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Therapeutic Use of Self: A Guide to Integrate the 5 Love Languages into Practice

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Therapeutic Use of Self: A Guide to Integrate the 5 Love Languages into Practice

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Approval

This scholarly project, submitted by Haley Folkens, MOTS and Emily Roberts, MOTS in partial fulfillment of the requirement for the Degree of Master of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

Faculty Advisor

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Abstract

Title: Therapeutic Use of Self: A Guide to Integrate the 5 Love Languages into Practice

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Healthcare institutions have become businesses and, subsequently, these institutions are oftentimes structured to maximize profits consequently leading to a sacrifice in quality of care (Beltrán-Salazar, 2014). The emphasis on business in healthcare results in a push for productivity and reimbursement consequently decreasing attention to the therapeutic relationship. There are many definitions that offer a better understanding to the idea of therapeutic use of self, but they offer little to guide therapists in what using therapeutic use of self looks like in everyday practice (Solman & Clouston, 2016). Additionally, a vast majority of occupational therapists perceive the therapeutic relationship to be vital elements to engagement in therapy, however, only half of therapists feel they sufficient knowledge about use of self beyond the basics he or she learned during their education (Taylor, Lee, Kielhofner, & Ketkar, 2009).

A literature review was conducted on the current state of healthcare, topics relating to the 5 Love Languages (Chapman, 1992), lack of humanized client-centered care, therapeutic use of self, and the influence of use of self on therapy outcomes and client satisfaction. Concepts from the Canadian Model of Client Centered Enablement (CMCE) (Townsend et al., 2013), the framework of the 5 Love Languages, and information obtained from the literature review were used to guide development of the product.

The final product is a guidebook that is intended to be used by occupational therapists, occupational therapy assistants or the healthcare team. We believe the application of the 5 Love Languages to the therapeutic relationship will improve the therapy process for both the practitioner and the client and result in improved therapy outcomes.

Chapter I

Introduction

"One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient"- Harvey Chochinov

Significance of Identified Problem

Healthcare is simultaneously a system devoted to maintaining and improving health of people and a business. Subsequently, there are a number of implications for the actual care that is delivered to the consumers of the business, also known as the clients. Business institutions, including that of healthcare, are oftentimes structured to maximize profits consequently leading to a sacrifice in quality of care due to numerous cost containment processes that can limit time with clients, number of staff, and other resources (Beltrán-Salazar, 2014). Quality of care and overall client satisfaction have been found to have direct links to a practitioner's interpersonal skills and ability to interact effectively (Batbaatar et al., 2017; Kelly, 2014). These skills in occupational therapy practice are considered to be part of therapeutic use of self. Although there are many published descriptions of therapeutic use of self, few resources are available to guide therapists in using therapeutic use of self in a practice (Solman & Clouston, 2016) to build a therapeutic relationship with clients.

Many practitioners have indicated the importance of the therapeutic relationship to be a crucial element to engagement in therapy, however, only half of therapists feel they sufficient knowledge about use of self beyond the basics he or she learned during their degree education (Taylor, Lee, Kielhofner & Ketkar, 2009). Not receiving thorough learning of and training on the subject other than its basic tenants provided in the academic setting, as well as lack of continuing education once in practice, leads to practitioners feeling incompetent in the art of therapeutic use

of self. As a result, there is a push for practitioners to rely on their minimal knowledge and own instincts regarding how to best apply therapeutic use of self in a therapeutic relationship. Within occupational therapy, support for participation from the client can be better achieved when the therapist understands the client's preference for how he or she would like to receive his or her care (Mroz, 2015).

We conducted a literature review on topics relating to the 5 Love Languages (Chapman, 1992a), lack of humanized client-centered care, therapeutic use of self, the current state of healthcare, and the influence of use of self on therapy outcomes and client satisfaction. Through the completion of the literature review, we identified gaps in client care, as well as in practitioners' knowledge and skill regarding the use of therapeutic use of self. The need for a guide addressing the lack of humanized, client-centered care was apparent.

Theoretical Base

The Canadian Model of Client-Centered Enablement (CMCE) was used as a guiding theoretical framework to structure the content of the product. Concepts from the CMCE developed by Townsend and Polatajko (2013) provided a framework for occupational therapists to envision how he or she can work with their clients. The CMCE is intended to promote a client centered approach to occupational therapy and emphasized that therapy should be done with the client, not to or for the client (Townsend & Polatajko, 2013). To further inform the content of this product, Gary Chapman's 5 Love Languages were used as a conceptual basis to categorize preferences of clients, and to structure a foundation of care that is built upon those preferences. Chapman's concept The 5 Love Languages, focuses on the idea that each individual receives love differently, and that he or she is more or less receptive to receiving love in different "languages" (Chapman, 1992a). Finally, various principles of adult learning were considered

within the creation of the product to maximize ease of use and practicality of implementation into daily practice.

Product:

The product, *A Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting,* is a physical guide for occupational therapy practitioners to work through to guide learning and skill building regarding the implementation of the Five Love Languages into practice. The intended population chosen for the product is occupational therapists and occupational therapy assistants (together referred to as practitioners), working in any setting with clients of 18 years of age and older. The product was created with the intent of being introductory in nature with a wide array of applicability in terms of clients, settings, and therapist experience. It may be used by a practitioner individually or by a team of health care professionals. Notably, because this guidebook was written for occupational therapy practitioners, an occupational therapist or occupational therapy assistant should be included in the team.

The guidebook takes the user through foundational concepts such as the background of the Love Languages (including exploring Gary Chapman's work directly), to then learning to decipher a client's preferred language, and finally implementing his or her preferences into practitioner-client interactions. Our intent for the product is for it to be an understandable guide for practitioners to thoughtfully work through and thus gain knowledge and skills regarding the implementation of the 5 Love, in order to incorporate their use into daily practice. Doing so addresses our overall goal of moving towards and towards enhancing the quality of client-centered, humanized care.

Key Terms

- **Adult Learning Theory:** Adult learning theory, also known as andragogy, is the art and science of teaching adults. Within this theory are assumptions and principles including but not limited to, adult learning should be self-directed, focused on problem-solving, and that the role of the teacher is one of a facilitator (Bastable & Dart, 2011).
- **Canadian Model of Client Centered Enablement (CMCE):** Believes that enablement is the core of occupational therapy and can be used to help guide reasoning and choices in therapy (Townsend & Polatajko, 2007).
- **Canadian Model of Occupational Performance & Engagement (CMOP-E):** intends to promote client-centered practice and the view that occupation is the core domain of concern. The model is made up of three components, the person, the environment, and the occupation with spirituality situated at the center of the individual (Polatajko, Townsend & Craik, 2007).
- **Client:** Defined as persons (including those involved in care of a client), groups (collectives of individuals e.g. families, workers, students, communities), and populations (collectives of groups of individuals living in a similar locale e.g. city, state, or country - or sharing the same or like characteristics or concerns) (AOTA, 2014, S3). Interchangeable with the term patient in most healthcare settings
- **Client-Centered:** "An approach to service that incorporates respect for and partnership with clients as active participants in the therapy process" (Schell, Scaffa, Gillen, & Cohn, 2014, p. 54).
- **Five Love Languages:** Concept developed by author Gary Chapman, that categorizes the way humans receive love into five different Love Languages. These languages include:

Acts of service, Quality time, Physical Touch, Words of Affirmation, and Receiving Gifts. (Chapman, 1992a)

- **Healthcare Setting:** Hospitals, clinics, industry, schools, homes, and communities (AOTA, 2014)
- **Humanized Care:** Incorporates the philosophy of humanism into client care in that individuals are viewed as having inherent worth and potential.
- **Love (Agape):** selfless love that is comprised of actions and behaviors for the greater good (Perrotto, 2017). This type of love "seeks to understand, recognizes that there can be understanding without acceptance, allows forgiveness, fosters humility, and values and seeks the good of others" (Wilson, 2017, p.488)
- **Occupational Therapy:** "The therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community and other settings" (AOTA, 2014, S1)
- **Occupational Therapy Practitioners:** Refers to both occupational therapists and occupational therapy assistants.
- **Therapeutic Relationship:** Socially defined in that the therapist and the client are engaged in an interaction within publicly understood roles. Personally, defined in that the therapist and client are human beings who encounter each other with the same potential range of thoughts and emotions that occur when any two people interact. (Taylor,2009, pg. 54)
- **Therapeutic Use of Self:** "Allows occupational therapy practitioners to develop and manage their therapeutic relationship with clients by using narrative and clinical

reasoning; empathy; and a client-centered, collaborative approach to service delivery" (AOTA, 2014, S12).

Introduction to Chapters

This project is divided into several sections that outline the steps in the formation of the product. Chapter II is a literature review that offers a comprehensive explanation of current literature available on this topic. Following the literature review, Chapter III, methodology, describes the overall decision-making process and steps taken in creation of the product. Chapter IV is an introduction to the product, and the product itself is included in the appendix. The scholarly project is then summarized as a whole in the conclusion in Chapter V, followed by a list of references and the appendix.

Chapter II

Review of Literature

Overview of Occupational Therapy

The American Occupational Therapy Association defined occupational therapy as "the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings" (American Occupational Therapy Association [AOTA], 2014, p. S1). Occupational therapists and occupational therapy assistants are skilled practitioners who enable engagement in everyday occupations through facilitating change or growth within clients and/or modification of their environments (AOTA, 2014). Occupational therapy practitioners work in a variety of environments including hospitals, schools, skilled nursing facilities, home health, and outpatient clinics. Within these settings, practitioners work with individuals of all ages and stages of life ranging from birth to the final days of an individual's life. Practitioners use theory (facts, concepts and assumptions that give meaning to a phenomena) and/or frames of reference (specific guidelines or methods for interventions) to guide development of a plan for therapy and to provide rationale for the purpose of treatment (Case-Smith, 2015; Oberle, 2016).

Current State of U.S. Healthcare

Despite being one of the most developed countries across the globe, the U.S. is ranked 37th in world healthcare (Christopher, Murray, & Frenk, 2010). Another measure of healthcare systems, looking specifically at developed countries, has continually ranked the U.S. last, with factors of consideration being that the U.S. has failed to achieve better health outcomes, as well as its lack of access, efficiency, and equity (Schneider et al., 2017). Additionally, the U.S.

healthcare system has been shown to be far more expensive than other developed countries, however, it has not yielded considerably better outcomes (Davis, Stremikis, Squires & Schoen, 2014). Many individuals in a lower income bracket are unable to receive care due to the high costs associated with U.S. healthcare (Davis et al., 2014). Conjunctively, "1 in 5 adults in the U.S. do not believe they receive good value for what they pay" ("patients' perspective,", 2016, p. 11).

Reducing costs to the U.S. healthcare system, including those such as hospital readmissions, is beneficial to the client and healthcare system as a whole. Rogers, Bai, Lavin, and Anderson (2016) found that occupational therapy is the only medical profession that has a statistically significant association with lowering hospital readmission rates. With the US spending twice as much per person on health related issues, it is imperative that healthcare providers, including occupational therapist practitioners provide services that optimize client outcomes and reduce hospital/clinic readmissions (Sawyer & Cox, 2018). Occupational therapy is uniquely positioned to combine technical skills with knowledge of interpersonal communication to provide services that are aimed at improving individuals' independence in their everyday life.

Client Satisfaction with Healthcare Today

Client satisfaction is often used as one outcome measure in determining the quality of healthcare services. When receiving information regarding how satisfied a client is, satisfaction generally refers to the client's perceptions between expectations and lived experiences (Custer, Huebner & Howell, 2015). Client satisfaction corresponds with outcomes, such as decreased usage of medical services, less malpractice litigation and better prognosis (Huang, Lai, Tsai, Hu, & Yang, 2004). Changes within healthcare as time passes along with the use of social media as a

platform for which consumers can use to leave reviews (both positive and negative) open for the public to see, are all factors that have peaked the interest of health care providers and organizations to investigate the clients' experiences with their care (Crawford, 2018).

Client satisfaction survey scores, and ratings are used to assess outcomes and the overall client experience (Crawford, 2018). Kelly (2014) described two components that affect client satisfaction as being technical knowledge of the provider and service quality formed on interpersonal skills. The latter of the two has been shown to be more important in determining client satisfaction as consumers expect their providers to be knowledgeable in what he or she is practicing (Kelly, 2014). Importance should be placed on the interpersonal skills and relationship between provider and client in an effort to improve client satisfaction and the overall client experience.

In a systematic review, Batbaatar, Dorjdagva, Luvsannyam, Savino, and Amenta (2017) examined determinants of client satisfaction. Batbaatar et al. (2017) found a strong positive association between client satisfaction and the quality of healthcare providers' and their interpersonal skills. It is important for occupational therapists to examine their mechanisms for service delivery in an effort to increase client satisfaction and the quality of occupational therapy services. Knowledge of the determinants of client satisfaction and shifting towards understanding client experiences places a greater emphasis on the client as an active consumer rather than simply a recipient of therapy (Speight, 2005).

Healthcare System Pressures Influencing Client-Centeredness

With any health service comes the necessary elements that make the practicality of it functioning in society possible, which in turn can affect the way the foundational elements are carried out. These elements include reimbursement systems and productivity standards for

practitioners. Winistorfer, Scheirton, and Yarett Slater (2017) released an advisory opinion to the AOTA ethics committee regarding productivity, billing and reimbursement The purpose of the advisory opinion was to bring to the forefront that although remaining client-centered is integral to the profession itself, there are factors in relation to reimbursement, productivity standards, and billing that can deter occupational therapists from provided client-centered care. (Winistorfer et al., 2016). Summarize the last two sentences here. What is your perception of that piece?

Reimbursement.

Reimbursement is "managed care Payment by a 3rd party–e.g. an insurance company, to a hospital, physician, or other health care provider for services rendered to an insured/beneficiary" (McGraw-Hill Concise Dictionary of Modern Medicine, 2002). In other words, reimbursement is a common medical term used to describe when healthcare providers are paid by insurance companies or government payers for the services the providers are providing. In medical settings, occupational therapy services are heavily influenced by reimbursement practices and systems. Burke and Cassidy (1991) described the disparity between reimbursement-driven practice and the humanistic values of occupational therapy, including being client-centered. This shift to being reimbursement-driven, "has increased our attention to efficient discharges, shortened lengths of stay, maintenance of high census, development of referral networks, and provision of care in the least costly way" (Burke & Cassidy, 1991, p. 174) Burke and Cassidy (1991) also highlighted that practitioners feel pressure to deliver protocol-based therapy that is designed for a specific diagnosis, rather than for an individual. The pressure coming from this type of system leads to the question of whether or not providing cost-effective care allows enough time to fully get to know a client and his or her individual values and goals in order to elicit client motivation to participate and thus have success in therapy (Burke, & Cassidy, 1991).

In addition, Gray (2014) published an article in AOTA's Special Interest Section Quarterly detailing concerns surrounding reimbursement, specifically, how reimbursement has come to equal productivity. In 2013, the Centers for Medicare and Medicaid (CMS) implemented Value Based Purchasing (VBP), which created an incentive model of reimbursement for Medicare covered services (Gray, 2014). The addition of VBP resulted in a reduction in reimbursement for some services, while increasing reimbursement for others, leading to additional stress on healthcare providers to meet specific criteria to qualify for higher reimbursement (Gray, 2014). In short, the reimbursement systems in U.S. healthcare pose a threat to the client-centeredness of care and thus to the positive outcomes as well as client satisfaction that client-centered care has been shown to elicit.

Productivity push.

Along with reimbursement-driven practice in today's business-based healthcare is the requirement of increased productivity by practitioners. For example, many employers today have set standards for how many billable units a therapist should log per workday, driving therapists to manage his or her time in a way which allows him or her to see more clients than ever before. One illustration of this includes the predicament in which a practitioner working in a skilled nursing facility found herself. During the AOTA's 2015 Annual Conference & Expo, the therapist discussed concerns with ethics and productivity sharing the following:

> Yesterday I was asked to see six Medicare patients at the same time in a 30-minute period, document their daily notes, and complete four progress notes due on them. I was only familiar with one of the patients, so I needed to read the goals, precautions, etc. I also was expected to transport all of the patients to and from the clinic in this time period.

> My expected productivity requirement is 90% and I had a full caseload of patients on top of these 6. When I told my director that this was not physically possible to do, she was not pleased and said that this is how we do things. (Yarett Slater & Bogenrief as cited in AOTA).

Rigorous productivity standards can challenge practitioner's ethics and undermine the delivery of the best quality of care. Winistorfer, Scheirton, and Yarett Slater (2017) shared a case example in which a therapist was treating up to five clients at a time and not requesting reimbursement appropriately, as the therapist did not count the session as a group session. This displayed unethical documentation practices despite the fact that the therapist was unaware of her wrong-doing and appropriate education was provided to her thereafter (Winistorfer et al., 2017). The overall quality of treatment may have also been affected if the practitioner had been grouping clients for convenience and, as a result, was not able to be as client-centered due to managing multiple clients. With changes in the healthcare system resulting greater productivity requirements and a heightened focus on reimbursement as a goal, it is important that occupational therapists remain established in the roots of the profession by remaining client-centered.

Lack of Humanized Care

Due to the nature of healthcare institutions also being a business, the interest of the institution is oftentimes on obtaining the highest profit possible, consequently leading to a sacrifice in quality of care (Beltrán-Salazar, 2014). When the focus of the healthcare institution is placed on financial gain rather than satisfying client needs the result is a lack of humanized care. Hadi, Alldred, Briggs, Marczewski, and Closs (2017) identified barriers to humanized care that included poor client-professional partnerships due to lack of trust, communication, and empathy.

Effective client-professional relations can improve health and self-management, whereas lack of trust in the medical professional can negatively affect client outcomes (Hadi et al., 2017). Beltrán-Salazar (2014) asserted that currently the focus of healthcare is on curing and the business of medicine, reducing the person to the category of his or her disease rather than seeing clients as human beings deserving of humanized care that is focused on person to person interactions. Some institutions have made efforts towards more humanized care, however, at the same time have profit-oriented policies hindering the progress towards humanization and quality of care (Beltrán-Salazar, 2014). For example, efficiency of providers is often judged by completion of documentation or number of clients seen rather than by the delivery of care resulting in lack of individualized therapy plans (Beltrán-Salazar, 2014; Hadi et al., 2017).

Steele, Jones, Clarke and Shoemaker (2015) conducted a study identifying and ranking clients' needs and expectations and applying principles of service delivery stemmed from the hospitality industry. Client centered care is similar to customer centered hospitality as the services provided should be respectful and responsive to the clients' preferences, needs and values (Steele et al., 2015). Steele et al (2015) found that clients valued acknowledgement of their condition and being "treated like a person, not a number" more than privacy, and short waiting times. In order to provide humanized care, occupational therapists must attend to the client's needs. There are a variety of factors affecting the delivery of humanized care, however in order to provide services that satisfy the needs of the consumer, healthcare providers need to understand the factors most important to their clients.

Client-Centeredness in Healthcare

Client-centeredness is an element of occupational therapy that is tied to the interpersonal skills correlated with client satisfaction. "Clients cannot be considered as a uniform group and

practitioners have to investigate which form of relationship and participation each client prefers rather than acting on the basis of established routines" (Palmadottir, 2006, p. 400). The aforementioned quote describes what it means to be client-centered as a therapy practitioner. The term "client-centered' is defined as "an approach to service that incorporates respect for and partnership with clients as active participants in the therapy process" (Schell, Scaffa, Gillen, & Cohn, 2014, p. 54). In addition to aligning with the history of the profession's foundation, the importance of being client-centered is also prevalent within its future, as evident in the AOTA 2025 Centennial Vision. Among the four pillars of the vision, being client-centered is mentioned not once, but twice (AOTA, 2017). The pillar of *collaboration* emphasizes that the profession will strive to excel in working *with clients,* and the pillar of *effectiveness* mentions being client centered of one of its three areas of focus (AOTA, 2017).

When discussing client-centeredness and what client-centered care means, it is important to note that each individual (practitioner or client) has his or her own description of what client centered care looks like. Oftentimes the words of respect, autonomy, and dignity are associated with providing client-centered care. Beach, Branyon and Saha (2017) conducted a qualitative study that examined client perspectives on respect in healthcare. Beach, Branyon and Saha (2017) found that the individuals in the study had varying definitions of respect and that in order to provide client centered care, it is vital to determine how each client feels respected and disrespected. It is imperative to determine how the client would like to be treated in order to provide client centered care.

Emphasizing the concept of client-centeredness is for good reason, as not only does personalizing care tie into the interpersonal skills that impact client satisfaction, but it also has positive implications for therapeutic outcomes, as shown by research evidence. Ji-Yoon, So-

Yeon and Jin-Kyung (2018) conducted a study that compared the effects of a client-centered leisure program with an existing leisure program for elderly residents in a long-term care facility. The researchers found that the leisure program in which clients engaged in personalized leisure activities (experimental group) exhibited significant improvements in the Canadian Occupational Performance Measure, upper limb functioning, self-esteem, and depression as compared to the control group. (Ji-Yoon, So-Yeon, & Jin-Kyung, 2018). Reeder and Morris (2018) interviewed therapy practitioners who reflected on the importance of the relationship with parents of children with long-term disabilities whom he or she was treating. The practitioners shared that maintaining a positive (yet professional) relationship with the clients' parents was vital to the process of effectively sharing important clinical information him or her (Reeder & Morris, 2018). Viewing and positioning the client as the center of the therapeutic process is an integral part of providing care that is effective and meaningful to the client.

Existing Tools for Client-Centeredness

We reviewed assessments, tools, and methods that are intended to assist occupational therapists in being client-centered in their practice. In regard to assessments, there are some in which client preferences are taken into consideration. For example, the Canadian Occupational Performance Measure (COPM), asks client to "identify and prioritize everyday issues that restrict or impact their performance in everyday living" ("About the COPM," n.d., paragraph 1). This provides the practitioner with insight into what the client has challenges with in his or her everyday life as well as how important those activities are to the client, thus helping the practitioner tailor therapy into a personalized direction that will address what matters to the client. Other similar assessments include the Occupational Questionnaire, the Modified Interest Checklist, The Volitional Questionnaire, The Occupational Self-Assessment 2.0, The Model of

Human Occupation Screening Tool, The Child Occupational Self-Assessment, The Occupational Performance History Interview-II, The occupational Role Checklist, and The Occupational Circumstances Assessment Interview and Rating Scale. All of the mentioned assessments are similar in purpose to the COPM example in that they collect information regarding priorities of a client as well as data on how he or she performs, or feel he or she performs, certain occupations in his or her lives.

While some assessments are crucial in providing information about what areas of occupation to address with a particular client, they do not contain specifics about clients' satisfaction with therapy as well as his or her therapy outcomes. Formal assessments do not typically include information such as how a client learns best, communicates best, performs best, and how he or she prefers to be treated. This lack of information requires the therapist to rely on his or her clinical judgement and interpersonal skills to decipher what approaches will be most successful with a client.

Therapeutic Use of Self

The concepts of the therapeutic use of self and the therapeutic relationship are deeply embedded in the foundation of the occupational therapy education and practice. Therapeutic use of self is defined by the AOTA (2014) as "an integral part of the occupational therapy process… which allows occupational therapy practitioners to develop and manage their therapeutic relationship with clients" (p. S12). The therapeutic use of self can be described as an occupational therapist's ability to adapt his or her approach in order to relate to, and interact with a client in the given circumstance. It is this use of a therapist's self that can largely influence how a therapeutic relationship forms and can ultimately impact the overall experience and outcomes with a client. Occupational therapy's emphasis on therapeutic use of self has varied throughout

different eras and paradigms. In the early 1900s, the early era of the occupational therapy profession, began the practice of the practitioner using his or her interpersonal skills to inspire joy and confidence in their clients (Taylor, 2008). Various events in history, such as wars, caused a shift in focus for therapists where the emphasis of therapy was a more biomedical approach in that the focus was on curing and pathology (Taylor, 2008). In essence, during this time period, occupational therapy was more concerned with the science of the profession, and the art of occupational therapy was often neglected. Another shift in paradigms came about in the 1960s, when practitioners were recognizing that they had moved away from the profession's roots of occupation (Taylor, 2008). Although re-emergence of using occupation as the main focus of therapy was bringing the profession back to its origins, the therapeutic relationship was still not of emphasis (Taylor, 2008).

Research has shown that when assessing client experiences and thus his or her perceptions of therapy, clients are less concerned with rehab content and technical expertise of the practitioner and more focused on the relationship formed with the provider (Palmadottir, 2006). This indicates that clients value the interpersonal connection with the practitioner as much as, or even more than his or her practitioner's actual therapy techniques. Like Palmadottir's (2006) study, there have been many others to support the value of the therapeutic relationship, to both the practitioner and the client, however, little has been published regarding a particular approach to implement therapeutic use of self (Taylor, Lee, Kielhofner & Ketkar, 2009).

Embedded within the construct of therapeutic use of self is client-centeredness. In order to best serve a client, it is essential that a practitioner hear and respond to the clients' needs and desires for his or her experience in therapy, thus focusing the therapy around the client's interests, needs, wants, etc. This, in turn, requires the therapist to use his or her use of self-skills

to best suit the particular client when serving his or her needs. The ability of a practitioner to develop a supportive relationship that is based on the preferences of the client can not only leave the client feeling heard and valued, but it can also lead to more positive therapy outcomes.

Occupational Therapy Students' Education Regarding Use of Self

Occupational therapy is recognized as both an art as well as a science (Peloquin, 1994). The science in this phrase refers to an occupational therapy practitioner's ability to apply logical knowledge of the body, its systems, and of the rehabilitation process for particular diagnoses, particular populations, and so on (Peloquin, 1994). The reference to art, on the other hand, indicates that a practitioner possesses skills that require one to read a situation and approach it in a way that will yield success with a particular client (Peloquin, 1994). The ability to apply one's self to a situation in a way that will create harmony and facilitate progress within a client's experience in therapy is not easily acquired, and like the science of the profession, it requires knowledge, attention, and practice of application.

We wanted to know to what extent occupational therapy students are prepared to use this art throughout their schooling, and how confident he or she is with these skills when entering the workforce. Historically (during eras in which the Biomedical Model reigned), priority had been placed on the technical skills of therapy rather than the therapeutic relationship developed between a client and therapist (Palmadottir, 2006). The profession has since evolved and accredited programs have applied more emphasis on educating their students on the art of therapeutic use of self, to an extent. Davidson (2011), conducted a research study in which 79 faculty members across 39 academic programs for occupational therapy shared via survey (as well as 6 supplemented by interview) about how he or she included concepts of therapeutic use of self within their curriculum (Davidson, 2011). The results were ranked to show the frequency

in which concepts were taught as well as with what instructional methods were used (Davidson, 2011). Though all 14 concepts were claimed to have been addressed by the participants, the researchers indicated "substantial variations in the frequency and time allotted to teaching the different concepts and skills" (Davidson, 2011, p. 93). Concepts that were noted to be emphasized within curriculums included collaborative goal setting, empathy, establishing rapport, self-awareness, interpreting nonverbal communication, active listening, giving praise or encouragement, expressive nonverbal communication, and giving corrective feedback (Davidson, 2011). Concepts of setting limits, conflict negotiation, dealing with clients' attempts to coerce or manipulate, dealing with potential aggression toward self or others, and sharing bad news were noted to be taught less frequently (Davidson, 2011). Additionally, when asked about course objective that focus on therapeutic use of self (as well as textbooks used to teach the concepts), 38% of the respondents did not have any course objectives related to therapeutic use of self, and 59% of the respondents indicating not using any texts for teaching the material (Davidson, 2011). These numbers are quite high when considering that the therapeutic use of self is supposedly a fundamental piece to the profession. Interestingly, participants from the supplemental interviews to this study shared concern that there may be an over-reliance on implicit teaching methods (lecturing, discussion, reading etc.) when it comes to educating students about the use of self in therapy, lacking the hands-on, explicit methods of learning that are proven to be most effective (Davidson, 2011). In other words, the faculty themselves recognized that the way in which he or she was teaching this art may not be the most effective, and that change may be needed in this area (Davidson, 2011). Occupational Therapy students have expressed that they understand the value of the therapeutic relationship but felt they lacked education on how to use it in practice (Taylor et al., 2009).

Efforts to boost education of therapeutic use of self for occupational therapy students has been discussed and addressed to an extent. Schwank et. al. (2018) examined the 10-month trajectory of self-efficacy regarding using therapeutic use of self of Norwegian occupational therapy students. Their longitudinal study included gathering initial feelings of students regarding his or /her abilities to apply their therapeutic use of self with clients, followed by participation in IRM workshops based on the Intentional Relationship Model (IRM) (Taylor). Finally, a follow-up survey assessing the change in the student's self-efficacy on the use of self was given. (Schwank et. al., 2018). Results indicated that participants rated increased confidence that he or she possessed skills required to use each therapeutic mode as described by the IRM, as well as the confidence in the ability to recognize interpersonal characteristics when interacting with clients (Scwhank et. al., 2018).

Despite the boost in self efficacy in the students included who attended a workshop in the study by Scwhank et al., (2018), there are students throughout occupational therapy programs who do not receive such additional training and thus do not fully develop self-efficacy of applying therapeutic use of self-skills learned in the classroom once in practice. This leaves many students feeling incompetent in the art of interacting with clients, and ultimately in providing the best, most personalized care possible when he or she begins his or her careers. This noted lack of education on how to best apply concepts of therapeutic use of self is something that needs to be addressed.

Current Practitioner Training Regarding Use of Self

Lack of education on therapeutic use of self in occupational therapy programs results in new graduates feeling incompetent in the art of use of self. It also leads to seasoned therapists who are forced to rely on his or her own instincts and notions regarding how to apply therapeutic

use of self within the therapy relationship. Taylor et al. (2009) conducted a survey to better understand practitioners' attitudes and experiences towards the use of therapy use of self. Of the participants who responded to the survey, only 4% had taken a course related to therapeutic use of self (Taylor et al., 2009). Currently, the Intentional Relationship Model (IRM), developed by Renee Taylor, is one of the only published books aimed at provision of information and processes for navigating and improving the therapeutic relationship between a therapist and client. The IRM includes six therapeutic modes of relating to a client (Taylor, 2008). One of the assumptions of the IRM is that each therapist has his or her own preference based on experiences and interpersonal traits and should attempt to align the therapeutic mode he or she is using with the client's preferences (Taylor, 2008). The IRM is directed at aligning with the client's preferences however it still requires the therapist to use his or her personal judgement and intuition to determine what the client prefers (Taylor, 2008). However, not all current occupational therapy practitioners were educated on this model during his or her professional education and the lack of continuing education surrounding therapeutic use of self results in the absence of its use with clients.

Hinojosa's Urge to Innovate

The medical field is continually growing, changing, and adapting in accordance with current research findings resulting in medical practitioners being faced with an era of hyperchange. Hinojosa (2007) defined hyperchange as "increasing uncertainty, rapid pace of change, growing ambiguity, and increased complexity in the workplace" (p. 630). Within this era of hyperchange, Hinojosa (2007) encouraged practitioners to become innovators of his or her practice and focus on relationships within the workplace. Although there are many positive changes occurring within the profession, the practice of occupational therapy has become less

individualized and more routine (Hinojosa, 2007). Hinojosa (2007) wrote that therapists were becoming more focused on procedures and protocols and spending less time getting to know his or her clients. As the era of hyperchange continues, it is important for occupational therapy practitioners to remember the roots of the profession and remain grounded in client-centered, occupation-based practice.

Problem Statement

There is currently an abundance of literature detailing the importance of providing client-centered care in an effort to improve the therapeutic relationship and improve client satisfaction and outcomes. Although the literature provides information on the importance of client-centered care, there is a lack of research and developed frameworks describing how to go about providing more effective client centered, humanized care. Accompanying the lack of literature is an absence training on how to use one's therapeutic use of self to better provide client centered care for both new graduates and seasoned occupational therapists. The current tools surrounding providing client centered care are focused on what to address with the client, however, lack practical information about evaluation of and addressing the client's needs, particularly regarding how a client prefers to be approached. The absence of a framework/tool focusing on how to work with the client to provide client-centered, humanized care results in the therapist relying on his/her interpersonal skills to determine how to work with each client during his or her time in therapy.

Further confounding the use of therapeutic use of self and client-centered care, is the institutional push towards productivity and reimbursement. These factors act as detractors for providing client centered care (Beltran-Salazer, 2014; Burke & Cassidy, 1991; Gray, 2014; Hadi et al., 2017; Winistorfer, Scheirton, & Yarett Slater, 2017). For example, in the current

healthcare system, most providers are evaluated on his or her productivity and ability to generate a profit for the institution rather than the quality of their care. (Beltrán-Salazar, 2014).

Occupational therapy practitioners and students need a guide to enable client-centered care. Specifically, a guide that provides a comprehensive and applicable way to provide humanized, client-centered care for individuals that will allow clients to indicate preferences and for the therapist to respond appropriately to this client feedback and use it within that client's therapy journey.

Summary and Intent

This literature review discussed the current state of health care, the pressures on occupational therapy practitioners, as well as the current lack of tools and education/training to guide therapists to remain grounded in the person-first foundation of the profession. It is our intent to use this literature in combination with Chapman's concept of The 5 Love Languages in order to create a therapeutic use of self-focused guide for therapists to address the lack of humanized, client-centered care. The Canadian Model of Client-Centered Enablement (CMCE) will act as our guide throughout this process and will be woven into the resulting product. The resultant product from this literature review will be a guide to better understand how clients would like to be cared for while in therapy and a way for occupational therapists to improve their therapeutic use of self to enhance the therapeutic relationship.

Chapter II, Literature Review, consisted of an evaluation and synthesis of literature pertinent to the topic area of the current state of healthcare, client satisfaction, and the need for humanized care. Chapter III, Methodology, will provide an overview of the processes used to create the product.

Chapter III

Methodology

Chapter III Methodology is comprised of a description of the literature review, an explanation of the theories guiding the product and a description of the decisions made towards creation of the product. This product originated from our desire to deliver client-centered, humanized care that is meaningful and effective for our future clients regardless of institutional and/or personal barriers. We chose to create a product aimed at remaining rooted in some of the occupational therapy profession's core beliefs, in combination with application of The Five Love Languages as conceptualized by Gary Chapman, in order to provide unique, individualized therapy interventions centered around the client, despite a productivity, reimbursement driven, healthcare environment.

Throughout our education in the University of North Dakota Occupational Therapy Program, we have been exposed time and time again to the fundamentals of the profession, including client-centeredness and its importance in….?. Our initial idea of developing a product revolving around client-centered care stemmed from a class discussion about a journal article entitled *Dignity and the essence of medicine: the A,B,C, and D of dignity conserving care* (Chochinov, 2007). Chochinov (2007) highlighted the main concepts of attitude, behavior, compassion, and dialogue as main components contributing to dignified care. Chochinov (2007) stated "[o]ne of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient" (p. 186). The essence of Chochinov's article, in combination with prior knowledge of therapeutic use of self and the Five Love Languages, sparked our desire to create a guide for improved client-centered, humanized care.

Additionally, we have taken courses dedicated to personal and professional development, and have addressed the implementation of the therapeutic use of self (with emphasis given to the Intentional Relationship Model (IRM) (Taylor, 2008), into daily practice. We have come to understand that therapeutic use of self and client centered care are central to the provision of best care to our clients. While we value these factors, they can be different to actively implement in practice. Understanding each unique client and deciding how to best approach each individual within time-sensitive interactions, due to a push for productivity, proved challenging on our level I and level II fieldworks, and we found ourselves longing for guidance in this area. Reading Gary Chapman's work on the 5 Love Languages produced an admiration for its direction and clarity when applied to treating others in a way in which he or she is most receptive. Chapman's work then provoked a discussion of how we could apply the 5 Love Languages to healthcare. Thus, our exploration in the chosen topic began.

Initially, we sought to better understand the current state of the US healthcare system and how policies in place, such as reimbursement and productivity standards, influence occupational therapists' ability to provide client-centered, humanized care. We began our search for information regarding the US healthcare system by searching terms such as "healthcare policy", "healthcare legislation", and "patient-professional communication". We utilized organizational websites such as the American Public Health Association (AHRQ) as well as the international, World Health Organization (WHO). Consultation with the occupational therapy program librarian, University of North Dakota (UND) law librarian, and UND government documents librarian, aided in this process.

Next, we sought to gain an understanding of patients' perspectives of their experiences receiving healthcare. In addition, we also wanted to know how healthcare professionals,

including occupational therapists are continuing to provide client centered care in the face of the business of medicine. CINHAL, Pubmed, and Medline databases were accessed through the Harley E. French Library of the School of Medicine and Health Sciences at the University of North Dakota to accomplish this review. Insert Specific search terms (as you did above)

Currently, authors of occupational therapy models recognize the need to understand clients values and motivations. One example is the Canadian Model of Client-Centered Enablement or CMCE. Critical evaluation and synthesis of literature obtained contributed to the selection of the Canadian Model of Client-Centered Enablement (CMCE) to support and structure development of a guide that emphasized client-centered, humanized care. This model includes recognition of the client's contribution to the therapeutic process and provides a framework for occupational practitioners to further enable their clients.

The Canadian Model of Client-Centered Enablement (CMCE) developed by Townsend and Polatajko (2013) stems from the Canadian Model of Occupational Performance and Engagement (CMOP-E) and details the nature of the encounter between a client and occupational therapist. The purpose of the creation of this model was to raise awareness about how occupational therapists are practicing. The CMCE provides a framework for occupational therapists to envision how he or she can work with their clients (Townsend et al., 20113). Enablement is defined by the CMCE as "drawing on an interwoven spectrum of key and related enablement skills, which are value based, collaborative, attentive to power inequities and diversity, and charged with vision of possibility for individual or and/or social change" (Townsend & Polatajko, 2013, p.89). The CMCE also defined occupational therapy enablement foundations as "choice, risk, responsibility, client participation, vision of possibilities, change, justice, and power sharing" (Townsend & Polatajko, 2013, p. 101). Effective enablement is

described by Townsend and Polatajko (2013) as positive and generative, a mutual and valued process with mediated and negotiated values and beliefs as well as sharing expertise and responsibility and remaining accountable for enablement conditions, processes, and outcomes (Townsend & Polatajko, 2013). Within the CMCE, the term client is used to describe a range of service users including the individual, family, group, community, organization, and population (Townsend & Polatajko, 2013). The CMCE advocates for a client centered approach to occupational therapy and emphasizes that therapy should be done with the client, not to or for, the client.

The CMCE uses two asymmetrical curved lines that intersect and enclose 10 verbs that Townsend and Polatajko (2013) identified as necessary for enablement. These verbs include "adapt, advocate, coach, collaborate, consult, coordination, design/build, educate, engage, and specialize" (Townsend & Polatajko, 2013, p. 107) and are to be used as strategies/tools to collaborate with the client. The asymmetrical curve suggests diversity in collaboration and that the nature of the collaboration will not be "symmetrical, straightforward, static, standardized, predictable, or prescriptive" (Townsend & Polatajko, 2013, p. 109).

The Five Love Languages

In addition to occupational therapy models, other frameworks have been used as a method to improve relationships, including within the workplace. Gary Chapman, author, speaker, and relationship counselor, developed a framework called *The Five Love Languages*. The Five Love Languages is based on the idea that each individual receives love differently, and that he/she is more or less receptive to receiving love in different "languages". Egbert and Polk (2006) conducted a study to better understand the validity of Chapman's Five Love Languages in comparison to other relational instruments and determined the instrument to be constructually

valid. The five identified languages are words of affirmation, acts of service, quality time, receiving gifts, and physical touch (Chapman, 2010). Chapman has interpreted these languages in a variety of settings such as within romantic relationships or as languages of appreciation within the workplace. Application of the 5 Love Languages to better understand how a client would like to be cared for can in turn help support clients in a way he or she appreciates resulting in him or her being a more active participant in their care.

When considering therapeutic use of self and integrating the Five Love Languages, the basis of the therapeutic relationship and client-centered practice cannot be overlooked. When developing a therapeutic relationship with clients, knowing how he or she would like to be cared for is imperative. Understanding the individual using the Five Love Languages as well as other tools and examining the nature of the encounter between the client and the therapist can lead to occupational therapy that is client-centered. Use of the Five Love Languages allows occupational therapists to individualize and vary his or her therapeutic use of self for each client in an effort to enhance the therapeutic relationship and enable the client through occupation. This type of guide will be beneficial for both the client and therapist as it will facilitate a successful therapeutic relationship, and ultimately the best therapeutic outcomes.

When developing the product, we sought to make it readable as well as understandable for a wide audience. The layout, color choices, and arrangement of information was considered in an effort to make the document aesthetically pleasing and user friendly. Within each section detailing the 5 Love Languages, intention was put towards including principles of Bloom's Taxonomy. Priority was set to first define the language, then highlight relevant literature supporting its use in practice, and finally present a case study of each Love Language for users to be able to apply the knowledge he or she is learning. A thorough review of the literature was

integrated with concepts from Gary Chapman's concept named The Five Love Languages to guide the development of *Training Guidebook: Integration of Love Languages in Your Healthcare Setting.*

Chapter III Methodology consisted of a description of the theories used to guide creation of the product and an explanation of the process that occurred in creation of the product, *Training Guidebook: Integration of Love Languages in Your Healthcare Setting.* Chapter IV Product consists of an introduction to the product, which can be located in the appendix.

Chapter IV

Product

This chapter is comprised of a brief overview of the outcome of this project, while the actual product is located in the appendix. The product, titled *Training Guidebook: Integration of the 5 Love Languages in Your Healthcare Setting,* is a guide to provide occupational therapy practitioners with the knowledge and skills to integrate the 5 Love Languages into their healthcare setting in an effort to enhance the therapeutic relationship and ultimately improve client outcomes.

The product is guided by the Canadian Model of Client Centered Enablement (CMCE), the 5 Love Languages, and principles of adult learning. In the same way that the CMCE advocates for a client centered approach to occupational therapy and emphasizes that therapy should be done with the client, not to or for the client, it is our hope that the product will be a first step towards more humanized, client-centered care (Townsend & Polatajko, 2013).
The product is divided into sections outlined by a table of contents. The organizational flow of the guidebook was designed with intent of walking the user through a process from learning general knowledge to actively applying concepts into his/her workplace. The introduction of the product contains a case study, a definition and description of love in healthcare, an introduction to the 5 Love Languages, and a brief background of the theoretical basis for development of the product. The second section is a how-to guide for identifying client preferences provides a framework for the user to take the Love Language quiz (Chapman, 1992b) for his or herself, to develop setting specific questions, as well as a guide for cues to look for when identifying client preferences. Following this portion is an individual section addressing each individual Love Language. When dissecting each language, the language is first explained in detail according to

the definitions of Gary Chapman (1992a, & 1992b), and supporting scholarly evidence is provided. A case study and application activity are available in each language section for the user to apply the information learned to a practical scenario. The final section includes a reflection looking back at the initial case study, as well as a guide for creating both a personal and team implementation plan to incorporate the Love Languages into practice. The product in its entirety is located in the appendix

Chapter V

Summary

Chapter V Summary consists an overview of the *Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting*, strengths and limitations of the guidebook, possible outcome measurements as well as recommendations for future development and collaboration on this topic.

Project Overview

Currently, there exists a lack of practitioner knowledge and skill regarding the use of therapeutic use of self, despite literature supporting the benefits it has on client satisfaction, and overall outcomes. Care that is client-centered has been shown to yield higher client satisfaction rates as well as improved outcomes (Huang et al., 2004; Ji-Yoom et al., 2018). Occupational therapy students have expressed that they understand the value of the therapeutic relationship, however, feel they lack education on how to use it in practice (Taylor et al., 2009). Additionally, occupational therapy practitioners are more focused on procedures and protocols, resulting in the practice of occupational therapy to become less individualized and more routine (Hinojosa, 2007). Occupational therapy practitioners would benefit from a guide to provide information and training regarding the application of the 5 Love Languages to improve relationships with clients and provide humanized, client centered care. The product, *Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting*, was informed by the Canadian Model of Client Centered Enablement (CMCE), the 5 Love Languages, and adult learning theory. The product is a workbook-style guide intended for occupational therapy practitioners to complete either individually or as a therapy team.

Project strengths.

The product created was made to provide occupational therapy practitioners with a guide for implementing therapeutic use of self that is in alignment with how a client prefers to be treated. The product is designed to be used in a variety of settings with a wide array of client populations in an effort to improve the therapeutic relationship and client experience in therapy for all individuals.

Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting created possesses a number of strengths that make it applicable to clinical practice. Being that it is a workbook for occupational therapy practitioners to work through, attention was given to layout and content in a way that will provide ease of use and maximize carryover of the learning into daily practice. The contents of the product are clearly organized, with elements such as a table of contents as well as color coding to aid in navigation of the sections within it. Is written in appropriate terms that are understandable to both occupational therapists and occupational therapy assistants who have completed their academic programs. The embedded worksheets allow the practitioner to work through scenarios and brainstorm ideas, and thus they encourage active learning that will further solidify concepts presented. The open-ended nature of these worksheets also allows for practitioners in any therapy setting (working with adults 18 years of age or older) to learn and implement the use of the Five Love Languages, therefore making the product more widespread and provides potential for it to reach a wider scope. Additionally, the inclusion of case studies and relevant examples of implementing the Five Love Languages results in the content being relatable, and perhaps more appealing for practitioners to apply.

Abundant thought and attention was given when determining ways to encourage implementation of the Five Love Languages within practice once the workbook has been

completed. First, an entire section of the workbook, the final section before the appendix, was dedicated to guiding practitioners through creation of an implementation plan. Creating a plan that includes specific goals, and outcome measurements for the goals provides an action plan for the users to apply what he or she has learned. Finally, the appendix of the product contains numerous additional worksheets as well as "Quick Reference" cards, that are intended to aid in a practitioners daily practice when first working to implement the Five Love Languages into practice.

Project limitations.

Anticipated challenges in implementation of the *Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting* includes lack of time in clinical settings, practitioners' reservations of using a concept (love) not traditional of healthcare settings, and that the use of therapeutic use of self alone is not a billable service. In order to address time limitations, we intentionally created quick tip cards as well and a condensed worksheet with cues to aid in identifying a client's Love Language.

We also are aware that there may be some resistance to using the product due to the unconventionality of using words such as love in a workplace setting with clients. The *Training Guidebook: Integration of the 5 Love Languages into Your Healthcare Setting* contains a detailed description of how love can be translated appropriately and effectively into the workplace to enhance the therapeutic relationship and ultimately client outcomes.

Lastly, we anticipate a challenge to implementation to be that a practitioner will not be able to bill to a third party payer for time spent determining a client's Love Language. It is our hope that if a practitioner is able to identify a client's preferred Love Language (likely outside of the session) and implement care that is in accordance with this during session interventions, the

practitioner and the client will experience an enhanced therapeutic relationship and improved client outcomes. We believe that although therapeutic use of self alone is not billable, it is embedded in the process of building rapport and establishing a trusting relationship with the client. Recite the study about increased outcomes with increased time

Outcome measurements.

Both formal and informal outcomes can be measured to determine usefulness and success of the product. A formal outcome measurement of the product could include a significant increase in patient satisfaction ratings as well as patient outcomes of those receiving occupational therapy services. In order for these measurements to be meaningful, the practitioner and/or therapy department would have to determine patient satisfaction before and after implementation of the product. A second and informal way of measuring the products usefulness could include the practitioner noticing increased participation in therapy from clients as well as improvement in patient outcomes on the basis of observation.

Potential for Further Development & Collaboration

Potential for future work with this topic has been noted. As this is the first project of its kind, we chose to complete a broad overview of how the product could be used in a variety of settings. Further development of the product in specific healthcare settings, such as acute care or outpatient, would be helpful in increasing the depth and understanding of what implementation would look like at different contexts of care. Additionally, we would have liked to create an identification form that could be added to a client's medical chart making their identified Love Language information accessible to the entire care team.

Some additional developments possible include the growth of or adaptation to the Love Language quiz into a more concise format that would be applicable and efficient to use in the

healthcare setting. Further development could be done with the content of the product in order to hone in on specific practice settings (i.e. acute care) and/or client populations (i.e. pediatrics or mental health). Further research on the impact of therapeutic use of self and its impact on outcomes, specifically when employing the use of the Love Languages, could also be beneficial. Finally, continued communication with Gary Chapman has been of importance to us, and potential for collaboration with him on further scholarly papers or publications would be an honor.

Conclusion

This product, offers a unique and first of its kind approach to improving the therapeutic relationship through utilization of the therapeutic use of self. With the proper implementation, occupational therapy practitioners will have the knowledge and skills to apply the 5 Love Languages with the clients he or she serves and ultimately improve client outcomes and satisfaction. Connecting with clients in a way that is truly meaningful and individualized holds the power to put the human at the center of humanized care.

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Appendices

Training Guidebook: Integration of the 5 Love Languages in Your Healthcare Setting

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Table of Contents

Section I: Introduction

Case scenario

Father Jerry is a 74-year-old male resident in a skilled nursing facility (SNF, who is also a former priest at a church in the community. Father Jerry sustained an incomplete spinal cord injury 20 years earlier. He was recently admitted to the SNF due to secondary complications from pneumonia, which resulted in weakness and inability to do basic activities of daily living (ADLs). His goal was to return home with personal care services that would be delivered by nun. A few other people from the church would also be able to offer some service-related support such as grocery shopping; however, the nun would provide all of the primary personal care assistance. The nun was small in stature and would not have been able to safely assist Father Jerry with his cares, especially transfers. Father Jerry was referred to occupational therapy to address limited ADL ability. The occupational therapy practitioner attempted to establish rapport with Father Jerry by using a warm, encouraging, and conversational approach. Despite this effort, Father Jerry fervently denied occupational therapy services, and the practitioner accepted his choice. As time went on, she regretted not being able to provide him with the occupational therapy services that would have enabled him to return home to independent living without over-burdening the nun.

Occupation:

Father Jerry's primary occupation was being a priest. Prior to his recent illness, he demonstrated modified independence in all ADLs. He had also used a wheelchair as his primary method of mobility but he was able to do standing pivot transfers independently as he could stand and weight shift. Since his illness, he has been requiring maximal assistance with hygiene, dressing, transfers, toileting, bed mobility, and grooming. He was able to feed himself with set up assistance.

The occupational therapy practitioner assigned to work with Father Jerry was working at two SNFs as well as being an adjunct instructor in occupational therapy education. Because of the high quantity of work tasks at that time, she was struggling to be mindful during her communication with clients, staff, and students; she was distracted by her task list and the clock.

Personal:

Personal characteristics pertinent to Father Jerry is that he is authoritarian by nature. Over the course of his priesthood, he had provided spiritual direction, administrative direction, and church services to thousands of people. He also had received many services in his role as priest such as housekeeping, yard care, and healthcare. He was a highly respected priest, with a clean record of service; he truly helped many people, despite having a strict persona. Upon first meeting the occupational therapy practitioner, Father Jerry sternly denied occupational therapy; he displayed minimal eye contact and was not

reciprocal in the conversation. He stated "I don't need to be able to do this. I have people at home who can take care of me".

The occupational therapy practitioner has a strength of using a warm, conversation based approach to building rapport with residents. The practitioner enjoys seeing people gain independence and finds meaning in working with the skilled nursing population. Personal factors that contributed to her interactions with Father Jerry include the disconnection between their differing values of independence. At that time, she was also aware of feeling a negative bias against priests' due to contextual factors going on at that societal time.

Contextual:

Father Jerry's context includes that he lives in a rural area, in a lake home, and is used to being in solitude, with the exception of individuals who offered services to him. Licensed home health services were not available where he lived. Due to his life being embedded in the church, Father Jerry is surrounded by the concept of service (in regard to serving both God as well as others). Additionally, Father Jerry is from the baby boomer generation, and has traditional views of gender roles, such as women needing to serve men.

Contextual factors that the occupational therapy practitioner was working in include temporal constraints of dividing her time between multiple facilities and working within the standards and policies of all three facilities. Contributing to her personal bias against priests included recent societal concerns about some individual priests abusing their powers to harm others.

Spiritual:

In Father Jerry's life, spirituality plays a quite literal role in that he has dedicated his life to the Catholic church and lives his life according to aspects of his faith.

The occupational therapy practitioner's spiritual orientation is expressed by facilitating participation in meaningful activities to promote quality of life.

In this case scenario, barriers to a successful therapeutic relationship between Jerry and his occupational therapy practitioner included lack of time to establish rapport and the occupational therapy practitioner's personal biases. There was a misalignment between the practitioner's approach to building rapport and Jerry's preferred method of connecting with others.

Supporting Literature

The case scenario presented previously depicts an all-too-common occurrence for healthcare providers, including occupational therapy

practitioner. Interacting with individuals much different from one's self leaves room for lack of attachment as is seen in the aforementioned case. This therapist-client detachment can lead to the provider feeling defeated and unsuccessful and a client feeling unsatisfied, misunderstood, undervalued, and even mistreated. Below is a list of evidence supporting the need for increased focus on the therapeutic relationship.

- Batbaatar et al. (2017) found a strong positive association between patients' satisfaction and the quality of his or her healthcare providers' interpersonal skills.
- Hadi, Alldred, Briggs, Marczewski, and Closs (2017) identified barriers to humanized care to include poor patient-professional partnerships due to lack of trust, communication, and empathy.
- Effective patient-professional relations can improve health and self-management, whereas lack of trust in the medical professional can negatively affect patient outcomes (Hadi et al., 2017).
- Beach, Branyon and Saha (2017) found that the individuals had varying definitions of respect and that in order to provide client centered care, it is vital to determine how each client feels respected and disrespected.

Love in Healthcare

Typically, the work "love" does not often arise in healthcare settings when practitioners describe their work with clients. Likely, a majority of practitioners do not think of love as being an acceptable form of affection within the workplace. There are many policies and regulations in place to protect patients and staff from experiencing inappropriate love in the workplace such as forms of love that is unprofessional, aggressive or undesired. The word love, specifically in workplace settings, may be off putting, however, love is defined in many ways and can represent a broad spectrum of relationships. There are six main Greek words for love, all having different meanings and drawing on separate, but

equally important elements of human connection (Perrotto, 2017). For example, the type of love defined as Eros, encompasses sexual passion, sexuality, and sexual expression (Perrotto, 2017). On the other hand, Ludus, is a playful love often characterized by laughing and dancing and is a kind of love that children often display (Perrotto, 2017). For the purpose of this product, we would like to draw attention to the form of love called Agape. Agape is defined as a selfless love that is comprised of actions and behaviors for the greater good (Perrotto, 2017). Wilson (2017) described this type of love to "seek to understand, recognize there can be understanding without acceptance, allow forgiveness, foster humility, and value and seek the good of others" (p.488). Wilson (2017) described that Agape love "fuels appreciation and fosters a love that nudges, encourages, and challenges us to want to continually improve patient care" (p.488).

When reflecting on medical organizations mission statements, many of the descriptors of agape are in alignment with what healthcare organizations strive for in regard to patient care. For example, the American Occupational Therapy Association (AOTA) defined seven core concepts that represent the core values and attitudes of the occupational therapy profession. These values include "altruism, equality, freedom, justice, dignity, truth, and prudence" (AOTA, 1993, p. 1085-1086). Specifically, the values of altruism and dignity closely align with the definition of Agape love. Altruism refers to "unselfish concern for the wellbeing of others" and dignity is referred to as the "importance of valuing the inherent worth and uniqueness of each person" (AOTA, 1993, p.1085). The values of altruism and dignity, as well as the additional values outlined by AOTA, are concepts that represent the core philosophy and values of the occupational therapy profession. In relation to the definition of agape love, striving to understand, valuing and seeking the good of others as well as doing things for the greater good are all ways that healthcare professionals can uphold to the values of altruism and dignity for their patients. Within this product, we want to

challenge you to "go against the grain" and redefine love within the realm of healthcare in an effort to best understand our guide to applying The Five Love Languages with clients.

Introduction to the Five Love Languages

We have selected the work of Gary Chapman, author, speaker, and relationship counselor known by many worldwide, to serve as a guiding notion in which to apply to and expand on the field of occupational therapy, specifically within therapist-client relationships (Chapman, 2019). Chapman's credentials include holding a Bachelor's and Master's degrees in anthropology from Wheaton College, and Wake Forest University Respectively, and MRE and PHD degrees from Southwestern Baptist Theological Seminary (Chapman, 2019). He has also completed postgraduate work at The University of North Carolina and Duke University (insert source). In addition to being a New York TImes bestseller, he has authored 13 books published with a variety of publishing companies as well as co-authored 14 books with scholars of expertise in various fields (Chapman, 2019). He holds over 35 years of experience in pastoring and marriage counseling (Chapman, 2019).

Permission to use his work as an inspirational basis was granted by Chapman (See Appendix). The central tenants of his work, the Five Love Languages, includes the idea that each individual receives love differently, and that he or she is more or less receptive to receiving love in different "languages". Within occupational therapy, support for participation from the client can be better achieved when the occupational therapy practitioner knows how the client would like to receive his or her care (Mroz, 2015). Application of the Five Love Languages to better understand how a client would like to be cared for can help support clients in a way he or she appreciates, resulting in a positive therapy relationship, increased client satisfaction, and better therapy outcomes. The five identified languages are Words of Affirmation, Acts of Service, Quality Time, Receiving Gifts, and Physical Touch (Chapman, 2010). Each of these

languages, which may be interpreted through a variety of lenses, such as within romantic relationships or within the workplace, are both lenses that Chapman has already explored. Our intent, is to explore and apply the Five Love Languages in relation to occupational therapy, particularly within therapeutic relationships, in order to provide a guide for determination and implementation of a client's preferences for care.

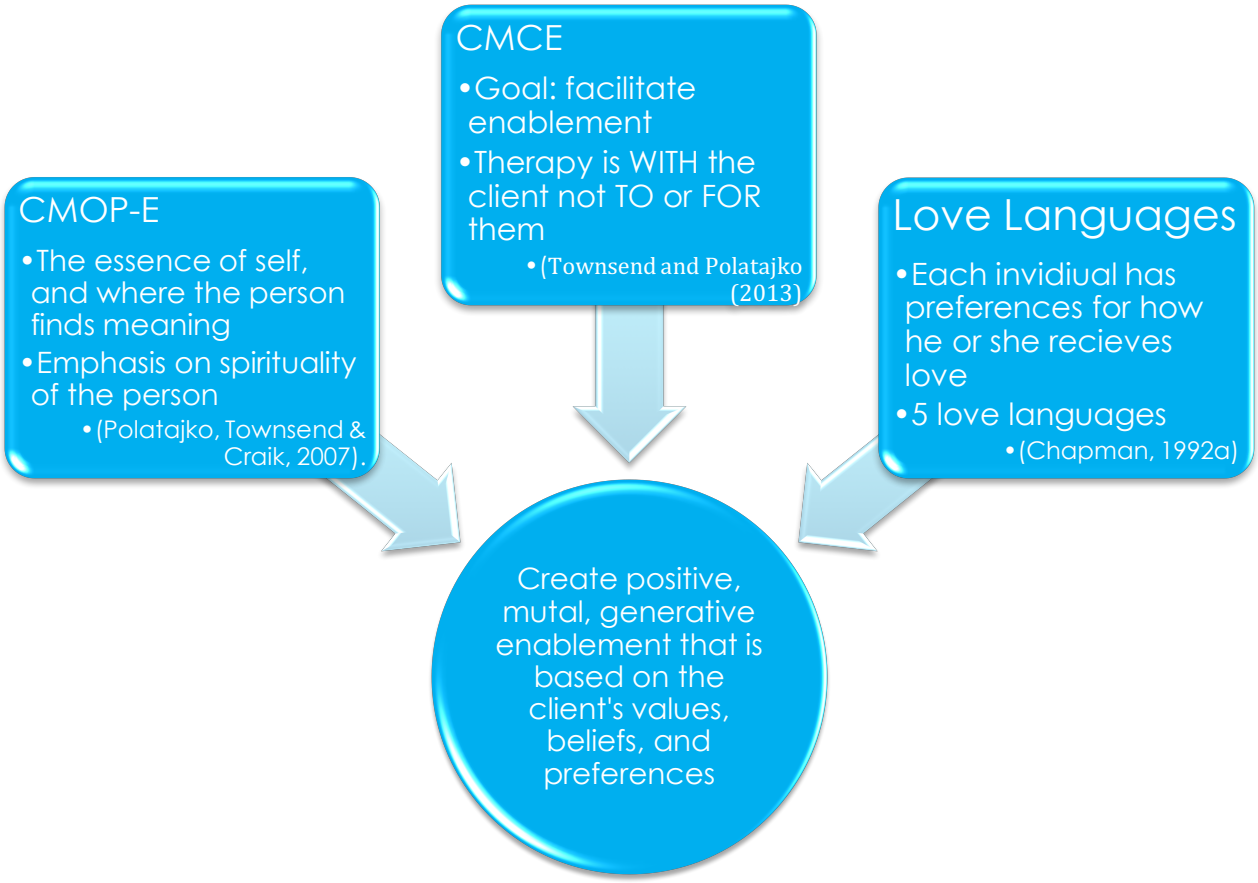
Introduction to Product and Intent

A training guidebook to inform occupational therapy practitioners on Gary Chapman's work and facilitate the inclusion of the Five Love Languages into practice in any given setting serving clients 18 years and older.

Theoretical Base

We have chosen the Canadian Model of Occupational Performance (CMOP), Canadian Model of Client Centered Enablement (CMCE), and The Five Love Languages to serve as a theoretical base for the creation of our product. Figure 1 details the fundamentals of the chosen models. The CMOP is comprised of the person, environment and occupations (Polatajko, Townsend, & Craik, 2007). Unique to the CMOP is that the person is situated at the center of the model, and emphasis is placed on the individual's spirituality (Polatajko, Townsend, & Craik, 2007). Spirituality is described by the CMOP not as religion, but the essence of self, and the place where determination and meaning are drawn (Townsend et al., 2013). The CMCE is a subset of the CMOP. Within the CMCE, significance is placed on the practitioner facilitating client enablement by providing therapy that is with the client not to or for him or her (Townsend et al., 2013). The Five Love Languages is also serving as a theoretical base; please refer to aforementioned sections of this introduction to view the central tenants of the Five Love Languages. We have integrated the foundational components of the Five Love Languages, the CMOP and CMCE to create positive, mutual, generative enablement that is based on the clients values, beliefs, and preferences (cite all relevant sources).

Figure 1. Theoretical Foundations



Section II: A How-to-Guide for Identifying Client's Love Language Preferences

Step 1: Determining Your Love Language

In order to best understand how to apply the principles of the Five Love Languages to your healthcare setting, each professional should take the quiz and determine his or her own love language. Below is the link to Gary Chapman's Love Language Quiz (Chapman, 1992b).

https://www.5lovelanguages.com/profile/

Once you have completed the quiz to determine your own Love Language preferences, complete the following reflection guide.

List the order of your preferences	What stood out to you?	How can you see your love language playing out in daily life?
•		
•		
•		
•		
•		

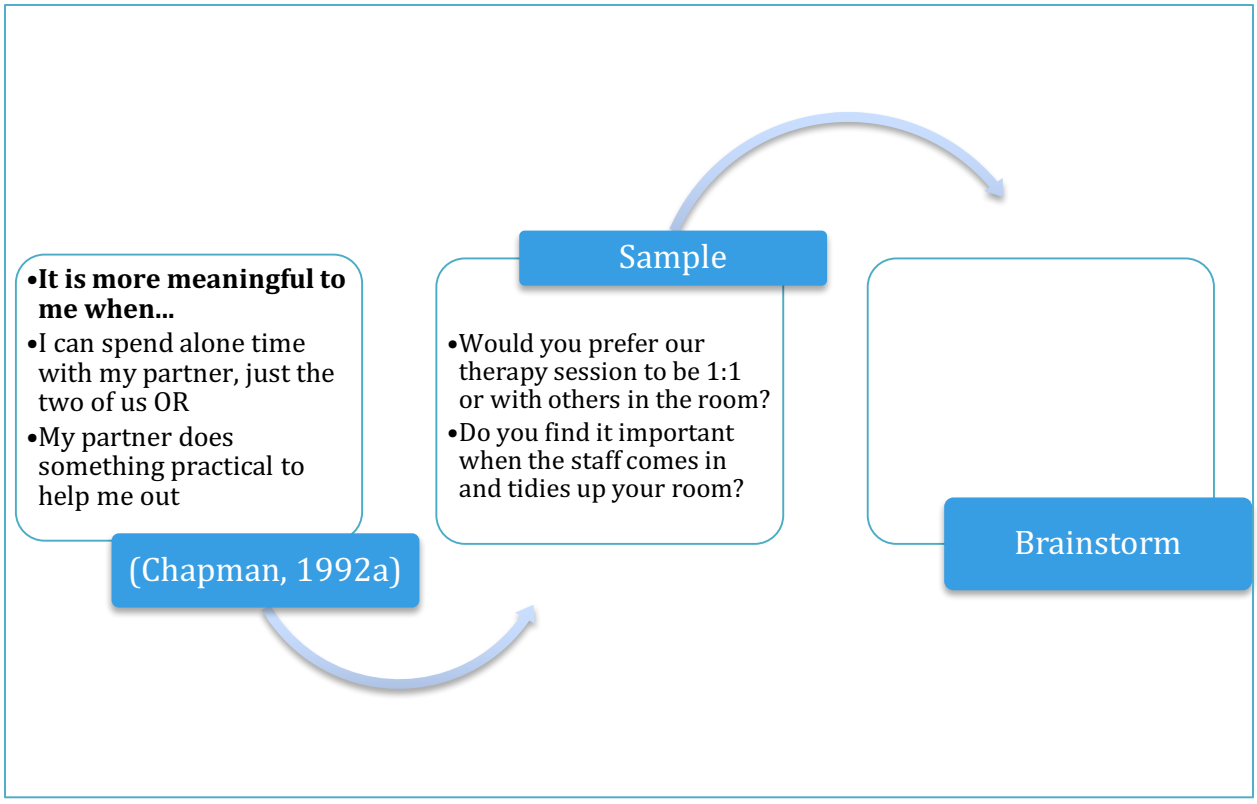
Reflect on a time when someone interacted with you using your least preferred language. How did it make you feel? How does it compare to when you are treated with your top Love Language?

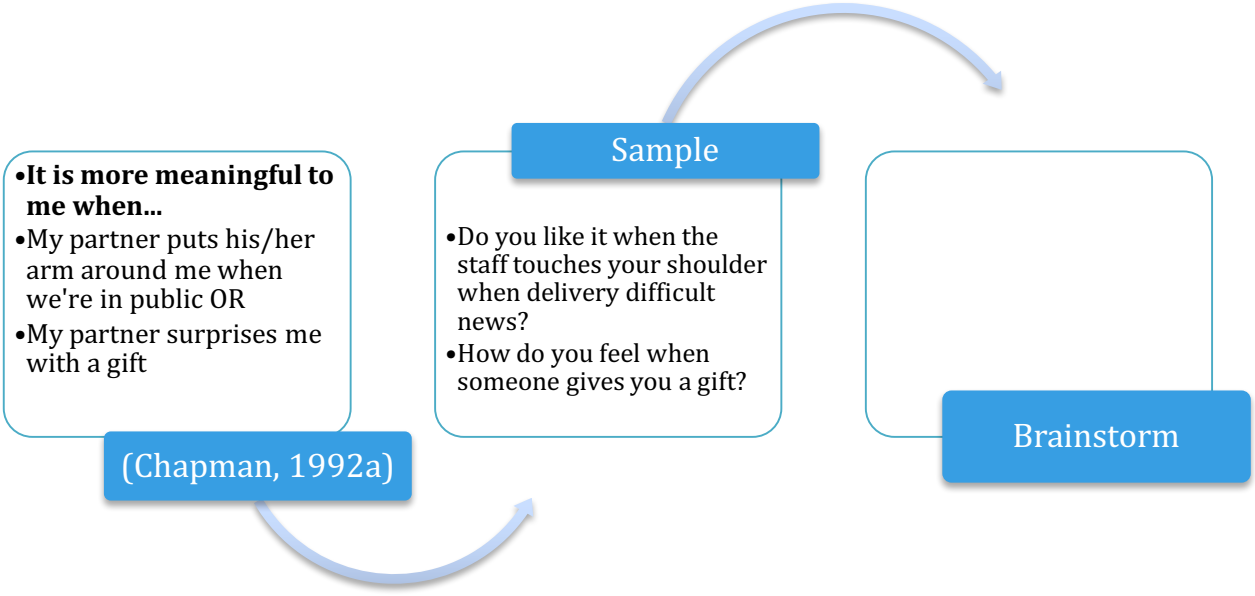
Now think about a client's position and how treating someone in his or her preferred vs. unpreferred love language may impact his or her satisfaction/outcomes.

Step 2: Brainstorming Questions for Your Setting

You have now seen the Love Language Quiz and have reflected on the value of knowing the Love Language preferences of both yourself as well as others (including clients). Through this interactive brainstorming session, you will now take into account your therapy setting and devise a plan as to how you may determine your client's Love Language preferences through everyday encounters.

The diagram on the following page provides examples of quiz questions straight from Chapman's (Chapman, 1992a) source. You are encouraged to use the sample to then brainstorm questions that may be applicable within your setting that you can ask during daily interactions with those you serve.





Here are some other cues that we developed/brainstormed to help you identify a client's Love Language:

Words of Affirmation	**Cues he or she may prefer this language** ❖ Do not take constructive criticism well ❖ Attentive and responsive to compliments ❖ "Fishing" for compliments **Cues he or she may <u>not</u> prefer this language** ❖ Passively accept compliments ❖ Does not care to initiate/engage in conversation
Acts of Service	**Cues he or she may prefer this language** ❖ Expressing appreciation for help with task ❖ Asking for help for small tasks **Cues he or she may <u>not</u> prefer this language** ❖ Commenting that he or she would rather do it themselves ❖ Not recognizing when something is done for him or her
Receiving Gifts	**Cues he or she may prefer this language** ❖ Becomes emotional/expressive of thanks when given physical items/reinforcers ❖ Saves/collects/displays items that he or she has been given **Cues he or she may <u>not</u> prefer this language** ❖ Paying little to no attention to gift given ❖ Does not save items such as cards-prefers clean, uncluttered space
Quality Time	**Cues he or she may prefer this language** ❖ States missing you when appointment/session was missed ❖ Brings up new topics/asks questions at end of session to prolong time together **Cues he or she may <u>not</u> prefer this language** ❖ Frequent late arrivals/missed sessions ❖ "Get to the point" attitude
Physical Touch	**Cues he or she may prefer this language** ❖ Move close to you during treatment ❖ Prefer hands on explanations **Cues he or she may <u>not</u> prefer this language** ❖ Turning away when reaching ❖ Appear uncomfortable during hands on techniques (tense up, nervously laugh etc).

Section III: Love Languages - Simplified

Words of Affirmation

What is it?

- Uses words as primary action of affirming others
- Simple, straightforward statements of affirmations (Chapman, 1992a)
- Can be encouraging, kind, or humble words that carry significant meaning (Chapman, 1992a)
- Praise for accomplishments or personality or an affirmation for character (Chapman & White, 2010).
- May also be preferred to be shared on a one-on-one basis (which tends to be the most valued), in front of others, in a written format, or in public (Chapman & White, 2010).

Highlights from the Literature Regarding its Use

- Monitoring the emotional state of the client and matching it with the emotional tone of the occupational therapy practitioner's feedback (Weiste, 2018, p. 49)
- Be specific when providing positive feedback (Weiste,2018)
- Align with client's perspective when he/she has described his/her behavior in positive terms (Weiste, 2018)

Case Study Instructions

The following page contains a case study depicting a client who has Words of Affirmation as a preferred language. As you read the case, underline what cues told the occupational therapy practitioner that this was the clients love language, and circle what the practitioner did to implement it.

Case Study:

Nick is a 24-year-old male in outpatient therapy (following an inpatient rehab stay) who has sustained a T3 spinal cord injury in a motor vehicle accident. Nick has been recently diagnosed with depression and is having difficulty adjusting to his new life at home. He has moved back in with his parents following his injury and has shared he is finding his dependency on them to be disheartening. During his initial evaluation, Nick identified that he really wants to return to driving and working as a real-estate agent.

During the first outpatient session with Nick, the occupational therapy practitioner talked with him about his goals (driving and work), and provided him education on the process of therapy. The practitioner explained that in order to achieve his goal of driving, he would first need to begin with basic skills, picking up where he had left off in inpatient rehab (ex: strengthening, transfers, range of motion etc.). While explaining this, the practitioner noticed Nick had become less engaged in the conversation as evidenced by slouching, not maintaining eye contact, and becoming quieter than he had been in the beginning of the session. The practitioner asked Nick what he was thinking about and he responded saying "it is just kind of discouraging knowing I have a long road ahead of me still". The practitioner responded to Nick by explaining how much progress he has made since his injury and the possibility of more independence in the future. During this conversation, Nick's facial features softened, he regained eye contact and said thank you to the practitioner with watery eyes.

At the next session a few days later, Nick brought up that it meant a lot to him that the practitioner identified his progress thus far, sharing that his family has been primarily talking about what he cannot do versus what he can do as they adjust to being caregivers for him. In subsequent sessions, the practitioner made an effort to point out each victory, even if small, and would write encouraging notes on his home therapy program materials.

Integration of Theory:

The enablement skill from the CMCE model evident in this case is the skill of coaching. This skill is described as having the aim of "encouraging clients to reflect and discover their own motivations in their desired occupations". This was included in the case when the practitioner took time to discuss with Nick the therapy process as well as in helping him gain perspective regarding is progress in order to maintain motivation towards future goals.

(Townsend et al., 2013, p.119)

Other Ways to Implement the Language of Words of Affirmation

- Writing positive statements on the whiteboard in a client's room
- Verbalizing specific successes
  - ex. I was so proud you were able to stand for 1 minute today, way to go!
- Complimenting the client when speaking to others when the client is present
- When giving feedback, start and end when a positive statement
- Practice positive self-talk and positive affirmations
- Picking up on things that the client shares with you that shows progress, whether he or she views it as a success or not
  - Ex. "I walked 40ft with physical therapy today" Occupational therapist: "You've come so far! You should be proud of all the hard work you are putting in"

Reflection Activity

Words of Affirmation

Think about a client you have known who preferred this language. Use your reflection to complete the following chart

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?

If no...	In what ways could you have implemented it in your client Interactions? Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Acts of Service

What is it?

- Expressing love/appreciation by doing something for another person (Chapman, 1992; Chapman & White, 2010).
- Must be freely given and not demanded (Chapman & White, 2010)
- Acts of Service that are most meaningful to recipient will speak the loudest (Chapman & White, 2010)
- Do the act of service in a way recipient prefers (if appropriate)-he or she feels appreciated when it is a job well done in their eyes (Chapman & White, 2010)

Highlights from the Literature Regarding its Use

- Positive consequences: patient being more compliant with treatment regimens, better outcomes in health, higher satisfaction, & cost effectiveness (Person & Finch, 2008)

Case Study Instructions

The following page contains a case study depicting a client who has Acts of Service as a preferred language. As you read the case, underline what cues told the occupational therapy practitioner that this was the clients love language, and circle what the practitioner did to implement it.

Case Study:

Maria is a 72-year-old female who was diagnosed with Multiple Sclerosis (MS) 20 years ago. Until 6 months ago, Maria (with the support of her family) was able to manage her MS with minimal outside assistance needed. However, in recent months she has experienced decline and is now living in a skilled nursing facility. She was referred to occupational therapy due to her physician's concern about the progression of the disease and Maria's ability to continue completing her self-care tasks.

During the first encounter with the occupational therapy practitioner, Maria shared that she was previously a homemaker and described the multitude of tasks she performed for her family on a daily basis. She stated that as her MS-related fatigue had worsened, it has been difficult for her to step down from these tasks, but she has found a new appreciation for her husband and adult children who have helped with those tasks. She became tearful stating "they really have been such a blessing the last six months". The occupational therapy practitioner was picking up on the fact that Maria was emphasizing the help of her family. To confirm her hunch that Maria's Love Language may be Acts of Service, she asked what Maria has appreciated the most since moving into the skilled nursing facility. Maria stated, "oh all the little things that the staff has done to help make me comfortable and ease my transition".

In subsequent sessions with Maria, the occupational therapy practitioner made a point to ask if there was anything else she could do for her before leaving the session. The practitioner reflected upon her insights on Maria and was reassured that she had identified her Love Language correctly as Maria had written a thank you note during her recreation therapy session showing her appreciation for the occupational therapy practitioner's attentiveness to her needs.

Integration of Theory:

In addition to the enablement skills within the CMCE are the overarching enablement foundations. The foundation of power sharing connects with the language of acts of service. By outwardly serving clients in such a way as completing an act of service, it can reinforce to the client that he or she has ownership over their situation and that an occupational therapy practitioner is there to assist him or her on their journey, rather than just to "fix them" or tell the client what to do.

(Townsend et al., 2013, p.107-109)

Other Ways to Implement the Language of Acts of Service

- Making sure all needed items are in reach
- Assisting with room technology (ex. getting TV to right channel)
- Ask client if he or she would like assistance ordering his or her next meal
- Offer assistance for activities such as helping the client to the bathroom
- Offer to relay concerns to appropriate staff
- Tidying up room if client desires (ex. offering to clean up lunch tray)

Reflection Activity

Acts of Service

Reflect on a past client who, thinking back, preferred this language. Use your reflection to complete the following chart

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?

If no...	In what ways could you have implemented it in your client Interactions? Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Receiving Gifts

What is it?

- Does not always need to be a physical thing but could be intangible such as time off or your physical presence (Chapman, 1992a; Chapman & White, 2010)
- The gift serves as a symbol of thought rather than the tangible item itself (Chapman, 1992a)
- Gifts may be purchased, found, or made and come in many varieties including those that are expensive as well as free (Chapman, 1992a)

Highlights from the Literature Regarding its Use

- The receiving of gifts is seen as a thoughtful expression of caring from the staff and often meant more to the clients than just opening a present (Turkel, 2003)
- Individuals entering hospice care were given comfort care packs and viewed them as a thoughtful recognition of going through a difficult time. The study found that the value of the packs was not in its contents but in the symbolic representation that somebody cares (Oliver, Hillock, Moore, Goble, & Asbury, 2010)

Case Study Instructions

The following page contains a case study depicting a client who has Receiving Gifts as a preferred language. As you read the case, underline what cues told the occupational therapy practitioner that this was the clients love language, and circle what the practitioner did to implement it.

Case Study:

Jim is a 62 y.o. male recently admitted to the inpatient rehabilitation unit following a total knee arthroplasty. He has transferred here from the acute hospital setting due to continued difficulty with safely completing ADLs. Jim is not thrilled to be here as his wife is the one who pushed for him to have a couple more days of therapy. She is concerned with being able to care for him at home due to chronic back pain of her own.

Going into his therapy session, the occupational therapy practitioner was warned ahead of time that Jim may be resistant to therapy, as he had already attempted to refuse physical therapy earlier in the morning. With this in mind, the practitioner made sure to greet him warmly and ask him what he wanted to achieve in therapy, letting him know he was in charge. Despite this effort, Jim bluntly stated "I already did therapy today, I don't want to do anything". In an effort to not irritate him further, the occupational therapy practitioner decided to sit down and have a conversation with Jim in an effort to build rapport. As they begun talking, the practitioner glanced around his room and noticed several items that friends and family had brought to make his stay more comfortable. When asking Jim about these items, Jim's eyes lit up, and he became more talkative, sharing that the flowers were from his daughter who lived out of state, and that the pictures hung on the walls were drawn by his two grandchildren. The occupational therapy practitioner stated, "it must make you feel good to have a supportive family." Jim replied, "Oh yes, I'm a lucky guy, I got a whole fridge full of them at home" he said pointing to the pictures on his wall.

After some time of discussion, the occupational therapy practitioner asked if Jim would like to get dressed for the day. Jim stated, "I worked on that in my other room" (referring to his stay in acute care). The practitioner remembered a box of free reachers that had been sent to the department, and thought introducing this to Jim as something he could keep may be appealing to him. She asked Jim if he'd be willing to try out the reacher and made a point to let him know it was his to keep if he thought it was helpful. Jim was interested to try the reacher and with it, the occupational therapy practitioner and Jim reviewed dressing techniques for the remainder of the session. Before leaving, the occupational therapy practitioner wrote Jim's name of the reacher, reminding him it officially belonged to him free of charge. As the practitioner was leaving, Jim's wife walked into the room and the occupational therapy practitioner overheard Jim beginning to tell his wife about what he had learned in therapy and that he was able to take the reacher home with him when he was discharged.

Integration of theory:

Within this case, the nature of the encounter between the occupational therapy practitioner and client can be viewed under the enablement skill of **engagement** as described by the CMCE. Central to this skill is the practitioner's ability to engage the client in an occupation. This is evident in the case when the occupational therapy practitioner utilized Jim's love language of receiving gifts in order to encourage engagement in practicing the occupation of dressing.

(Townsend et al., 2013, p.126)

Other Ways to Implement the Language of Recieving Gifts

- Give a coupon to the coffee shop in the hospital
- Play the client's favorite music during the therapy session
- A certificate of completion when acheiving a goal (ie. can safely perform activities of daily living independently)
- Bringing a newspaper or magazine meaningful to the client's interests
- Preparing his or her favorite meal during a cooking session
- Giving the client a holiday card
- Providing a wheelchair pocket/bag for carrying his or her belongings

Integration Activity

Receiving Gifts

Reflect on a past client who, thinking back, preferred this language. Use your reflection to complete the following chart

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?
If no...	In what ways could you have implemented it in your client interactions?

	Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Quality Time

What is it?

- Includes focused attention, active listening, quality conversation, and/or quality activities (Chapman, 1992a)
- "Sharing experiences, thoughts, feelings, and desires in a friendly, uninterrupted context" (Chapman, 1992a, p. 60-61)
- Includes empathetic listening - eye contact, avoiding multitasking, listening for feelings as well as thoughts, affirming feelings, noticing body language, and not interrupting (Chapman & White, 2010)
- Quality time doesn't have to relate to the amount of time spent but rather the quality that the time spent consists of (Chapman & White, 2010)

Highlights from the Literature Regarding its Use

- Quality time between patients in an inpatient psychiatric facility and staff promotes recovery and reduced staff stress (Cleary, Hunt, Horsfall, & Deacon, 2012)
- Quality time with patients improved patients' adherence to taking their medications (Petrou, 2013)

Case Study Instructions

The following page contains a case study depicting a client who has Quality Time as a preferred language. As you read the case, underline what cues told the occupational therapy practitioner that this was the clients love language, and circle what the practitioner did to implement it.

Case Study:

Dylan is a 37-year-old male with a diagnosis of posttraumatic stress disorder (PTSD) following a tornado 8 months ago that took his home and a family member. He is in a partial hospitalization program five days per week, and is receiving psychiatric guidance and occupational therapy services. Before the hurricane, Dylan worked as a high school science teacher, but has since taken a leave of absence due to his mental health status. In his free time, Dylan loves to coach his son's soccer team, go to concerts with his wife, and play on a community softball league with friends. When developing goals during his initial occupational therapy evaluation Dylan shared that he would like to resume his roles of parent, husband, and teacher, expanding that he misses the interactions that have been absent since the traumatic event. Specifically, Dylan shared he would really like to take his wife to a concert for their upcoming anniversary.

While receiving this information from Dylan, the occupational therapy practitioner gathered that many of his identified occupations involved spending time with others. The practitioner asked Dylan what it was about these occupations he enjoyed most, to which he stated, "I guess it's that I can bond with them over something we both like to do". The practitioner used this answer as confirmation that his preferred Love Language was most likely quality time. In the sessions to come the occupational therapy practitioner developed rapport with Dylan by asking questions and connecting over common interests. For example, the practitioner learned that Dylan enjoyed listening to country music and they spent many sessions discussing memories of country concerts they have attended. For some of their sessions, the practitioner and Dylan developed a plan for managing PTSD symptoms specifically for attending a concert. A week after Dylan's discharge the practitioner called Dylan to check in and see how he was adjusting. He shared that with the help of the strategies learned in occupational therapy, he had been able to attend a small concert with his wife at the local theater.

Integration of theory:

The concept of quality times connects to an overall fundamental element of the CMCE model, as opposed to a specific enablement skill. In its diagrammatic representation, two asymmetrical, curved lines represent the relationship between the client and the professional. Spending time to develop rapport both initially and throughout the duration of the relationship, works to effectively enhance the relationship and brings this representation to life.

(Townsend et al., 2013, p.111)

Other Ways to Implement the Language of Quality Time

- Stopping by a client's room to check in on him or her
- Avoid doing two things at once (ex. documenting when talking with the client)
- Be cognizant of when family is visiting and attempt to schedule therapy at a different time
- Acknowleding when a therapy appointment was missed and let client know you thought of him or her
- Find a common interest that can enhance the quality of your conversations with the client
- Allow client time to tell you their story
- Give the client a heads up if he or she will be seeing a different therapist

Integration Activity

Quality Time

Reflect on a past client who, thinking back, preferred this language. Use your reflection to complete the following chart

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?
If no...	In what ways could you have implemented it in your client

	Interactions? Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Physical Touch

What is it?

- Can be a method of acknowledging person's value and offer encouragement (Chapman & White, 2010)
- Implicit touch includes subtle, requiring only a moment, and usually given without thought (Chapman & White, 2010)
- Can lead to a sense of trust, connectedness, caring, and expressing excitement and joy (Chapman & White, 2010)

Highlights from the Literature Regarding its Use

- Occupational therapy assistants were found to utilize expressive touch twice as often as the occupational therapists (Morris et al., 2009)
- Those with Autism Spectrum Disorder respond to touch in conjunction with other soothing techniques (McCormack & Holsinger, 2016)
- Karrlsson, Post, & Bergbom (2010) referred to physical touch in two ways: present carers and distant carers. Present carers were those that demonstrated feelings of confidence, safety, protection and comfort through the use of physical touch.

Case Study Instructions

Next is a case study depicting a client who has Physical Touch as a preferred language. As you read the case, underline what cues told the occupational therapy practitioner that this was the clients love language, and circle what the practitioner did to implement it.

Case Study:

Iris is a 58 y.o. female with a diagnosis of arthritis in both hands. She is seeing an occupational therapy practitioner in an outpatient hand therapy clinic 2 days a week to address her goals of continuing to work as part of the cafeteria staff at an elementary school and to get back to her desired leisure occupation of knitting. Iris is also a mother of two and a first time Grandma of a 6-month-old baby.

When greeting Iris on the first day of therapy, Iris initiated a handshake with the occupational therapy practitioner and walked closely as they headed back to the therapy gym. Following protocol, the practitioner asked permission to touch Iris to better examine her hands and understand the extent of her arthritis. Iris responded saying "no problem". After finishing her evaluation, the practitioner performed manual massage on Iris's hands in an effort to relieve some of her pain before leaving the clinic. This became Iris's favorite part of her visits, often sharing with the practitioner that she appreciated the manual therapy and felt that it was working on taking care of her arthritis. The occupational therapy practitioner acknowledged that Iris preferred this type of treatment stating, "I'm glad this has been helpful for you, not everyone prefers the hands on stuff". Iris responded stating "people call me the hugger, I'm quite comfortable with being in close proximity to others". In future sessions, the occupational therapy practitioner made a point to touch Iris on the shoulder when greeting her and sat next to her rather than across from Iris when giving her feedback.

Integration of theory:

The enablement skill of **specializing**, as outlined by the CMCE, is evident when discussing the application of physical touch. This skill is described as a composite of many skills that contribute to a practitioner's competency in enabling occupation. The use of therapeutic touch (as well as simply caring touch) is used with careful thought and attention to how its use may benefit a client in his/her journey of enablement, making its use a professional skill.

(Townsend et al., 2013, p.128)

Other Ways to Implement the Language of Physical Touch

- Using your body or the client's body to explain where problems are happening
- Giving a client a high five when he or she has accomplished something new
- If appropriate, offer a hug when comforting or encouraging the client
- In treatment sessions attempt to use hands on techniques when possible
- When refraining from touch due to level of appropriateness, provide education to a family member on how he or she can provide more intimate cares

Integration Activity

Physical Touch

Reflect on a past client who, thinking back, preferred this language. Use your reflection to complete the following chart

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?
If no...	In what ways could you have implemented it in your client Interactions?

	Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Section IV: Implementation Plan

Initial Case Review

Thinking back on the initial case scenario, had the occupational therapy practitioner identified Jerry's Love Language of Acts of Service, what are some ways the occupational therapy practitioner could have successfully built initial rapport and carried out therapy?

Examples:

- Start initial encounter by asking Jerry if there is anything the occupational therapy practitioner could do for him.
- Making an effort to explain to Jerry that he is "in the driver's seat" and you are here to work for and with him.

Brainstorm additional ways to fulfill Jerry's Love Language:

-
-
-

Implementation Planning Guide

You have now gained an understanding of what the love languages are, have practiced how to identify a client's preferred love language, and have considered each language's application within your setting. The next step is to create a practical plan for implementing the knowledge and skills gained into daily practice.

This section includes the following items to be utilized to your benefit when forming goals for incorporating the Five Love Languages into practice.

1. **Personal action plan outline with tips**
2. **Whole setting (ex: therapy department, clinic etc.) action plan outline with tips**

Personal Action Plan

Main Takeaways:
(use this space to add some notes about what you understand regarding the benefits of treating clients with their preferred approach in mind, how to determine what a client's preferred Love Language is, how to practically apply their preferences etc.)

- ❖
- ❖
- ❖
- ❖
- ❖

Personal Goals
(create goals for yourself in regard to applying the knowledge and skills you have gained. Keep in mind goals should be **practical, achievable, and measurable**.). For each goal, record how you will take action to achieve it, list a desired achievement date, and list how you will measure that you have achieved it. A sample goal is included below this section of this workbook.

Goal 1:

_____

_____

_____

- ❖ How I will reach this goal:
  - ➢
  - ➢
  - ➢

- ❖ I will achieve this goal by (date):
- ❖ I will know I have achieves this goal when:

Goal 2:

_____

_____

- How I will reach this goal:
  - ➢
  - ➢
  - ➢
- I will achieve this goal by (date):
- I will know I have achieves this goal when:

Goal 3:

_____

_____

- How I will reach this goal:
  - ➢
  - ➢
  - ➢
- I will achieve this goal by (date):
- I will know I have achieves this goal when:

Reflection (to be completed when after some time spent addressing goals):

Since applying the Love Languages to my practice, I have noticed…

_____

_____

_____

Sample Goal:

I will identify 5 of my clients preferred Love Languages within the next 2 weeks.

- **How I will reach this goal:**
  - ➢ Review the Five Love Language categories and become familiar with them
  - ➢ Brainstorm questions I can ask my clients to better understand their Love Language.
  - ➢ Print and review the additional cues handout and carry it with me to assist in identifying clients Love Languages
- **I will achieve this goal by (date):** 2 weeks from today
- **I will know I have achieved this goal when:** I have received feedback from clients confirming that he or she is in agreement with my approach

Whole Setting Action Plan

In addition to making personal goals, it may also be beneficial to decipher goals for your therapy team, department, clinic, or setting as a whole. The following guide aims to aid in this process and is intended to be completed as a group.

Main Takeaways:
(use this space to add some highlights from your team discussion regarding the benefits of treating clients with their preferred approach in mind, how to determine what a client's preferred Love Language is, how to practically apply their preferences etc.)

- ❖
- ❖
- ❖
- ❖
- ❖

Team Goals
(create goals for your team in regard to applying the knowledge and skills you have gained. Keep in mind goals should be practical, achievable, and measurable.). For each goal, record how your team will take action to achieve it, list a desired achievement date, and list how your team will measure that you have achieved it. Be sure to include how you can support each other in implementing your action plan. A sample goal is included in the Appendix of this workbook.

Goal 1:

_____

_____

_____

- ❖ How will we reach this goal:
  - ➢
  - ➢
  - ➢

- ❖ We will achieve this goal by (date):
- ❖ We will know we have achieved this goal when:

Goal 2:

_____

_____

- How we will reach this goal:
  - ➢
  - ➢
  - ➢
- We will achieve this goal by (date):
- We will know we have achieved this goal when:

Goal 3:

_____

_____

- How we will reach this goal:
  - ➢
  - ➢
  - ➢
- We will achieve this goal by (date):
- We will know we have achieved this goal when:

Reflection (to be completed after some time spent addressing goals):

Since applying the Love Languages to our practice, we have noticed…

_____

_____

_____

Sample Goal:

As a therapy department, we will raise our client satisfaction rating (per survey at discharge) by 10% or more in the next 4 months.

- **How will we reach this goal:**
  - ➢ Provide each practitioner with Love Language Quick Tip cards
  - ➢ Weekly team meetings to talk through challenges & support each other
  - ➢ Host incentivized drawings to encourage clients to provide feedback on comment cards
- **We will achieve this goal by (date):** 4 months from now
- **We will know we have achieved this goal when:** our survey ratings have raised by 10% (data compiled monthly)

Section V: References

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Section VI: Appendix

Quick Tip Cards!

Below are cards with some "go-to's" for implementing each love language. You are encouraged to make copies to post in your therapy setting and/or keep in your pocket as a reference when working on treating clients using their preferred love language.

Tip: cut and laminate cards to keep on a key ring!

Words of Affirmation

- Writing positive statements
- Verbalizing specific successes
- Complementing the client
- When giving feedback, start and end when a positive statement
- Practice positive self-talk and positive affirmations
- Picking up on things that the client shares with you that shows progress, whether they view it as success or not

Acts of Service

- Making sure all needed items are in reach
- Assisting with room technology
- Ask client if he or she would like assistance with a task
- Offer assistance for activities such as helping the client to the bathroom
- Offer to relay concerns to appropriate staff
- Tidying up room if client desires

Recieving Gifts

- Give a coupon to the coffee shop in the hospital
- Play the client's favorite music
- A certificate of completion when acheiving a goal
- Bringing a newspaper or magazine meaningful to the client's interests
- Preparing the client's favorite meal during a cooking session
- Giving the client a holiday card
- Providing a wheelchair pocket/bag for carrying his or her belongings

Quality Time

- Check in on client frequently
- Avoid multitasking
- Schedule therapy at convenient time for client
- Acknowledge time missed in therapy
- Form conversations around common interests
- Allow client time to tell you their story
- Give the client a heads up if he or she will be seeing a different therapist

Physical Touch

- Using client's body to explain where problems are happening
- Giving a client a high five
- Offer a hug for comfort or encouragement
- Use hands on techniques
- Educate family members on more intimate cares

Additional Reflection Worksheets

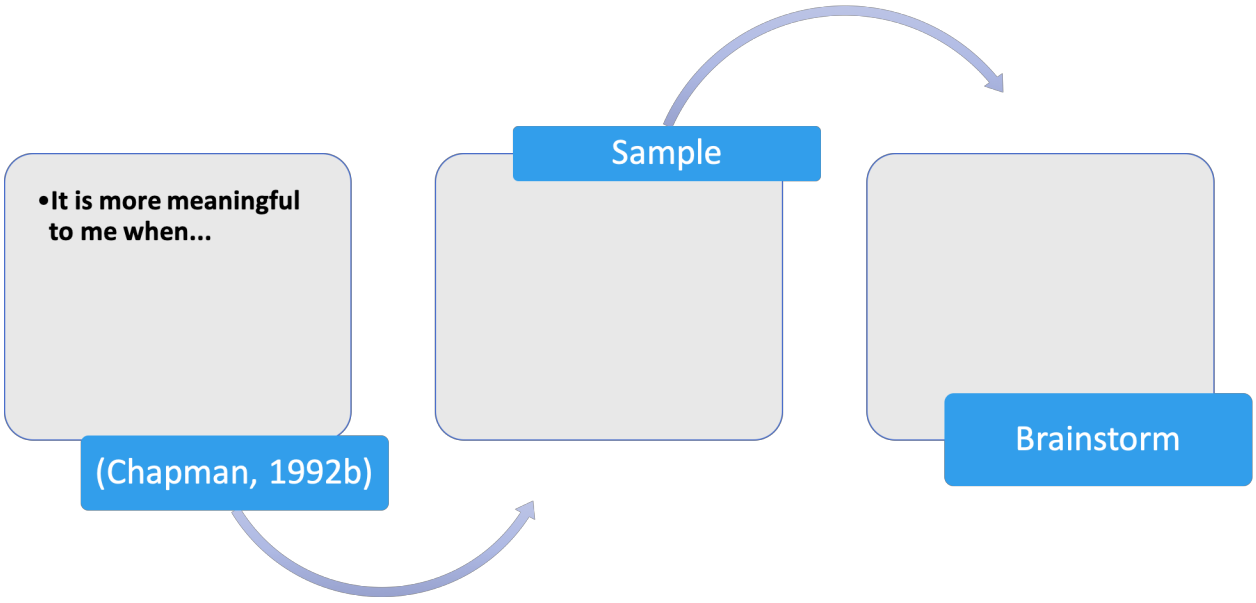
Determining Love Language Worksheet

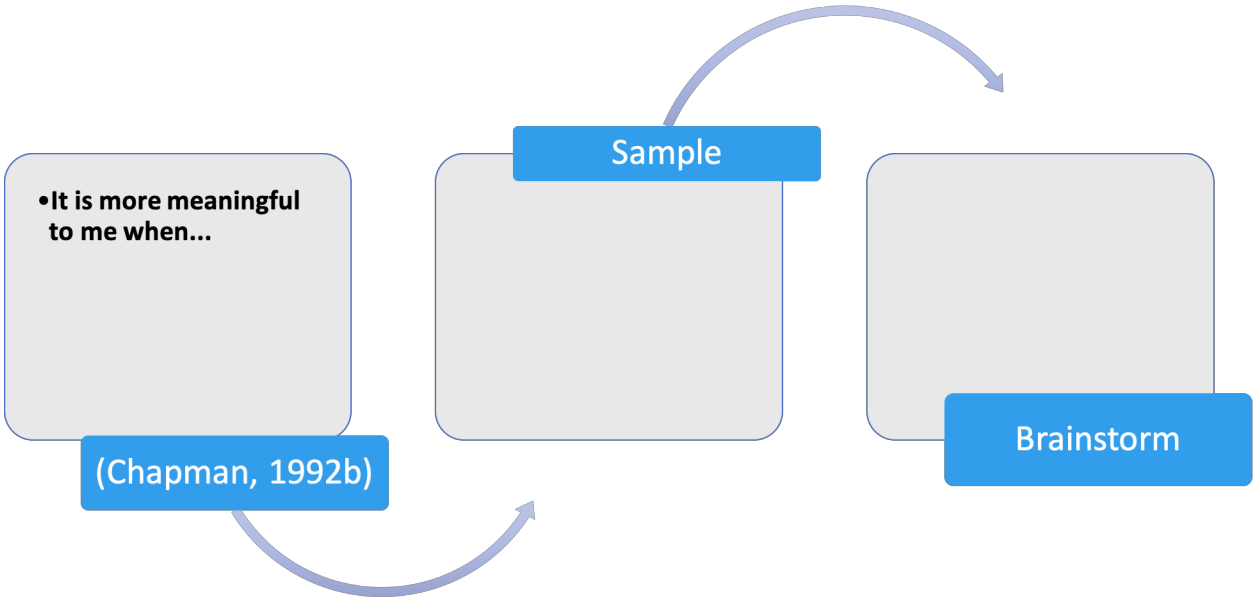
List the order of your preferences	What stood out to you?	How can you see your love language playing out in daily life?
• • • • •		

Reflect on a time when someone interacted with you using your least preferred language. How did it make you feel? How does it compare to when you are treated with your top Love Language?

Now think about a client's position and how treating someone in his or her preferred vs. unpreferred love language may impact his or her satisfaction/outcomes.

Brainstorming Questions Worksheet





Integration Activity Worksheet

What signs told you this was his/her preference?	
Did you naturally implement this language?	Circle: Yes/No
If yes...	In what ways did you treat the client with his or her preferred language? How did the client positively react to this treatment?
If no...	In what ways could you have implemented it in your client interactions?

	Upon reflection, how did the client negatively react to being treated in his or her non-preferred language?
List other ways you could have treated this client in his or her preferred language	

Email of Permission from Gary Chapman:

From: Gary Chapman [redacted]
Sent: Wednesday, August 8, 2018 3:53 PM
To: Roberts, Emily
Subject: permission

Emily: I received your e-mail regarding permission to use the 5 Love Languages in your research project. I'm happy for you to do so. I would just request that you send me a copy of the results when you complete your study. [redacted]

I wish you well in your graduate studies.
Gary D. Chapman, Ph.D. author of The 5 Love Languages
August 8, 2018

Email Response to Product Draft

From: Gary Chapman [redacted]
Sent: Saturday, March 16, 2019 8:57 AM
To: Roberts, Emily
Subject: RE: permission

Emily: Thanks for sharing. I am impressed with your project. The case studies are very helpful. If I were your professor, I'd give you an A+ on the project. [redacted]

I wish you well both in your project and with your future contribution to the world.
Gary Chapman