When the challenge isn’t physical

Cynthia Saver, RN, MS

When patients can’t meet a therapy challenge because of a physical problem, therapists usually know just what to do. What’s harder is when patients aren’t meeting goals because of emotional difficulties. What to do then?

“We don’t feel very comfortable with mental health in our society,” says Sam Kegerreis, PT, ATC, a professor in the Kraner School of Physical Therapy at the University of Indianapolis, Ind.

Physical therapists (PTs) and occupational therapists (OTs) can feel more comfortable in the psychosocial realm by understanding more about it. Moreover, they can take steps to nurture a therapeutic relationship so it’s easier to manage any behavioral or treatment problems that may arise.

A different approach

Kegerreis says the traditional biomedical model is dualistic: one half is the physical world and the other half is the psychological world. However, that model doesn’t work for patients who have chronic conditions. Response to therapy is complex, with many different influences. “That’s why we need to take a biopsychosocial or patient-centered approach,” he says.

As PTs naturally focus on the patient’s physical challenges, it’s easy to lose sight of emotional needs. It’s best to start by building a strong relationship, watch for signs of a problem, and address issues as soon as they’re identified.

Prevention through therapeutic alliance

Kegerreis says the first step in collaborating with patients is to create a therapeutic alliance (TA). “People need to feel they’re understood,” he says. “You can’t put diesel into a car that wants regular gas. You have to empower patients.”

Mary Seaton, OTR/L, MHS, an instructor in occupational therapy at the Washington University School of Medicine, St. Louis, Mo., agrees. “I try to develop a collaborative relationship through therapeutic use of self,” she says. “You have to first establish trust.”

Seaton says to recognize that the loss of control that patients experience produces anxiety. “If you barge in with your goals and don’t listen to patients, they’ll see you as taking away more of what’s in their control, and they’ll just put up barriers,” she says.

Seaton shares the example of a woman who had a brain tumor and hemiplegia. “The referral was for hand function, but the patient’s priority was caring for her baby.” In this case, patient-centered care meant incorporating exercises that directly related to caring for the baby.

A TA allows therapists to anticipate potential problems, says Ashley Northam, MS, CCC-SLP, coordinator of the Speech Language Pathology Assistant program at Chemeketa Community College, Salem, Ore. Northam conducts an information interview with patients (or parents if a minor is being treated) before starting therapy. “I find out about their lives,” she says. “I get a picture as to how the family runs so I get a hint of possible stressors.”

Kegerreis says establishing a TA makes it more likely patients will tell therapists about undisclosed biopsychosocial comorbidities that can seriously compromise compliance and outcomes.

Northam also looks for “bridging opportunities, where I can go above and beyond to help.” For example, she might attend an Individualized Education Program meeting at no additional charge.

“Patients make progress based on the relationship they
Watch for yellow flags

Northam likes to “keep tabs on” her patients’ lives during therapy. “An adult might be getting worried about something coming up, like a job interview, or be concerned about a stressful situation with a coworker,” she explains. “You have to put on a counselor hat even though you’re not a counselor.” Northam is alert to changes in behavior from one visit to the next and pays attention to how patients are communicating. “If they can’t stay on topic, or can’t follow what you’re saying, that may indicate a problem.”

Just like there are red flags that signal a patient needs additional medical attention, Kegerreis says there are yellow flags that alert therapists of a patient’s psychosocial needs (see Yellow flags for mental distress).

Some PTs and OTs may feel less comfortable in this area, but Kegerreis notes that part of a therapist’s professional responsibility is to screen patients for previously undetected conditions that may affect outcomes: “Just as a physical therapist may refer a patient with an ACL (anterior cruciate ligament) deficient knee to an orthopedist, it may be equally appropriate to refer a patient suffering from depression to an appropriate medical practitioner.”

The therapist isn’t attempting to be a physician or psychologist, but rather a contributing member of the healthcare team.

Although formal assessment scales are available, such as the Beck Depression Inventory, asking questions can be a more effective—and more efficient—tool for screening patients. Don’t be afraid of discussing the problem, says Jennifer Werdell, PT, GCS, MS, clinical coordinator at Suburban Hospital, Bethesda, Md. “Let them know you’re concerned.” For example, you might ask, “You sound like you’re down. Is this unusual for you? Have you talked to anyone about this?”

Gently explore possible reasons for the patient’s behavior, without stereotyping expected psychological response. For example, Kegerreis says it’s not unusual for patients who have been involved in a serious motor vehicle crash to experience posttraumatic stress disorder (PTSD). A subtle way to tease out this information is to simply ask about the patient’s sleep pattern. If the patient expresses that his sleep is problematic, a natural follow-up question would be to ask about nightmares related to the crash, which often accompany PTSD.

Kegerreis also stresses that PTs and OTs must take the lead in exploring a problem behavior, identify yellow flags, and not rely on the patient to raise the issue. “We are the professionals,” he says.

Contracts and rewards

A contract can help establish a structured therapeutic relationship and prevent difficulties down the road, says Sam Kegerreis.

“First I ask patients what they want to change,” he says, adding that it’s important to be sure goals are realistic. “A person might say he wants to be pain free, but I tell him that no one is pain free.” Further exploration may reveal a patient simply wants to use less pain medications or be able to go outside and play with her grandchildren.

“You’re here about their goals, not yours,” says Mary Seaton. “You might have an opinion as to what the goals should be, but you’re there to help patients identify their own goals.”

Kegerreis develops a contract that typically lasts for six sessions. Then both he and the patient evaluate progress and determine next steps.

Another tool to help patients feel good about their progress is a reward system. Ashley Northam says this strategy can be particularly effective in children. “A child earns a token at each session and has the option to earn more by doing ‘homework’ between sessions,” she explains. The child collects tokens and trades them in for small prizes such as candy or jewelry. The items are priced at different levels.

Detective work

When problem behavior occurs, the therapist needs to play detective. “You can’t just tell a child to stop crying and you can’t just tell a patient to stop a problematic behavior,” says Kegerreis. “You have to understand where the patient is coming from.”

For example, patients may be upset because they don’t understand the need for therapy or because they don’t want to return to work for fear of injuring themselves again.

When patients aren’t completing therapy at home, Werdell suggests asking, “Is there something you think we should be focusing on that we’re not?” The response can serve as a yellow flag for the therapist that the patient doesn’t understand how a therapy relates to a goal.

If patients react negatively to a lack of progress, you can ask, “It sounds like you’re frustrated about not making progress. Is there something I can do differently to help you meet your goal?”

Another problem occurs when patients’ and therapists’ perceptions differ. “They may think they can do an activity once they get back to work and don’t see the exercise as useful,” says Seaton. She simulates what the patient will do on the job to link the exercise with reality. “Let them discover it through simulation,” she says.
Consult others

As a new OT, Seaton worked with a young man who had suffered a spinal cord injury. The young man was very depressed. “He kept telling me how terrible he felt and what he was going to ‘leave’ for me, like his stereo,” she says. “Basically he was saying he was going to commit suicide.” Seaton was about the same age as her patient, who was in his 20s. She admits being devastated. “I had no idea what to do.”

Although today Seaton would have the maturity and expertise to discuss the situation with the patient, at the time she chose another option: She pulled in her resources. Sometimes turning to others for help is your best option.

Werdell, who suggests using other therapists as resources, feels fortunate to work with PTs and OTs who have varied backgrounds. “Therapists fresh out of school have a lot of good ideas, and more experienced therapists have tips for younger staff.”

She says talking with others helps you to think “outside the box” and suggests discussing the situation in a staff meeting or over lunch, always protecting patient confidentiality. Werdell adds that collaborating with family can sometimes be helpful.

Of course, also refer patients as needed to social workers, psychologists, and psychiatrists.

You can’t save the world

“We’re not about trying to ‘get’ people to do things,” says Seaton. “We’re about helping people ‘go’ where they want to go.”

Unfortunately, you can’t always be the one to help your patient. Sometimes patients just aren’t ready for therapy.

Werdell says straight talk may be helpful for those who won’t do their exercises. She tells these patients, “My job is to give you the tools you need to be able to do it on your own. If you aren’t going to use the tools, you’re wasting your time and my time.” This candor helps patients understand that they’re responsible for their therapy.

Werdell says a personality conflict between patient and therapist may necessitate a switch in therapists. “It’s not that the therapist isn’t competent. It’s just that a different approach might work better in this specific case.” Or, you simply might need a break from a patient. “Sometimes you need to have another therapist step in for one time or ask to be reassigned,” says Werdell. “Your ultimate goal is to act on the patient’s behalf, so you’re doing the patient a service by linking him with someone he can work with.”

You may not be able to save the world, but by keeping alert, you may save the life of one patient.

Yellow flags for mental distress

Sam Kegerreis uses this list of clues to mental distress for early identification of patients’ psychological needs. He emphasizes that these patients “aren’t bad people,” rather they’re using unsuccessful coping mechanisms.

Keep in mind that any patient may have one or two of these clues without a problem being present.

• Extensive medical history, such as multiple surgeries and illnesses. These patients may be the “worried well” and more likely to see a physician.

• Nominalistic (general, nonspecific) symptoms for more than 6 months.

• History of personal, family, or vocational problems.

• Negative view of medications, feeling they’ve “tried them all and nothing works.”

• History of sleep disturbances.

• Criticism of previous care.

• Multiplicity of symptoms. Patients may complain of hurting all over or may have multiple symptoms at the same time that wouldn’t normally be related.

• Excessive gestures and protective posturing.

• Inappropriate distress responses. For example, patients who break out into a sweat when faced with an exercise similar to what they do on the job may be afraid they’ll be injured again. Or patients who suddenly experience problems when it’s time to be discharged from therapy.

• Passive aggressiveness or controlling actions.

• Nonadherence to therapy, tardiness, or absence.

• Conditional improvement. The patient says, “I’m improving, but…”

• Polar/concrete cognition. Patients who view the world as black or white and are convinced they know specifically what’s causing their problem. For example, they report an “L4-L5 disc problem” instead of describing their pain.

• Diminished libido.

• Prolonged caretaker role. Patients who are worn down from caring for an aging parent may feel their injury is an “honorable” way out of the caretaker role, making them slow to respond to therapy.

• Childhood or spousal trauma, abuse, abandonment.

• Catastrophizing. For example, patients who take a small setback and say they’re “never going to get better.”

• Social isolation.

• Economic concerns.

• Alexia or learning disabilities.

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