EFFECTS OF A FAMILY-ORIENTED TRAINING EXPERIENCE ON THE ROLE OF THE PHYSICAL THERAPIST

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This article describes ways in which a family-oriented psychologist contributed to a reconceptualization of the appropriate role for the physical therapist in patient care. The article identifies aspects of the changing role of the physical therapist, specifically its expansion to include skilled psychosocial interaction with patient and family for the purposes of reassurance, support and instruction. A primary shift involved changing from focus on the individual and his or her disability to focus on the patient in the context of his or her family. The article briefly describes elements of appropriate psychological training which can be incorporated successfully in a physical therapy educational experience, and concludes with a case example illustrating the basic points relevant to this type of interdisciplinary collaboration.

Psychologists have developed important roles as consultants to professionals in other disciplines such as education, business, and, more recently, medicine. Part of the value of this consultative capacity has been to redefine world views, priorities and appropriate professional roles for the members of these disciplines. Thus, businessmen have been made aware of psychological factors affecting job performance; teachers have learned to stress emotional as well as academic growth; and physicians have learned the importance of treating the whole person rather than the disease. The present article examines how an interdisciplinary, family-oriented training experience for physical therapists can contribute to a more holistic involvement in patient care.

Physical therapy is commonly stereotyped by lay persons as the mechanical manipulation of limbs, massage, learning how to get in and out of wheelchairs, etc. Yet physical therapy involves many other variables: the relationship of the physical therapist and patient; dealing with the effect of illness or disability on the patient's life (Mabry, 1964); and, perhaps most important, understanding that any physical therapy skills must be communicated only after taking into consideration the total physical and social context of the patient (Maddox, 1975).

As an illustration of the potential complexities confronting the physical therapist, consider the following situation:

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A 72 year-old black woman underwent a right-above-knee amputation resulting from severe vascular problems. Her other foot was beginning to appear gangrenous and there was a strong possibility of a second amputation if she did not have excellent care. Prior to this episode she had been the primary caretaker of the house she shared with her husband. The husband was a 78 year-old man who had suffered a stroke 5 years previously; he also had a "bad back." Despite their disabilities, they were dependent upon each other and wanted for the patient to be discharged home. However, they also had many doubts and fears about how they could possibly care for one another under these new conditions. Both the patient and husband expressed their fears privately to their physician but they had not communicated these fears to one another. The patient had further problems dealing with her altered body image and her fear of losing the other leg.

Where do such people turn to seek help? Whose role is it to teach the husband stump wrapping and transfer techniques so that he will not injure his back? Who will explain the medications and diet restrictions to the patient? Should this patient simply be sent on to a nursing home? Can anyone help her and her husband to make a successful readjustment to the home?

Questions such as these were explored through the implementation of the Family Focus project, operated by the Stanford Medical School's Department of Physical Therapy from 1972–1978.

Description of Family Focus Program

Family Focus began as the brainchild of Dr. Kay Shepard and Dr. John Bell (Blood, 1978; Shepard & Barsotti, 1977). The program was designed as an experiment in transitional health care, and emphasized the mutual reintegration of patient and family. Patients selected for participation in the program were transferred from Stanford Hospital to "Family Focus" (a self-contained apartment unit) for the last three to five days of their hospital stay. The family joined the patients in the unit, bringing with them all necessary food supplies. The term family was expanded to include friends, relatives, neighbors, church members and occasionally a nurse or aide who would be living with the patient at home.

A Physical Therapy Clinical Instructor was the coordinator of services. All allied health professionals involved with the patient in the hospital continued to see the patient in the unit. However, their role was slightly altered as they now had to transfer their skills to the family and patient rather than work directly with the patient. Two Physical Therapy students were assigned to each family and were supervised by the Physical Therapy Instructor. A Clinical Psychologist observed the students working with the family and patient and then met with the students to discuss family dynamics and psychosocial aspects of patient care. The patient and family were discharged directly home following their stay in Family Focus if this was feasible.

Effects of the program on patient and family have been reported elsewhere (Blood, 1978). The purpose of this article is to describe how the process of focusing on patient and family as the appropriate unit for health care delivery simultaneously necessitated a reconceptualization of the role of the physical therapist. First, the changing role of the physical therapist as it emerged in the Family Focus program is explored. Then, the theoretical and experiential interdisciplinary training utilized to facilitate this new role, including the pivotal role of a family-oriented psychologist, is described. Finally, a case example of this interdisciplinary approach to patient care is presented.

The Changing Role of the Physical Therapist

The nature of the physical therapist/patient relationship was altered dramatically in the Family Focus program. First, the therapist had significant contact not only with the patient but with family members as well (Bell, 1977), in contrast to the traditional

hospital setting where contact with family members was peripheral if at all. This emphasized a switch from direct therapy with a single patient to teaching family members certain functional skills. Thus, the emphasis was on teaching and consultative functions.

Secondly, the therapist's relationship to patient and family was significantly less formal than in the hospital. Because of the home-like environment of the Family Focus unit, patient, family, and physical therapist were able to express various personal qualities for which there was considerably less opportunity in a hospital setting (Goffman, 1963).

Another effect was that the lines of authority within the patient/therapist relationship were changed. In the Family Focus setting, the physical therapist had less authority than he/she would have had in the hospital. The family dynamics which were allowed to be recreated in the Family Focus setting established a counter-force to the professional expertise and authority that the physical therapist brought to the unit. The physical therapist's authority was also challenged in the sense that the family could take more initiative regarding the therapist. In the social atmosphere of the unit, patient and family felt freer to ask questions, to express their own needs, to set times for treatment sessions, etc.

As therapy became more integrated with the family life, family members were able to assume a primary role in taking responsibility for its execution. Conversely, the expertise of the physical therapist gradually became less important. Thus, there was a positive effect of "normalizing" therapy. Therapy became something not done in a clinic or hospital, but part of home life, a shared activity in which all the family could participate as they might participate in a sport such as volleyball or swimming.

The physical therapist often assumed yet another role, that of a group facilitator. While in no sense did the physical therapist function as a minipsychotherapist (Egnew, 1977), there was frequent opportunity to deal with small crises within the family unit as well as problems of everyday living. Often the physical therapist was in a position to facilitate communication between family members. Perhaps more important, "talking" or interacting with their patient became seen as an integral part of their role as physical therapists. Whereas in the past, a physical therapist would tend to refer any mention of psychological distress to a psychiatrist or psychologist, the Family Focus program allowed students to realize that many psychosocial skills are not beyond the competence of a physical therapist.

A further expansion of the role of the physical therapist occurred as a direct result of the reintegration of the patient and family as a unit. Quite often the physical therapy goals were greatly influenced by the health status of the family members in conjunction with the patient's physical problems. Evaluation of the patient was followed by assessing if the patient's needs could be met by the assistance available from the family. A transfer safely performed between patient and therapist meant nothing unless this task could be repeated by a family member and patient.

Training Components

Manipulation of the Physical and Social Environment. In part, changes in the role of the physical therapist were effected simply by altering the physical environment (Shapiro, 1980). Both patients and therapists tended to behave differently outside the traditional hospital setting. The therapists' role was also affected by redefining the term patient—in this case, expanding it to include the family. This redefinition forced physical therapy students to pay attention to their patients in the context of the family.

Role of the Psychologist. The active presence of a family-oriented psychologist was critical in facilitating the role redefinition of the physical therapy students. In the Family Focus program, the psychologist was behaviorally trained with post-doctoral experience

in brief family therapy. This background enabled the psychologist to identify the family as the unit of treatment, and to focus the physical therapist's attention to the interaction among family members as providing information critical to the identified patient's well-being. The psychologist was also able to help physical therapy students understand and appreciate the changing boundaries of their professional role.

In the Family Focus setting the psychologist had several responsibilities. First, the psychologist was responsible through a regular consultative process for the direct supervision and training of students in the area of psychological skills. The psychologist also had responsibility for patient observation as well as occasional direct patient contact.

Both one-way mirrors and *in situ* observations were used to facilitate feedback for the physical therapy students. The latter allowed for the easy exercise of interventions in terms of modeling specific psychological techniques eliciting information, probing, etc. Also, the concrete presence of a psychologist on occasion served to salvage a crisis situation which a physical therapy student was not trained to handle.

The psychologist and physical therapy instructor worked closely together in the training of students. In considering any given patient, through their collaboration they attempted to demonstrate how psychological concerns and physical therapy concerns could easily and profitably be integrated. This collaboration facilitated the student's understanding of the patient as a complete person with both psychological and physical needs.

Perhaps the primary role of the psychologist in this setting was to model and teach a different world view to physical therapy students: to focus on the patient in the context of the family rather than on the patient in isolation; to be sensitive to interactional processes, as well as physical processes.

Psychosocial Skill Training. Several fundamental psychological skills proved valuable in student training. These were transmitted through informal consultation process with the psychologist. The emphasis of this training was on the practical application of psychosocial skills in the physical therapy setting; the experience was tailored to the student's primary role of physical therapist.

Communication and Interviewing Skills. In this context, observation skills were found to be of great importance. Students needed training in how to observe family and patient interactional situations accurately. They needed to realize that attachment of preconceived theories could be destructive to an accurate perception of events.

The students also needed training in development communication skills—the use of affective questions and statements, reflective listening and empathetic remarks, confrontation, etc. Finally, they needed help in learning how to conduct initial interviews (Bernstein, Bernstein and Dana, 1974).

Theoretical Training. The students were exposed to several psychological theories during their course at Family Focus. They studied communication theory (Satir, 1967), for the insights that could be gleaned into interaction patterns among family members. They learned principles of behavior modification (Ullman & Krasner, 1969) in order to have tools to elicit behavior change in their patients and families. They also were exposed to many concepts of family therapy (Ackerman, 1966; Bell, 1978; Patterson, 1971), and learned to view the patient as part of a family system.

Behavior Modification Skills. Students also received training in the area of brief therapy (Weakland, Fisch, Watzlawick and Bodin, 1974), and behavior modification (Bandura, 1969; Patterson, 1970). These particular therapeutic skills proved to be especially useful with the short-term patient population in the Family Focus unit. Through the use of behavior modification principles they were able to help patients and families modify old behavior patterns which were no longer adaptive given the nature of

the existing disability or disease entity. Students developed skills in goal-setting such as establishing measurable and observable short term and long term goals (Mahoney & Thoresen, 1974) for the patient and family, and for themselves as professionals.

Students also learned how to conduct a functional analysis of the environment (Kanfer & Saslow, 1969). They practiced identifying behaviors in the patient/family which needed to be changed or modified, decreased or increased, in order to enhance optimal therapeutic functioning. They were also trained to identify antecedents and consequences of these behaviors which increased their understanding as to how environment "causes" behavior, and how behavior in turn impacts on the environment.

Functional Problem Solving. The stay in Family Focus stressed functional problem solving rather than teaching physical therapy techniques in a void. This tended to encourage active patient involvement and place stress on the importance of patient and family goals as well as therapist goals. Students also developed an appropriate sense of how much to help or not to help their patients. They developed somewhat different norms for this decision making than they had held in the traditional clinic setting where patient safety was the primary goal. In the Family Focus unit, patient self-responsibility was the primary objective, with patient safety an important secondary objective.

Interdisciplinary Collaboration in Patient Care: A Case Example

In the case described at the beginning of this paper, traditional physical therapy goals would have included patient training in stump wrapping, transfer maneuvers, and use of a walker. But a traditional physical therapy approach would not have addressed some of the more salient psychosocial aspects which figure prominently in this case. For example, were there any stereotypes or biases which two white, middle-class physical therapy students might be sensitive to in dealing with an elderly black couple from a northern California ghetto? Further, how could the physical therapy students attend to both patient and spouse revulsion at the amputated leg and its care? How could they successfully gauge to what extent the woman's situational depression affected her avoidance of the walker? How could they effectively mobilize husband and extensive family and community support for this disabled, but courageous woman?

Without training and consultative support along the lines mentioned above, these and other issues would have been largely ignored by the physical therapist, despite the fact that they were all directly related to treatment and eventual positive or negative therapeutic outcome. Discussions with the psychologist enabled physical therapy students to explore their own feelings in relation to patient, spouse, and extended family. Issues raised included these therapists' previous lack of experience with the American black sub-culture, a simultaneous fear of offending, and enthusiasm for discovering many values similar to their own. The extensive family network was impressive to the students, but they needed assistance in analyzing the patient's role within this familial network, as well as in identifying specific ways in which a willingness to help on the part of many concerned people could be transformed into a series of concrete behaviors directed at enhancing patient physical and mental well-being. Encouragement to share feelings separately for both patient and spouse was a successive approximation of open communication in the marital dyad. Physical therapy students learned to express their own feelings about the family's plight in ways which were honest and also therapeutically beneficial to the patient.

Subsequently, after a below-knee amputation of her other leg, patient and spouse were treated again in the Family Focus unit. This time, with the help of the psychologist, students examined their own sense of shock at the patient's physical diminution. They dealt with the helplessness and hopelessness of the patient's severe clinical depression,

and the related depression of several family members. Soon after, the patient died of a massive stroke, and physical therapy students were directly involved in dealing with their own and the family's grief reaction.

Simultaneous to the developing awareness of these psychological aspects of patient care, the physical therapy students continued to maintain their primary role as physical therapists. Thus, conversations about changed body image occurred within the context of exercise of the disabled limb and use of a walker. Husband's mastery of stump-wrapping was supplemented by a discussion of his feelings at being thus intimately involved with his wife's disfigurement. A home visit to the family was used to gather important psychosocial information, but also gave the physical therapist an opportunity to explore physical adaptations needed in the home environment.

Thus, the physical therapy students were able to successfully integrate psychological and physical therapy skills. Physical therapy remained the primary mode of intervention and treatment. However, therapists were now able to make the family, rather than the individual patient, the focus of treatment by integrating therapy into aspects of family life and by training family members to use principles of reinforcement and extinction to increase the probability of successful execution of therapy. Therapists were also able to help patients explore the feelings that accompanied the development of major illness or disability, as well as the role changes inevitable in such a situation.

Training Benefits of the Family Focus Program

In general, our experience was that the Family Focus cottage had a powerful, positive impact on student Physical Therapists. The student physical therapists gained much insight from their experience in Family Focus. The opportunity to practice physical therapy skills was only a minor part of their responsibility in the cottage. With the guidance of the psychologist and the physical therapy instructor, the students expanded their view of the patient. Rather than treating a person's limbs, the students saw the patient as a whole entity and realized the importance of transferring skills to the patient and family. The students developed an ability for realistic goal-setting as they learned to understand that the ultimate goal was getting the patient and family to function well in their own home. By communication with the family, the students became aware of the architectural set-up of the home and could then transfer the appropriate skills or arrange for assistance necessary for a particular home.

By having the students see the patient in the hospital setting; then by following that patient and family to Family Focus; and finally by concluding the experience with a home visit one month after discharge, physical therapy students received an appreciation for the impact of environment on patient and family. From a sterile, isolated hospital room to the comforts of a patient's own home, one observes a very different functioning pattern and role behaviors of patient and family member. The student had the opportunity to see the benefits and disadvantages of working with patients in various settings. It was often noted by students how quickly they were accepted by patient and family members once they were in the cottage and also how cooperative and anxious to learn family members were when offered the opportunity to assume responsibility.

Another advantage of the Family Focus experience for students was that they were in an excellent position to observe interpersonal relationships of family members. They could see firsthand cultural differences and how people related to illness and disability. The psychosocial aspects of disability were stressed throughout the student's experience.

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