in their mental health care. Due to the lack of research in this area we also look to research regarding self-help group members' perceptions of helping processes of self-help groups to gain some insight into what clients find helpful and perhaps not so helpful about mental health care delivery.

Power and Control in Mental Health/Rehabilitation Services --Who Decides?

"Power or lack of power", writes Elaine B. Pinderhughes (1983), "[are] critical issues in people's lives" (p.331). The perception of having some power over the forces that control one's life, she adds, is essential to one's mental health. As we have seen though, a major problem with the mental health system has been the lack of power of users of mental health services not only over treatment decisions but also over critical decisions affecting their lives. Domination by professionals and mental health providers of services over the lives of users of mental health has been carried out in the name of "treatment" and is in part rationalized by the notion that knowledge of professionals is derived from "objective scientific truths" (Walsh, 1988) therefore professionals know better than clients what
is in their "best interest". This idea combined with professional concern about client “competence” to make independent decisions can leave clients feeling powerless and dependent which is what Tyler et al. (1983) refer to as “an essential paradox in helping models” (p.388).

This section reviews studies both qualitative and quantitative which examine the helping relationship and reveal the often disparate perceptions and values about decision-making power and control among clients and their therapists. Interestingly, while many therapists in several studies espouse the goals of client independence and egalitarian client-therapist working relationships, these ideals are often contradicted by some of their own comments and/or practices which reveal paternalistic attitudes. For example, some persons are assumed by therapists to be incapable of making good decisions simply because they are rehabilitation clients or are receiving therapeutic counselling (Murphy and Salomone, 1983; Hendrickson-Gracie et al., 1996). In the Hendrickson-Gracie et al. (1996) study, only one of the four rehabilitation workers interviewed actually agreed with their client’s goals or pursued these in rehabilitation. In this study, the workers’ and clients’ previous experiences in mental health influenced assumptions made about each other and consequently contributed to a sense of alienation in both clients and workers. Therapists in these studies expressed doubts about client competence to make decisions for themselves and use the “best interest” rationale for at times controlling the decision-making process with regard to goals and services offered. In the Hendrickson-Gracie et al. (1996) study it is apparent that some therapists confuse a clash in personal values with client competence. When a client disagrees with a therapist’s
values, often therapists assume the client's disagreement is due to incompetence and so feel that they "know best" what is in the client's interest and end up dominating the decision-making process.

Hendrickson-Gracie et al. (1996), utilizing a qualitative methodology, explored the process of setting goals for psychosocial rehabilitation from the perspectives of rehabilitation practitioners and their clients from various settings in Canada.

The authors were interested in discovering, 1) the effect of the shift towards client autonomy in decision-making on the process of goal setting in rehabilitation of clients with a psychotic illness, 2) how practitioners and clients resolve value differences in light of the shift towards client autonomy, and 3) how the issue of competence fits into this process.

While the autonomy movement has appeared to have affected the four rehabilitation workers by increasing their sensitivity to the client's role in goal setting, the researchers found that therapists were less consistent in adhering to those goals when they had concerns about them. In fact, only one of the four workers agreed with his client's goals or pursued them in rehabilitation. The three other workers who disagreed with their clients' goals tried to persuade their clients to accept other goals which they believed to be more "realistic" or they proposed modifications. Interestingly, in spite of the disagreement of the workers and their tendency to modify goals or suggest alternatives, the clients, reluctant to openly disagree with their workers, maintained their own original long term goals while complying with the process, according to the authors.

There were several reasons the clients did not openly communicate their intentions with their workers. Most of these
reasons were related to perceived punitive consequences of "noncompliance". For example, one client believed that staying in his apartment was contingent upon agreeing with his worker. Another client:

...felt he needed to pretend that he agreed with the worker in order to get moved to a different program in which he believed he might have more opportunity to pursue his original goals with fewer obstacles. This client found his worker cold and angry toward him until he started acting as if he were in agreement, after which he noticed a positive change in the worker's attitude toward him. (p.28)

A third client wanted to keep his proctor so he appeared to be complying with his worker's plan in order to maintain that involvement. The authors do not state the significance for this client of keeping his proctor nor why he would lose the proctor. Likely it was the support of regular contact with someone. Proctors typically provide regular assistance with a variety of life skills--grocery shopping, cooking, social/emotional support. One can assume that either keeping the proctor was contingent upon his compliance with "treatment goals" or that the client perceived his compliance to be contingent upon keeping his proctor due to past experiences with mental health services (this is not an uncommon practise in mental health --I know of a case where clients' receipt of monthly metro subway passes were contingent upon regular attendance at a treatment program). However, the clients, the authors indicate, did not communicate these reasons/concerns to their workers. This is a striking example of the "submissive decisions" discussed in Chapter Two, where clients acquiesce to the professional worker to prevent perceived or real punitive consequences such as loss of approval and support of the worker(s), loss of services, or loss of "privileges" such as the receipt of monthly metro subway passes, for example.
Time to develop a therapeutic relationship, clients’ and workers’ expectations of each other, and clients’ sense of control over the process were other factors reported that influenced the goal setting process. Both workers’ and clients’ previous experiences affected their resultant expectations of each other. Workers appeared to have underestimated the perceptiveness and insight of their clients and their determination to achieve their own goals with or without their worker’s assistance. The authors report that: “...the workers did not generally expect their clients to be as perceptive and as motivated (to achieve their own goals) as they were and they may have made assumptions about the clients’ silence or passivity in the process” (p.29). However, the cause of clients’ silence was that they expected their workers to be paternalistic and punitive and so did not always directly communicate their thoughts and feelings to them. It would certainly appear that in these instances due to a lack of time for rapport and trust to develop, misunderstandings and a lack of communication prevented a truly collaborative goal setting process to occur. As the author’s point out, clients’ true desires and values are unknown to the worker and their silence seems to be interpreted by workers as either apathy or agreement. Similarly, the clients’ expectations of their workers and resultant mistrust prevented them from openly disclosing their concerns and fears about the negative consequences of not agreeing with their worker’s suggested goals. These fears are quite understandable when we consider the power differential inherent in most mental health worker-client relationships. Mental health workers, their sincere concern with their client’s well being notwithstanding, do have considerable influence with the treatment team as well as with the myriad other mental health
agencies/services with which the client is currently or in future may need to be involved.

**Goal-setting**

Perception of control over the goal setting process also affected clients’ level of commitment to the goals. Clients reported that they felt they should be ultimately responsible for their rehabilitation outcome but, not surprisingly, assume this responsibility only when they feel that they have had some control over the process. Naturally, when clients do not feel a sense of ownership of goals or plans, they are not committed to the outcome and thus are labelled as "unmotivated" in the process by workers. Clients reported that they did want their workers to directly communicate any concerns regarding their goals and valued their experience and input, particularly if they felt that their workers really cared about their success. However all clients wanted the process to be collaborative but only one felt that this was possible and that his worker would be supportive of him regardless of his decisions.

**Confusing Personal Values with Competence**

Differences in value systems were apparent in all of the cases examined in the above study and it was differences which were not understood as opposed to concerns about competence in setting certain goals that led to judgements by the worker regarding the quality of those goals, according to the researchers. One worker and client, for example, appeared to have very different values with respect to hygiene. The worker felt that, in relation to the way he maintained his living environment, the living situation of the client was unsafe and offensive. The worker developed rehabilitation goals and a plan to change the situation—"to clean it up" in spite
of the client's desire to be left alone in his home (p.29). This led to the client's sense of alienation and marginal involvement with his worker in order to keep his proctor. Thus, while the worker's professional value was to be "client-centered", this was outweighed by his personal values of hygiene. As pointed out in Chapter Two, in mental health services, there is a tendency of staff to confuse personal values with clinical judgements.

I can recall a similar situation from my own working experience. A resident of a 24-hour rehabilitation group home was preparing to live independently. One of the workers expressed concern about this resident living independently due to his very poor hygiene. The director of the Occupational Therapy program emphatically informed this worker: "We can't keep someone locked up in the hospital because they have poor hygiene!"

Workers who stated that they had very different personal values from those of their clients, the researchers report, became alienated from their clients. Alienation of the client from the rehabilitation process also occurred as a result of similarities in value systems which were not recognized. However, the authors do not elaborate on this finding.

**What is Mental Competence?**

Recent literature on competence (Grant & Steel, 1990; Van McCrary & Wolman, 1990), cited by the authors of the above study, reveals that an individual is presumed to be competent unless declared otherwise by legal process. However, it is pointed out that in practice the evaluation of mental competence contains formal and informal components. Evaluation may also take place over a period of time so that different measures of competence may be observed. Generally, an individual is considered competent if s/he
demonstrates rational understanding and reasoning and appreciates the consequences, in terms of risks and benefits, in the decision making process. This is distinct from the quality of a decision as someone who makes an unwise decision is not necessarily incompetent. Traditionally, the researchers note, professionals have held that they have a responsibility to act in the individual’s best interest sometimes at the expense of the individual’s own choices and values. The harm of overriding the individual’s choices is judged to be lesser than the harm prevented. Clearly, there is a tendency of mental health workers to confuse clinical judgements of mental competence with personal values as revealed in this study.

Clashes in personal values between staff and clients which result in staff judgements of incompetence and the consequent overriding of individual choices can perhaps be illuminated by an incident from my own experience working in mental health. A woman in her fifties, a resident of a 24-hour rehabilitation program, was found to have a malignant tumor in her intestine. After discussing the treatment, side effects, and prognosis with her doctors she decided against a long, intrusive, painful, and uncertain series of chemotherapy in favour of maintaining the freedom of her current lifestyle. She was assessed to be totally cognizant of the consequences of her decision but because staff could not understand it they pathologized her decision. Were it not for her psychiatrist who appreciated her right to refuse treatment, she would have been coerced to undergo the therapy against her will.

The assessment, formally or informally of the client’s competence in making decisions in this study, had a major influence on goal setting. All of the workers made judgements about the client’s competence in their decisions to override the client’s
goals using the "best interest" rationale, the authors report. One worker admitted focusing on the "best interests" of the client even when this conflicted with the clients' own judgements, despite agreeing that people can and do make decisions regarding their lives when they are psychotic. He remarked:

When we're looking at the whole issue of competency and what's in their best interests, the client is affected by their illness...Often their judgement is impaired and their ability to make decisions is impaired because of the illness, because they're sick, because they're psychotic (p.29)

The clients, in three of the four cases, saw themselves as incompetent to make decisions but wanted the opportunity to do so with their worker's support. In the fourth case, the client felt that he had never been unable to make decisions and remarked that, "once you take over somebody's decision-making processes you make it difficult for them to function on their own" (p.30). This client is referring to the dependency created in clients when therapists dominate the decision-making process.

The researchers indicate that all of the clients had reported making decisions for themselves when they were psychotic or "incompetent" despite lacking confidence in their choices. Moreover, the authors state that many of these decisions, regarding housing, employment, and rehabilitation programs for example, were good decisions in the long term. Thus, perhaps, mental health workers need to try to share power with clients and carefully examine their concerns about client competence for clashes in values and/or stereotyping tendencies.

Another study revealing the significance of participant power and client control over decision-making and stereotyping tendencies of counselors in rehabilitation was conducted by Murphy and Salomone
(1983). Using a series of extended, open-ended interviews, they explored client and counselor expectations of rehabilitation services. They interviewed 7 rehabilitation counselors who held master's degrees in rehabilitation counseling and 12 of their clients, three of whom had psychiatric problems and 9 various physical disabilities. Murphy and Salomone discovered a disparity between the perceived roles of the clients and counselors, the values and assumptions about the needs and attributes of disabled persons and about the nature of the rehabilitation agency.

Perceptions of Counselor Roles

Initial service expectations of clients and therapists differed on one major point: job placement. Almost all clients clearly believed that vocational rehabilitation was a service designed to help them find employment. However, counselor perceptions on their role of job placement seemed much more ambiguous and ranged from mild acceptance to outright rejection of this role. According to the authors, clients perceived the role of rehabilitation counselor to be that of providing concrete, comprehensive vocational assistance including direct job placement assistance. As one client remarked: “The idea...is to place a person in a location—not just train them for it, but get them right out there doing it. What good is getting a degree if it's not going to do you any good?”(p.84). Counselors, however, seemed to perceive their role as helping clients develop job-seeking skills such as resume writing, interview skills, and making employer contacts as opposed to direct job placement. As well, the authors indicate that several counselors expressed a dislike for job placement not only because it was time consuming and frustrating but also for personal reasons, i.e. it was not compatible with their personality or
interests. It would have been perhaps instructive if the authors explored further what precisely it was that counselors found frustrating and distasteful about job placement.

The authors do indicate, however, that counselors expressed feelings of resentment about their roles being defined narrowly and unprofessionally. Counselors felt that the wrong services were being emphasized by their agency and that the most important professional functions of the rehabilitation counselor, particularly counselling, were being deemphasized.

In fact, the authors report that most counselors assumed a diagnostic orientation and focused on the psychological-emotional status of their clients. This assessment was confirmed to some extent by results of standardized psychological testing; however, according to the authors, counselors also made their own judgments about a client's psychological status. Regardless of problems presented or services requested by clients, counselors saw the routine collection of vocational and psychological impressions as being in the best interests of clients and was transformed into concrete intervention plans. Clients, however, were often not considered capable or willing to address psychological or emotional problems and were not aware of counselor impressions. Thus one would conclude that clients had little opportunity to express approval or disapproval of counselor's actions and thus had essentially no decision-making or participant power in this regard.

**Decision-making Power**

In fact, decision-making power was a major theme in this study, as with the previous study, both with regard to vocational goals per se as well as with regard to what services clients would receive. It was also another area in which clients' and therapists'
viewpoints diverged. Clients believed that they should have the major role in decision-making with regard to their vocational destiny, however counselors often perceived clients' expectations as unrealistic or unreasonable. As with the Hendrickson-Gracie et al. (1996) study, the counselors used the "best interest rationale" for determining client goals and services clients should receive. The authors indicated that what counselors end up doing is redefining the limits of rehabilitation services for each client. A counselor is quoted as saying:

_We have to decide what is appropriate. Some people do come to us thinking we're a grocery store and they'll get whatever they want, not realizing that someone has to sit down and decide what's appropriate toward reaching a vocational goal. I think that in a certain respect that's really part of their [the agency's] role—they are there to say 'no'; that they are there to make sure that I'm doing the right thing and that I can really justify it and say that what I'm doing is a good decision._ (p.87) (Italics added)

The above quote also reveals the professional and economic constraints imposed upon the actions of counselors by agencies and institutional systems. Murphy and Salomone explain that the stereotypic expectations of counselors derive in part from these constraints as well as from idiosyncratic attitudes, experiences, and training.

Counselors, despite often speaking of consumer involvement in the rehabilitation process assumed some persons to be incapable of making good decisions simply because they were rehabilitation clients or because they were receiving therapeutic counselling. Moreover, the authors report that, "Counselors occasionally indicated that clients...were too emotionally needy, ill-equipped, or uninformed to participate fully in vocational decision making" (p.90). As with the previous study by Hendrickson-Gracie et al.
(1996), the rehabilitation counselors in this study perceived a widespread presence of emotional disorders in clients which they believed thwarted competent decision-making consequently leading to a paternalistic approach to the working relationship. For example, a counselor is quoted speaking of a client who had a severe physical disability in the following way: "There's not a specific psychiatric disability. You could say there's a personality disorder that's so ingrained because of her whole developmental process that I personally don't feel there is a potential for much change" (p.86).

While most clients expressed doubt about their abilities and about being accepted by non-disabled persons, particularly employers, getting a job was what they wanted help with most and was integral to their sense of well-being and to a successful general recovery.

Even though some clients acknowledged having serious psychological problems, they did not expect to relinquish their decision-making rights. Participant power and the right to determine one's own future was perceived by clients to be directly related to their psychological well being. In fact, one client, as with a client in the previous study, believed that his emotional state require that he not compromise vocational goals. Murphy and Salomone write:

...many clients expect to control their own vocational destiny, which they feel is intimately related to their general well being, even to their very survival. Based on the current investigation, there seem to be good reasons for rehabilitation consumers to adhere to such convictions, even in light of professional disagreement (p.91)
As well as being tied to an emotional sense of well being, clients had very practical reasons and incentives for prioritizing job placement. Murphy and Salomone report that for many, poverty was a major fear. They quote a client who describes how her financial desperation was the primary motivating factor above all in determining her course of action: "I just wanted a job. That was my feeling. I've got to work. I don’t want to live on welfare; you just exist on welfare. They said that [the agency] was the way to get a job; they said you could go to college. It was the best thing I could have done" (p.86).

Murphy and Salomone characterize the counselor-client relationships in their study to be similar to what Gliedman and Roth (1980) termed a "power relationship". It would seem that there was not only a "power relationship" between counsellors and their clients but also between counsellors and their agencies. It would have been illuminating to further explore the agency's influence in shaping the counsellors' views of their roles. It would seem that counsellors experienced considerable pressure from agencies to maintain certain mandates which originated with institutional constraints of a particular agency, according to the authors. It would have been interesting to explore further the conflict between the services emphasized by the agencies and the counsellors' strong identification with what they saw as their "professional function of counselling" which they felt was being de-emphasized.

These two studies also reveal the tendency of therapists/ counsellors to place the focus of their work on individual defects, illness, or skill deficits as opposed to difficulties with poverty, unemployment, social isolation, and housing, and so on.
The above studies reveal the significance of power (or control) and lack of power both real or perceived by clients in mental health programmes. Previous experiences with mental health services has influenced both client and worker expectations of each other and in the above studies led to some assumptions which alienated client and worker from each other. In both studies, internalization of the "sick-role" of clients and the "professional as expert" role of workers contributed to assumptions and alienation and to the mental health workers' tendency to control the decision-making process based on what Hendrickson-Gracie et al. (1996) termed "best interest rationale". In the Murphy and Salomone (1983) study, the authors characterize the relationship between counsellors and clients as a "power relationship". Often a blurring of "clinical judgement" and personal values on the part of therapists occurred which led to domination of the decision-making or goalsetting process.

The disparity of perceived roles of workers between worker and client is revealed by the researchers. Workers highlighted their "clinical" roles whereas clients were more interested in the "practical" concrete assistance and advocacy they could receive from workers which in the Murphy and Salomone (1983) study was employment. However, these clients' desire for jobs stemmed not only from their concerns for basic survival as most clients were afraid of living in poverty but also from insight into the significance of employment for self-esteem and psychological health via social advancement, security, and personal expression.

The importance of collaboration and a "therapeutic alliance" is underlined in the above studies. Literature regarding the
"therapeutic alliance" emphasizes a strong "working alliance" in which a collaboration between client and therapist is central (Allen et al., 1988; Borden, 1988). Borden (1988) has outlined three components, which deal with client perceptions of treatment, which need to be met in order for collaboration or a true "alliance" to occur: 1) mutual agreement and understanding regarding the goals; 2) the client must perceive the tasks (steps to achieve the goal) as relevant; and 3) a bond between therapist and client. The bond characterizes the closeness dimension of the helping relationship whereby the client feels "connected" with and understood by the therapist.

In the aforementioned studies all three components of a therapeutic alliance seem to be lacking. Due to the asymmetrical nature of the client-therapist interaction caused by professional power or social control and the inequities created by social structure communication is a complex interactional process. The attempt to enter into another's life-world or intersubjectivity is especially difficult for professional and client interactions (Crepeau, 1991). In addition, socio-economic class is also a barrier to intersubjectivity with the therapist typically belonging to a higher socio-economic stratum. These factors may have made it difficult for the therapists and clients in the above studies to establish a bond or sense of connection.

Support for individual's own perceptions as more important in predicting functioning, even when these judgements are viewed as unrealistic by others, is found in Tanzman's (undated) research of psychiatric consumer preferences for housing and support cited in Clark et al. (1993). If the workers in the above studies took the time to develop a therapeutic alliance, one might conclude that they
may have been able to dispel stereotypic views and expectations and clients may have felt safe enough to openly disagree with their workers and share their desire to maintain their own goals thus establishing a true collaboration.

Clients' and Therapists' Perceptions of Helping in OT Groups

Therapy groups have traditionally been a cornerstone of Occupational Therapy. The purpose and nature of these groups vary widely. Generally groups are provided to teach independent living skills and promote self-awareness (Polimeni-Walker et al., 1992) and can include such diverse groups as cooking, assertiveness training, social-skills, stress-management, community meeting (daily activities are reviewed, participants discuss weekend activities/plans and share feelings and experiences), self-care, money-management, woodworking, art, crafts, and recreation (bowling for example). Many groups include a combination of task-oriented activities, didactic teaching and role-playing (Polimeni-Walker, Wilson, & Jewers, 1992).

The following studies examine the perceptions of clients and therapists in terms of what they value in groups. Polimeni-Walker et al. (1992) compare therapist and client perceptions of reasons for attending occupational therapy groups in a psychiatric hospital in Canada. The Webster and Schwartzberg (1992) study adopts a well-known therapeutic factor methodology employed in psychotherapy research--the Q sort--to determine what therapeutic factors are rated highly by hospitalized clients of psychiatric occupational therapy groups. Wollert (1986) examines self-help groups and the therapeutic or help-giving processes characteristic of these groups and Weitz (1983), a former psychiatric patient and mental patient.
advocate/self-help group leader, articulates the distinctions between self-help groups and traditional mental health delivery.

**Comparison of client and therapist perceptions of OT groups**

A study which explores perceptions of both users and providers of services in the field of psychiatric occupational therapy, examined the reasons for participating in hospital-based psychiatric occupational therapy groups from both patient and therapist points of view. However, in this study, as with most studies examining psychiatric care, Polimeni-Walker, Wilson, and Jewers (1992) utilize a quantitative methodology and employ an inventory with a list of 32 items, each referring to a specific reason for participating in the occupational therapy programme and a 7-point scale ranging from "Very Unimportant" to "Very Important". The inventories were distributed to 127 adult psychiatric inpatients of a Canadian psychiatric hospital. However, the group of 31 occupational therapists who completed the inventories included individuals working in a variety of settings and was not restricted to those whose primary assignments were in psychiatry.

The authors indicate that the goals of the study were: "1) to obtain a better perspective on the factors which motivate adult psychiatric inpatients to attend occupational therapy groups and 2) to determine the extent to which their reasons reflect an appreciation of the therapeutic function of the groups" (p.241). Thus, in this study the therapeutic function of the groups per se and its relevance for clients is not questioned.

While some of the items selected for the inventory were based on clinicians' opinions and some on the basis of anecdotal reports from patients, with this tool there is no possibility to learn about motivational factors which were not preconceived. Moreover, the
reasons indicated may only reflect motivational factors involved in the particular groups the patient attends in the absence of more relevant groups. Furthermore, reasons which are identified on the inventory may not necessarily be the factors which are most salient for patients. In other words, if a particular patient would like to learn how to cope with auditory hallucinations for example, but there is no such group available, with this instrument it is impossible to determine such a need. With this instrument, it is only possible to determine the reasons for attending only those groups which are currently being offered and only the reasons from those indicated on the inventory. Say for instance, a client may indicate that the particular reason for attending a particular group is "To work on crafts" but the reason per se--i.e. working on crafts, is not especially important or meaningful to the individual, in fact s/he may be much more interested in other groups that are not being offered or may have other reasons for attending this group which are not listed on the inventory. What does this really tell us about the experience of the patient and about her/his motivation? These limitations are characteristic of quantitative instruments such as the Q sort of the Webster & Schwartzberg (1992) study below (although they did include an open-ended question after the participant completed the Q sort) and the HPQ of the Wollert (1986) study discussed at the end of this section.

The results of the Polimeni-Walker et al. (1992) study indicated that for patients the two most highly rated reasons for participation in activity groups were from the sub-scale "Escaping Hospital Routines": 1) "To decrease boredom" and 2) "To avoid sitting around doing nothing". But we do not really know what this result means for the patients, i.e., we do not really know how to interpret
the finding that diversion emerges as a strong reason for participation in occupational therapy groups. Is diversion highly rated because the currently offered groups do not meet any other needs of the patients? Or is diversion per se viewed positively by patients as it offers patients an important source of structured social activity, social interaction, and purpose which is lacking in their current context and thus it is rated highly? Or can we interpret the relief of boredom rated most highly as do the authors, that "it is questionable whether the patients are deriving optimal benefits of the therapy" (p.246)? Interestingly, the authors do not seem to question the benefits of the therapy itself or of the suitability and relevance of the groups to the patients needs in the first place.

The authors do consider, though, that in the absence of alternative ward activities, the occupational therapy groups offer patients the opportunity to do something with their day and cite another study (Burton, 1984) which found that most patients in an acute psychiatric unit attended occupational therapy for "diversional reasons". This finding is consistent with the Webster & Schwartzberg (1992) study, cited subsequently, in which relaxation/diversion emerged as a new category from participant responses to an open-ended question.

Interestingly, the authors point out that many of the reasons gathered from anecdotal reports from patients for inclusion as items on the inventory had little to do with therapeutic aspects of the programme but rather pertained to the role of occupational therapy groups in the overall context of ward life. This fact reveals the significance individuals place on the meaning of activity in terms of the context in which they live. Indeed, a common criticism of
institutional mental health programs as well as some community-based programs is that they decontextualize the individual, ignore the objective historical/social/cultural/economic world of the person and tend to interpret all behaviour psychiatrically or intrapsychically (Rose & Black, 1986; Walsh-Bowers & Nelson, 1994).

Many of the reasons for participation in activity groups acknowledged by the patients in the Polimeni-Walker et al. (1992) study were rated by the therapists as relatively unimportant therapeutically. "Therapeutic Gains" such as "To enhance my self-confidence" and "To improve how I get along with people in social situations" were rated significantly more highly by the therapists, than were items in any of the other scales such as "Escaping Hospital Routines". Whereas for the patients' ratings for "Therapeutic Gains" were about comparable to the diversional function of the groups. However, "To enhance my self-confidence" was ranked third in importance among the 32 reasons for participation in OT groups for the patients. The authors are, however, assuming that various groups do in fact "enhance the participant's self-confidence" or increase social skills and are overlooking the possibility that for the client, the experience of the particular group may in fact not enhance self-confidence or improve social skills.

Because "Escaping Hospital Routines" was as strong a factor as "Therapeutic Gains" for the patients, the researchers point out that this may indicate that patients perceive themselves as not having enough to do and suggest that providing other ward activities to help meet patients' needs for diversion and social interaction would allow OT groups to deliver the other therapeutic benefits that they are intended to provide.
The authors suggest that this finding may also reflect a problem with the blanket referral system in place at the Centre at the time the study was conducted. As new patients were constantly being introduced to the groups, opportunities to offer an explicit explanation of the rationale and goals of occupational therapy were limited. The authors indicate that this problem has been solved by replacing blanket referrals with individual referrals.

**Helpful/Therapeutic Components of OT Groups—Perceptions of Clients**

Webster and Schwartzberg (1992) attempted to apply therapeutic factor methodology to a psychiatric occupational therapy group in order to clarify what participants find helpful in occupational therapy groups. This study is rather unique in that the authors, both occupational therapists, did not begin with the assumption that if clients are not valuing particular groups for the therapeutic values assigned to them by therapists they lack understanding. Instead, they set out to discover what therapeutic factors clients find helpful or valuable with a view to alter groups to meet client needs.

A modified version of Yalom’s Q-sort of 60 statements, typically used for psychotherapy groups, that were ranked from the most valuable to least valuable were administered to participants. Prior to administration to participants, the researchers circulated the list of 60 curative factor items among senior group therapists to get their feedback. It might have also been instructive to circulate these factor items among clients as well. In an attempt to reach closure, a follow-up question was also included and allowed patients to add any new material. Consistent with Yalom’s (1975) use of the Q-sort, the authors indicate that patients who felt that they did not benefit from the clinic group were excluded. This is
unfortunate because these clients may have been able to provide valuable new information/insight for therapists such as alternative factors that they should be considering regarding group goals, composition, dynamics, or procedure.

The occupational therapy group was a weekly voluntary group available to clients with varying group leaders. A variety of media was used such as arts, crafts, pencil and paper tasks, and resource books. This type of occupational therapy clinic was necessitated by the short-term nature of the participants' stays and no other group guaranteed sufficient attendance to use it for the study.

Webster and Schwartzberg report that several studies have shown that "...the therapist has a poor sense of what clients perceive as most helpful" (p.6-7). They point to the shortcomings of activity analysis, a popular approach within psychosocial occupational therapy from the 1940s through the 1960s, as limited by its dependence on the views of the therapist. Thus the authors wanted to use a tool which would determine what therapeutic factors are generally valued by clients to inform therapists' decisions about group goals, composition, and content as well as treatment planning and evaluation.

In their literature review, Webster and Schwartzberg discovered that strikingly, the same therapeutic factors generally were rated highest by participants in study after study (Bonney, Randall, & Cleveland, 1986; Butler & Fuhriman, 1983; Lieberman, Yalom, & Miles, 1973; Long & Cope, 1980; Marcovitz & Smith, 1983; Rohrbaugh & Bartels, 1975; Schaffer & Dreyer, 1982). When used with patients in the occupational therapy group, Webster and Schwartzberg hypothesized that the Q-sort would show different results from those cited in the psychotherapy group literature. Group cohesion, which
was rated highly in group psychotherapy research (usually in the top four), was excluded because of the varying membership and attendance due to the short term nature of the groups in the occupational therapy clinic studied. The authors hypothesized that the most highly rated factors in the occupational therapy group would be: (a) instillation of hope, (b) altruism, (c) interpersonal input, and (d) universality (though not necessarily in that order). However, they were forced to reject their hypothesis based on the results of their study which in fact revealed that while instillation of hope and altruism were ranked in the top four by participants as predicted, cohesion emerged as the number one ranked factor with interpersonal output being ranked second and catharsis as tied for fourth. These results, the authors report, are strikingly similar to Perl and Falk-Kessler’s (1989) study of therapeutic factors in occupational therapy groups. In their study cohesion was also ranked at number one, interpersonal output number two, and hope at number three. The authors compare their results with the Yalom (1975) study in which cohesion is ranked third and the Maxmen (1973) where it is ranked second with hope at number one.

**Therapeutic Factors**

The authors adopt Yalom’s (1975) definition of therapeutic factors as “those elements which patients appear to find important in advancing their own self-knowledge or [Maxmen’s (1973)] promoting a cure of their psychic distress” (p. 6). Maxmen’s (1973) summary Yalom’s (1975) therapeutic or curative factors in the Q-sort relevant to the study are as follows: “altruism [italics added]—reflects the patient’s giving to help others” (p. 6); “catharsis [italics added]—expressing uncomfortable feelings that had been bottled up inside” (p. 6); “group cohesiveness [italics added]—the
patient's sense of being accepted by others in the group" (p. 6); 
"identification [italics added]-patient imitating the positive attributes of others in the group" (p.6); "instillation of hope [italics added]-patient’s optimistic feelings" (p. 6); 
"interpersonal learning, input-receiving feedback as to one's own behavior" (p. 6); "interpersonal learning, output [italics added]-gaining success in dealing with other people" (p. 6); and 
"universality [italics added]-learning one’s problems are not unique, but shared by others" (p.6).

Cohesion. It was interesting that cohesion unexpectedly emerged as the most valued therapeutic factor. The authors indicate that this was not hypothesized because the occupational therapy clinic was not seen as a cohesive group, but rather as a task group where participants worked on similar projects separately. The authors posit that one explanation for the high value placed on cohesion by participants may be that the clinic was attended by participants who wanted to be together, communicated with one another frequently, and developed a strong sense of group cohesiveness. They indicate that this was sometimes observed anecdotally. Another possible explanation, not mentioned by the researchers, is that in a context of isolation and loneliness which is characteristic of institutionalized patients, a sense of cohesiveness, acceptance, belonging, and camaraderie become salient needs for clients. Thus they value this factor very highly. While the kind of cohesiveness in such groups may not be sufficient in itself, it is better than no social contact at all. Support for this explanation can be seen in two other studies of hospitalized groups (Maxmen, 1973) and (Perel & Falk-Kessler, 1989) where cohesion is

**Altruism and instillation of hope.** The predicted valuing of altruism and instillation of hope by the participants in the study is consistent with Maxmen’s (1973) study of short-term inpatients in a psychiatric hospital. The authors interpret this finding as confirmation for the view that the focus of short term groups is on participants giving to others and “seeing some reason to look to the future (instillation of hope)” (p.16). One might also explain the high value placed on these factors by psychiatric patients as arising from feelings of hopelessness, powerlessness, and inadequacy commonly experienced by institutionalized psychiatric patients and reinforced by the institution (Goffman, 1961; Rosenhan, 1973; Chamberlin, 1978; Deegan, 1990). In such a context we can see why a particular activity or group, in which participants feel more hopeful about their future and feel they are “giving to others” thus increasing feelings of competence and self-worth, would be highly valued. Moreover, it is in the consumer literature that hope is often mentioned as a very important therapeutic factor; one which is critical to recovery (Clark et al., 1993; Deegan, 1991).

The finding that altruism or giving help to others is valued highly by the participants in this study is also consistent with an empowerment ideology and well-documented in the literature on self-esteem, and is particularly relevant for users of psychiatric services. Walsh-Bowers & Nelson (1994) note that typically patients and ex-patients tend to receive more support (problem-solving, emotional or social) than they provide to network members and/or professionals. They purport that: “This pattern or non-reciprocity of social support exchanges may foster dependency and lower self-
They cite Riessman's (1990) hypothesis that providing support to others is important for one's mental health and point to a recent study of ex-patients residing in supportive apartments or group homes or board-and-care homes (BCH) as support for this hypothesis. "...the frequency with which residents provided emotional support to others was directly associated with positive feelings, a sense of mastery, and community integration" (Nelson et al., 1995) p.13. Mathews et al. (1985) also found that reciprocity in support exchanges results in increasing self-determination of clients and minimizing unnecessary dependence on professionals. They promote the use of "peer counseling" in independent living programs (ILP) as a way to actively involve consumers in the rehabilitation process. Moreover, peer counseling, according to the authors, provides peer role models and counselors who are more sensitive to the needs of helpees because peers have had direct experience with both disability and mental health services. Utilization of peer counselors is an effective way of empowering the person to move beyond historical roles.

**Interpersonal learning output.** While not predicted by the authors as being a highly ranked therapeutic factor, they indicate that in retrospect it is understandable. Participants learn to express themselves to others and value this in occupational therapy, according to the researchers. They also refer to the findings of Perel & Falk-Kessler (1989) which suggest that the high valuation of interpersonal learning-output in a group is reflective of behavioral changes as opposed to the insight gained in psychotherapy groups. The authors interpret this finding as confirming the value of activity in increasing social skills.
Identification. It is also noteworthy that identification was least valued by the clients in this study as well as in the Yalom (1975), Maxmen (1973) and Perel & Falk-Kessler (1989) studies. This may be due to the fact that participants often have a very low self-esteem and lack confidence; particularly with regard to clients who have been institutionalized and have internalized the sick-role. It might be that clients are influenced by the stigma of the client status and thus do not aspire to emulate one another as they do not see each another as viable role models.

The Open-ended Question: Clients Speak Out

What is particularly remarkable about the results of this study is how "...the participants' opinions burst through the limitations placed upon them by being given only one question at the end of a somewhat puzzling task" (p.21). From the open-ended closing interview question, the researchers were able to discover new categories which did not fit into any of Yalom’s (1975) categories. These unsolicited categories include relaxation/took my mind off my problems, creativity/self-esteem, enjoyment/fun, and increased skills/concentration.

The authors explain that these categories are not found in Yalom’s (1975) group description because the curative factors in Yalom’s groups are based upon intra-personal insight and interpersonal interaction. They also point out that the context of these activities for clients is central.

Relaxation/diversion. The fact that concentration on concrete activities may be relaxing for some patients in an acute hospital setting, the authors note from their own observations, is probably due to the fact that "...they are reminded about their intra-psychic problems at least 50 times a day (p.19). A relaxing atmosphere is
consistent with many occupational therapy programs, the authors point out, where patients can learn better, acquire social skills in "a less pressured environment", and more easily return to the clinic or group. Some of the clients' representative comments for this category are as follows: "... 'I forgot about myself and my problems' 'I could let my hair down' 'I liked the easygoing, relaxed atmosphere'." (p.14) The diversional aspect of this factor is recognized by the authors who refer to Finn's (1989) qualitative study in which she categorizes "diversion" as a distinct therapeutic factor in her study of hospitalized patients. She suggests that as well as a supportive atmosphere encouraged by group leaders, the tactile nature of craft activity could be helpful to participants in focusing on an external object and thus deflecting their thoughts from their problems.

**Creativity/self-esteem.** The authors describe this category as reflecting "... combination of pleasure at achieving results, a sense of self-expression in the process of craft work, and possibly some sense of positive feedback that staff and patients give to the patient doing the work" (p.20). They point out that this factor is consistent with the occupational therapy concept of "purposeful activity" (Fidler & Fidler, 1978). Purposeful action is defined as:

..intrinsically motivating, and also as a stimulant to the central nervous system, in a way that rote work or repetitive exercise cannot be. By fitting a particular craft activity within the goals of the participant, it acquires a value and meaning that is seen in the comments made by the participants in this study. (p. 20)

For some clients this opportunity to express themselves creatively had an impact on the client's overall self-esteem—"I came out feeling great" (p.20). Other participant comments representative of this category are: " 'I tried new stuff!' 'I did things I forgot
I could do.' 'I still have talent.' 'I would go in feeling bad and come out better... oh wow, I can do it'...." (p. 14).

The high value placed on activity which enhances creativity and self-esteem by clients of psychiatric services, particularly those hospitalized is not surprising. There is an abundance of literature which reveals how the mental health care environment itself and the label of "mentally ill" is destructive to a healthy self-esteem, sense of competence/mastery and self-confidence (Goffman, 1961; Szasz, 1971; Rosenhan, 1973; Chamberlin, 1978; Rose & Black, 1986; Deegan, 1990; Clark et al., 1993; Walsh-Bowers & Nelson, 1994).

**Enjoyment/fun.** The authors point out that while this category, too, is not often seen in the therapeutic factors or psychotherapy group literature, it is central to occupational therapy work. Participants enjoying a task or being together, the authors say, is an "under-valued skill". Some representative comments for this category are: " 'It was a quick gratification for me.' 'For me, it was like being a kid.' 'It was hard work that I enjoyed.' 'I enjoyed it, the music was great.' " (p. 14).

**Increased skills/concentration.** This category reflects participants' value of gains in specific skills as well as learning generalizable skills such as channelling frustration productively which the authors state is perhaps most central to occupational theory and practice. Clients comment: " 'I learned to work with more concentration, and learned about perfectionism.' 'I channeled my energy better.' 'Helped me expand my interests and skills.' "..." (p. 14). This category could conceivably be related to the value of a sense of accomplishment or achievement as with the creativity/self-esteem category. As the authors note when distinguishing this new
category from the therapeutic factor of insight: "Gains in concentration...are gains in a very important skill but not one that reflects insight as much as an increase in abilities." (p. 21). Again for individuals who typically have a poor self-image, achievement and a sense of accomplishment are especially important.

This study clearly reveals the significance of the context of activity in terms of how groups/activities are perceived as meaningful and relevant. While many of the factors are intrinsically valuable to most of us, context plays a very large role in how salient they are for us at any given time. Hope becomes very important to individuals who feel hopeless; cohesion and social contact, to individuals who feel utterly isolated and alone; creativity/self-esteem, to those who feel self-contempt and inadequate; achievement, to those who feel incompetent and lack confidence; enjoyment/fun, to those who live in a joyless, controlled environment. In the following section, we see how self-help groups, particularly ex-psychiatric patient groups, recognize the significance of context for activity and are grounded in the everyday, experiences of socially meaningful life.

**Self-help Group Members’ Perceptions of Help**

"People who share common beliefs, experiences or a commitment to change often come together to offer each other support and to become more effective through group action. This process of mutual aid is called self-help" (Hutchison et al., 1986, p. 45). As mentioned in the Introduction, due to the widespread dissatisfaction with traditional mental health services, consumers have attempted to explore their own empowering alternatives through the psychiatric self-help movement.
Increasingly, Church (1989) reports, mental health self-help groups are gaining recognition by governmental and non-governmental agencies, at least in print, as a viable resource within a total community resource base. By examining the perceptions of individuals involved in self-help groups we can gain insight into the kinds of dynamics, activities and experiences that they find helpful and into their experiences of more traditional mental health delivery of which they are critical and/or actively reject. For this reason and due to the lack of studies exploring client perceptions of helping this section reviews some of the literature on self-help groups as well as literature written by consumers themselves regarding their perceptions of traditional mental health care and their visions of empowering alternatives.

In a unique study of self-help groups, Wollert (1986) explores participants' perceptions of the psychosocial helping processes/therapeutic factors. The author was interested in determining what helping processes occur in a heterogeneous sample of 13 self-help groups. Wollert felt that examining self-help interventions would be

... useful in delineating the potential of self-help groups for the delivery of mental health services to specific target populations and for elaborating the range of techniques that may be effective in facilitating personal change" (p.64)

The questionnaire used in this study lists 27 help-giving activities which, the author explains, have been commonly described in the literature on psychotherapy techniques or were identified by the authors' experience working with many different self-help groups (Levy, 1979). Although not necessarily valid, the underlying assumption of this approach is that the help-giving activities which occur most often in the self-help groups are valued by the members
of those groups. With this research methodology, we cannot ascertain that frequently occurring help-giving activities means that they were valued by group members.

**Psychosocial Helping/Therapeutic Processes**

In the two ex-mental patient groups surveyed, the psychosocial helping processes that were rated as most highly occurring were *mutual affirmation, empathizing, instilling hope, checking in,* and *instilling confidence.* The summary operational definitions of the above are as follows: "**empathizing** [italics added]— when a person expresses his [sic] emotions in the group, other members let that person know that they understand and share his [sic] feelings" (p. 67). "**mutual affirmation** [italics added]— members assure one another that they are worthwhile and valuable people" (p. 67). "**instilling hope** [italics added]— group members assure other members that their problems will be worked out positively" (p. 67). "**checking in** [italics added]— group members share everyday experiences, thoughts, or feelings with other members" (p. 67). "**instilling confidence** [italics added]— members assure one another that they are capable of handling their problems" (p. 67). As with the Webster & Schwartzberg (1992) study, instilling hope and self-esteem (i.e. mutual affirmation, instilling confidence) are important themes in Wollert’s study.

Not surprisingly, Wollert found that group interactions become less naturalistic as professional involvement in self-help groups is increased. As with his previous research (Wollert, Levy, & Knight, 1982), the current study points to the conclusion that self-help groups have a common core of interventions in attempting to meet the needs of their members. They enlist mutual support and promote personal expression, the author reports. These interventions tend to
be "positively-toned", simple, and are grounded in the everyday interpersonal experiences of members thus, they are considered "naturalistic".

Another finding which supports the author's previous anecdotal observation (Wollert, Levy, & Knight, 1980) and which has implications for professional involvement in self-help groups is that human service professionals tend to "practice their professions" within a self-help group setting. Wollert adds that this finding also implies that professional roles should be structured so that they conform to group goals. For example, the author notes that a professional role might be more appropriate for groups which are oriented toward personal growth and what Yalom (1975) termed "interpersonal learning" as opposed to groups characterized by peer support and autonomy in which professional activities might be severely restricted.

**On Our Own--Self-help in Action**

The naturalistic and authentic nature of self-help groups is reiterated by Weitz (1983), an ex-psychiatric inmate and co-founder of the Toronto-based "ex-psychiatric inmate-controlled" self-help group, *On Our Own*. He outlines the distinctions between the approaches of self-help groups and traditional mental health delivery. The fundamental difference between ex-psychiatric patient self-help groups and psychiatry is that self-help groups are based on the theory of empowerment while the latter is grounded in the medical model. Self-help group members are acutely aware of the objective conditions of their oppression--such as poverty, unemployment, stigma, substandard living conditions, and the hegemony of the mental health system. Thus the primary goal of self-help groups is to work towards "power reversal" in society. And this
means, as Hutchinson et al. (1986) explain, "shifting the base of control in decision-making from institutional structures to individual citizens" (p.45). Confronting the issue of power as a formal task, is a key distinction between self-help groups and traditional mental health delivery. Self-help groups are consumer-controlled in that the structure ensures that consumers have the power to make binding collective decisions on all issues within the mandate of the group. The emphasis of self-help groups, Weitz (1984) says, is on: 1) alleviating isolation and promoting solidarity; 2) keeping members informed of-- a) their civil and legal rights, b) risks and dangers of side effects of drugs and electroshock treatment, c) alternatives to mainstream psychiatry, and d) what is happening in the Movement elsewhere via regional and national newsletters and magazines and international conferences; 3) networking and sharing information; 4) participation and democratic decision-making; 5) raising public awareness; 6) exploding myths about 'mental illness' and exposing psychiatric abuses; 7) offering members training through ex-inmate-controlled drop-ins, co-op housing projects and businesses, advocacy/political action groups; and 8) political action and advocacy.

In a context of marginalization and social isolation of ex-psychiatric patients, providing a great deal of support for people becomes critical. An example of the practical application of an empowerment ideology, On Our Own, writes Weitz, "...has helped many people by allowing them to feel accepted and respected again or for the first time in their lives, and by supporting their basic human right to control their own lives and to be themselves" (p.32). A unique characteristic of self-help groups is the support, acceptance, and understanding of other members who share and
identify with the problems specific to users of mental health services. Weitz explains:

People who have experienced a particular problem, illness, institutionalization or invalidating label such as 'mental patient' or 'schizophrenic' know what it's like, they've 'been there' too. Such people have an almost instinctive grasp of each other's problem(s). It is this intuitive understanding and acceptance together with mutual caring, sharing personal experiences, and giving each other support which are the real sources of strength and solidarity. (p.28) (emphasis added)

Social support, meaning receiving information from others that one is loved, cared for, and valued in addition to being part of a network of communication and mutual obligations (Cobb, 1976) has been identified in the literature as a causal contributor to well-being (Cohen & Wills, 1985). For example, studies of AIDS patients showed that patients' perceptions of higher social support was associated with reduced depression and hopelessness (Zich & Temoshok, 1987). Researchers have also found a relationship between social support, stress, and psychological and/or physical well being (Cohen & Wills, 1985; Taylor, 1991).

Self-help group members believe, says Judi Chamberlin (1978), a former psychiatric patient, "The ability to give help is seen as a human attribute and not as something acquired by education or professional degree" (p.329). Here again we can see the empowering effect of mutual caring or as termed in the Webster & Schwartzberg (1992) study--altruism--giving help to others. Similar to the Wollert study of self-help groups where empathizing and checking-in was a prominent factor of the groups he studied--understanding each other, "knowing what it’s like" from common personal experience and sharing these personal experiences, is felt to be a source of strength and solidarity. We could also draw parallels with this sense of solidarity to cohesion which has been ranked very highly by
psychotherapy group members in a number of studies, particularly those exploring perceptions of institutionalized individuals (Webster & Schwartzberg, 1992). The highly valued need for cohesion most likely stems from the isolation and alienation that most current and former psychiatric patients experience. Weitz (1983) explains that self-help groups attempt to combat this isolation and oppression by providing people with "...a real sense of belonging, acceptance, and understanding" (p.28). Group cohesiveness is promoted by egalitarian interactions, familiarity, informality, fluid and flexible structure, and a relaxed and friendly atmosphere where "...members typically call themselves and others by their first names and treat each other like friends, brothers or sisters—not 'clients' or 'patients'" (p.28). Interactions among and between group members characterized by egalitarianism, authenticity, warmth, and mutuality or reciprocity of support are unique to alternative mental health services such as self-help groups, reiterates Chamberlin (1978):

The present system, in which the givers of help derive status and financial rewards, while those who seek help are seen as needy or sick, perpetuates the rigid separation between the helper and the helped. Detachment and impartiality, which mental health professionals believe are the proper therapeutic attitudes, become, in practice, either cold formality or the shallow pretense of friendliness. Alternative services replace medical and bureaucratic distance with real friendliness—not the bland, impartial 'friendliness' of a person behind a desk but the open give-and-take of a relationship between equals. Having problems is seen as a normal component of living in a sometimes difficult and threatening world and not as part of an illness existing only in some unfortunate people. (p. 328)

Another major distinction between self-help groups and traditional psychiatry, Weitz explains, is that members experience a real sense of power, choice, and hope—people’s feelings and opinions
are encouraged and respected, they have decision-making power and voting rights on issues affecting the group or the Movement.

Unlike some of the self-help groups studied by Wollert (1986) which were heterogeneous and ranged from groups like Alcoholics Anonymous, Overeaters Anonymous to Parents Without Partners where the focus was on personal-growth and change, most ex-mental patient groups are political. A critical inquiry of objective oppressive social conditions is central and so a fundamental mandate of these groups is advocating and lobbying for social structural change through annual conferences and advocacy/political action, for example. Weitz says that: ‘People join and become active in the Movement or self-help groups of ex-psychiatric inmates for one or more of these reasons: support; information-sharing; power; developing alternatives to psychiatry; changing unjust ‘mental health’ laws” (p.28).

Success Stories

Weitz (1984) traces “Alf”, who had some business and selling skills, the group opened their own booth for selling used goods in a flea market. Alf trained and encouraged many interested members including Weitz himself. John, who would not talk with anyone for two or three months after joining the group, after a few weeks working in the flea market with Alf, was talking with customers and selling as well as socializing with other members. He was elected as the group’s first chairperson. At the time he was unemployed but with the increased self-confidence and skills gained with the group, he obtained full-time employment with a major electronics company where he has been working for the last four years and has been promoted.
Another member, Susan, who had been involved with the group for four years, had been very depressed, talked little and was in and out of psychiatric institutions for many years. She had rarely worked for longer than a six-month period. Encouraged by Alf, Susan occasionally volunteered at the flea market booth. She began working at the store first as a volunteer and shortly after as a sales clerk trainee under Canada Manpower's "Work Adjustment Program" when the group's store, The Mad Market, opened in 1980. Four or five months later she secured a full-time, permanent position as a tourist guide for the Ontario Government.

Weitz reports that federal, provincial, and municipal funding have helped the group expand to a membership of over 300 and employ a paid staff of eight members. Two of the largest grants from the Ministry of Health and Health and Welfare Canada have allowed the group to develop more activities and hire more members as staff. Since 1980, the group has managed its own non-profit used goods store, The Mad Market. A Store Committee operates the store, with a store manager and assistant manager, van driver, sales clerks and volunteers who are all members. The store manager, assistant manager and van driver, partially funded by a city grant, are paid a salary and volunteers receive money to cover basic expenses such as meals and travel. The Mad Market, providing a valuable training ground for many unemployed members who lack various skills, self-confidence or both, Weitz (1984) reports, has led to at least twelve members obtaining permanent or temporary employment. "Their growth in self-confidence, self-respect and competence has been priceless. The Mad Market has proved to be more helpful and humane than any 'industrial therapy program or 'sheltered workshop'. We are proud of The Mad Market and its successes" (p. 31).
Psychiatric-based programs such as industrial therapy or sheltered workshops are rejected by self-help groups for a number of reasons which include: meager wages [which can be as low as 30 cents an hour--essentially slave labour], the requirement to perform tedious and sometimes demeaning tasks (Herman, 1985), and the lack of control, feelings of ownership, and decision-making power of clients with regard to their work or work environment. As many of the jobs involve repetitious or monotonous tasks it is rather doubtful that clients find them meaningful or satisfying. Thus, as Walsh-Bowers and Nelson (1994) observe, "...both extrinsic and intrinsic motivation factors, which are very important for work satisfaction, are often lacking" (p.8). Moreover, sheltered workshops sustain the pattern of segregation of patients and ex-patients from the community. All these factors reinforce the mental patient identity or the sick role of the person. Chamberlin (1978) observes:

Most services offered to ex-patients continue to place them in the category of needy, incompetent individuals who couldn't possibly help themselves or one another without outside intervention. Mental patients are taught to think of their difficulties as 'symptoms', which require professional expertise to treat. Even practical problems, such as finding a job or a place to live, tend to be handled by social workers within the overall psychiatric framework. And within this framework, every difficulty the patient or ex-patient experiences may be viewed as an indication of mental illness. (p. 329)

Human Activity vs. Mental Patient Activity--The Relevance, Meaning, and Authenticity of Help

Rose and Black (1986) are also critical of the "decontextualization" by mental health workers of psychiatric clients which leads to the internalization of the mental patient identity on the part of both workers and clients. This mental
patient role or sick role is a "socially constructed oppressive role" which Rose and Black (1986) term "mental patienthood" (p.20). They criticize many mental health programs and activities as reinforcing this role through "mental patient activity", such as industrial therapy or sheltered workshops cited earlier, as opposed to "human activity" such as raising issues and questions about concrete, real life issues and providing opportunities for activity which is socially useful. The medical-psychiatric paradigm which underlies most mental health service delivery, is at the root of this socially constructed oppressive role:

In these programs [in-patient group-focused 'therapy' of some kind], as in community-based programs operated by most mental health service providers, the likelihood is that the conceptual model for implementing the activities involved was a medical-psychiatric approach. In program terms, this has meant that groups, both large and small, were premised on the assumption that the participants' behavior patterns, which reflect the social role of the mental patient, and their human identities were the same. In such groups people either learned to behave 'appropriately' or participated in condescending rituals directed at improving their 'functioning', with this latter concept used to connote 'proper' behavior within the confines of the mental patient role. (Rose & Black, 1986, p.103)

In their program, consistent with the approach of mental patient self-help groups (Chamberlin, 1978; Chamberlin et al., 1996; Weitz, 1984; Wollert, 1986) activities and issues discussed are grounded in the daily life. Implicit in the activities/programs of self-help groups and those in Rose and Black's empowerment/advocacy scheme is the articulation and clarification of the concrete problems permeating the social reality of the participants and the recognition that these problems are complex in nature; that they are social/structural in nature; that they are externally imposed and experienced in common. When one person feels safe enough to complain
publicly about a particular issue, the staff pursue the substance and serious basis of the issue vigorously.

The types of groups often spring from the community meeting as participants raise personal issues in their lives and become accustomed to being taken seriously. The premise underlying these programs is that groups which allow people to critically examine the conditions of life, their feelings, and possible action are conducive to social development. Groups are an integral aspect of the empowerment/advocacy program advocated by Rose & Black (1986) because they, as with psychiatric survivor self-help groups, illuminate the shared experience of oppression of the group members: "We believe that the common base of people’s experience is undermined in daily life, in the everyday ideology of social life and, in heightened form, for anyone with experience in the mental health system because of its saturation by an individual defect form of problem definition." (p. 108)

Ex-psychiatric inmates, current psychiatric patients, consumers of mental health services, self-help groups more than mental health professionals all tend to emphasize the significance of personal experience grounded in everyday life or what we might call-- authenticity. Their concerns are shaped by context, by the concrete circumstances which face most users of mental health services where basic needs comprise the things which most of us take for granted-- a job and an adequate income, quality housing, community integration and interdependence, family, friends, a social support network, and choice.

**Intra-Psychic Focus vs. Real-life Issues**

Clark et al. (1993), in an article where they review and discuss the limitations of traditional methods of collecting client
satisfaction information and the lack of new methods, propose the active involvement of clients in programme evaluation and research for occupational therapy. They point to Estroff's (1991) ethnographic research which reveals that clients and professionals have very different perceptions of client needs. She found that unlike professionals who tend to focus on management of illness, clients are concerned with everyday real-life issues such as, sexuality, happiness, warmth, intimacy and privacy. Her work has been reiterated by Pat Capponi (1990), a client advocate, among others. Research comparing client and clinician perceptions of desired treatment outcome also reveals this divergence. Also cited is a report by Luft et al. (1978) who found that in comparisons between therapist and client perceptions, concurrence was reached on only one of ten symptoms of possible improvement. In addition, a study on barriers to using mental health services by Lynch & Kruzich (1986) discovered that clients focused on financial issues and clinicians on issues of treatment resistance. These studies would also seem to reveal the tendency of clinicians to locate the problems and difficulties of clients within the clients themselves rather than within the environment and thus focus on illness or intra-psychic issues, ignoring or minimizing the objective realities i.e. poverty, marginalization, social isolation, with which clients must struggle.

A split in client writing and professional writing reported by Bacharach (1991), which reveals how clients' concerns are grounded in everyday life as opposed to symptomatology, also cited by Clark et al. (1993). Clients write much about their concerns with stigma, unemployment, and societal attitude. Hope, courage, the need for encouragement and being given a chance, involvement, and overcoming
fear of illness are also strongly emphasized in the consumer literature such as reported by Weitz's (1986) paper on self-help groups discussed previously. Jobs, community integration, need for better housing, and getting an education also emerged as major goals and/or concerns from the open-ended questions of an informal survey conducted by the Occupational Therapy Department at a major metropolitan mental health centre in Canada (personal observation, 1993). While clinicians may tend to minimize these concerns and attribute the problems in living of users of mental health services to intrapsychic, psychosocial, or coping deficiencies (Walsh-Bowers & Nelson, 1994); they emerge loud and clear from the few qualitative research studies which have been done with regard to the perceptions of users of psychiatric services. The following section will outline some of these studies.

What Do Clients Want Help with?: Real-life Issues

In studies employing a qualitative methodology which does not limit participants to forced choice responses or preconceived categories, the concrete objective realities of individuals involved with the mental health system as well as their subjective perceptions come alive; indeed they cannot be suppressed. It is these problems in the social environment that are seen by clients as most disabling.

In such qualitative studies, several themes regarding clients' desire for help with problems in the social environment emerged: poverty, employment, decent housing, social isolation, self-esteem and internalization of the sick role.

In a qualitative study by Lord et al. (1987) in which in-depth interviews were conducted with 16 current and former patients with chronic mental disabilities in four Canadian provinces (two in the
East and two in the West) -- unemployment, housing, poverty, and powerlessness were major issues and stigma, social isolation, identity and self-esteem were themes which cut across categories or were interwoven between categories. These were also themes in another qualitative study by Herman & Smith (1989) in which 139 formerly institutionalized patients living in various areas of Eastern Canada were interviewed and in an ethnographic study by Herman (1985) in which she interviewed 285 ex-psychiatric patients from Southern Ontario, Canada over a three-year period. In addition, in a Canadian Mental Health Association project, part of which comprised a qualitative study based on interviews with users of mental health services across Canada (Hutchinson et al., 1985) as well as other documents which outline a community support system model (Pape, 1987; Trainor & Church, 1984), revealed that the concrete, daily realities of impoverished living were paramount for people with mental health problems. It is these problems which individuals involved with psychiatric services see as disabling and impediments to quality of life. Patricia Deegan (1990), a clinician and former psychiatric patient, succinctly and powerfully explains:

...whereas clinicians usually insist the disability resides 'within us', we understand that what is truly disabling to us are the barriers in our environment preventing us from living out the full range of our human interests and gifts and preventing us from living, loving, worshipping, and working in the community of our choice. What is truly disabling to us is stigma which, though rampant in the general population, is also widespread in the helping professions...In addition to stigma, we find discrimination in employment, housing, and education are disabling. Poverty, oppression, segregation and unemployment are conditions we find disabling. Staff attitudes characterized by low expectations, prophecies, and prognoses of doom as well as policies, procedures and practices which teach us to be passive, helpless, dependent and irresponsible are also disabling to us. (p. 309-310)
Deegan points out how helping professionals, in addition to minimizing environmental obstacles for clients, also minimize the harmful affects of psychiatric interventions and practices such as the tendency to underestimate the potential of clients and to diminish hope. The tendency of clinicians to de-emphasize hope is very curious, indeed. As the studies by Webster and Schwartzberg (1992) and Wollert (1986) have shown--instilling hope is not only considered therapeutic by clients and self-help group members, but has been long established as a therapeutic factor in the psychotherapy literature--most mental health workers should be well aware of this factor. In fact, consistent with an empowerment ideology, instilling hope is a pivotal aspect of many self-help groups (Chamberlin, 1978; Weitz, 1987). Other researchers and clinicians have recognized the tendency of mental health workers to minimize the negative and “iatrogenic” effects of their diagnostic and treatment practices (Walsh-Bowers & Nelson, 1994). In addition, there is increasing evidence of the failure of service providers to identify and respond properly to the sexual and physical abuse so prevalent in the psychiatric population (Walsh-Bowers & Nelson, 1994).

**Poverty**

Poverty and unemployment are facts of life for people who have received psychiatric treatment. Most ex-patients are forced to depend on disability pensions or social welfare benefits which provide only a subsistence-level income (Walsh-Bowers & Nelson, 1994). From my experience working in the mental health field and in psychiatric institutions, I have noted, as Walsh-Bowers and Nelson (1994) report, that ex-patients do not have an adequate income to meet even the most basic necessities of life (food, clothing, and
shelter). For them, luxuries such as having a car, pursuing leisure activities, taking a vacation are out of the realm of possibility. In the Herman and Smith (1989) study, 93% of the ex-patients listed poverty as a problem. But this is also the case for institutionalized patients, while food and shelter are provided by the institution, many patients do not receive enough income to allow them to purchase daily items such as a coffee or snack let alone decent clothing. A memory of working at one psychiatric institution elucidates the desperate financial situation of many patients: a common sight in corridors, lobbies, or the cafeteria would be patients checking the coin return of pay telephones and vending machines for loose change. This became such a habit for one of the clients I worked with--she could not pass by a telephone or vending machine without checking the coin returns.

Poverty can lead persons to take desperate measures in order to survive. Herman and Smith (1989) quote how one woman was forced to resort to prostitution.

You know, it's hard to make ends meet on a disability pension. The boarding home takes most of it and I'm only left with thirty bucks for the whole month—that's not enough to keep me in smokes. And a woman needs to buy certain personal items too. So, I've resorted to turning a few tricks. I'm not a pro, though; I do it with one of the night staff at the home—he pays me five or ten bucks each time; sometimes other guys on the street give me a twenty!

The above woman's situation also points to the reality of sexual exploitation of women patients which The Women and Mental Health Committee (1987) criticizes the mental health establishment for disregarding (Walsh-Bowers & Nelson, 1994).

Housing

"A living situation that feels like a home is often a primary source of stability and security in our lives...most people in the
world today spend a great deal of time selecting their dwelling space, customizing and decorating...Unfortunately, mental health professionals have generally overlooked the importance of these factors for people with psychiatric disabilities" (Carling, 1988, p. 47).

Herman and Smith (1989) found that in addition to poverty, unemployment, stigma, and self-esteem, housing presented major problems for ex-patients. For 89% of the participants in their study, the aftercare homes where they were placed major problems in terms of food, space and general living conditions existed:

At 'St. Ann's things are pretty bad. The sheets are dirty and the whole place smells like a toilet. I've seen roaches walking around too. The food is awful and there's never enough to eat. My dog used to be fed better things than we get. They're dealing with peoples' lives here and they don't even care...I share a room with four other men--they don't like it much neither.

Carling (1988) indicates that many barriers to finding and keeping normal housing (i.e. housing which is available on the open housing market and not affiliated with mental health programs or systems) exist in the environment rather than the individual. Lack of affordable housing is one of the major problems as most people with psychiatric disabilities are poor (Carling, 1988). As in Canada, in many parts of the United States, Carling (1988) states, it has become virtually impossible for people on public assistance to compete in the rental housing market. Moreover, he adds, discrimination is widespread due to public and professional misconceptions and constant misrepresentation in the media.

Most clients prefer to live in an apartment as opposed to structured transitional group homes. However, as with other mental health services, clients have not been offered many real options. As
Carling (1988) points out "...choosing between the state hospital and an available bed in a group home can hardly be considered a choice" (p. 50). He adds: "Yet for people who feel powerless, re-establishing a sense of mastery and control may well be the single most important step toward recovery" (pp. 50-51).

**Employment**

Of all the community needs mentioned by people with chronic mental disabilities, employment was most often and most emphatically noted in the Lord et al. (1987) study. The participants of this study, as with those in the Murphy & Salomone (1983) study, reveal a keen insight into the connection of self-esteem and mental health with work or meaningful activity of some kind: "I'd like to have some sort of schedule every day. Even if I was not making much money, it's just to have something to do. Just something to keep our mind active...or else you go stale" (p. 29). Indeed, the importance of occupation or meaningful activity for one's mental health is an integral concept of occupational therapy (Kielhofner & Burke, 1980). Former patients, Lord et al. (1987) note, recognize that work is part of the pattern of normalization: "Yes, I had to work full time. I always worked. It's my life. In order for me to get back to normal living, I had to get back to an 8:30 to 5:00 day. There was no way I could live a normal life and not get up in the morning to go to work" (p. 30). Despite the overall importance of work, only two people in this study were engaged in full-time, full-paying employment. Similarly, for 78% of the participants in the Herman & Smith (1989) study, securing a "normal job" was impossible. Moreover, it is particularly difficult for individuals who have been institutionalized for a number of years to keep this information confidential as they must explain periods of unemployment to...
potential employers. Once prospective employers are aware of an individual's psychiatric history, this becomes yet another barrier to obtaining full-time employment.

Walsh-Bowers and Nelson (1994) in their explication of an empowerment model to community support assert that to reduce and eliminate the marginalization and oppression of people who have received psychiatric treatment it is fundamental that they have an adequate level of income and/or employment. In fact, clients themselves have identified financial resources, employment resources, and vocational skills as presenting the greatest barriers to community integration (Mallik, Reese, & Dellario, 1998). In a similar vein, Carling (1988) argues that "...until peoples housing needs are met, other treatment or rehabilitation interventions are seriously jeopardized" (p.47). Walsh-Bowers and Nelson (1994) outline three necessary goals for an empowerment model to deal with the problems of poverty and unemployment: 1) increased income, 2) experience of meaningful activity, and 3) integration into normal community work settings.

Poverty and unemployment are also linked to the stigma of mental illness. Herman (1985) found that the stigma of mental illness was a major barrier to employment opportunities and that the few places which would hire ex-psychiatric patients, the sheltered workshops, require "...individuals to perform menial and sometimes degrading tasks for low wages, thereby impeding the rebuilding of a more positive non-deviant self-image" (p.221). The damage of such experiences to the individual’s self-image and the subsequent internalization of the “mental patient identity” is evident in the words of a participant in Herman & Smith’s (1989) study:
When I got out, at first, I tried to find a normal good job that paid decent wages. Anything would do—I wasn’t fussy. But I didn’t have any luck. No one wanted to hire me. I went to Manpower to get help, but that wasn’t no use either. When I went to fill out the application and they found out that I hadn’t worked in eight years because of my problems—that I was hospitalized for mental problems, they just looked at me funny. The girl suggested that I go to ‘Welcome Industries’ where people who have had mental problems can get work...I don’t like it much. I mean, it’s OK doing something with your time, but...I only get paid forty cents an hour. It sure can’t buy you much. I guess that’s all normals are worth! Working there makes me remember what I really am—a mental patient! (p. 390)

**Self-esteem and Internalization of the Sick Role**

"Self-depreciation is another characteristic of the oppressed, which derives from their internalization of the opinion the oppressors hold of them" (Freire, 1968, p.49 cited in Rose & Black, 1986, p.20). Rose and Black (1986) refer to the process of internalization of the sick role as “submergence”. Much has been written about the negative effects of institutionalization and the socialization of people with psychiatric disabilities into a “sick role” (Goffman, 1961; Szasz, 1970; Rosenhan, 1973; Scheff, 1976; Rose & Black, 1986). Individuals are taught that the problem exists within them.

The low self-esteem and internalization of the sick role or “mental patient identity” was a theme, Lord et al. (1987) report, interlaced throughout the interviews. They observed, “...that people may become engulfed in a system that mounts a frightening and powerful assault on their sense of identity” (p.33). The researchers conclude that the people who do rebuild lost dignity and overcome the “self-curtailment” or “mortification”, as Goffman (1961) so aptly termed, of institutionalisation and labelling, have “...jobs, a supportive family or friends—a life and therefore an identity outside of the psychiatric system” (p.33).
The internalization of the sick role and the attack on self-esteem is pervasive among individuals who have been institutionalized as a result of, among other things, the ubiquitous practice of diagnostic labelling. Herman & Smith (1989) found that 97% of the ex-patients interviewed felt that their label of being "mentally ill" represented personal failure to "measure up" to the rest of society. They quote a middle-aged person: "Being diagnosed as a 'manic depressive' or 'chronic schizophrenic' separates you from the rest of society. All of a sudden, you realize that you're not 'normal'. You have somehow failed-in society's eyes and also in your own eyes!" (p.388). The tendency for many individuals to become resigned to mental patienthood and their belief that this is a permanent condition is clearly expressed in the words of a young male who has been institutionalized several times:

After trying to get a job for so long and failing, and after being kicked in the teeth by almost everyone around me, I now realize that I can never change who I am. No one will let me. It seems as though everyone wants 'ex-patients' to remain 'patients'. So, I make it on the outside now by not by trying to change, but by avoiding contact with 'normal' strangers and even 'normal' friends. That way, I don't get hurt!(Herman, 1985; p. 388-389)(emphasis added)

This process of self-curtailment, mortification or internalization of mental patient identity has resulted in what people with disabilities call "spirit breaking" (Deegan, 1990). This term powerfully conveys the "deep sense of apathy, despair, personal worthlessness, and self hatred" (p.310) resulting from the dehumanizing nature of human services which Deegan (1990) explains is more disabling than the mental illness or physical injury/syndrome with which people are diagnosed. She writes: "These wounds 'numb' or at times 'break' our will to live [and] rob us of hope"(p.310).
While most individuals in these studies express the desire for jobs, community integration, and friends for some individuals living in such impoverished conditions in the community, suffering from stigma and social isolation and having the mental patient role embedded so deeply and having lost all confidence, many have given up all hope for attaining such things and resign themselves to a life in the institution. In fact when discharged, these persons will adopt the strategy of malingering or feigning "mental illness" in order to be readmitted. Herman and Smith (1989) report that 62% of the "elderly chronics" and 41% of the "middle-aged chronics" in their study employed this strategy which they refer to as "institutional retreatism". They quote such an individual:

I just can’t stand being out. It’s not for me. I belong in the hospital. It’s safe there. I know what they want from me--what is expected from me and I give it to them. No problem. No one bugs me or makes fun of me. And I get three square meals a day to eat...Last time I wanted to go back, I stopped taking my meds and then I got real sick...The time before that, I got admitted after I set fire to my room at the boarding home--you gotta be sick or at least ‘act sick’ to get back in there [mental institution].

Social Isolation

All those interviewed in the Lord et al. (1987) and the Hutchinson et al. (1985) studies were deeply concerned about having friends and the need for support in adjusting to community life. In spite of the ‘demoralizing’ experiences and powerlessness many individuals suffer in the mental institution, some patients feel ambivalent about leaving for the reasons cited above [poverty, unemployment, poor housing, stigma] and due to the social isolation and loneliness they experience when living outside of the hospital (Lord et al., 1987). As well, the strong attachments and bonds some individuals develop with their mental health workers, in a context
of deprivation of social contact, cause them to become very
dependent on the staff and the institution (Wash-Bowers & Nelson,
1994). As one person interviewed by Hutchinson et al. (1985)
explains: "What I’m really afraid of when I go out (of the hospital)
is the loneliness…it is really hard for me to have to cope for the
first little while to living without other people, and sort of
adjust to being by myself" (p. 27.

Indeed, for individuals who have been institutionalized and
thus segregated from community life for years and years, the notion
of living alone in the community can be terrifying. An older woman
interviewed by Lord et al. (1987) expresses this problem as it
relates to stigmatization:

Anyone who’s been institutionalized for more than two or three
years without having been on the outside for more than long
weekends has got an awful problem on their hands...getting
adjusted again. Some people (in the community) are going to
accept them, some are going to be scared of them, and there
will be some that will never accept them...If you’re no longer
sick, they’re not going to keep you in the hospital. You have
to go to a nursing home or someplace. It’s cheaper to board
them out than keep them in the hospitals. Some people will be
on drugs forever. (pp. 31-32)

Participants in the Herman (1985), Lord et al. (1987), and
Herman and Smith (1989) studies all express the belief that their
"mental illness" is permanent. This is in part a result of the
internalization of the sick role or "mental patient-hood" was also
reinforced by the psychiatric system’s enforcement that many patients
take medications for all their life. These medications, as I have
noted elsewhere, can cause many severe side effects that are often
not only damaging physically but also socially. Lord et al. (1987)
explain:

Also, although some people talked of the help they received
from medication, others noted it plays a role in devaluing
their person-hood. This is because psychoactive drugs alter
the appearance and behaviour of people who then, because they look and act differently, are treated as 'different' by others. Thus, a person's interpersonal and societal difficulties can actually be increased by the use of medication. (p. 31)

Lord et al. (1987) emphasize the importance of understanding the contradictions and dilemmas of hospitalization and medication in order to increase our insight into people's need for acceptance and support.

There has been much research recently, point out Walsh-Bowers and Nelson (1994), which has revealed that, "...social support is either directly related to mental health or that support serves the important function of protecting individuals from stressful life events" (p. 12). People who have been involved with the mental health system are only too aware of this. They know how important friends, support, and reassurance are for a healthy self-image and self-esteem. One woman from the Lord et al. (1987) study stated: "I mean, you need someone to believe in you cause you don't believe in yourself" (p.32). They quote a former patient who emphasized that friends and support as well as help one believe in oneself, can help prevent hospitalization: "In my new home, I felt that for the first time, I discovered myself on my own, without drugs...Finding myself meant I didn't have to return to hospital" (p.32).

In fact, emotional support, validation, camaraderie, and sense of belonging or solidarity are cited by members to be very important functions of self-help groups (Weitz, 1984).

**Summary**

This chapter has surveyed the literature regarding patient/client and therapist perceptions of mental health care.
Hope, choice, self-esteem, creativity/fun, relaxation/diversion, reciprocal supportive relationships, and the need for a sense of belonging and cohesion were some of the themes which were identified by clients as highly valued in groups and/or mental health care in general. Moreover, the meaning clients place on activity/programs is shaped by context and tends to be naturalistic or rooted in everyday life experiences.

We have seen that there exists some divergence between what therapists and clients perceive to be the things with which clients need or want help. Clients tend to be concerned with the concrete difficulties, such as poverty and stigma, that they must face in daily life whereas therapists tend to locate problems within the individual and overlook or minimize the environmental barriers to well-being. An institutional-disease model of helping has encouraged this tendency among professionals as well as the tendency to dominate the helping relationship resulting in a unidirectional relationship and lack of power and choice for clients to make important life decisions as fundamental as choosing a place to live.

In addition, while most individuals in the above studies expressed the desire for jobs, community integration, friends, and so on, many have given up all hope for attaining these things and resign themselves to a life within the psychiatric system due to internalization of the sick role, marginalization in the community, stigma and social isolation.

To reiterate, the purpose of the study is to look at...[bridge between what have talked about I have identified a number of factors clients find helpful and will show in the results
As I am interested in meaning from the participant’s perspective and want to give the participants a voice, I have chosen to frame questions not by operationalizing variables but rather by dealing with complexity, in context, in order to find out what the participants’ lives, experiences, and interactions with regard to occupational therapy mean to them. Thus I have utilized the Interview Guide Approach (Patton, 1980) (Appendix 2) which allows the researcher to explore in an in-depth manner the unique experience of the participant and using a guide of open-ended questions ensures some uniformity among interviewees. With this approach, the participants have the freedom to take the topic and develop it providing a new direction and allowing the interview to change course and the interviewer to explore unexpected topics/themes.

Open-ended interviewing is typically as close to a natural process as possible. There is more freedom in the type of questions, in the wording of the questions, and in the choice of setting all of which adds to the naturalness (Books, 1997) as well as being more consistent with an empowerment approach.

The Interview Guide Approach is more compatible with the theory of empowerment, which provides the theoretical foundation for the current study, as it treats the participant as subject not object as does the experimental method. Due to the objectification of the participant with quantitative methodologies, Yerxa (1991) rejects them and proposes that qualitative research approaches have
a "goodness of fit" with finding out what is relevant for occupational therapists from research in occupational therapy:

Experimental, positivistic methods do not seem to fit the specifications for the knowledge necessary to support the practice of occupational therapy... The experimental method requires a controlled research milieu that must ignore or manipulate the environment, often decontextualizing the experimental subject. Even when the environment is included as a variable, it is reduced to causal variables. It is therefore not a real environment (p.201).

Since the current research study aims to increase understanding of the subjective experience of clients and therapists with regard to occupational therapy services within the context of institutional psychiatry, qualitative methodology is more suitable than quantitative. Moreover, implicit in an empowerment ideology, is the critical inquiry of an individual's objective social/cultural/economic/political context. Thus, for this research, a methodology that would not inhibit contextual factors to emerge was critical.

Problems of Methods in Previous Research

Most research regarding client perceptions of psychiatric services focuses on evaluating existing psychiatric services and predominantly utilizes a quantitative methodology. (Clark et al., 1993). This involves staff administering questionnaires developed by staff. However, many researchers (Schwartzberg, 1982; Herman, 1985; Lord et al., 1987; Elbeck & Fecteau, 1990; and Clark et al., 1993) question the validity of this method of collecting information for several reasons. The main problem with this approach is that there is an inherent assumption that the current model of service delivery is sufficient; questionnaires or surveys contain questions about current services and programs. Further, quantitative methodologies are limited by the researcher’s own frames of reference,
conceptions, and experiences. For example most of the questions are closed-ended and have set responses which are created by the researchers and thus can only discover that about which the researchers already have preconceived ideas. So there is no room for the possibility of responses of which the researchers have not thought or conceived. Moreover, most researchers have not been on the user end of psychiatric services and thus are limited by their professional perspective. The vast and variable array of experiences, feelings, emotions, and opinions—complex and complicated cannot even be touched upon with this method.

Lord et al. (1987) also criticize traditional methods of needs assessment for relying primarily on incidence and prevalence rates in a particular locality and assuming that incidence of a particular disability translates into required services. Another problem with survey research, particularly when administered by treatment providers who have the power to give or withhold care, is a high potential for social-psychological artifacts which often lead to elevated reports of patient satisfaction (Pascoe, 1983).

The Setting

The setting for the study was a large metropolitan psychiatric hospital where I had been working for over two years as a part-time employee in the occupational therapy department. Thus, obtaining access to the centre for my research was expedient. In fact, as staff of the department were familiar with me I believe they expressed their opinions, perceptions, and feelings quite openly and freely. The fact that I was a part-time employee and a student with temporary status may also have contributed to staff's openness. Similarly, two of the clients had participated in a centralized social skills group for which I was the co-facilitator and thus
rapport had already been established. With the other clients who
did not have prior contact with me, I participated in their various
occupational groups and activities to allow for prolonged engagement
(Lincoln & Guba, 1985), an important strategy for establishing
credibility in qualitative research by enabling the researcher to
check perspectives, identify recurring patterns and increase
informants' trust. These activities included participating in
cooking groups, community meetings, and recreational activities such
as bowling. At the same time, however, the fact that I was a part-
time employee of the centre during part of this research, may have
caused participants to be less open than they might have been were I
not associated with the centre in any respect.

Participants

The data for this investigation was obtained through tape-
recorded interviews of six Occupational Therapists and two of each
therapist's clients who agreed to volunteer for the study.
Therapists were asked to submit a list of clients on their current
caseload with whom they had the most contact. The rationale for this
was to ensure that clients will have had sufficient experience with
the occupational therapy services with which to make an informed
opinion. From the lists submitted by therapists, client informants
were randomly selected by drawing names from a hat and then
approached individually to seek permission. Therapist informants
were similarly randomly selected among all therapist names from the
Occupational Therapy department. The clients, who met the selection
criteria outlined below, a total of 12, were approached individually
and asked if they would like to volunteer for the study. Of the 12
clients interviewed, four were outpatients. Therapist informants
were also approached individually. One therapist refused to
participate and thus another name was randomly selected. Informed consent was obtained in writing from all patient participants through a consent form (Appendix 1).

Exclusionary criteria for the client participants are as follows: a) individuals who were assessed as actively psychotic by a member of the multidisciplinary treatment team who has had contact with the client on the day of the interview. The reason for this is that a psychotic episode may make it difficult for individuals to listen, attend, and answer questions for one to two hours. Inclusionary criteria for client participants are as follows: a) fluency in the English language, b) regular contact with therapists, and c) capacity to attend and answer questions for approximately one to two hours.

One client’s tape-recorded interview was inadvertently erased by the researcher thus another client’s name was drawn from a hat (from the list previously submitted by the therapist) and this client was approached and asked permission to be interviewed. In addition, as one therapist who was interviewed left the centre before I interviewed this therapist’s clients I needed to interview another therapist and again using the same procedure for random selection chose a new therapist along with two of that therapist’s clients.

Procedure

Interviews

Individual interviews were completed with all participants and tape-recorded using a mini-cassette tape recorder. While participants readily allowed the researcher to record their interviews and had consented to same in writing on the consent form, a mini-cassette recorder was used to reduce the possibility of distraction of
participants. The format of the interviews was semi-structured utilizing the Interview Guide Approach (Patton, 1980). A series of lead questions (see Appendices 2 and 3) were uniformly asked of all participants but specific follow-up questions relevant to a particular person or issue were raised. The interview schedule was developed with the view to explore the groups and activities that clients participated in with their therapists in OT. Participants were also asked about what information they gave/received about these groups, the goals and purpose of the various groups which they attended, their affective reactions to them, what they would like to change. I also asked clients how they decided which groups to attend; and therapists how they decided which groups their clients should attend. This was to determine the nature of collaboration of the client-therapist relationship. I also asked about information given/received regarding groups to again explore collaboration between therapist and client. In addition, they were asked what they thought was the OT's role/job and how much time they spent individually with their therapists and the content of this contact. They were asked about their perceptions of qualities of a good OT, best ways to help, and goal-setting with their OT/client. Questions regarding OT role were asked to examine the extent of client's knowledge of their OT treatment in order to explore the collaborative nature of the client-therapist relationship. Goal-setting was explored for the same reason. Interviews ranged from two to four hours with each individual. When interviews exceeded two hours they were continued on another day convenient for participants. Interviews with therapists were conducted in their individual offices. Some clients were interviewed in the
researcher's office and others in a private lounge on their ward at the Centre.

Interestingly, three therapists asked to obtain copies of their interview transcripts as during the interviews through reflection and discussion of their activities they had thought of new ideas and approaches to try with regard to various groups as well as solutions to problems. Half of the therapists said that as they spoke during the interview it was the first time they had actually clarified the goals and objectives of some of their groups as they had been too busy to sit down and mentally analyze them.

**Focus Groups**

Two focus groups were facilitated. One was comprised of the occupational therapist participants and the other the client participants. The purpose of these groups was to explore participants' reactions to a summary of the data from the individual interviews and learn from the process of group reflection and discussion.

The focus groups were tape-recorded and both groups were held in a music therapy room at the Centre which was comfortable and spacious. One of the advantages of focus groups is that they offer the opportunity to observe participants engaging in interactions concentrated on attitudes and experiences which are of interest to the researcher (Morgan & Spanish, 1984); in this case the experience of helping in psychiatric occupational services. In addition, the process of group discussion often generates new ideas on the part of the participants (Morgan & Spanish, 1984). Furthermore, the focus groups also served as a debriefing for participants of the emerging concepts in the data and provided an opportunity for participants to
exchange ideas/reactions on evolving concepts and themes in the data with each other and the researcher.

**Data Analysis**

The data analysis procedures conformed to accepted procedures of analyzing qualitative data (Bogdan & Biklen, 1982) and adopted the constant comparative method (Glaser & Strauss, 1967). With the constant comparative method there is an exploration of key issues, recurrent events, or activities in the data which become categories of focus. These categories of focus are determined through a line-by-line analysis of transcriptions of the tape recordings which were completed by the researcher. Notations were made on cards as to the location of the statements in the transcripts. Once transcript themes were identified, they were cut out and placed in envelopes according to categories. The data was reviewed several times until no new categories emerged. General themes were developed by combining one or more of the categories.

In order to maintain confidentiality and anonymity, participants' names were deleted from the interview transcripts and were replaced by codes known only to the researcher. In addition, any identifying characteristics were obscured. Pseudonyms have been used when reporting the data in the results sections.

Participants received a summary of the research results upon request. In addition, I also conducted a presentation of interim results for the Occupational Therapy Department and submitted two written interim progress reports to the OT Department.
In this section, I will report on the participants’ perceptions of goal-setting and individual therapist-client contact. In occupational therapy, goal-setting is the process whereby the client and therapist together plan specific long-term and short-term goals for the client based on the client’s needs, values, roles, interests, and aspirations. The Guidelines for the Client-Centred Practice of Occupational Therapy, prepared by the Canadian Association of Occupational Therapists, the Health Services Directorate, and the Health Services and Promotion Branch (1985), specify that therapist and client should collaboratively decide upon goals for treatment usually at the initial interview or within the first few meetings. Goal-setting is increasingly being emphasized as a critical component of mental health care delivery due to the shift from traditional models of helping to empowerment models which stress collaboration between client and therapist.

I will be examining the perceptions of helping by looking at the important area of goal-setting. The results will be organized under the following categories: 1) Perceptions of helping, 2) Perceptions of what would be more helpful, and 3) Barriers to helping

**Perceptions of Helping**

**Supportive Counselling/therapeutic Relationship**

Whether or not clients report feeling psychologically ready to engage in goal-setting with their therapists, what they typically do identify as being most helpful is the opportunity for a supportive relationship in which another person listens, attends, empathizes, discloses, and provides positive support. So while most clients say
they do not feel ready to make specific goals, they do indicate that they find it helpful to talk and to ventilate. This need was particularly obvious to me during the interviews. Clients particularly seemed to enjoy the undivided attention they received during the interview process. In fact, some clients started to express personal problems which either they wanted concrete assistance (such as getting out of the hospital) or emotional support. Indeed, clients have been expressing the need for some very important factors fundamental to the goal-setting process. For example, several clients stress the importance of their therapist, as in the words of one client: "sharing, letting people realize their humanness [disclosing]." Of course, this is important of any therapeutic relationship as it helps to, among other things, establish trust and rapport. However, it is of particular importance with psychiatric clients who experience an extreme hierarchical barrier between themselves and their therapists; self-disclosure of the therapist helps to diminish this barrier.

Listening. Moreover, "listening" was identified by both the therapist and client groups as one of the most important helping characteristics of an OT. As Esther reports: "being able to talk with [the therapist]" and having someone listen to her was one of the things she found most helpful. Other clients also emphasize the importance of sharing their problems with their therapist. Interestingly, it is these kinds of interactions which are fundamental to the goal-setting process. As Ken reiterates: "Well it eases your mind a bit when you've got somebody else you can share your problems with. I find the clients aren't very good at that. Like being able to show empathy or something to somebody else...the OT's are better able to."
The role of friend was also particularly important to clients and more often than the OT’s this was identified by clients as a part of the OT role. For example, when asked what he sees as his OT’s role Ken replies, “Ya, I think they’re also our, I would say they’re also our friends even though it’s a professional relationship, it provides us with a friend that can help us.”

However, almost all the therapists talked about finding the informal interactions with their clients the most rewarding aspect of their work. However, they did express some ambivalence about “being friends” with their clients due to professional boundaries. On the one hand, they felt as if their relationship with some clients resembled a “friendship” which they found satisfying but on the other hand, they felt this was unprofessional due to their training.

Therapists’ Perceptions of their Role in Goal-setting

Most therapists feel that their role in goal-setting is as a facilitator in helping clients define goals, establish time frames, and determine what steps are required to reach those goals. Some therapists indicate that they think the most important aspect of the goal-setting process is helping the client to break down the goal into steps and to rank steps according to importance.

Many therapists feel that one of the major difficulties with goal-setting is that clients cannot identify their own personal needs, interests, or problems and so they believe a fundamental part of their role is to help clients with this process. Ted explains the problem:

I try to give them a broad spectrum of choices or potential goals that they might want to achieve [because] often you’re dealing with people who simply can’t identify their own
personal needs or their interests or their problems...They're not used to talking about what they like or what they want so I have to present them with a range of choices and then slowly help them get used to making choices.

Almost all of the therapists identified one of the major barriers to the goal-setting process to be the sick-role identity prevalent among clients. Ted describes his clients as believing, "...Well, I'm sick so I can't do that." Consequently he feels his prime objective to help clients with setting goals is: "...trying to get them out of that sick-role."

**Perceptions of What Would Be More Helpful**

Due to such overpowering feelings of uncertainty and hopelessness, clients express feelings of anxiety and fear when talking about goal-setting. However, after spending as many as 7 hours or more with client informants, which included both interviewing and participating in a variety of activities with clients to allow for prolonged engagement (Lincoln & Guba, 1985), and framing questions differently, eventually many do express their values, wants, needs and goals. Prolonged engagement is an important strategy for establishing credibility in qualitative research by enabling the researcher to check perspectives, identify recurring patterns and increase informants' trust.

**"Just a Few Waitresses and a Guy Named Max"-- Social Isolation**

Social contact was particularly important to all the clients in the study, who in a context of marginalization, disenfranchisement, and utter social isolation are deprived of these-- things which many of us take for granted. The words of John, when responding to my question of what kinds of things he feels he needs help with, underline the isolation, marginalization and loneliness of clients.
Uh, it’s hard to explain that; if I could find the words...To be, to have some kind of, some kind of comradeship or fellowship with the rest of the people in the world or everybody in the world, or a few people like you or that I know. Have more fellowship, know them better. I think that’s what I meant... Uhm, more personal connections. I had it with...but then I don’t know anybody, just a few waitresses and a guy named Max.

All clients speak about the need for social contact and some outpatients report that sometimes their OT and/or other mental health workers are the only contact they may have had for weeks. Paul expresses how the sometimes the importance of social contact surpasses the significance of the content of a group: “I think sometimes patients need a push to get up. Like going to groups, it’s, sometimes the topic that they talk about is not important, but just the fact that you’re around people—that’s important, just being around people.”

**Community Integration and Establishing Relationships**

Many clients when talking about the desire to meet people in the community express feelings of intense isolation, fear of rejection and alienation due to the stigma of being labelled mentally ill. For example, Ken says he would like help with:

“Meeting other people—in the community. It’s hard to meet people. It’s like we’re floating on the edge of society.”

In this study, as we saw in the qualitative studies of Hutchinson et al. (1985), Lord et al. (1987), and Smith and Herman (1989), the themes of low self-esteem and identity are interwoven between categories. Ken speaks of his low self-esteem and how it inhibits socialization with others consequently leading to isolation:

One thing would be to try to meet some people. Most people have some type of network if...it’s almost a support system. I don’t feel right now I have that. That would be one thing. I guess
that's a little tied up with how you feel about yourself. How you present yourself to another person. You know it's harder if you don't feel good about yourself sort of thing...[so you are] isolated.

Clients also reveal insight in identifying the connection between their social isolation and such symptomatology as depression, paranoia and hallucinations. Nick explains: "...I used to-I'd sit for hours at home and say nothing, too much time with my own persona. That's another thing that I found activated the paranoia-- the isolation." Lew, also adds that the diversional aspect of OT, providing structure and a place to go is what he finds helpful/therapeutic: "...go somewhere, it's better than just sitting at home or sitting around and thinking thoughts of depression and anxiety...if you have something to do it keeps your mind busy on something else."

Over half of the clients express the desire for a partner or a family of their own but due to their mental patient identity they see this as unattainable. For example Lew says, "...Been a while since I had a girlfriend...It doesn't matter really because I'm sick, they said I've gotta get well before I can do most things." He later adds that he would like "...meeting, to talk to a female and [establish] a female-male relationship, you know, someone to exchange a few words to make you feel better sometimes, you know what I mean." While he has the need for a relationship, Lew, as did some other clients, expresses reservations about establishing relationships with other patients:

When I have cigarettes I just go all over the place and ask all the girls if they'd like a cigarette (laughs) they think I'm crazy or something but I just, you know, I offer them a cigarette just to strike up a conversation or something, you know. Ya, it's tough some of the times, you know, some of them
are in a bit of trouble themselves sometimes you know so you got to be careful with who you talk to, you know.

**Self-esteem, Competence and Control**

Many clients, when asked how they would like their OT to help, report that they want to “feel better”. What clients say this means is that they want: (1) to feel better about themselves in terms of self-confidence and self-esteem: “I have to feel more confident, more peaceful in myself.” “[The OT] should help them [clients] feel more secure and accepting of themselves.” (2) to feel better about their future in terms of acquiring a more positive, “optimistic outlook”: “...trying to be more optimistic...I seem to have a negative outlook on life; it’s hard to be positive. I don’t think you can do much when you’re in a negative state of mind.” (3) to feel in control as so many clients appear to be overwhelmed by feelings of powerlessness and helplessness: “To be in control of my presence, my being.” ‘...reassurance that you’ll be able to handle problems.”

**Poverty**

Poverty is another problem with which clients report wanting more help. Many clients when asked about their needs or problem areas speak of their poor quality of life, very poor living conditions, and isolation due to living in poverty. For example, when asked what kinds of things he feels are his needs or problems, Ken replies: “...living in poverty is a problem by itself.” John replies to the same question: “My worst problem is the-- economic, the budgeting, that’s my worst problem.”

When asking Lew about how a money management group helps, he replied; “Ya, but would you go?--You see these shoes, these are the only shoes I own and it’s going to be time, I’m going to have to go
to the market again to get a new pair of shoes, you know, cause these are the only shoes I have." Many clients say that because they have such little money a money management group is irrelevant—they just don’t have enough money on which to survive let alone budget.

**Employment/Vocation**

Some clients also talk about the need for employment in order to increase their quality of life and decrease their isolation as with Lew: "...I’d like a part-time job, that’d keep me clear, you know. Like I won’t sit around in the coffee shop all day, nursing one cup of coffee and then again, [because] when you can’t afford it, you got nowhere else to go. And I have to stay home and watch TV all day, you know."

Most clients in this study also connected having a job to self-esteem and a sense of self-worth. John points out that not being financially independent is demoralizing: "I feel inferior to most people. I feel less than. I’d feel better about myself if I worked for my own money, support myself instead of getting money from the government."

Lew, John, Ken, and Paul also talk about wanting to take courses or some kind of vocational training which they see as necessary for securing employment.

**Easy Access to Information—Promoting Independence**

Julianna expresses the importance of access to information about available programs, groups, and housing options. For example, when asked what changes she would make in a particular OT group if she had the power, she replied that clients should have access to comprehensive information at their fingertips, possibly in the form of a manual, regarding all the various kinds of available housing and resources. She explains: "...you know, if we had a better idea
of what to choose from, that would make us more autonomous." and
"...you see it's second nature to a social worker to do this [choose
housing], she's got her book in front of her, but what do we have
like that? So any time we want something we have to go to the social
worker..."

**Need a Push/Encouragement**

Some clients have said that because they have such
overwhelming feelings of hopelessness and uncertainty they lack the
desire to do anything or to attempt to achieve anything and
consequently one of the things they would find helpful from their
therapists is what several clients refer to as "push" to take steps
to achieve their goals and/or to maintain a certain activity level.
A few clients also mention that due to the medication side effects
of lethargy or drowsiness they even have difficulty getting out of
bed. Paul explains that this desire for external prodding,
encouragement and reassurance is due to feelings of hopelessness and
uncertainty:

> It's like when you get sick you really don't care about the
> community or this or that. You just, you don't want to do
> anything...cause you gotten sick and you went through that
> hell and you don't think there's anything out there for you
> anyway so you don't want to take that step. That's why there
> should be somebody willing to push you, to give you that extra
> push. Just to say,'It will be alright.'

Julianna, also points to the importance of the OT pushing the client
a little when asked what qualities a good OT should have:

> J: She must be compassionate, forbearing and patient...I'll
> put patient at number four because the thing is you have to be
> patient, but the thing is like sometimes you have to overlook
> that a person doesn't want to do something but it's for them
> to do it now. He has to be pushed a little bit so patience
doesn't always work out there. Sometimes you have to push them
a little bit.
Q: So you don’t mind when you’re pushed a little bit, you find it helpful?
J: Ya, ya, I think everybody does. We wouldn’t be here unless we didn’t have to go and do all these things ourselves.

This expressed need for a “push” is also reflected in clients’ views on who should have the majority of input into the goal-setting process. Many clients, contrary to their therapists who in theory advocate collaboration with clients having the majority of decision-making power, feel that their therapists should have the most input.

**Barriers to Helping**

**Conceptualization of Goal-setting--Clients**

Three clients mentioned that they do goal-setting with staff from other disciplines as opposed to OT, such as a social worker, primary worker (nurse or community worker, for example), or psychiatrist. For example, when John was asked if he made any kind of short-term plans with his therapist, he replied:

> Just my psychiatrist, we discussed [a vocational-training program] in the spring. I don’t discuss that thing with [my OT]. I discuss that with [my psychiatrist]. He knows me, knows my whole history and has the [files] over there. He knows me from the first breakdown to the last one.

This quote also suggests that it is important to John that the person with whom he makes plans and goals is someone who knows him very well, is familiar with his history, and understands him.

It may be that clients are defining goal-setting differently from their therapists. Clients tend not to see goal-setting as a process. For example, many clients seem to conceptualize goal-setting either as deciding on a long-term goal, such as choosing a career, without acknowledging all the small steps that are involved in reaching such a goal or as planning for obtaining practical things such as money, accommodation, or medication without a long-
range view. Therefore, perhaps the three aforementioned clients identify these things with the corresponding disciplines of community support, social work, or psychiatry as opposed to Occupational Therapy.

Their therapists, however, conceptualize goalsetting as a process of first identifying values, roles, and interests and then setting specific goals that will enable the client to fulfil these things. If, for example, after determining that a particular client values the role of partner and wants to establish a sexual relationship, the therapist would then attempt to design a series of steps, with the client, which would achieve this goal. One of these steps, for example, might be as simple and immediate as brushing one’s teeth every day to improve one’s physical appearance or it could be more long-term such as learning a specific interpersonal skill through joining a social club, attending a social skills group, and/or attending an assertiveness training group.

"I Can’t Plan My Life"—Hopelessness and Uncertainty

Half of the clients indicated that they do not feel psychologically “ready” to make any goals. For example John remarks, “No, no, I’m not in that state. I’m not ready for that. Cause I do one day at a time”. Most clients report that they do not think in terms of the future; that they are not “forward-looking” and thus this present-orientation may help to explain why clients do not view goal-setting as a process.

This present orientation seems to be related to the internalization of a “mental patient” or “sick-role” identity that results in feelings of powerlessness and hopelessness in clients. Thus the concept of actually setting goals is too threatening for individuals who feel they have no power or control over their own
lives. For example, another client, Ken, when asked if he would like to sit down with his OT to discuss the skills/problems with which he would like help and make a plan to learn a particular skill which would meet a particular goal, explains: "I don't know if I can. My goal is to stay in the community. And if you're struggling from one day to the next, it's hard to envision long-term goals."

This lack of a future orientation or hope makes the process of planning specific steps to achieve short-term and long-term goals related to their values, roles, beliefs, and desires, irrelevant. So that if clients are conceptualizing goal-setting as immediate and do not acknowledge the relevance of small steps involved in a process of goal-setting it is no wonder that they express feelings of apprehension and anxiety when discussing it. However, more importantly, the way clients perceive themselves and the way they perceive the goal-setting process combine to make establishing goals a very overwhelming and terrifying prospect. For example, when asked how he felt about planning specific steps to achieve short-term goals, Ken replied:

Maybe that, maybe that. But I think the short-term goals are kind of getting better, getting to feel better, and able to cope in the community a bit better...And I can't say that I'm going to become a great physicist or something and plan out a route because I'm not feeling well enough to do that or thinking about that...I guess it's maybe setting attainable goals...compared to an overall life plan...I can't plan my life because I don't know how I'm going to be feeling tomorrow, next year, or what the conditions are going to be like, you know. So it's pretty hard to accomplish anything. So I don't think about it, you know.

The above quote reveals the utter hopelessness and uncertainty expressed by most of the clients with regard to thinking about the future. Almost all of the clients interviewed expressed a lack of confidence and uncertainty about the future, which was related to
their status of "mental patient". Ken's comments about the usefulness of the community meeting, a group in which time management is one of the foci underline these feelings:

I think when you set goals, if you got no goals you don't need a time management thing cause you're not looking towards anything. Specific problems are related to having a mental illness and not being able to see anything in the future other than just coming here everyday and surviving, you know. You don't feel confident enough to do anything.

We can really sense Ken's feelings of hopelessness and powerlessness. He can't imagine the possibility of change. So the connection between the goal (which in this case is a desire to feel better and to stay in the community) and the behaviour (i.e. designing steps to achieve this desire, making plans, structuring his time,) seems to be severed by a mental patient identity which creates a prevailing sense of impotence.

Interestingly, it is the tendency of clients to remain fixed in the present that therapists find perplexing. Adrienne expresses her frustration with this tendency:

I get the impression that they are only motivated to do things where they get an immediate reward. They often seem to have difficulty to focus on things which are future oriented. They seem to prefer activities...they do right here now, without any kind of planning for the future. I think at times it's rather frustrating. Because I feel that both things are very important.

It would seem that the reason clients may desire mainly those activities in which there is an immediate benefit is because, as stated earlier, often they do not believe it is possible to take steps to achieve their goals. They lack the confidence required to take risks and they lack the belief that attainment of what they value is possible. In essence then, they tend to repress their
needs, wants, and desires as a sort of learned helplessness response.

This tendency is clearly revealed from the following remarks of Ken after defining goal-setting to him: "You gotta want something though. You gotta have the presence of mind to be able to, have enough self-esteem and confidence to say, 'I want something.' and then go after it and I don't think the clients here have that." If every day is a struggle for clients and they have little hope for their future, understandably then, the connection between actively planning and taking steps towards goals and attaining them, appears less salient. Many clients seemed to repress goals or aspirations. As Ken explains: "So, I don't think about it, you know." Over half of the clients repeatedly emphasized the belief that because they have a mental illness they will never be capable of achieving anything. Unfortunately, this belief is prevalent among psychiatric clients and is one that was reiterated by many of the clients I interviewed. For example, Nick says, "I still think of myself in a half-centred way as being a psychiatric patient, this is the way I will be..." and later, "If I could change something I would be more productive in society. But I'm not going to reach for these goals that might never be achievable or attainable."

**Lack of Time**

Most clients report that they are not doing formal goal-setting with their therapists on a regular basis. Esther describes her therapist as: "an exceptionally busy man" when indicating that they have had only a "few occasions" to talk one-to-one. Nick, perhaps protective of his therapist, explains: "Well, he usually finds a few moments to talk to me on the side and when you mathematically add it up, it all comes down to a few good hours."
Later, when asked about making a specific plan with his OT, he remarks: "...I know [my OT] has very little time to spare..."

Esther, too, explains about the lack of time for individual contact with her therapist, "Well, the people here are kinda busy, you know, they’re working pretty hard here."

In addition to a general perception that there is a lack of time for individual contact, a few clients report that when they do have private meetings with their therapist, the discussion focuses on the present programs in which clients are involved within the hospital. Paul explains: "We were just talking about the programs in the hospital, the programs that I’m involved in, in the hospital. We haven’t made any future plans."

Perhaps due to a shortage of time and to the group nature of many activities, some therapists said that they do not always specifically indicate to clients that what they are doing is, in fact, goal-setting. They indicate that sometimes they make plans with clients informally and not always on a one-to-one basis so that the client may be unaware that the therapist is trying to establish goals or plans. Another therapist said that she had made goals for some of her clients but did not share those goals with them.

However, out of all the therapists, only Naomi, said that setting goals with clients was "very rare". However, all of the therapists except Naomi, indicated that they would like to be doing more goal-setting with their clients than they are actually doing. They point to a lack of time and an emphasis on group work as primary barriers to goal-setting. Some therapists feel that they could help their clients if they had more time to work with clients individually. Ted explains:
It really comes down to a lot more time to be able to spend individually. I think right at this time I'm involved in about 10 hours of group during the week and I think they [clients] are also involved in other groups so I mean they get a lot of group work but I think there's a lot of things that can't be addressed or can't be done in groups.

Adrienne, who also feels there are enough groups but not enough time for individual contact, points to the heavy caseload of an OT as a barrier to helping:

I feel it's [one-to-one contact] never really enough. There are groups, where one-to-one is never really enough...Because there's only one OT to one unit for 33 patients and they seem to have a lot of different needs and there never seems to be enough time.

And Charles indicates that: "...there has to be a set, a distinct time, set aside to sit with a client, look over their goals, what they'd like to work on, what you're capable of helping them with. I don't think that's always done due to the time constraints."

Most therapists said that they don't do goal-setting with all of their clients basically because it is a very time-intensive process and they simply do not have sufficient time available to work with all their clients in this way. Charles acknowledges this lack of time for work with his own clients as well: "But I would have to admit I would like to do more of that [goal-setting]...it's very challenging and very time-consuming."

In addition, therapists say that many times it depends on which worker has the best rapport with the client. And as goal-setting is a long and intensive process this means that therapists do goal-setting only with those clients with whom they work intensively and on a long-term basis. Due to the lack of time available most therapists report that they can work intensively with maybe only one or two clients at most.
All of the therapists I interviewed agreed that the goals should be "client-driven" and that the process should be a collaborative one. Most therapists said that the client should have the majority of input in the goal-setting process whereas therapists' input should be primarily for assistance in identifying values, setting time-frames, and breaking goals down into steps.

They also agreed that goal-setting is an in-depth process which involves first of all establishing a relationship with the clients and "spending alot of time just talking with them" in order to "clarify values and identify personal criteria". Therapists point out that this part of the process is particularly time-consuming albeit critical and without it meaningful goal-setting is unlikely to occur.

Curiously, while all the therapists agree that the goal-setting process should be collaborative, some therapists reported that they establish goals for their clients without discussing them. Cathy said she did not frame what she was doing with her clients as establishing goals; yet throughout the interview it became apparent that clearly, she had defined goals and objectives for working with her clients but she was not communicating these to her clients. I drew her attention to this and asked her for clarification:

That's another thing that I've toyed with changing in what I do to a more formal introduction of what I can offer the patients so that I sit down and I talk to them and I listen to what they want to do and then sort of more formally say what it is that I have to offer and what their goals would be and this sort of thing. I don't know why I don't do it. I mean I've talked to [my supervisor] about it to try to find out what he did but I never followed through. I'm not sure why...It takes time.

One major reason for this contradiction could be that therapists recognize the importance of collaborative goal-setting.
with clients but are not exactly sure how to do it. As Cathy indicates when she says she has consulted her supervisor to learn from him how he was doing goal-setting with his clients. In addition, because it is so time-intensive therapists simply do not have enough time to do it with all of their clients.

Marilyn describes the time-intensive nature of goal-setting:

There is this whole process which involves clarifying values and identifying what you call personal criteria and all of this involves finding out specifically what they want and so I mean it's interviewing them, asking them, asking for clarification, and probing and all that. And there are specific exercises and questions that you ask to go through this process and that's a real in-depth process. I mean not everybody [staff] does that...but most of it, I guess most of the time is just talking with them you know, after you establish a relationship with them and I think given the opportunity, people will express what they're interested in and what they want.

Unlike some of the other therapists, Marilyn does feel, that clients will given the opportunity, express their interests, goals, values, needs and wants--it just takes time.

Another reason for this discrepancy between therapists' expressed commitment to collaborative goal-setting and their limited action in terms of applying it in practice, may be what Charles refers to as the "challenge" involved in setting goals with clients. He speaks of a struggle between client and therapist due to a discrepancy in perceptions of what is realistic and what is not; what the client is capable of and what s/he is not. He says:

I think it's a real, there's a real battle because on the one hand you want to be client-centred but I find that some of the goals, once I've assessed them to the best of my ability and I have feedback from others, [from] some of my colleagues and [other treatment team members], sometimes their goals are really unrealistic given their present state of affairs and I think they're setting themselves up, sometimes, for failure.
Charles further clarifies the above point and explains that it is this discrepancy in perceptions and the process involved in coming to some sort of compromise which is a barrier to doing goal-setting with clients and which is why many therapists avoid it altogether despite recognizing its importance:

...you see, you have to balance your clinical judgement and prejudice with the person’s wishes and their aspirations, you know, and that’s the real [problem] I find, that’s why it’s so easy to avoid. So you just have them come to group and you have [written down] ‘client will come in 3x a week’ but that’s not really goal-setting, you know, and unfortunately we have that loop hole, if you will.

Thus it appears that this discrepancy in perception creates a dilemma for therapists who struggle to empower clients and who believe that goals should be client-driven on the one hand yet feel that the clients goals are not realistic or appropriate. Many therapists say, as in the words of Naomi, that they “...end up modifying goals...modifying them in the length of time, or modifying the goal itself.” Charles describes this modification process further:

...if someone wants to be an astronaut, and I’m not saying that cynically because some of the goals they set for themselves are as unrealistic as someone coming out of [a Grade 6 education] and saying ‘I want to be an astronaut.’ ‘Great, but you [have only Grade 6], there’s a big gap here.’ So what I find you end up doing is negotiating, bargaining, bartering- in a way it ends up being some coercion and some persuasion but I find in most cases it’s inevitable and it’s unfortunate but we do have our own agenda, legitimate or not. It’s rare that your agendas are going to be identical, I find. It would be wonderful if it happens.

Charles explains that one of the precursors to this “negotiating” process is that therapist and client have their “own agendas”. This he says refers to the fact that the therapist receives all sorts of “information” on the referral about the client such as diagnosis, educational history, past functioning and so on
which leads to "a bit of a tainted picture" and which leads the therapist to question: "...so how could you possibly be completely objective or completely open to whatever goals they formulate?"

Another dilemma for therapists who try to empower their clients, which might also be partly related to the apparent discrepancy between therapists' stated commitment to collaborative goal-setting in theory and their limited action in practice, is the sick-role identity of clients and their subsequent over-dependence on the psychiatric system. Historically, clients have not been consulted about their wants, values, goals, and so on; they were not considered capable of participation in their treatment. This paternalistic attitude toward clients has contributed to their feelings of powerlessness and to their dependence on the system. Thus, many clients feel incompetent with regard to decision-making and are not accustomed to the increased responsibility of this new collaborative role in their treatment.

**Staff-Patient Hierarchical Barriers**

Two-thirds of the client group point out that one of the reasons they feel reluctant to initiate private meetings with their therapists is that they believe them to be very busy. Rather than risk rejection, clients would prefer that therapists initiate individual contact and usually wait for their therapists to do so. As Ken remarks:

I don't want to have to go to him. He should somehow come to me...I guess you fear that you might be rejected or what you're saying is not important, it's trivial. You know you think when you go to these people, they, since they're the authority figures around here, you think that any small problem you have is not important enough to bring to [them].

The above quote also underlines the low self-esteem and feelings of inferiority that most clients experience. This client,
as with many, seems to be intimidated by what he perceives as a
distinct staff-client hierarchical barrier. Later, he further
comments that he feels there is "a mired wall" between his therapist
and himself also due to differences in socio-economic status, as
well as his own general feelings of being alienated from the
community-at-large.

John, referring to himself as "a lower station" compared to OT
staff, feels too intimidated to tell his therapist his suggestions
about the program he attends. He says that one of the things he
would change about the program if he had the power is: "...having
time where you can get to meet each of the members of the operation
[team] here for a coffee or something in a restaurant and have a
talk for an hour...". He explains that even though he has thought
about this idea for a long time he has never mentioned it to any of
the staff because: "I’m a little afraid of, of upsetting their, you
see they’re staff; staff is staff. I haven’t got, I’m too shy to go
in and tell [his OT] this. They’re well-educated; they have more
education than I got. In a way I’m educated, in my own way..."

John’s idea of meeting and talking with team members to get to
know each other in a more neutral and informal atmosphere, is a way
to help diminish the staff-client hierarchy as well as the class
barriers so that the he can more comfortably and on a more
egalitarian basis relate to and dialogue with the various team
members. Interestingly, his idea is consistent with the recent shift
in mental health care from a traditional paternalistic approach to
an empowerment one emphasizing a staff-client collaboration where
there is a deliberate attempt to diminish barriers (Tyler et al.,
1983).
Both groups overwhelmingly share the perception that there is little time for one-to-one contact and thus for true goal-setting. Due to the time-intensive nature of the process if done properly, therapists have time to do goal-setting with only one or two clients at most. Moreover, one OT is responsible for as many as 33 clients on a unit and recently an OT may be assigned to more than one unit. Sheer caseload numbers alone almost preclude the opportunity for engaging in goal-or a collaborative relationship with clients.

Yet, one-to-one contact is emphasized by both groups as being very significant for allowing the opportunity for a supportive relationship to develop in which another person listens, attends, empathizes, discloses, and provides positive support. Interestingly, "listening" was identified as one of the most important characteristics of an OT by both the client and therapist groups. Further, time for establishing the rapport and trust essential to a supportive relationship is particularly crucial with this population as some clients report experiencing a barrier between their therapists and themselves due to the stigma associated with being a mental patient and due to differences in class, education, and socio-economic status.

Both therapists and clients identify goal-formation difficulties. Therapists report that they feel one of the major barriers to goal-setting is the difficulty clients have with identifying their own needs, wants, values, and interests. Therapists point to the sick-role identity of clients and to institutionalization as the major factors in this difficulty. Clients say that they don't feel psychologically "ready" to think about the future. During the interviews, they poignantly reveal a
pervasive fear of the future and a subsequent tendency to be locked in the present due to overwhelming feelings of utter hopelessness and uncertainty tied to their mental-patient identity.

Therapists reiterate that a "mental-patient identity" is responsible for this fear of the future and lack of confidence, which subsequently inhibit decision-making and goal-setting. The widespread self-reproach of clients for being "a psychiatric patient", "a mental patient", or "sick" and the resultant feelings of being incapable of achievement or productivity would seem to corroborate therapists' perceptions. Further, some clients have expressed that they "need a push" from their therapists to take steps to achieve their goals and/or maintain a certain level of activity. Therapists acknowledge that such feelings of helplessness are related to a "mental-patient identity" and view getting clients out of this sick role as the prime challenge for engaging them in the process of goal-setting.

The main differences in the perceptions of goal-setting between the two groups seem to originate in the mental patient or sick-role identity of clients. This embedded identity, which creates an increased dependence of clients on their therapists and on the psychiatric system, clashes with the goals of their therapists who are trying to empower clients and encourage independence and increased responsibility in the goal-setting process.

This clash leads to a disparate conceptualization of goal-setting between the two groups. Therapists perceive goal-setting as a process whereas clients perceive it either as immediate attainment of a practical need such as money for example or as the having to decide on a future career but failing to acknowledge all the small steps involved in attaining such a goal. The aforementioned tendency
of clients to be locked in the present inhibits thinking about an overall life plan or about long-term goals. Due to the sick-identity of clients, it seems that they believe they will never be able to function in society and so tend to subjugate or repress any goals or visions of a "productive future". As in the words of the client quoted earlier, most clients experience pervasive feelings of hopelessness: "If could change something I would be more productive in society. But I'm not going to reach for these goals that might never be achievable or attainable."
As mentioned in Chapter Four, therapy groups are a fundamental part of occupational therapy and assume a wide variety of forms. Partly for various therapeutic benefits and partly due to the huge caseloads of individual therapists, much of occupational therapy practice is conducted in groups. Therefore as a large part of occupational therapy is carried out in groups this was an important area to examine.

The groups which the therapists I interviewed facilitated and the clients participated in were the following: social skills, cooking, community meeting (provides a forum for announcements and discussing daily schedule, weekend activities/plans, personal experiences, and complaints), self-care, money management, woodworking, crafts, music therapy, life-skills, and recreation (bowling).

I asked therapists and clients to describe their vision of the ideal occupational therapy group. Often various economic or institutional constraints place certain restrictions on therapy groups. I was interested in exploring with the therapists and the clients the kind of group in the best of all worlds that they would like. What would we see happening in such a group? In addition, I was interested in finding out whether the perceptions of the ideal group varied sharply between therapists and clients and if clients were desiring groups or qualities of groups of which therapists had not conceived. Are there groups or characteristics of groups that clients feel are more helpful and would meet their needs more effectively?
Both therapists and clients feel that a successful and fulfilling group is one where everyone is participating and involved. Cathy, a therapist, notes: "A group works when patients are very involved. They do it. Ken, a client, suggests: "Everybody should be involved somehow...there should be some emotional excitement somehow maybe...laughing." Henry, a client, expresses his sense of fulfillment from evoking excitement and the involvement of clients in a group which he felt was stagnating:

Well I know she [therapist] tried, she did her best to invigorate people, to get them going, well I threw in a couple of questions to spark them up and I think I did that. Well, if I'm trying to arouse something in them, hoping I'd have an opinion on it...well, if I tried to stir them up I might think well I'm doing something right but that's my opinion...and I did that because they weren't gettin anywhere and I just asked a sharply question and oh, that sparked them up, somebody had an idea and then they were all talking...I think I did get them involved. (emphasis added)

Henry values the involvement of group participants and gains a sense of accomplishment and pride from being able to inspire other clients become involved and participate in the activity.

Laughing and emotional excitement suggested by Ken and Henry as components of a successful group are reiterated by Marilyn, a therapist, who feels a successful group, one that is working is:

...having people smiling and enjoying themselves and laughing and things like that...I would like to see that you know, have it be very successful if I had everybody talking and putting up their hand but I mean that's unrealistic, I mean if somebody initiates one idea or question in the group it is successful. (emphasis added)

However, these qualities of a group, which as we have seen are what the clients would like to see as well, seem to depart from Marilyn's
experience as she defines her vision of a successful group as "unrealistic".

Connectedness or cohesiveness of a group was also identified as being one of the most important characteristics of a successful group by both clients and therapists. Cathy, a therapist, stresses the importance of a feeling of connectedness to each other and to the activity.

It would be a group where the patients are interacting with each other, helping each other, basically doing the tasks themselves...the patients are absorbed in it, whatever it is they’re doing, maybe they’re absorbed in the conversation they’re having at the time.

The value of connectedness in a group was also reiterated by Charles, when discussing the community meeting group. Here we can clearly see the relation of openness, informality, and spontaneity; sharing and disclosure of both therapists and clients to a feeling of connectedness.

What I really like about this group I would say is getting to, I suppose it’s because of the deliberate lack of structure or empowerment is a better word. I like that I think it gives the clients a chance to really be themselves. You really hear, there isn’t these stereotypical or these rehearsed answers you know when you ask them ‘how do you feel?’; sometimes people tend to frame it in a very specific way; whereas I think in this type of group they really are very open and very spontaneous. I really like that. I like the fact that we can share, we also can disclose what happened on our weekend and it’s a much more personal type of connectedness. I mean I think it’s more personal than when you run a more structured group; there are predetermined goals or if you determine topic whereas here you don’t have that, you don’t really know what’s going to be discussed...(emphasis added)

Julianna also values the personal nature of the therapist-client relationship of which sharing and disclosure of therapists are characteristics. She says, when discussing what qualities she thinks make a good OT: “Be herself...Talking, sharing, sharing, letting people realize their humanness--disclosing.” Mary also
values the personal connection between clients and therapists when she talks about the "checking-in" time at the beginning of each group. During the check-in therapists, in addition to, group members have the opportunity to share everyday experiences, thoughts, or feelings with other group members. When asked what makes a good group Mary replied: "When you tell how you’ve been. I like to hear how you and [co-therapist] are doing and share what’s happening in your lives, too.” Paul, too, emphasizes the importance of involvement of the therapist: "Well, the OT has to be willing to get involved with the patients and rather than being there in a corner by herself. I like somebody that gets involved with the patients, that talks to them, communicates well with the patients.”

Naomi, a therapist, feels that different groups serving different purposes and objectives would have different pictures but in general her vision of a successful group is one which is very cohesive.

I would like to see the group, very cohesive, it may not be a closed group, it could take in patients at all times and have patients discharged at all times, but I would like to see the group have a very good, tight cohesiveness.

Paul elaborates: “Well just have alot of people there that I could talk with, people, communicating with them, participating in what they’re doing there, talking about what they’re participating in; stuff like that. That’s what I like about a group” (emphasis added). Julianna, echoing Paul’s sentiments when she describes what she dislikes about a particular group, reveals the importance of clients requiring time to get to know each other and feel comfortable with each other as well as with the therapist--time for rapport and group cohesiveness to develop.
I went to one group and I disliked it because only one or two people were talking but that was at the beginning and we were all feeling each other out. Things were pretty quiet and people were not too talkative...you know they seemed a little hesitant and now it's getting not as quiet.

Both therapists and clients identify several of the conditions that help foster communication, cohesiveness, connectedness, and camaraderie of a group. They mention the value of openness and spontaneity of participants, therapist and client disclosure, time for rapport and trust to develop, involvement of participants, relevance and meaningfulness of the activity or topic.

**Human activity vs. mental patient activity--Relevance, meaning, and authenticity**

As we have seen in Chapter Two, many mental health programs tend to provide programs for people understood as mental patients in a psychiatric program not people as human beings in the social world. This means that, as Rose and Black (1986) explain, programs such as industrial therapy or sheltered workshops or life appreciation groups reinforce the mental patient role by focusing on “skill-building of deficit skill areas” and “functional skills” and ignoring or minimizing concrete real-life issues. Only one therapist talked explicitly about the importance of a group being meaningful to the client. Cathy, discussing her cooking group, the one which she says is the most successful because “it works”, identifies the importance of a group’s “meaningfulness” to a client.

And that’s exactly what I want as an occupational therapist to have something for patients to do where they’re doing it and where they either they get satisfaction out of it or they get frustrated by it which happens sometime but it brings up something to them. I think that’s the big thing, it *means something to the patients*, whether it’s a negative thing or a positive thing, usually it has an impact on them.
She goes on to say that this is one of the groups she likes the best because “that’s the one I have success with...it works”. She adds: “I get allot of information from it, from the patients and I think it brings up allot of, I don’t know how to put it, but for the patients I think it has some value, it has some meaning for the patients, not just a meaningless activity.”

Interestingly, cooking groups were one of the most popular groups with other therapists as well as clients. When Julianna replies to my question about the reason she goes to the cooking group we can see how she is distinguishing albeit unconsciously perhaps between meaningful human activity and mental patient activity. “Um, me, to learn new ideas about cooking. Like I go strictly for my own to get new ideas. Maybe it’s very selfish but all I go there for is to learn a new recipe.” Due to the pervasive pressing home to clients of the “therapeutic” nature of programs (for example, socialization training) it seems that Julianne feels she is “selfish” because she is not interested in these other aspects of the group. For her what is meaningful is the very concrete and useful aspect of learning new recipes which are relevant for her when she will be living independently. She adds that the fact that the group takes place off the ward area it makes her feel more hopeful and reassured about leaving the hospital to live independently. We can also sense how this group helps “disconnect” her from her mental patient identity:

Well, it’s a chance to get off the floor [ward]. It’s a little more intimate because you’re away from everyone else [other patients/ward staff], you’re off the floor and you’re doing something disconnected from the floor, you know what I mean. It kind of makes you think: ‘Well, jeepers, I’m working my way out of the hospital. I’m learning how to cook and be with others you know in a different setting.’ (emphasis added)
A sense of accomplishment was reported by both clients and therapists to be a very helpful component of groups. Therapists also considered a sense of accomplishment to be important for themselves as well as for their clients. For example, Charles when discussing the community meeting group which has three facilitators and anywhere from 10 to 15 clients participating, he explains that it challenges his skills and gives him a sense of accomplishment:

I also like the fact that sometimes with that unpredictability it really challenges your skills, you know because sometimes it's quite chaotic and sometimes it's not so good, sometimes I dislike it but at times it's good because you really can try and learn sort of how to intervene and how to calm a client down, how to de-escalate you know.

Perceptions of What Would Be More Helpful

Client-led vs. Therapist-led Groups

Most therapists, unlike clients, feel that the ideal group should be client-directed rather than therapist-directed. Charles explains that the ideal group should have two therapists as co-leaders whose major role is facilitation and that clients should be the ones who direct the group.

I think a successful, ideal group is where you have clients basically running the show, with facilitation on the part of the group co-leaders. That to me is, it’s not the activity or the focus of the group per se, it’s the process, that is what’s a success or lack thereof.

Clients as well as therapists expressed the desire for everyone to participate actively in groups and indicated that they enjoyed groups far more when this happened. Charles adds:

They [clients] come up with ideas, they participate equally with the group leaders to the direction the group is taking. There’s an open discussion of the things they like and dislike, they’re comfortable feeling, discussing that, there isn’t this fear of reprisals you know...You’d probably see a fairly spontaneous interaction, appropriate spontaneous interaction. I
think you would see some disclosure, you'd see a lot of people helping, you know helping each other maybe.

**Disruptiveness and Tangentiality**

Clients, however, with the exception of Henry as quoted above, felt that the onus to facilitate the participation of other clients was on the therapist, not themselves. Clients want the therapist to control the group. Particularly in situations when a client or clients become disruptive by being tangential, interruptive, or dominating, clients report that they find this frustrating and want the therapist to take control. In fact, disruptiveness and tangentiality has been reported by both clients and therapists as a widespread problem. Indeed, "maintaining control of the group" is cited by Ken as one of the qualities of a good OT.

...Shouldn't be too authoritarian although they should be able to maintain authority in the group but make it seem like he's not; however you do that. I don't think the clients like to be forced but you gotta have some line that you're still in charge which sometimes they [OT's] don't do.

John, also complains about the disruptiveness of clients in groups and when talking about the group he likes least, a "life appreciation" group, he comments:

I guess the one I like least is life appreciation because I appreciate life. I don't need anybody telling me this and that or what to do in life. They don't know, they haven't been there... Uh, it's just boring. This guy Murray talks too much, he gets mad and talks [off topic]. The other people get tired of him. I don't go there sometimes. I just leave it alone so I don't go there so it doesn't bother me. That's my worst group.

Curiously, neither therapists nor clients question the cause of the disruptiveness, interruptiveness or tangentiality of some group members. It seems both groups take it for granted that these behaviours are simply the "symptoms of mental illness". Neither group suggests the possibility that the group content is not
relevant to (a) disruptive participant(s) and thus the participant(s) is (are) not engaged.

The expectation or desire for wanting the therapists to direct or control the group in part probably derives from the historical socialization of institutionalized psychiatric patients to be passive and obedient. Historically, there have been very few opportunities for clients to make their own decisions. Decision-making power for patients typically had been stripped upon entering the mental institution. As Blanch et al. (1988) point out: "For persons with psychiatric disability—many of whom have had their freedom of choice taken away in the past—even believing that choices are possible may be a major step" (p.50) (emphasis added). Thus, clients first need to believe that they have choices within the group—they need to feel safe and supported in taking control and second, they need to be trained in the necessary skills for group facilitation—as do most of us with no prior experience.

Furthermore, the internalization of the sick role and the erosion of self-confidence and sense of competence that goes with institutionalization may be another reason clients do not participate actively let alone lead or direct a group.

Ken elucidates the problem with tangentiality of group participants as being destructive to the process of bonding with one another, to intimacy of group members, and to group unity. It would seem that because connecting with others, having a feeling of "fellowship" is so important to clients who are so socially isolated and deprived of social contact; these needs are salient for clients. Thus, they find the interference to bonding and intimacy particularly frustrating and want the OT’s to intervene. Ken explains at one point during the interview when discussing the
current events group that he likes that group because it is small--usually only four or five participants which he says he likes because:

...I find that when we’re in that group the discussions become more intimate, sort of like one on one. You’re in a smaller group, you’ve got the dynamics of a smaller group as opposed to [a larger group]. It’s a larger group and you’ve got less chance to bring up things and talk to other people.

In the following quote, Ken reveals how group members’ tangentiality and lack of focused communication interferes with the bonding process of group members and leads to feelings of alienation:

Well I like that group [current events] for the discussions. Again with all the groups we have the tendency of getting off topic. I notice the OT’s don’t stop that. I guess it helps you focus your mind. I just, again they get to be disorganized, you know. One person’s talking about this, another person’s talking about that and we’re not bonding or relating, we’re still in our own isolated unit. But I find it’s better there [current events group] than in the [larger group]. The [larger group] becomes a real free-for-all sometimes. (italics added)

**Needing a “Push”/Encouragement**

Paul adds that social contact, which so many psychiatric clients utterly lack, is critical, is sometimes even more important than the activity or content of the group, and so he feels that as many clients do not tend to go to groups independently therapists should “push” clients to attend groups. He explains: “I think some patients need a push to get up. Like going to groups, it’s sometimes the topic that they talk about is not important, but just the fact that you’re around people, that’s important, just being around people.”

One client, Nick, summed it up with these words: “Cooperation, facilitation, motivation...I mean to facilitate the needs and wants and the goals and objectives of people.” Interestingly, both clients and therapists noted that in general, clients do not participate
actively in groups and that consistent group attendance is infrequent as Charles, a therapist, indicates: "I think the most successful group is one where, first of all, client participation is consistent, they come of their own accord. That's a big one. That's a big indicator."

Therapists tended to explain the infrequent attendance and low participation as resulting from a lack of "motivation" on the part of the clients. Adrienne, a therapist, when talking about her social skills group for instance says: "I think they have the need but I don't know if they have the motivation. They attend very irregularly." Therapists also go through periods when they feel less motivated as a result of irregular group attendance and the perception of low client motivation. When I asked her which of the groups she facilitates she likes best, Adrienne explains:

They're all very different. I usually like them but I go through some periods when my motivation is rather low because their attendance fluctuates so often. I might be prepared for the session but nobody shows up so I couldn't really tell which one I prefer. As long as they turn up, as long as there is attendance and they are motivated and they are all interested...After all, I don't think the activity itself is so important.

All the therapists I interviewed talked about the general problem of consistent group attendance of clients and the need to encourage and gently "push" clients to attend groups. Therapists do not want to have to do this, however, and feel clients would/should attend independently if they're really interested in the group. Naomi indicates that: "A successful group is the members of the group they really want to come." Conversely, more than one third of the clients raised the point that they wanted and needed the therapist to gently "push" them to attend groups and to stay active. In fact, Ken, when asked what are the most important ways his OT can
help him, says: "One thing is motivate you. And helping you get
interested in things. Ya, keeping you interested, and keeping you
active." And again later in the interview when asked what qualities
a good OT should have he replies:
"Should be a good motivator, that’s one thing." During the focus
group Ken reiterates his feeling that the OT’s should take a more
directive role in trying to get clients to participate in more
activities and says, “Well, they could light a fire under some
people more.” To which John remarks:

...there are people in Ken and my program, they don’t go to any
groups, they don’t do cooking, they’re just there and they sit
there...I can see Ken’s point that they need a fire beneath them
to wake them up more, be made to go to these different
activities. I think after a while if you’re made to go you
might like it, you know.

As already reported elsewhere, clients identified several
reasons for needing a “push” to attend groups. Many clients, heavily
medicated with psychotropic drugs, explained that they feel very
lethargic and sleepy due to side-effects of medications and some say
that they even have difficulty getting out of bed every day.
Depression, which is not uncommon among psychiatric patients, could
be another factor involved in this lethargy. In the client focus
group, Ken cites his “illness” as preventing him from doing many
things and says: “But I find in my condition, I can’t whip up any
mental energy so I mean...Until that condition changes I can’t see
myself accomplishing too much, that’s the symptoms of an illness”
(emphasis added). In the individual interviews, when talking about
what he would find more helpful about the cooking group Ken replies:

Well, we, maybe the OT should include us in more of the, force
us to work in the kitchen ya...Well, I guess it improves your
coping skills you know, keeps you active I guess...These people
have to be, including me, I’m not, I’m not...I think they need
pushing to, meaning I guess the OT’s don’t want to nag us but I
I think these, at least I should say myself, I need, I need to be pushed a bit to get working on. I think maybe the others do too...the OT's don't want to be ragging on you all the time—push, push, push, but then sometimes I think these people need to be. I think they, if you, if everything is a big deal, like you got a mental illness, everything is a big challenge and you know you gotta, your thinking is slower and uhm I think you have a tendency just to say, 'Well, forget it, I'm going to sit here and smoke this cigarette and do nothing'. And you know uhm, I don't know, I don't know how you'd get around that. (italics added)

The medical model paradigms from which mental health theory and practice, including psychiatric occupational therapy, emerge, creates a tendency for mental health professionals to focus on "illness" (Rose & Black, 1986). This leads to patients/clients internalizing the "authority's" conception of them as mentally ill or sick. Unfortunately, this identity becomes prominent and patients assume a "sick role" as we can see with Ken quoted above.

**Access and Presentation of Information**

Access and presentation of information about the kinds of available groups is another factor which may be involved in irregular attendance of groups. However this was something that was reported by clients only. For Julianna the en masse presentation of group information listed on the bulletin board was rather overwhelming. She describes her confusion when asked what kind of information she received with regard to the types of OT programmes available:

Well, when I first came here um, I, I had no idea what was available, what group I would fit into or where I would go or what was available. I would go to the board every day, I would stand there and stare and look at it and see groups, groups, groups, groups, you know. Should I go to this one, should I go to that one? Um, where am I supposed to go. I felt lost, you know.

She also indicated that she was not always cognizant of when and where groups were taking place. She explained that sometimes she
does not attend groups because she cannot always focus enough to remember that the group is going on. "Half the time I don't commit myself to the cooking group just because I'm unaware that it's taking place. Sometimes the groups will slip by me because like I'm unaware that they're taking place." She goes on to say that the cooking group takes place every two weeks and so she cannot seem to concentrate or focus on that but she said that recently her therapist puts a specific reminder on the board on the day a particular group is being held which she finds very helpful:

I find that [her therapist] lately has been making a little note on the board indicating there's a group and I thought that's been very helpful because without that little indication on the group there really is a...like cooking group or he'll put social skills or no life-skills and you know he's pretty good at doing that...I turn around and look at the board and say, 'Oh, there's a group today. Oh I want to go to that.' You know.

Julianna added that she finds it particularly helpful when her therapist indicates the group is taking place on the board with only a very short message using coloured chalk to make it "stand out". She felt that this would be a good idea particularly for the menu planning and shopping groups which also run only every second week.

The fact that Julianna seemed very confused and "lost" about which groups to participate in would suggest that her therapist had not sat down with her to explain what groups/programs were available, what was the purpose and goals of each group, and together decide which group(s) would best meet her needs. As we have seen from the data elsewhere, it would seem that this may, be due at least in part, to a lack of time for individual contact with clients. All the therapists, save one, said that they would like more time for individual contact with their clients. Part of empowering clients to be able to make their own choices about
programmes is providing information in a way that is accessible to them and in a way that they can easily comprehend.

**Barriers to Helping**

**Internalization of the Sick Role**

Like Ken quoted above, 75% of the clients I interviewed believed that their "mental illness" was responsible for their inability to achieve and they believed that it was a permanent condition. For example, John, when answering my question of what kinds of information he was given regarding the different groups available, says:

J: Uh, [my OT] said: 'You will be expected, if possible...less by chances of illness, or Dr.'s advice or medication to attend all these groups...You should not take a day off, it's a full program and to get the metro-pass everyone has to be coming...If you don't come here, you may lose your metro-pass.

[The doctor] made that clear to me too...They [Doctors] take to me for some reason, they take to me because I talk, you know. They get a kick out of me...I'm a challenge to them too you know. I think I'm, I realize that.

Q: What does that mean to you, that you're a patient?

J: It means my past experiences have driven the fact down right into the truth that I am psychiatrically, mentally ill...I honestly believe that I'll be like that for the rest of my life. I'll take medication.

They also mention a lack of self-confidence, self-acceptance, sense of self-worth as incapacitating. In fact, almost all clients said they would like help with raising their self-esteem as noted in Chapter Six.

**Similar vs. Different Levels of Group Members' Functioning**

Ken points out that one of the reasons for the disruption which occurs in many groups, is the fact that clients are at different levels of functioning. He thinks the ideal group would be
more homogeneous in terms of members' ability to focus and communicate.

I think there's something of being with people at your own level. Certain people in here are so sick that they can't really communicate with anybody. That's kind of one thing. The perfect OT group would give a sense of accomplishment after you've done it. It should provide a little challenge, I guess. I guess also provide some type of camaraderie, that maybe we don't get when we're outside, outside of the program. (emphasis added)

Adrienne, a therapist, agrees that the homogeneity of a group is important for it to be successful.

...prepared, motivated group, an ideal setting, a group which has some quality of being homogeneous--people who are on some kind of similar functional level so that they are able to support each other. It doesn't have to be exactly the same kind of level, but just similar, so that they fit together in the same group. The group, motivated clients, the clients are continued to be motivated, they're most likely satisfied...and their attendance and their input and their feedback.

Paul also alludes to the difference in clients' abilities to communicate when explaining the reason he didn't return to a social drop-in group after attending it only twice: "Well, there, you know, there aren't patients who are communicating." Interestingly, this was a group identified by a therapist as one of her least favorite groups for the reason cited by Paul. And again when talking about the art explorations group, Paul says the one thing he would like to change about that group is: "...Maybe just the patients would express themselves better, I don't know, that I could talk to. Like some patients you can't talk to, you know, they...".

Heterogeneous groups and the concomitant disruptiveness, lack of group unity and lack of intimacy may be key factors in the low or irregular attendance of clients at OT groups about which therapists express concern.
Three other aspects of CT groups which are important are cited by Ken in the previous quote: 1) a sense of accomplishment, 2) a challenge and 3) camaraderie--again underlining the social isolation psychiatric clients face. This isolation is very poignantly expressed in Ken’s words “...some type of camaraderie that we don’t get when we’re outside, outside of the program.” Here “outside the program” refers to the community. These three things were also cited repeatedly by other clients and therapists.

**Need for Training and Resources**

When discussing individual groups as well as therapists’ ideal group the issue of lack of training for a particular group and lack of resources for group facilitation arose. The kinds of things therapists would change about their groups if they could -were more money to buy various updated equipment/resources. This was indicated by 70% of the therapists. Audio/visual aids in addition to manuals on facilitation techniques for certain kinds of groups were some specific examples of resources required. Others were related to the opportunity to brainstorm and share information/experience/expertise with other colleagues, and/or actually have a colleague to co-facilitate groups. For example, Naomi said that her worst group, the craft group, was the one in which she felt untrained to facilitate. “...I lack the skills and the knowledge of other crafts that is suitable for them. That’s why it’s quite difficult to run a very successful group.” Marilyn, when discussing how she’d like to change a group, says:

...there’s lots of things I’ve been looking at changing. I mean I’d like to have more kinds of material and equipment to pull on, like more maybe those little audio-visual aids, that kind of thing and more resources for groups like that. I was even actually at the library ...I really didn’t find that much. Where is the stuff on how to teach people self-care skills? I really think maybe what I need to do is take some time, take a
day go to the library and really look for something; there
must be some information out there somewhere. Or take the time
and get together with some of these other people that are
running some of these groups...and brainstorm some ideas and
that kind of thing.

She adds that a co-facilitator for groups would be beneficial for
several reasons:

...I think that would be really good to get their perspective
on things just to have another person there running the group
because it is, I'm always pulling people in and that and I mean
sometimes it is quite exhausting after you leave and you're
trying to get everybody involved and so that would help having
somebody else there.

**Summary**

I explored with clients and therapists what qualities of a
group they find helpful/unhelpful. What I found was that the
dynamics of occupational therapy groups which are valued are similar
for therapists and clients in many respects. They are also similar
to the dynamics that we would expect participants of many kinds of
groups to value whether it be a small group discussion for a
university seminar or a community group. Words such as “involved”,
“informality”, “fun”, “communication”, “relax”, “excitement” and
“laughing” are used repeatedly by clients and therapists to describe
what they value in a group and what they think makes a group
successful.

When we examine clients’ and therapists’ comments on the ideal
OT group and the kinds of things they value or dislike about the
groups they attend we can see a repetition of distinct themes: 1)
the need for human contact and companionship for clients, 2) the
need for fun and relaxation, 3) the need to “feel good about
yourself”, improve self-esteem, self-confidence, self-acceptance and
feelings of competence (clients), 4) the need to achieve/accomplish,
5) the need for a "push"/encouragement to do things and reassurance (clients), 6) the importance of a certain level of homogeneity of functioning levels in groups to allow for communication, cohesiveness, connection and companionship and 7) the internalization of the 'sick' role.

Interestingly, therapists also noted the importance of a sense of competence and the need to accomplish not only for their clients within the groups but also for themselves as facilitators. They expressed the need for training and resources to enable them to feel more competent in helping clients get the most out of group programs.
When facilitating the focus groups I attempted to be non-directive in order to avoid interfering with the process of group reflection and discussion and to allow the participants to naturally explore aspects of the data which were salient to them. Each group of participants was presented with a brief summary of the data and a leading question for discussion. Prior to the focus group with the therapists, I had conducted a departmental presentation of the data from the individual interviews. Clients and therapists were given a brief summary of the therapist-client perceptions of the most important client needs and ways OT helps. The leading discussion question for the therapist focus group was: "Which of these things [client-identified ways to help in the data summary] are you currently doing, which are you not doing, and for those which you are not doing what are your feelings and opinions about incorporating them into your role as OT?"

It should be noted that one of the participants of the therapist group was a senior OT and a supervisor of two of the therapists in the focus group. This may have influenced the candor with which these two therapists and others as well as the supervisor spoke.

For the client group I first asked the clients what they could recall about the purpose of my research and research question (it had been almost about six months since the individual interviews) and gave a brief summary. In order to get the participants thinking about their experiences with OT and to react to the data, they were then asked to briefly describe their knowledge and experience with
OT by answering the following question: “What is occupational therapy and how does/should it help?” Clients were then given the same data summary as the therapists and asked to give their reactions.

**Perceptions of Helping**

**Skill-teaching and Functional Assessment**

When asked what they saw as their roles, all of the occupational therapists I interviewed said that one of the most important was skill-teaching and skill-building with regard to activities of daily living (ADL) which comprise social skills/interpersonal skills, cooking and shopping, housecleaning, self-care (personal hygiene and grooming), and leisure. All but one therapist said that functional assessment of ADL was another core aspect of their role. For example, Ted defines his role as:

> Various activities and life-skills groups, social skills training...And I’m doing that through the life-skills groups that I run, social drop-in...the cooking group that I run there is an emphasis on teaching basic cooking skills but even more so is the social aspect--enhancing socialization, increasing an awareness of others, focus on strengths as opposed to problems and increase skills...

Charles emphasizes skill-building and adds other aspects such as computer training, supportive counselling, and prevocational preparation as part of his role:

> One thing I omitted which is pretty important is there’s also, basically myself work with clients on the computer and its become more and more a significant part of the program because we do also get referrals...from the clinic. My role, one is definitely teaching a variety of skills, skill-building, another role would be also providing supportive counselling...I see myself doing quite a variety of things, they can be also prevocational preparation or training though it isn’t necessarily labelled as such for alot of reasons...skill building can be either functional task skills or social skills...
Most clients also believed that the major role of their therapist was skill-teaching and assessment. Julianna says for example about her OT: "...He he's assessed me and I imagine he assesses me. He sees me in the group, he knows where I'm at. He's a good judge of character..." (emphasis added). And elsewhere she states: "[My OT's] job is to guide my person into a better being and as he sees fit in my character development or my personality development. He offers suggestions as to where I should be going and what I should be doing." (emphasis added). Here we see how clients have been socialized into the role of the mental patient; how their human identity/character becomes blurred. Therefore, they believe it is appropriate for their OT to "judge character" [i.e. character of the mental patient].

Community Integration/Outreach

Charles when discussing his OT role adds:

"...we do take the community outings so integration into the community... some of them are quite isolated so we do want them to, as great an extent as possible, to be a part of the community." Again we see the limited aspects of what 'community integration' means to many OT's. Here it refers to simply taking clients out in groups into the community for movies, meals, and shopping trips.

Clients Want More Help

About two-thirds of the clients, however, express the desire to be more integrated into the community such as Ken, who, even though he is living in the community he does not feel a part of it. He said he would find it very helpful if the OT's provided more community support such as finding a place to live, and providing emotional support by going with him talk to his landowner.
I find I'm uncomfortable out there [community]. I don't feel good about myself so it helps to have somebody along for emotional support you know. More than I can probably solve the problem but what I need somebody along for is emotional support. Like if I have to go and see a landlord and I have to explain my situation to him, it's nice to have somebody else along, so you're not there alone. I've thought of that, moving, I would want somebody to come out with me and then just be along for emotional support, me having to answer these questions. I feel awkward dealing with the people in the community. I don't know how well we're accepted out there. I don't, well, I don't think we're well accepted.

In this quote we can see the effect of the stigma of being a psychiatric patient on clients' self-confidence and feelings of competence in dealing with people from the community. When asked if he thought of asking his OT to help him with this he replied:

Not an outside problem, no. Not where I've thought of him to come out in the community with me. No I haven't asked him. I don't know if that's part of his job, so I've never asked him. I might though, if I decide to move... I might, see if he can help me. I could probably do it, but I just need somebody along for, so you don't feel so isolated, you know what I mean. Have to answer some tough questions or something.

One quarter of the client group did not have a clear conception of the OT's role. For these clients, this may due to minimal individual contact with their OT or with OT programmes.

Structure, a Sense of Purpose, and Diversion

In both the individual interviews and the focus group, clients identified providing structure to one's life, giving one a sense of "purpose"—(i.e. "somewhere to go and something to do"), and providing diversion from thoughts of depression and anxiety as important aspects of Occupational Therapy groups and/or programs. John describes how OT gives him a sense of purpose, structure, and diversion:

But we have a program and the morning consists of [talking about] what we did on the weekends... and that's good because you get to talk about. I think OT gives you somewhere to go, with me having a problem... it's somewhere I go where I don't think about [my addiction] and it strengthens me for the
nights, I won’t think about [my problems] during the day. But I think it’s [OT] a place to go where you keep busy, occupied, and not get...or something like that.

Paul adds: “That’s the way I feel about, that you have somewhere to go and something to do...It’s sort of a schedule you get up at a certain time and have somewhere to go.” As most clients are not working or involved in any work programs they have very little to do during the day and so probably see OT as an opportunity for some activity. Later on John talks about how he finds programs where he has opportunity to work with his hands helpful because: “...your mind isn’t wandering around and thinking of different, even thoughts of beer, depression, anxiety. It, if you’re doing something active, in something and you’re concentrating you’re not thinking of the wrong thing so that’s why I think it’s very important.” Lew later also reiterates the connection between diversion and reduced symptomatology: “I think the main thing is that the gentleman [John] says, if you have something to do it keeps you occupied.” John asks him: “In terms of?” and Lew replies: “Go somewhere, it’s better than just sitting at home or sittin around thinking thoughts of depression and anxiety... If you have something to do it keeps your mind busy on something else.”

Mary also says she finds OT groups helpful in that they provide a structure and purpose: “I like the cooking group but they cancelled the group and I like the social skills group, it gives me something to do and somewhere to go during the day.” [italics added].

Creative Expression and a Sense of Accomplishment

In the individual interviews one-fourth of the clients spoke about the importance of creative expression and a sense of
accomplishment and said that through various OT groups they were able to experience both. This was reiterated by a couple of clients in the focus group as well. John describes how writing for an OT program newsletter gave him a sense of achievement and enabled him to express himself creatively.

It's helped me, OT, alot because I lost the insight to write and [my OT therapist] turned me on to writing the paper [newsletter] here and it took me out of my shell a little bit that to write you know. It was a great outlet, a release for me to write something for that magazine and that helped me alot writing for that magazine cause I can go home now and I can compose a poem. Like I have two at home, I didn't bring them but I had two at home and Saturday night I got [to go to] a place to read them to people, patients. I can read them and then Tuesday I can put them in the paper. So it's a great release for me to be able to do that, it's to write something creative and especially if it rhymes. I like to rhyme something. I always liked doing that. I always like to do that so that was more or less what I was meant to do I guess.

John also seems to be talking about how a natural gift which was forgotten was rediscovered through the opportunity to write for an OT program newsletter and now he is newly inspired to write. He also speaks with pride about the poems he composed and how he was asked to read them to a consumer group.

In an exchange between John and Lew, they speak about feeling a sense of accomplishment in being able to cook things during a cooking group. Lew also seems to feel a sense of accomplishment is heightened by sharing his product with other patients and seems to feel frustrated when his therapist tells him to keep it for himself. John also paraphrases Lew's frustration and rejection.

John: How to cook helped me though. I can cook different things that I couldn't cook before, that did help me.
Lew: On the ward they had a bit of that. There's a kitchen, right, so the patients cook. Just to show like if they're on their own how to make a meal for yourself. To get it going eh. It's just for yourself, you know what I mean, a whole bunch of things and then I ate some and I try to offer [what I made] to the patients, my therapist goes: 'NO, no, no, it's just for
you, just for you!' So I put the rest in the fridge and I just couldn’t take it, three or four days after, I threw it out. John: That would be kind of a rejection I think too, if nobody took it, if I cook something and nobody ate it I wouldn’t feel very good. John: I wouldn’t feel very good.

Q: You would have liked to have shared it?
Lew: YA!
John: Ya, sure, me too. I’d feel rejected a bit if I cooked something and...

Perceptions of What Would Be More Helpful

Financial Resources--Clients

Poverty was another problem that clients said they must deal with and that isolates them from mainstream community life. Clients spoke about coping with poverty in both the individual interviews and in the focus group. Ken explains, when asked what he would find more helpful about the OT program he attends and he replied: "More money...that would make a real difference." Low expectations and the objective reality of unemployment and/or few opportunities for adequate-income jobs for ex-mental patients are illustrated as John continues to explain. "At least we have a place to stay. I got a brand new home [group home]. I could never get that if I was working. I got a room and the use of a brand new home. Well I can’t complain about..."

Therapists did not talk about the economic hardship of clients either in the focus groups nor in the individual interviews.

Empowerment vs. "Needing a push"

Therapists and clients seem to be at odds in terms of empowerment and dependency issues. Therapists express the desire to empower clients but point to the dependency, fear, and sick-role of clients as barriers. In the focus groups as well as in the individual interviews, client participants speak about the need for a "push" from staff to become active and do things and/or to
participate in OT groups and activities. Conversely, their therapists express frustration at clients’ need for a push to do things such as attend groups. They feel that a successful group is one where clients attend of their own volition. However, while therapists express the desire to “empower” their clients they feel that it is a real challenge primarily due to the sick role of clients, their dependence on the psychiatric system, and their difficulties with making decisions and assuming more responsibility for their lives. Therapists acknowledge the crippling affect of the sick role on clients’ functioning. Charles speaks of the dilemma in trying to empower clients who are not accustomed to a collaborative approach to treatment and the increased responsibility that goes with it.

...we’re working pretty closely with the supportive employment and we’re finding that alot of the clients when we try to empower them, it’s such a drastic step from what they’re accustomed to. It’s almost like they don’t exactly know how to deal with that. I guess freedom and responsibility goes with the freedom to make your own choices and we’re having a lot of trouble placing people in “normal jobs”. There’s sort of a gap between sort of the sheltered workshop and sending someone out to a competitive situation.

More than half of the clients interviewed said that they felt staying active was important but did not have the energy or initiative, as Paul explains:

It’s like when you get sick you really don’t care about the community or this or that. You just, you don’t want to do anything cause you gotten sick and you went through that hell and you don’t think there’s anything out there for you anyway so you don’t want to take that step. That’s why there should be somebody there, willing to push you, to give you that extra push; just to say: ‘It’ll be alright. Take that step and maybe there’ll be something out there that you like.’

Ken continues: “Until that condition changes I can’t see myself accomplishing too much, that’s the symptoms of an illness.”[italics added]. Even though Ken is aware of some of the
objective conditions of his oppression, for example he talks about living in poverty, tends to attribute most of his difficulties to it. He, too, speaks about the need for clients to be “pushed” to do things. The following exchange between Ken and John during the focus group highlights this sentiment also reveals John’s defensiveness about the program they both attend.

John: They put, well I don’t know. Maybe they don’t put enough responsibility on the clients. I don’t know.
Q: Can you give us an example of what you mean?
Ken: Well it’s, I don’t exactly know, but I feel some of our people there work the system to their advantage so they’ll never get better, eh?
John: ...there are people in Ken and my program, they don’t go to any groups, they don’t do cooking, they’re just there and they sit there...I can see Ken’s point that they need a fire beneath them to wake them up more. They, I don’t know. Sometimes I think if you’re there you should be made, be made to go to these different activities. I think after a while if you’re made to go you might like it, you know.

Barriers to Helping

Sick environments

A few clients also talked about how they felt that psychiatric institutions and programs are unhealthy or “sick” environments and help to reinforce feelings of dependence and sick identities of patients. The therapists, however, as with issues of poverty, neither acknowledged this problem in the focus group nor in the individual interviews.

Isolation, inactivity, and feelings of lethargy due to medication side-effects all combine to make clients feel “unwell”. When Lew says that he feels tired most of the time and needs “a bit of wakin up sometimes”, John talks about the cutbacks in funding and the decrease in programs and says: “The government has changed all this, they don’t have the funds to do it. That’s why he’s getting
this sleep, they’re putting him to sleep, the government, because they should be having more activities for him to do.”

During a conversation of how activity and recreation in the community help clients feel better, Lew talks about how he feels much better when he is out of the institution and when he is able to leave on weekends (he is granted weekend leave) and starts to feel bad as soon as he returns to the hospital.

Just to get out in the community, get my head clear. Uh, I, sometimes, when I get out of here on weekends and when I come back as soon I eat and sleep, I gettin sick again. Geez, you know I spend the weekend out most of the time...but when I go out and I come to this place, I find that I’m sick again. Ya.

Later he adds: “You know by being around them [other psychiatric patients in the institution] you get sick yourself.” Ken expresses a similar sentiment: “You work at the level of the people around you.”

When asked for elaboration he states:

Well, your environment has alot to do with just about how motivated you’re gonna be, you know, obviously. Well, although I must say some people are so sick that I’ve seen patients that are so sick it doesn’t even matter what environment they’re in you know...

In the words of the above client, we can again see the tendency, of some clients to also feel hopeless about other clients’ possibilities in addition to their own.

During the discussion of how the psychiatric hospital can make people unwell John cites a former institutional patient management practice in which patients who had no off-ward privileges and were thought to be escape risks were forced to wear their pajamas in the day and not allowed to wear day clothes as a method to prevent patients from leaving the ward and/or easily sight those that do manage to (which has been discontinued due to protests about patient rights violations):
Dr. put me in PJ's [pajama's] for a month and she kept me here too long...I consider myself being kept here too long and in my PJ's all the time. So I hear they don't do that anymore...But 1990 was pretty hard and I can see his point [above client] where this place makes you not well, if you're treated like that you don't get any better. She should have known that, Dr., she's a psychiatrist, should have known that [italics added].

Ken expresses succinctly how he feels the psychiatric environment is harmful: "But I think the psychiatric environment is bad for people. I mean if you're not sick when you go in, you will [be] when you get out.'

Alienation, the Sick-Role, and Ghettoization

Alienation and the Sick-Role

One of the most striking findings of the client group was the internalization of the sick role and feelings for alienation from the community-at-large. Participants were not only convinced of themselves having an incurable mental illness but also of the illness of other individuals with whom they had contact either at their own or other psychiatric programs and felt that some people were "beyond repair'. When Ken was asked specifically what he finds most helpful, he replied: 'Well I don't (clears throat) uh, no I think some people that are, really, that are sick there's nothing you can do to help them. Ya, you know they come there [OT program] but I don't know what you can do for them..." (emphasis added).

We can again see the internalization of the sick role and medical model when Ken, later reiterates his very low expectations for mental patients and how medication is the only thing that he feels can help clients with an illness.

Ken: What they overlook is these people, alot of them have thought disorders right away that aren't being cured by the drugs so they're not functioning very well to start with.
Q: What if they got help in the community?
Ken: That isn't gonna change their thinking disorder.
Q: No, but it might help them function better and feel better about themselves.
Ken: Well, that's probably not the problem. The problem is still they have a thinking disorder that hasn't been corrected or won't be corrected until some new miracle drug comes along. [italics added].

Ken, internalizing the medical model of psychiatric illness, he focuses on a medical solution despite his recognition of other external problems which clients must face, such as poverty, poor housing, unemployment, stigma, and so on. Yet he does say that he feels he would like more assistance from OT's in the community and criticizes the psychiatric system for hospitalizing individuals too long.

Marilyn, a therapist recounts a situation in which she observed clients labelling other clients:

The example, I really couldn't believe this when I went to [day program] with a group of people from our floor and I was standing at, getting some coffee for some people and there were a number of consumer/survivors and one of them said, 'Those guys are lifers.' And I thought here they were labelling the people as, because they figured these people were going to be in Queen Street for the rest of their life and I mean I was really upset by this but I realize, I don't think anybody, the people I was with, I don't think they were aware that people were looking at them and maybe the thing is, I don't know, maybe they were and they didn't show it or communicate it or maybe they're so used to it. But I think that might be more of a problem with people who are outpatients who've been in the hospital and then go back to the community and have to deal with that stigma of being mentally ill.

Social Isolation and Community Integration. Due to the stigma of mental illness in addition to the internalization of the mental patient role, clients make a clear distinction between themselves i.e. "mental patients" and other people in the community. In the individual interviews clients talked about the importance or desire to meet new people and make friends with people in the community but said they found it very difficult due to the stigma of mental
illness, to their self-consciousness and self-contempt about being a “mental patient”, to their lack of self-confidence in social situations, and to the ghettoization of “mental patients”. This difficulty was reiterated in the focus group:

Paul: I feel like it’s important to me. To meet people out in [the] community not just to be sort of stuck to this, have a chain on your foot just at this hospital, people in the hospital. I think it’s more important to have some people in the community, some friends in the community, as well, girls. [italics added].

John: But do you find, unless he's a real person, true person that really loves you alot, do you think that most people that have jobs when you say, 'Well you haven't been a psychiatric patient like I have for 30 years.' Once they hear that, they sort of take a second look at you or sort of shun away from you, show a little fear there or something, do you find that? [italics added].

Paul: I don't know, not with the friends I have, they know that I've been here but they still talk to me the same way that they talked to me before.

John: Did you meet the friends while you were in hospital, or...?

Paul: Did I meet new friends?

John: While you were in hospital or did you meet them outside?

Paul: Yes, I did...

John: Did you meet them outside? [refers to outside the institution/programs, i.e. mainstream community]

Paul: Yes I did.

John: Oh, you did better than I did, really.

Paul seems to be speaking about friends he made before he was hospitalized but as John has experienced difficulty making friends and integrating into the community and this is a salient issue for him and his sense of inadequacy is prominent he assumes Paul is referring to friends he made after hospitalization. In addition, John is quite a bit older and has been involved with psychiatric services much longer than Paul.

However, difficulty meeting people and making friends with people in the community was not a problem characterized by age.
The problem of a static mental patient identity and the concomitant ghettosiation of psychiatric clients is voiced loud and clear by Ken:

One thing I find about going to [Hospital community program] is that you’re dealing with people in a psychiatric system and if you only deal with those people you’re never gonna get better you know. Like those people represent a group of people in society but I don’t feel that we go out into the general public and...

While clients expressed the desire to have friends in mainstream community and the frustration with the difficulty in doing so, therapists seem to place less emphasis on this and in fact encourage clients to socialize and become friends with other patients in the hospital or other clients in similar programs. The words of Paul cited previously powerfully reveal his frustration and anger: “...not just to be sort of stuck to this, have a chain on your foot just at this hospital...I think it’s more important to have some people in the community, some friends in the community...”. His choice of the words “chain” and “stuck” seem particularly revealing and suggests his perception of a lack of freedom leading to feelings of animosity.

Such feelings of frustration and animosity are understandable when we see how therapists tend to emphasize clients interaction with other clients as opposed to true community integration. I directed the therapists’ attention to a portion of the data in which a client says: “...I don’t feel we’re well accepted in the community and I’m much more self-conscious when I’m interacting in the community.”, I asked therapists how they would “feel about integrating people in the community as part of their role”. Cathy explains:
I put so much effort into people feeling comfortable with the community here, like the community on the floor [ward] that I haven’t taken the time from trying to build a community here on the floor to do it in the community. I don’t know. Well, that’s the way it stands now anyway.

Later she reiterates that she feels it is very important to help clients establish relationships with each other and sees it as one of her major roles as an occupational therapist.

...I like running the groups on the floor [ward] because I think it’s really important for them to begin to interact with each other and develop relationships with each other and I think that’s a major role of mine so I’m happy spending alot of time with small groups and trying to foster that kind of an interaction amongst each other.

This was Cathy’s remark when Charles was discussing the importance of individual contact with clients but cited the difficulty in providing as much as he would like with as many clients as he would like due to heavy caseloads and lack of time.

Yet, therapists, did identify the tendency of clients to label themselves “sick” and to disassociate from individuals in the community or from individuals perceived as “normal”. For example, Cathy identifies a client’s feelings of alienation around the OT secretary.

It’s interesting because I was watching Bill [pseudonym] in the OT office...I was sitting waiting for Sandy [OT Department director] and the other secretary. He and I were the only ones there and the other secretary made a comment about how hot it was and his face was just blank, he didn’t react at all, and I thought that was quite interesting that he wouldn’t socially interact with her, when I thought it looked like the comment was directed at him. He was the only one there to react cause I was sort of.

Ted responds to Cathy’s comment a little later, revealing the mental patient identity and feelings of utter alienation of many clients:
there's a quote here on p.10 [of the summary data sheet] about meeting other people in the community, 'It's hard to meet people, it's like we're floating on the edge of society.' I think rather than floating on the edge of society in the sense that it's really living in a different society, in that the hospital itself has a society. And it's like you were mentioning about Bill, he's not in the society of the staff, in a sense. He doesn't see himself, so one staff makes a comment maybe he then naturally assumed it was directed at you rather than him, because he's not in our society.

Another therapist, Charles, later during the discussion also speaks about his role in helping clients develop friendship networks with other clients in the community but does not address the clients expressed need to develop friendships with people who aren't clients.

Well, we're talking actually ...about reorganizing some of the programs and maybe being a little more community...even more in the community, having more of not really clubhouse but social, social club type program and developing friendship networks between clients, having some more maybe evening type stuff which is also. [italics added].

When asked specifically what "being a little more community" would involve, Charles replied:

Could involve, like they would, it would involve like having a dinner group for example, but it could be out in the community and that way you could stimulate more relationships between clients. Movies but going out into the community rather than traditionally renting a movie, cheapie Tuesdays or whatever. Things like that where it's more, they're engaged in normal activities in the community.

It seems as if therapists do not define community integration as clients interacting with people in the community but as linking clients to other clients or to mental health resources or agencies in the community. It is interesting that therapists recognize the difficulty clients have "fitting in" with other people in the community and the social isolation of clients who live in the community, but do not speak about the importance of introducing
clients to people and recreational programs, in the community that are not affiliated with the mental hospital. Marilyn, however does identify “real” integration as a problem.

...And I guess I’m finding that with alot of the people that even though we’ve been successful in getting them in the community but they’re not really integrated into that community. Often they’re not even involved in as much as they were when they were in the hospital. This is just what we’re just starting to see. Like these are people that [are] used to programs and groups and now they’re living in the community and they spend alot of their day not doing anything or maybe going to one recreational activity a week.

The pervasive sick role of clients, their sense of alienation, and the stigma of being a “mental patient” is all too clear in the comments of Ted who, during a discussion on community support and continuity of care, questions whether the goal of helping clients feel as if they’re part of mainstream society should in fact even be a goal. He says:

But you know I often wonder is our goal really to have these people feel that they’re a part of what we see as the normal society and I don’t know. When they stigmatize themselves in a sense, of being self-conscious of having a mental illness, is that not always going to put them in a sense of ‘I’m different from all these other people’? Or is it for them to have a better understanding of probably if there’s ten people in a room, there’s another person in that room whose got some sort of emotional problem or that other people who seem more normal are not necessarily normal?...And you know there’s always going to be that wall though for these people, and if escorting them into the community is a way of introducing them, but if we’re always with them, they will always perceive themselves as ‘Well, I’m the patient and this is my therapist.’; even though you don’t perhaps take that role. We may not feel we’re taking that role on but is that perception always going to be there for the client?

In the above quote Ted raises a number of issues and conflicts/contradictions with regard to community integration and professional support. He brings up the question of what really is normality/abnormality and suggests that it is not uncommon for people to have emotional problems and that clients while focusing on
the fact that they have a "mental illness" are not really so
different from those who are not so designated. The other issue he
raises is the paradox of the "professional-client" relationship
which in itself brings home the fact to the client that they are
"different" and perhaps will feel "dependent" on professional
services. Curiously, there is no discussion of the OT's role in
demythologizing the label and working to promote an egalitarian
helper/helpee relationship which could be as Tyler et al. (1990)
conceptualize, a reciprocal, mutual relationship as opposed to the
traditional unidirectional relationship of expert-client.

Conflicts with Expected Roles—The Desire to Be Friends

Therapists themselves seem to have some conflicts with the
expectations of their role and with their own personal desires. Most
therapists themselves say they prefer a more informal, friendly
relationship with clients and derive much more satisfaction from
this type of a relationship but feel that it is "unprofessional" and
"inappropriate" due to their training, the pattern of hierarchical
relationships within psychiatry, and the traditional long-held
notion that helpers in order to help must assume an objective,
detached stance vis-a-vis the client/patient. Clients, too indicate
that they want a more informal relationship with their therapists
and in fact, many say that they consider their therapists their
"friends".

Therapists repeatedly spoke about the social isolation of
clients, their lack of confidence when interacting with others in
the community, and their lack of social skills which the therapists
feel contribute to the difficulty of their clients in truly
integrating into mainstream society. Charles speaks about how these
problems also contribute to clients' difficulties with supportive
employment in which clients receive job placements in the
community, for example, janitorial work, work at a hardware store,
or working at McDonald's.

And the other problem arises too [with supportive employment]
when once they're there [at the job] because of the
disorganized thinking, because of their lack of social contact,
cause of the isolation, once they're placed in a situation or
environment where they do have ongoing contact it can be really
overwhelming. So to take someone where they've traditionally
been in the sheltered workshop to this type of situation, it's
a giant leap and it's really difficult. We're finding that
maybe five or six percent of the population is ready for
supportive employment, if that.

Later Charles again speaks about the difficulty with job placement
programs to prepare clients for competitive employment during a
discussion of the data summary in which clients mention work or a
vocation as important goals.

Q: So you're saying that...you are currently incorporating
helping clients with work or vocation goals into your role?
Charles: Well we are, we are, and we're also looking at getting
programs getting, moving more, really moving into the community
and having more flexible programming and what not... but the
point being that there's a real gap. We're sensitive to the
clients wanting more empowerment, wanting to be more in control
but it's very difficult to go from the current situation.

Charles further describes the difficulty with competitive
employment for clients which recently is receiving more emphasis
which start out as job placements where the employer has the option
of keeping the client for a longer time or placing her/him
permanently in some other company. He points to the segregation and
isolation of clients and their fear as a factor.

I do speak quite a bit with the clients themselves and with the
supportive employment job coaches and it's a real, real
challenge. And a lot of the clients also express the fear. I
think they want to try but because they've been sort of removed
for so long. [italics added].
Ken, a client, also speaks about the difficulty integrating into the community after being segregated from it for so long due to institutionalization. He says, "But I know you just can’t be sick for five years and then go re-enter the community. There’s no possible way because things have changed too much in five years for you to understand what’s going on."

Again due to the ghettoization and lack of opportunity for clients to interact with individuals in the mainstream community in a 'normal' way we can see how this further reinforces their segregation and dependence on the psychiatric system. John explains his situation and his resignation to it.

I don’t really have any friends that are, my friends are mostly alcoholic, were, used to be...Most of my people, most of the people I know are either patients or have been alcoholics or are alcoholics or are members of staff or are staff and psychiatric patients. I go there quite a bit [OT program] so it’s the patient being, less and less, like I’m in a co-op house, I live with psychiatric patients as well. You get so used to that way of life, that you just accept it. You say, ‘Well I’m not gonna bother about going to look for a job because I’m being taken care of now so and I’m getting older so I’ll just do the best I can in my position.’ [italics added]

**Powerlessness and Dependency**

The previous quote also reveals the client’s feelings of powerlessness due to his position i.e. mental patient. It seems clear that because he believes he cannot change his situation he resigns himself to it and assumes a position of passive dependency. Ken seems quite aware of the above client’s self-resignation when he asks him: “But do you think that’s good for you?” And he replied:

I used to give up something, uh, I think I feel better being a little bit dependent. I must confess that. I’m not the most independent person in the world. Like when I get sick from, get really sick, I just want to go somewhere to a boarding house or something and I just want a stay in there cause I’ll be protected and taken care of. I am like that too sometimes. But I feel much better, I feel much better when I can face the, I don’t really face the real world, though I have a
friend, everyday, he used to go to work everyday and when he had no job he used to go to the ______. I got to know what the real world was like from him and I couldn’t quite, I said to myself, ‘I can’t quite do it like he does. I’m not the same as when I was younger. I can’t quite take life anymore on those side likes terms.’ You know what I mean, getting a job, going to work, or the benefits, you maybe have a good girlfriend or a good boyfriend. The benefits would be something, you know, but and you’d have a more positive feeling about yourself. But I don’t feel too bad right now although I’m still convalescing from, in fact the Doctor said it’s possible I’m a manic-depressive, now I’m graduated from schizophrenia to manic-depression. I don’t know, I don’t know, I don’t know, that’s what he told me anyway...[italics added]

Feelings of dependence, the need to be “taken care of”, and lack of confidence as expressed by the above client are related to the sick role of clients and is another theme that came out of both the individual interviews and the focus groups and was identified by both the clients and the therapists. The power of the psychiatric professional and labelling on the sense of self of the client and the creation of the sick-role are also apparent. This client, as with many, reveals a pervasive sense of hopelessness and powerlessness that cause him to abandon his dreams, wishes, aspirations, and even the simplest, most fundamental of human desires such as having a friend or a girlfriend in the community. Even though he knows he would have “a more positive feeling” about himself if he had a job and a girlfriend he is blocked from trying to get what he wants due to internalization of the sick-role, an assault on self-esteem and feelings of worth.

He, like many other clients, has an acute sense of the stigma of being labelled mentally ill and fears rejection and disdain from others. His inner struggle with his behaviour as a passive mental patient seems especially apparent in the above quote as he starts out to say that he “feels much better” when he “faces the real world” but trails off and continues with that he does not “really
face the real world." He recognizes that even though he feels the need to be taken care of he has a higher self-esteem when he is not dependent. As he says earlier, "You get so used to that way of life that you just accept it." He realizes that he has basically given up and so does the other client when he asks, "But do you really think that is good for you?" We can see his defensiveness and rationalization of his adaptivity to the sick-role and of his fatalism. This client, as with others feels a loss of dignity inherent in accepting the passive patient role.

The social isolation and segregation of clients from mainstream society combine with the sick-role to increase their dependence on the psychiatric system. This is reflected poignantly in the words of the John below.

...they [institutional psychiatric nurses] gave you affection which some people in these places [psychiatric institutions] never had. Like I'd never had much when I was growing up and you get affection here [psychiatric institution] so you want to stay here cause you're like a child that's getting warm, you know. You're alright, somebody cares for you. Out there [community] is blank, is blank...

Clients themselves are aware of their dependence on the psychiatric system and spoke about it repeatedly, more so than did their therapists. John explains:

...Because I figure, stay in the hospital long, you get more and more dependent than [when] you have to go to a boarding home, and you may never get out of there. It depends upon your age but you may never get out of that boarding house and maybe from there the hospital, hospital to boarding house, boarding house to hospital, that's the way the cycle goes for many patients, like that all their lives.

John also talks about how people involved with the psychiatric system become so dependent on it and afraid of the world they will do desperate things in order to become readmitted to or stay in a psychiatric hospital.
There’s two questions a psychiatrist will ask you and the way you answer those two questions is a matter of staying in [the psychiatric hospital] or being released. And one is ‘Are you going to harm yourself?’ and the other is ‘Do you think you’re a danger to somebody else?’ You say yes to both of those, and that’s a good way to stay in and don’t think alot of people might say ‘yes’ just to stay in here, for the security in here is great and you can get pretty well afraid of the world and want to stay in.

So we can see how institutionalism, clients’ feelings of powerlessness, and the social isolation and stigma clients experience in the community, cause them to become so dependent on the institution they will resort to extreme measures to become readmitted.
CHAPTER 9

DISCUSSION

The results of this research, as a whole, reflect critical issues addressed by the empowerment theory. While clients reported a number of factors to be helpful, such as social contact, diversion, the supportive client-therapist relationship, it became clear very early on in the interview process that the internalization of the sick role was a major barrier to helping. This was apparent in clients' sense of hopelessness and uncertainty about their future and contributed to the difficulty experienced by both therapists and clients in the goal-setting process. When asked directly about setting goals for themselves, due to a prevailing sense of impotence, clients said that they did not want to think about the future and expressed resignation to a life within the psychiatric system. This overwhelming sense of powerlessness in psychiatric clients has been identified by both consumers and professionals (Chamberlin, 1978; Deegan, 1990; Goffman, 1961; Rose & Black, 1986; Walsh-Bowers & Nelson, 1994). Therapists, too, recognized this problem and thus felt that one of the best ways to help clients was by getting them out of the sick role. However, they also reported that this was a struggle. In fact, the goal-setting process is an area in which three therapists said they would like further training or guidance as they are unclear about how to do it.

Another major finding of this study which was reported by both client and therapist groups was the lack of time for individual contact. This creates major barriers for helping in terms of preventing a true collaboration. Informed by the gradual shift to an empowerment model of helping in mental health care, therapists
expressed an awareness of the significance of collaboration with the client who becomes a partner in their treatment. However, due to time constraints for individual contact, therapists simply did not have time to engage in a truly collaborative goal-setting process with all of their clients. All the therapists interviewed said they believe that clients' should have the majority of input in the goal-setting process but due to lack of time for individual contact a mutual goal-setting process was not possible. In contrast, clients felt that the therapists should have the majority of input with regard to the goal-setting process. One possible explanation for this discrepancy could be the sick role of clients and their subsequent dependency on the psychiatric system. Clients do not feel confident or competent enough to take on the increased responsibility of this new role. In addition, as I have explained in Chapters One and Two, historically, clients have had very little voice in their treatment and thus are not accustomed to assuming an active role. As pointed out by Rose & Black (1986) using Freire's terminology of "subject" and "object", clients, oppressed by the psychiatric system, have little experience being treated as subjects and perceiving themselves as subjects or active participants in their own lives.

The internalized sick role of clients seemed to be a factor related to their lack of a sense of entitlement. They may not have felt that they had the right to express criticisms freely. For example, throughout the interview process, clients seemed reluctant to express critical comments about OT programs. The anger and sense of violation evident in the consumer movement was not expressed directly by the clients I interviewed. Although they had ideas of what they would find more helpful, they seemed to have no
expectations of their treatment. In fact, the more articulate clients made some very good suggestions about their OT programs but did not feel comfortable communicating these to their therapists. One client, who had thought about an idea for a long time, said he would not communicate it to his OT as he considered himself to be "a lower station". Other clients said that while they would find more individual contact with their therapists helpful they did not expect it as they realized that their therapists were "very busy". One client when asked what she would find more helpful, refused to answer.

Another reason for this reluctance to express criticisms of OT programs openly and directly and a possible limitation of the study, is that I was a part-time employee within the occupational therapy department and thus clients did not want to offend me.

Still another possible explanation is that clients were worried that their psychiatrist or other workers would have access to the information they gave and feared possible negative repercussions. In fact, a few clients mentioned this and though I reassured them that this was not the case they seemed guarded.

However, during the client focus group, eventually some clients did express criticisms of the hospital environment. For example, as one client explained: "But I think the psychiatric environment is bad for people. I mean if you’re not sick when you go in, you will [be] when you get out." These clients identified the social isolation, inactivity, and feelings of lethargy due to medication side-effects as institutional factors which make clients feel unwell. Their therapists, however, did not talk about the harmful effects of institutionalization.
In addition, when questions were framed differently, or periodically throughout the interview, clients did talk about issues with which they would like more help. Consistent with earlier studies (Deegan, 1990; Herman & Smith, 1989; Lord et al., 1987; Mallik et al., 1998; Walsh-Bowers & Nelson, 1994), these issues tended to be related to barriers within the environment as opposed to individual functioning or skill deficits which more often were the focus of their therapists. For example, clients wanted help with real-life issues such as poverty, unemployment, social isolation, getting friends in the community, and community integration. However, therapists did not raise these every day issues and did not speak about the “sick environment” of the psychiatric hospital. Instead they tended to focus on the need for increasing clients’ life skills such as interpersonal skills and hygiene. This discrepancy has also been noted in both the professional and consumer literature (Chamberlin, 1978; Clark et al., 1993; Deegan, 1990; Mallik et al., 1998). One possible explanation for this discrepancy is the fact that an OT’s training focuses on assessment and teaching of life skills and functioning in activities of daily living. In addition, as pointed out in Chapters One and Two, occupational therapy, is descended from the medical model and usually practiced within the psychiatric institution and thus the focus on individual defects is reinforced (Goffman, 1961; Szasz, 1978).

Other areas with which clients wanted help were: improving self-esteem, increasing confidence, feeling in control, and becoming more hopeful about their future. As outlined in Chapters One and Two, to some extent the negative effect of institutionalization and the sick role contribute to both actual deficits in these areas and
the clients' beliefs that they are deficits. (Chamberlin, 1978; Deegan, 1990; Goffman, 1961; Lord et al., 1987; Walsh-Bowers & Nelson, 1994; Weitz, 1984). Therefore, the client cannot be helped without also changing the way help is delivered and without demythologizing the psychiatric versions of reality.

The supportive relationship and social contact were areas which were found to be helpful to clients and which were identified as helpful by therapists as well. Many clients but only one therapist mentioned the value of therapist disclosure. Disclosure as helpful is consistent with the findings of Weitz, 1983 and Wollert, 1986 in their study of self-help groups. Clients but not therapists also mentioned "being friends" with the therapist as an important aspect of the helping relationship. Therapists expressed ambivalent feelings regarding the concept of being a client's friend probably due to their training which traditionally discourages informal, friendly relationships with clients. On the one hand, therapists said they found more satisfaction from these kinds of interactions with clients and sensed that the clients felt the same. On the other hand, they had some reservations about this as they felt they were not being "professional" and that this kind of a relationship transcended appropriate "boundaries". However, both therapist and client groups identified "listening" as one of the most important ways that an OT helps.

With regard to OT groups, the perceptions of clients and therapists converged for the most part. Both groups felt that the social contact, opportunity for achievement/accomplishment, increasing self-esteem and self-confidence groups provided was helpful. Both groups said that they valued a group where cohesion was high, where there was laughing, excitement, and a sense of
connection. Some clients also stressed the significance of a group for the sense of belonging it gave them. This study corroborated the findings of Webster & Schwartzberg (1992) who found that increasing self-esteem, sense of accomplishment, diversion/relaxation, and group cohesion were identified as helpful components of groups, with cohesion being rated as number one.

The dynamics of occupational therapy groups which were valued by therapists and clients were also similar to the dynamics that we would expect participants of many kinds of groups to value whether it be a small group discussion for a university seminar or a community group. However, we can speculate that many of the qualities of a group valued by clients are more salient for them due to the context in which they take place—clients are socially isolated, stigmatized, and rejected.

In contrast to the importance of groups as expressed by clients, only one therapist spoke specifically about the group’s relevance or meaningfulness to clients. Again, clients seemed to value the groups which were naturalistic and grounded in every day life. This finding has also been reported in the research on self-help groups (Weitz, 1983; Wollert, 1986). The most popular groups for clients were also the ones that therapists felt were successful. These were groups such as cooking groups and bowling. Clients said that they found the cooking groups helpful for very practical reasons such as “to learn new recipes” which they could use when they are living independently or simply to enjoy a good meal. One client also said that she valued this group because it took place off the ward, and made her feel that she was getting closer to living independently in the community. Therapists, however, stressed their importance for other reasons (i.e. learning social skills). A
few clients also said they found the cooking groups helpful for the sense of accomplishment they gave them when they could successfully prepare a meal which they had not done before. The bowling group was valued for the pure pleasure clients and therapists experienced from the activity and from socializing together. Therapists said they enjoyed the informal nature of this group. They also pointed out that it was a good opportunity for clients to feel a sense of accomplishment and increase self-confidence as this was something many could do well.

Another area of divergence in perceptions of clients and therapists was the issue of community integration. Clients spoke repeatedly about their desire to make friends with people in the community, to establish relationships, and to achieve a sense of belonging. The ghettoization of clients was something that therapists did not really speak about. In fact, therapists reported emphasizing social interaction with other clients and when talking about community integration referred to taking out groups of clients to see a movie, for example.

For therapists encouraging "community contact" essentially translates to contact with other clients in the community or agencies situated in the community. This is a phenomenon characteristic of most mental health programs as Rose & Brown (1986) point out:

Ironically, under the rubric of reintegration into the community, many former patients have little to no contact with anyone other than people who, similar to themselves, have recently been discharged from psychiatric hospitals. Even in the newer not-for-profit community residences, program requirements regularly send people from homes to programs and back, very much like the programs for the retarded which seem designed more to alleviate community fears than to genuinely assist in habilitation. (p. 16)
The prevalent ethic in mental health delivery systems, from institutions to ancillary services such as case management, day programs, or vocational training enterprises, which conceptualizes clients not as persons in the social world but rather as "mental patients in the community" is relevant to my study. Rose & Brown (1986) write:

The basic identity potential for the ex-patient thus emerges: she/he is encouraged and supported to stay symptom-free through medication monitoring and participation in an array of services designed to improve their functioning within the pre-existing social role of mental patient. Rather than living as a social being in a political, social, economic community, ex-patients subsist in a sub-community medicalized and static, and disguised or concealed as the community itself. (p. 16-17)
CONCLUSION

Part of the struggle for therapists in empowering their clients is to help the client move from a mental patient identity and passive powerlessness to one of self-worth, dignity, and self-determination.

The application of an empowerment model to occupational therapy could be useful to therapists in achieving this process. Through critical inquiry we demystify the psychosocial version of reality by linking objective conditions (i.e. harmful effects of their psychiatric history, poverty, social isolation) to subjective experience (i.e. lack of self-worth, sense of powerlessness, alienation). This process helps legitimate and validate the client as person in the social world and ultimately may lead to action.

Rose and Black (1986) explain this process:

The focus of direct practice is predominantly on the process of empowerment, of reconnecting the social, objective world to people’s subjective experience in order to reflect critically on that world and change it. The purpose of our practice is to liberate people’s capacity to produce socially meaningful activity from the confined realm of daily life shaped by profit housing, lack of control over one’s body and living situation, and the manipulations and mystifications inevitably embedded in psychiatric and psychosocial versions of reality. (p. 72)

This process involves a transformation of the individual by critically examining the context in which s/he lives. Part of this examination involves legitimating the impact of the individual’s psychiatric history or self-expression by demystifying the processes that socialize the individual into “mental patient-hood”. Rose & Black (1986) write:
The transforming process must confront the elements or ingredients existing in the present context which maintain or reproduce mental patient functioning/thwart personal development. The process aims to support an increasing autonomy and capacity for interdependence and to act against isolation; to support collectivity or network building and to deny the primacy of individual functional performances. (p. 40) (emphasis added)

The present study demonstrated the relevance of empowerment theory to working with clients in psychiatric occupational therapy. By expanding their role to include a critical inquiry into the objective oppressive reality of clients and advocating for clients' legal rights and entitlements, in addition to politicizing their role to include legislative activities, psychiatric occupational therapists could offer direct help to clients with the issues that clients clearly named as the real barriers to well-being: poverty, unemployment, lack of confidence, social isolation, stigma, and low self-esteem.
References


APPENDIX 2: Patients’ Interview Schedule

How long have you been on the unit?
How long have you been involved with Occupational Therapy (OT) services?
What does an OT do?

What groups/programs are you currently participating in?
What does this group do for you? Why do you attend it?
What do you like/dislike about it?
What do you think is helpful/not helpful about this group?
What would have made it more helpful?

If you had the power to change things, what would you change about the group?
What group/program do you like best/least? What is it about the group?
What other groups/activities/programs would you like to participate in?

What does your OT do to help you? When you spend time with your OT-just the two of you-what kinds of things do you do with your OT? What is helpful? What is not? What does your OT do with you that you like-makes you feel good? E.g. talks with you? Listens to you? Asks you what you want? Understands you? Help you figure out problems? If you had the power to change things about what you do with your OT, what would you change?

What else would you like your OT to help you with? What do you see as your needs? How does your OT help you meet them?

How do you decide which programs to participate in?

What information are you given with regard to the type of OT programs available? (How do you know about the different groups you can participate in?)

How do you decide what skill/problem area you are going to get help with?
What skill/problem areas are you getting help with from your OT now? Are there any other skill/problem areas you would like help with? Which of these are most important to you? (rate).

Which groups do you participate in?
   For each group: based on your experience, what are the goals of the group?
   What do you think are the strengths/weaknesses of this group?
Let me ask you about your feelings about the groups, what are some of the things you really liked/disliked?
If you had the power to change things, what would you make different?
Are there other groups/programs you think would be helpful?

Is there anything else you are not getting help with that you would like?

How do you know when you are being helped?
What do you think are the most important things your OT can do to help you?
What qualities should a good OT have?
APPENDIX 3: Therapists’ Interview Schedule

How long have you worked at the centre?

Can you tell me about the unit you work on? It’s treatment goals and philosophy?

What do you see as your role as a psychiatric Occupational Therapist (OT)?
I know you have a lot of different responsibilities as an OT. Can you describe what kind of things you do with regard to direct patient care?
In terms of one to one contact, what is it that you do which is helpful to your patients?
What do you see in general as their needs?
How do you determine them? And how do you meet them?
If you had the power to change anything about the one to one contact what would you change?

How do you decide what goals to work on with your patient?
Do you sit down with your patient and set goals together? What is that like?
What do you think is one of the most important factors in setting goals with your patients?
How much input into this do you think the patient should have?
How much input do you think you should have?
What proportion should your involvement be? For example: 50:50? 80:20?

What do you think most of your patients want help with?

How do you decide what skill/problem areas your patient should work on?

In general, what do you think are the most common skill deficit areas with which your patients need help? (rate in order of importance).

How do you decide what program your patient should participate in?

Which groups do you offer?
For each group ask: based on your experience, what are the goals of the group?
What do you think are the strengths/weaknesses of this group?
Let me ask you about your feelings about the groups, what are some of the things you really liked/disliked?
If you had the power to change things, what would you make different?
Are there other groups/programs you think would be helpful?

As a psychiatric OT, how do you think you could better meet the needs of the clients?
What do you think will improve your OT programs?
What would the best OT group look like to you?
What do you think are the most important ways in which you can help your patients? (rate in order of importance).

What qualities should a good psychiatric OT have?
Appendix 1: Consent Form for Patient Participants

Maria Haarmans is completing research to examine the similarities and differences between patients' and therapists' opinions about the goals and implementation of Occupational Therapy services. Maria is a part-time Occupational Therapy Assistant at the Queen Street Mental Health Centre and a graduate student in Community Psychology at the Ontario Institute for Studies in Education.

This research includes: (1) a tape-recorded one-hour interview in which I will be asked questions about my opinions and feelings regarding my occupational therapy treatment. (2) a tape-recorded one-hour group discussion with other patients who volunteer for the research. (3) a group comprised of occupational therapist participants in which a summary of all the interviews will be presented as a basis for a discussion group.

The information gathered during these interviews will be used for research purposes and confidentiality and anonymity will be maintained. No one will know what I say during the interviews. My occupational therapist will not have access to interview transcripts. All information will be stored in locked files in the office of Maria Haarmans. Information which may be published, presented at a scientific or educational meeting, or used by the occupational therapy department will exclude any details that may reveal my identity.

Participation is voluntary and I have the right to withdraw from the research at any time. Participation in the research and/or withdrawing will not affect my treatment.

I have read, understand, and agree to the conditions for participation in the research program as stated above. Maria Haarmans has explained the details of the research program as stated above.

Date Participant

Date Guardian (if necessary)

Date Witness