Fieldwork II Manual
2014

SECTION 4: FIELDWORK II ARTICLES
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DESIGNED TO:
- Meet the needs of the patient
- Provide restorative and preventive services to a community
- Provide services to reduce costs

HOSPITAL SERVICES
- General Medicine
- Burn
- Orthopedics
- Neurology
- Plastic Surgery
- General Surgery
- General Psychiatry

OUTPATIENT SERVICES
- Industrial rehabilitation
- Hand rehab
- Specialized clinics
  - Burn
  - Rehab
  - Amputee
  - Learning disabilities
  - Language
  - Life skills
  - Movement
  - Back clinic

RE-ENTRY PROGRAMS
- Return to work program
- Head injury program
- Life skill programs
  - Driving program
  - Technology center
  - Vocational readiness program
  - Wheelchair program
  - Specialized skill training
  - Vocational services

REHABILITATION
- Inpatient beds
- Rehabilitation Hospital

HOME HEALTH
- Nursing
- OT - PT - Speech
- Home health aide

WELLNESS
- Fitness programs for disabled
- Injury prevention
- Caregiver training
- Back school
- Community education
- Industrial consultation

COMMUNITY
- Schools - Programs
- Developmental disability center
- Clubs - Church
- Independent living centers
- Community centers

INDEPENDENT
Return to work, school, home and community activities
SERVICE DELIVERY & THE ROLE OF THE OCCUPATIONAL THERAPIST

FIELDWORK, New York University

A. HOSPITAL SERVICES
   1. **Setting:** may be a large state hospital or a private, city or general hospital; may be acute care for injuries or illnesses or rehabilitation, freestanding psychiatric ward with centralized or decentralized Occupational Therapy department or program, or a psychiatric ward within general hospital setting.
   2. **Mission:** to take care of individuals who are medically or psychologically unstable. In the case of rehabilitation, to rehabilitate those persons as soon as they are medically stable.
   3. **OT Role:** to help patients learn basic skills that give them a sense of control over their environment and to prevent further disabling conditions; help families solve basic problems such as how to get the patient home, how to manage after getting home, and how to find resources to help the patient become more independent in taking care of him/herself.

B. OUTPATIENT SERVICES
   1. **Setting:** hospital, physician’s or therapist’s office, health maintenance organizations, one-stop health care clinics, industrial sites, skilled nursing facilities or rehabilitation clinics.
   2. **Mission:** to take care of individuals outside the hospital setting either for extended care, to reach long term goals, to achieve level of function, or to prevent regression of further injury.
   3. **OT Role:** goal is to provide planning with the individual and the family on how to obtain additional services to help the client achieve independence if returning to work and community activities.

C. RE-ENTRY PROGRAMS
   1. **Setting:** clinic, clubs, centers, halfway houses, supported houses or supervised residences, freestanding psychosocial clubs affiliated with community outreach or a day treatment program.
   2. **Mission:** to provide individuals with the skills, physical endurance, emotional support and family support needed to function independently at a community level.
   3. **OT Role:** consultant to program planning, evaluation; lead specific groups or activities.

D. REHABILITATION
   1. **Setting:** hospital, rehabilitation centers, cognitive programs in rehabilitation settings.
   2. **Mission:** to foster optimal independence in patients; make him/her aware of his/her responsibility to work toward achieving the long-term goal of independence and move away from the role of patient.
   3. **OT Role:** for individuals leaving a rehabilitation setting-assist individuals and their families to develop a specific plan on how to obtain additional needed services to achieve
independence (d/c plan); re-evaluation of progress.

E. After completing required fieldwork experiences, students can choose to take additional fieldwork courses in a specialty practice area. This advanced optional fieldwork is usually chosen by a student who wants **HOME HEALTH**

1. **Setting**: patient’s home, shelters
2. **Mission**: to help an individual achieve optimal independence by providing the opportunity to determine the environmental modifications necessary to achieve independence in home activities.
3. **OT Role**: to develop and carry out activities that prepare an individual for work or community activities, and consequently to develop mechanisms for referring clients to other rehabilitation services; communication with referring source regarding client progress; direct care and training.

F. **WELLNESS**

1. **Setting**: clubs, centers, spas, hospitals, schools
2. **Mission**: to maintain health, disability prevention, and education
3. **OT Role**: direct care, teaching, consulting

G. **COMMUNITY**

1. **Setting**: agencies, schools and day facilities
2. **Mission**: to help students or clients to gain skills and to achieve optimal independence
3. **OT Role**: as staff or a consultant to achieve the facility’s mission; when necessary services are not available at the facility, to develop a plan for how to obtain additional services needed to achieve a higher level of independence; advocate for funding, resources and clients.

H. **INDEPENDENT**

1. **Setting**: any and all facilities or private practice/office
2. **Mission**: to deliver direct care, education or consultation
3. **OT Role**: multiple roles as needed by the hiring body or facility
RESOURCES:


The American Occupational Therapy Association’s Code of Ethics is a public statement of the values and principles used in promoting and maintaining high standards of behavior in occupational therapy. The American Occupational Therapy Association and its members are committed to furthering people’s ability to function within their environment. To this end, occupational therapy personnel provide services for individuals in any stage of health and illness, institutions, other professionals and colleagues, students, and the general public.

The Code of Ethics is a set of principles that applies to occupational therapy personnel at all levels. The roles of practitioner (registered occupational therapist and certified occupational therapy assistant), educator, fieldwork educator, supervisor, administrator, consultant, fieldwork coordinator, faculty program director, researcher/scholar, entrepreneur, student, support staff, and occupational therapy aide are assumed.

Any action that is in violation of the spirit and purpose of this Code shall be considered unethical. To ensure compliance with the Code, enforcement procedures are established and maintained by the Commission on Standards and Ethics. Acceptance of membership in the American Occupational Therapy Association commits members to adhere to the Code of Ethics and its enforcement procedures.

### Principle 1.

**Occupational therapy personnel shall demonstrate a concern for the well-being of the recipients of their services (beneficence).**

A. Occupational therapy personnel shall provide services in an equitable manner for all individuals.

B. Occupational therapy personnel shall maintain relationships that do not exploit the recipient of services either sexually, physically, emotionally, financially, socially or in any other manner. Occupational therapy personnel shall avoid relationships or activities that interfere with professional judgment and objectivity.

C. Occupational therapy personnel shall take all reasonable precautions to avoid harm to the recipient of services or to his/her property.

D. Occupational therapy personnel shall strive to ensure that fees are fair, reasonable, commensurate with the service performed and are set with due regard for the recipient’s ability to pay.
Principle 2.

Occupational therapy personnel shall respect the rights of the recipients of their services (e.g., autonomy, privacy, confidentiality).

A. Occupational therapy personnel shall collaborate with service recipients or their surrogate(s) in determining goals and priorities throughout the intervention process.

B. Occupational therapy personnel shall fully inform the service recipients of the nature, risks, and potential outcomes of any interventions.

C. Occupational therapy personnel shall obtain informed consent from subjects involved in research activities indicating they have been fully advised of the potential risks and outcomes.

D. Occupational therapy personnel shall respect the individual’s right to refuse professional services or involvement in research or educational activities.

E. Occupational therapy personnel shall protect the confidential nature of information gained from educational, practice, research, and investigational activities.

Principle 3.

Occupational therapy personnel shall achieve and continually maintain high standards of competence (duties).

A. Occupational therapy practitioners shall hold the appropriate national and state credentials for providing services.

B. Occupational therapy personnel shall use procedures that conform to the Standards of Practice of the American Occupational Therapy Association.

C. Occupational therapy personnel shall take responsibility for maintaining competence by participating in professional development and educational activities.

D. Occupational therapy personnel shall perform their duties on the basis of accurate and current information.

E. Occupational therapy practitioners shall protect service recipients by ensuring that duties assumed by or assigned to other occupational therapy personnel are commensurate with their qualifications and experience.

F. Occupational therapy practitioners shall provide appropriate supervision to individuals for whom the practitioners have supervisory responsibility.

G. Occupational therapists shall refer recipients to other service providers or consult with other service providers when additional knowledge and expertise is required.
Principle 4.

**Occupational therapy personnel shall comply with laws and Association policies guiding the profession of occupational therapy (justice).**

A. Occupational therapy personnel shall understand and abide by applicable Association policies; local, state, and federal laws; and institutional rules.

B. Occupational therapy personnel shall inform employers, employees, and colleagues about those laws and Association policies that apply to the profession of occupational therapy.

C. Occupational therapy practitioners shall require those they supervise in occupational therapy related activities to adhere to the Code of Ethics.

D. Occupational therapy personnel shall accurately record and report all information related to professional activities.

Principle 5.

**Occupational therapy personnel shall provide accurate information about occupational therapy services (veracity).**

A. Occupational therapy personnel shall accurately represent their qualifications, education, experience, training, and competence.

B. Occupational therapy personnel shall disclose any affiliations that may pose a conflict of interest.

C. Occupational therapy personnel shall refrain from using or participating in the use of any form of communication that contains false, fraudulent, deceptive, or unfair statements or claims.

Principle 6.

**Occupational therapy personnel shall treat colleagues and other professionals with fairness, discretion, and integrity (fidelity, veracity).**

A. Occupational therapy personnel shall safeguard confidential information about colleagues and staff.

B. Occupational therapy personnel shall accurately represent the qualifications, view, contributions, and findings of colleagues.

C. Occupational therapy personnel shall report any breaches of the Code of Ethics to the appropriate authority.

Author:
Commission on Standard and Ethics (SEC)
Ruth Hansen, Ph.D., OTR, FAOTA, Chairperson
Approved by the Representative Assembly: 4/77
Revised: 1979, 1988, 1994
Adopted by the Representative Assembly: 7/94

NOTE: This document replaces the 1988 Occupational Therapy Code of Ethics, which was reviewed by the 1994 Representative Assembly.
Summary of Ethical Issues

Philosophical Schools of Thought

• Teleological (utilitarianism):
  - outcomes, consequences are important
  - ends justify the means
  - greatest good for greatest number
  - overall society more important than the individual

• Deontological:
  - duties and rights that individuals have with each other
  - the individual’s rights
  - means is what’s important
  - right actions are important regardless of outcomes

Ethical Principles

- **Beneficence**: to do good. But how do you determine what is good?
- **Nonmaleficence**: do no harm
- **Fidelity**: trustworthiness, maintenance of confidentiality, faithfulness
- **Veracity**: truthfulness
- **Justice**: fairness:
  - **distributive justice**: how should services be distributed?
  - **compensatory justice**: retribution; restitution paid because someone harmed
  - **procedural justice**: rules, protocol
- **Autonomy**: respect for the individual to make own decision, self-determination

Types of Ethical Problems

- **Ethical Distress**: you know what the right choice is but there’s a barrier to it (payment, protocol)
- **Ethical Dilemmas**: 2 choices—both of which are negative:
  - value conflict dilemmas
  - justice dilemmas (how to distribute services)
  - locus of authority dilemmas (who has right to decide)
The document titled “Principles of Occupational Therapy Ethics” was adopted in 1977 by the Representative Assembly of the American Occupational Therapy Association (AOTA) and revised in April 1979. This document guides the value system of our profession by providing principles that are to direct our relationships with those we serve. As stated in the preamble, the principles...

...are intended to be action-oriented, guiding and preventive rather than negative or merely disciplinary.... Professional maturity will be demonstrated in applying these basic principles while exercising the large measure of freedom which they provide and which is essential to responsible and creative occupational therapy service. (AOTA, 1984)

In this document the designation occupational therapist includes registered occupational therapists, certified occupational therapy assistants, and occupational therapy students.

The document outlines 12 areas of ethical responsibility. The principles are a common bond among all involved in occupational therapy—occupational therapists (OTRs), certified occupational therapy assistants (COTAs), and students—who are to strive to fulfill identical values. The principles also may be used to direct one’s professional growth when they are applied to performance in occupational therapy. By internalizing the norms of occupational therapy given in the principles and by identifying with these professional responsibilities, occupational therapy personnel may examine what they have done and what they could do to improve professional performance (Cromwell; 1973).

The inclusion of students in the document prompted the decision to use the guidelines to have students examine their own value systems and compare them with the ethics of the profession. By drawing student’s attention to the ethical components of responsibilities they would encounter in the work setting, it was hoped that students could vitalize ways they would need to grow professionally as they completed their academic education.

When the Occupational Therapy Ethics Self-Assessment Index was developed, the principles were put into first-person action statements. Each major principle is restated as an “I” statement with three verb choices to indicate the behavior that most closely
matches present professional performance (See Figure1).

Students were asked to think of their responses to the question in the index in relation to practicum experiences and to mentally note them. The index was part of a presentation titled "Developing Your Potential as COTA," which was given to occupational therapy assistant students about to enter Level II fieldwork in the Indiana University Occupational Therapy Program. Students were surveyed 6 months after the presentation and were asked if they had used the index since the presentation. The presentation was also given by at the state conference, and again participants were surveyed 6 months later.

The total number of people who were given the index to date is 51 (47 were students). Of these, 27 (52.9%) responded to the survey. Twelve (14%) stated that they have used the index since the initial presentation. Two of the four practicing therapists who were given the survey stated that they had used it and shared positive comments about it on the response form. One student wrote that the index was particularly helpful during fieldwork as she integrated class work with practice.

This preliminary use shows that the index has been helpful to those who have used it more than once. The index may be used with professional as well as technical level students at both fieldwork levels. It has potential for use with practicing therapists as means of discussing ethical behaviors, particularly decisions that affect the patient’s welfare.

Applying values to professional behavior may involve risk and confrontation. It may afford an opportunity for growth by pinpointing areas that need improvement, or it may encourage positive reflection when guidelines are being met (Welles, 1976). Through the Occupational Therapy Ethics Self-Assessment Index, professional behavior may be assessed Index, professional behavior may be assessed privately at any time without documentation requirements or challenged from peers. It should be used with the knowledge that all of us are working toward the same goal: to provide the best service to patients and employers.

Acknowledgements:
I extend sincere thanks to Gayle Hersh, MS, OTR, and Zona Weeks, PhD, OTR, FAOTA, for their valuable editorial assistance and support.

References:
Table 1

**Occupational Therapy Self-Assessment Index**

This index is for your personal use in assessing your professional behavior and is intended as a tool for self-growth. Periodic use of the index may help you to put into practice the Principles of Occupational Therapy Ethics established by AOTA. The interpretations of the principles are the author’s alone and do not represent any AOTA interpretation.

Respond to the following statements by mentally choosing the behavior that best reflects your performance as a therapist at this time:

1. Related to the recipient of service *(almost always, sometimes, seldom)*
   a) I demonstrate a helping concern for the recipient of services.
   b) I work toward a goal-directed relationship with the recipient.
   c) I respect the confidentiality of the therapist/patient relationship.

2. Related to competence *(almost always, sometimes, seldom)*
   a) I work toward keeping my professional skills current.
   b) I use only techniques I know I am qualified to employ.
   c) I describe my skills accurately to others.

3. Related to records, reports, grades, and recommendations *(almost always, sometimes, seldom)*
   a) I conform to laws and regulations applying to my position.
   b) I obey the rules my employer has defined apply to me.
   c) I record data in an objective manner.

4. Related to extraprofessional colleagues *(almost always, sometimes, seldom)*
   a) I act with discretion and integrity toward my professional peers.
   b) I report a breach of ethics or substandard service using established procedures.

5. Related to other personnel *(almost always, sometimes, seldom)*
   a) I act with discretion and integrity toward others with whom I work.
   b) I report a breach of ethics or substandard service using established procedures.

6. Related to employers and payers *(almost always, sometimes, seldom)*
   a) I render my services to employers and payers with discretion and integrity.
   b) I protect the property in my employers and payers.

7. Related to education *(often, sometimes, seldom)*
   a) I am involved in teaching the public about health practices related to occupational therapy.
   b) I am involved in teaching health personnel about health practices related to occupational therapy.

8. Related to evaluation and research *(almost always, sometimes, seldom)*
   a) I take the responsibility for explaining services I provide in occupational therapy.
   b) I protect the rights of subjects, clients, institutions, and collaborators.
   c) I give credit to the work of others when appropriate.

9. Related to the profession *(almost always, sometimes, seldom)*
   a) I stay informed about the profession.
   b) I act as a representative for the profession.
   c) I uphold the principles of occupational therapy ethics in my own actions and those of others.

10. Related to advertising *(almost always, sometimes, seldom)*
    a) I advertise myself under my professional title in accordance with propriety.
    b) I advertise myself under my professional title in accordance with the precedent in health professions.

11. Related to law and regulations *(almost always, sometimes, seldom)*
    a) I obtain information about laws and regulations applicable to my position.
    b) I follow these laws and regulations as directed.
    c) I make these laws and regulations known appropriately.

12. Related to misconduct *(almost always, sometimes, seldom)*
    a) I act properly in regard to my position and profession.
    b) I avoid engaging in any action that will circumvent the principles of occupational therapy ethics.

13. Related to biotechnical issues and problems of society *(almost always, sometimes, seldom)*
    a) I obtain information about major health problems and issues.
    b) I learn their implications for occupational therapy and for my own services.

**Interpretation of Responses:**

First alternative – may show an area of performance where professional maturity is evident.
Second alternative – may reveal an area of performance where professional growth is hindered.
Third alternative – may uncover an area of concern where further reflection and/or peer support would be helpful.
Developmental Stages in Clinical Reasoning

Stage 1: Novice
- Context free responses
- Supervisor provides the guidance to individualize the plans according to a relevant future.

Stage 2: Advanced Beginner
- *Situational* responses are adapted to additional cues and the therapist acquires a broader view of his/her patients.
- Supervisor helps the student prioritize problems and keep several elements of evaluation and intervention possibilities in mind as he/she makes decisions.

Stage 3: Competent
- *Sees a set of facts* and brings those facts that are relevant to the foreground. Demonstrates efficient timing and accurate targeting within multiple demands.
- Supervisor helps the student play with ideas and possibilities to increase the supervisee’s flexibility and creativity.

Stage 4: Proficient
- Perceives the whole rather than isolated parts. Has vision as to complexity of therapy solutions and can lead a client/patient toward steps that are necessary to reach goals.
- Supervisor should focus on helping the supervisee research results and write about an area of expertise and document efficacy.

Stage 5: Expert
- Rules of therapy become background, and daring approaches that zero-in on individual demands and needs of the situation occur and appear effortless.
- Supervisor needs to encourage expansion and generative aspects of professional growth.
WHAT TO EXPECT DURING YOUR FIELDWORK

The field experience is an end and a beginning for you. It’s the end of the academic learning process; it is the beginning of the clinical learning experience through the application of prior knowledge and the acquisition of technical skills.

You will undoubtedly experience conflicting emotions when entering this period of professional growth. You will be eager to begin treating actual patients in authentic working situations, but, you may also be apprehensive and unsure about your skills with patients. The mechanical aspects of the working day are new and there is also the uncertainty of forming new interpersonal relationships with staff, patient/clients, and other students.

This should be a stimulating period when you, the student, can explore your own abilities. You will be encouraged to demonstrate resourcefulness, expected to be inventive with original ideas and to be able to act upon them, and to be creative in your approach to clinical problems. It will appear that the field experience is a very open setting – respective to new ways and ideas.

Realize, however, that although you are encouraged to be resourceful and original in your treatment approach, these goals have to be within the framework of the facility and the occupational therapy service program. You are one of many who pass through during the year. Consequently, it is not realistic to expect major program changes to accommodate you or your special interests. There will be times when your interests may be accommodated, but admittedly there are gaps between student’s idealism and working reality.

Because of the above, you may encounter difficulties while on the field experience. “Stress can be said to occur when an individual feels threatened and his or her adaptive mechanisms tend to collapse. It can be both the threat itself and the person’s reaction to it.” Not every student will experience difficulties. However, for those who do, a discussion about the dynamics of clinical fieldwork now may minimize some of the future problems and offer you possible alternatives for coping with the situation.

The field experience is a teaching-learning process. The basic components are the teacher, the learner, and the setting in which the learning process takes place. You should begin to explore when starting your fieldwork “what setting characteristics can be conductive to your learning,” and “what behaviors of the supervisor can facilitate the learning.” Relatedness, dependency, integrative capacity, trust, doubt, confidence, expectations, evaluations, rewards, coping adaptations and defensive adaptation, ambiguity and role conflict are few terms related to the positive and negative aspects of field experience. There may be conflict from poor supervision, inadequate feedback, and ambiguity regarding evaluations, reward produce confusion and stress over “proper” roles. “An individual’s capacity to tolerate stress depends on many factors including early emotional experiences, knowledge about his or her present situation, motivation and techniques for withstanding tension, self-understanding and present alternatives.” Conflicts may arise and the therapists and students may assume defensive attitudes. Clinicians are human, with attributes and faults that we all share. Your presence may be threatening because of your new knowledge and penetrating questions. Reduction of stress will require a cooperative effort between you and the supervisor.

“The learning environment is established by the educator, based upon the security base of that individual. The creation of a supportive climate within which learning can take place is necessary for the reduction of the
tension and the anxiety in the learner.”² “The educator has the important function of creating a climate conductive to learning.”² “The primary accountability of providing a good experience for you belongs to the instructor,”² but this climate is dependent upon a working relationship of cooperation from both parties. You should try to have an awareness of these problems in order to establish realistic learning in collaboration with the fieldwork supervisor.

This brief outline cannot cover nor solve all the problems that you may encounter during your field experience. Its major purpose is to generate thought and furnish resource material for your review. The information will not eliminate the problems because you are dealing with individuals, but it can minimize those that you may encounter within some settings. Knowing some of the dynamics of the field education process may assist you to identify the difficulties and better cope with your anxieties.

You are an individual filled with knowledge, but uncertain of its proper application. You will be assuming a professional role that has many definitions amidst an ever changing environment. You have to realize that if you take “the opportunity to find out what you are like and take the risk” to learn and move ahead, it may not be easy. If you “trade appearances” during your field experience to avoid conflict, will you do the same in your future working environment after graduation? There may be stress and anxiety from the uncertainties of these challenges, but as you move ahead so does the profession.

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DEPARTMENT OF REHABILITATION MEDICINE
OCCUPATIONAL THERAPY

*SUGGESTIONS FOR STUDENTS

An important part of the fieldwork experience is the opportunity to actively pursue the development and practice of professional qualities and behaviors attributable to a mature therapist. Such qualities would include personal initiative, punctuality, responsibility and resourcefulness, dependability, and the ability to relate openly and effectively on a professional level, etc. Although your supervisor and other staff members may provide guidance and direction in this area of professional development, you must assume the primary responsibility for professional behavior.

Below are some “helpful hints” as to how this responsibility might be independently assumed and reflected early and throughout your affiliation. If you think of additional ones, please let your supervisor or the Chief O.T. know so that they might be passed on to future students.

1. Communication is the most critical essential. Initiate and maintain open, honest, communication with your supervisor.
   - Provide feedback to your supervisor about the nature, quantity and quality of supervision time. You must assess your needs and openly share them with your supervisor.
   - Let your supervisor know your interests and goals/expectations. Clarify performance expectations with your supervisor – if you are unclear, ask.
   - If you feel you are not getting enough feedback, let your supervisor know.
   - If you feel the need to observe more or to be observed in patient treatment, let your supervisor know.
   - If you have a question or doubt in your mind, try whenever possible to take the initiative to find out the answer for yourself. However, never hesitate to utilize staff members as resources.

2. Independently take the initiative and time early in your affiliation to familiarize yourself with your unit’s organization and resources available. It is important to take time to find out where things are kept during the first week. Schedule time to look through the cabinets, file drawers, bookcases, etc., and see what is available. If you don’t schedule specific time to do this, you may find that a “convenient” time will never come. Becoming familiar with the unit, its supplies and equipment will prevent you from having to keep asking where equipment is kept. If you are uncertain about the use or purpose of any equipment, always ask and familiarize yourself with it.
3. Learn how to effectively plan and utilize your time.
   - Make out a schedule for each day - include lectures, meetings, and supervision times in addition to patient treatment.
   - Know your work requirements and set target dates for timely completion. Don’t wait until last minute to get things done. You will not be continually reminded or prodded once deadlines have been established.
   - Utilize your “spare” time appropriately (i.e., for reading, writing notes; developing patient’s treatment programs; observing treatment). Feel free to help out in the unit – ask what you can do to help if you cannot readily identify what the needs may be. Don’t get behind in note-writing. The amount of paperwork and documentation requirements is great; now is the time to develop personal discipline in fulfilling responsibilities in this area on a timely basis.

4. Procedures for routine day-to-day treatment and departmental responsibilities should be established as a habit as quickly as possible. If you are still confused after the first week, let your supervisor know.

5. Use your student manual – it is filled with information concerning performance expectations, departmental policies and procedures, and information regarding patient care. Use it as an on-going reference as questions arise.

6. Suggestions for treatment planning:
   a. Observe other therapists and keep a list of media/techniques they use. This can be a helpful resource during treatment planning.
   b. Write a list of treatment goals (brainstorm). When writing treatment plans, refer to this list. It will help you to be comprehensive.
   c. In the beginning prepare a list of treatment media or evaluations for each treatment session. Be sure to include alternatives in case equipment is not available. If you have any questions on a specific technique or evaluation, ask your supervisor to go through the procedure before you treat the patient. Although this takes extra preparation time, it can greatly increase your self-confidence during treatment.

7. For maintenance of Self-Esteem and Confidence!
   Realize that you know more than you think, at times, and you are just as much an expert in your field as PTs, nurses, and physicians are in theirs. It also helps to prepare a “working definition” of OT for patients, family and other professionals.

- Suggestions from both staff and former students at Michael Reese Hospital 1984
ESSENTIAL PROFESSIONAL BEHAVIORS – STUDENT THERAPIST

In addition to developing clinical competencies, an important part of the fieldwork experience is the development of professional behaviors. The following qualities have been determined essential to the position of student therapist and reflect the expectations for acceptable performance. This information has been adapted from the Staff Occupational Therapist Essentials Professional Behaviors description.

1. **Responsibility** – demonstrates independent initiative and readily assumes responsibility; demonstrates consistent dependability and reliability in fulfilling responsibilities; is conscientious in meeting responsibilities, demonstrating attention to routine responsibilities.
   
a. Ask questions when in doubt.
   
b. Punctual to meetings and conferences.
   
c. Recognize and act on personal responsibility for learning during the fieldwork experience (e.g., finding answers to questions, providing feedback to supervisor, utilize opportunities for observational learning experiences, i.e., other therapists, disciplines).
   
d. Take initiative to utilize resources (physical resources, personnel, grand rounds).
   
e. Read student manual the first week so that you are familiar with the information that is in it.

2. **Organizational Skills** – punctual in fulfilling responsibilities and requirements of the position (including adhering to schedules, meeting deadlines, etc.); by midterm, be able to create functional structure in an unstructured environment; ability to establish realistic priorities and set appropriate limits.
   
a. Plan and organize daily schedule for self and for patient treatment, for short- and long-term projects (e.g., preparation for lectures, note writing, preparation for staffing and rounds, discharge planning and SIP).

3. **Flexibility** – effectively adjust to changes in schedules, policies and procedures, patient and student program; ability to adjust priorities according to needs of the program and department and others.
   
a. Develop an attitude of flexibility – expect changes to occur (e.g., changes in lecture schedule, supervision meetings, etc.)
Advice from Second Year Students to First Year Students

The following are spontaneously-written “words of wisdom” or advice from the students completing Level II Fieldwork to the students anticipating fieldwork selection:

• Don’t be afraid to ask questions! About the site, their expectations, the population...

• Research the site—find out if it is the population and type of facility that you think you can fit into.

• Don’t worry; you are more prepared than you think!

• Relax, choose a site that matches your learning style and utilize supervision as much as possible.

• Wear a really comfortable pair of shoes.

• Communication is key—Ask, Ask, Ask. You learn something every day.

• The transition from classroom to clinical setting can be frightening at first, but with knowledge from NYU and supervision, you will be surprised at how easy the transition can be.

• It is important to know what kind of setting you want to be in, particularly for the mental health placement.

• You’ll encounter many different people with different backgrounds and ideas, be it clients or workers. Your views may not always be similar, but if you take the time to ask, you may learn to see things from a different perspective.

• Communicate openly and honestly with your supervisors.

• Try to identify your strengths and weaknesses before choosing your fieldwork site so you know what type of site to look for, based on what it can offer to you.

• Go to your site with an open mind. There is a lot to learn. Be flexible.

• Let students know that this will not be a very structured environment so they should be ready to be flexible.

• Be ready to take on clients independently in groups/evaluate.

• You make your experience here so come with ideas.

• It is important to be aware of community resources in order to advocate for clients.
- Think outside traditional OT roles and understand INDIRECT SERVICE.

- The importance of increased level of maturity, ability to self-initiate, ability to self-motivate and ability for student to be flexible and professionally appropriate.

- …be prepared to question your own thoughts on diversity, welfare, social justice

- Lots of deep breaths! I found the setting to be overwhelming in the beginning and it was helpful when the FWC and my clinical supervisor discussed personal and professional expectations with me, it’s a learning process and takes time.

- Be prepared for an extremely high pace environment. I would also recommend practicing transfer skills and remaining familiar with SCI levels, hip precautions, MMT/sensory testing (individual, gross and functional testing), as well as ROM. It would also be a good idea to come prepared with a watch, schedule planner and some type of organizational binder and system for handouts and paperwork.

- Review basic concepts: MMT, goniometry, NDT.

- It is crucial that a student is diligent and able to handle the workload. Students must be able to take feedback, especially constructive, in order to promote student development.

- Have confidence, be self-motivating and cheerful

- FLEXIBILITY! Also being creative or at least willing to accept the challenge to think creatively; collaborate with others, bounce ideas off co-workers and accept use of constructive criticism. Also, practicing client centered and individualized care is fundamental. Good time management and assertive communication skills are very important also.

- Think quickly and good personal skills for not only working with the patient, but with the family as well.

- The student should be fairly self-confident and mature, flexible, and have very good safety judgment.

- The student must be able to multi-task, take things in stride and have excellent stress management skills. Multicultural awareness is also important.
Patient’s Bill of Rights

American Hospital Association

1. The patient has the right to considerate and respectful care.
2. The patient has the right to obtain from his physician the complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand. When not medically advisable, the information should be made available to a person in his behalf.
3. The patient has the right to give informed consent prior to the start of any procedure and/or treatment. Except in emergencies, such information should include specific treatment, risks involved, and duration of incapacitation to qualify as informed consent. The patient has the right to know of medical alternatives to such treatment.
4. The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action.
5. The patient has the right to every consideration of his privacy concerning his own medical care program. Those not directly involved in his care must have the permission of the patient to be present.
6. The patient has the right to be treated with confidentiality.
7. The patient has the right to expect response to the request for services. The patient may be transferred to another facility only after he has received and explanation concerning the needs for alternatives for such a transfer.
8. The patient has the right to obtain information regarding any relationship to other health care and educational institutions of this hospital insofar as his care is concerned.
9. The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care or treatment.
10. The patient has the right to reasonable continuity of care.
11. The patient has the right to examine his bill regardless of source of payment.
12. The patient has the right to know what hospital rules apply to his conduct as a patient.

The NUREMBERG CODE defines that medical experiment on human beings must adhere to certain basic principles that must be observed in order to satisfy moral, ethical and legal concepts.

Summarized these are:

- Experiments must be for society's good, not arbitrary.
- Anticipated results justify the experiments.
- Subjects must be protected from risk such as death or disabling injury.
- Persons conducting experiments should be highly qualified and skilled.
Preparation to alter or stop the course of the experiment must be planned in the event that continuation could cause the subject harm or violate any provision of the code.

Affiliation Policies Regarding Confidentiality of Information

All NYU Occupational Therapy students affiliating on Level I and Level II must behave according to professional ethical standards in safeguarding all client/patient's rights. These rights are defined in the American Hospital Association's Patient's Bill of Rights, which has been summarized in this manual. Furthermore, specific rights of confidentiality and informed consent for any patient or client who is tested for or who has HIV/AIDS are provided in Article 27-F of the NY State Public Health Law, Chapter 592. This law requires informed written consent for any HIV related test and strictly limits disclosure of confidential HIV related information. In addition, students must preserve and carry out the mandates if The Family Educational Rights and Privacy Act of 1974 (EFPRRA). Each student is responsible for obtaining, knowing, and abiding by these laws in their actions with patients while they are on affiliation and when they become registered therapists. Students can begin gathering necessary information regarding HIV/AIDS by calling the New York City Department of Health at (212) 998-4775.

Working with Children with HIV and Their Caregivers

Need to know? / Right to know? / Who needs to know?

Positives of knowing
If the OT knows the HIV status of the child, they may be able to:

1. identify the illnesses earlier, get quicker treatment
2. have a better understanding of and recognize a child’s
   a. loss of abilities
   b. periodic fatigue
   c. depression/sadness
3. have a better understanding of a family’s
   a. difficulty getting therapy appointment
   b. need to have different people bring child and take care of child
   c. stresses: other appointments, own illnesses
   d. over exposure/experience with medical system
4. offer flexible service delivery options: e.g. schedule several children in one time slot to cover frequent absences
5. help the family be more comfortable talking to them

Negatives of knowing
If the OT knows the HIV status of the child, they may

1. discriminate against the child or family
2. treat the child “differently”
3. reinforce the stigma that the family feels
4. make the family feel uncomfortable to talk to them

The family may not want the OT to know the status due to fear of being treated differently or as a result of past negative experiences with other professionals.

Do we treat children and families with HIV infection differently?
Ideally we do not treat a person based on a diagnosis, but based on an individual needs. Things that can happen in less than ideal situation:

- Increase the use of protective measures, use of universal precautions less than universally
- Types of treatment less challenging, more maintenance, less focus on long term planning (self help skills, school work)
- Over protection – foster dependency, limiting experiences
Uncomfortable talking to family:
  - don’t want to overburden the family
  - lifestyles may appear different from those of the therapist
  - anger at parents for “causing” a problem child

Differently compared to what?
1. Early intervention/preschool, developmental delays
2. Children with chronic, progressive or acute illnesses

Reported reasons for not working with children and families with HIV infection
1. Children who may have chronic illnesses, or may be regressing or dying (upsetting to the therapist)
2. Fear of infection (therapist, family/friends of therapist)
3. Not considered a priority for OT service
   a. the therapist does not feel competent
   b. therapist does not see child with HIV as a “rehab candidate” – perceives HIV as a medical problem only and seen as having little potential for “improvement”
   c. popular treatment approaches may define who is seen in OT department and children with HIV infection may not be seen as eligible candidates for these approaches
4. Uncomfortable with families whose lifestyles may appear different from those of the therapist

Outcomes of these issues:
1. referring to other programs/services
2. recommending less or no OT treatment/services
3. not recommending other options

Inclusive or “dedicated programs

- There are positives and negatives to both types of programs related to the issues discussed.
- Both options should be offered and available to people.
- The existence of dedicated programs may prevent non-dedicated programs from developing and offering their own services.
- Staff in dedicated programs may not refer their clients to inclusive settings due to their desire to protect them.

Gary Bedell, MA, OTR; Margaret Kaplan, MA OTR
**Games People Play in Supervision**

by Alfred Kadushin

*This article attempts to make explicit the variety of games most frequently played in supervision, reviewing the rationale behind supervisory gamesmanship, the plays used, and the counter-games that have been devised. The emphasis is on games developed and utilized by supervisees, although the gamesmanship potentialities of supervisors are also suggested.*

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Gamesmanship has had a checkered career. Respectably fathered by an eminent mathematician Von Neuman, in his book The Theory of Games and Economic Behavior, it became the "Art of Wining Games Without Actually Cheating" as detailed by Potter in Theory and Practice of Gamesmanship.\(^1\) It was partly rescued recently for the behavioral sciences by the psychoanalyst Eric Berne in Games People Play.\(^2\)

Berne defines a game as "an ongoing series of complementary ulterior transactions—superficially plausible but with a concealed motivation."\(^3\) It is a scheme, or artfulness, utilized in the pursuit of some objective or purpose. A ploy is segment of a game.

The purpose of engaging in a game, of using maneuvers, snares, gimmicks, and ploys that are, in essence, the art of gamesmanship, lies in the payoff. One party of the game chooses a strategy to minimize his payoff and minimize his penalties. He wants to win as much as he can at a lowest cost.

Games people play in supervision are concerned with the kinds of recurrent interactional incidents between supervisor and supervisee that have a payoff for one of the parties in the transaction. While both supervisor and supervisee may initiate a game, for the purposes of simplicity it may be desirable to discuss in greater detail games initiated by supervisees. This may also be the better part of the valor.

**WHY GAMES ARE PLAYED**

To understand why the supervisee should be interested in initiating a game, it is necessary to understand the possible losses that might be anticipated by him in the supervisory relationship. One needs to know what the supervisee is defending himself against the losses he may incur if he eschewed gamesmanship or lost the game.

The supervisory situation generates a number of different kinds of anxieties for the supervisee. It is a situation in which he is asked to undergo some sort of change. Unlike the usual educational situation that is concerned with helping the student critically examine and hence possibly change his ideas; social work supervision is often directed toward a change in behavior and, perhaps, personality. Change creates anxiety. It requires giving up the familiar for the unfamiliar; it requires a period of discomfort during which one is uneasy about continuing to use old patterns of behavior but does not, as yet, feel fully comfortable with new behaviors.

The threat of change is greater for the adult student because it requires dissolution of patterns of thinking and believing to which he has become habituated. It also requires an act of disloyalty to previous identification models. The ideas and behavior that might need changing represent, in a measure, the injection of previously encountered significant others—parents, teachers, highly valued peers—and giving them up implies some rejection of these people in the acceptance of other model. The act of infidelity creates anxiety.

The supervisory tutorial is a threat to the student's independence and autonomy. Learning requires some frank admission of dependence on the teacher; readiness to learn involves giving up some measure of autonomy in accepting the direction from others, in submitting to the authority of the supervisor-teacher.

The supervisee also faces a threat to his sense of adequacy. The situation demands an admission of ignorance, however limited, in some areas. And in sharing one's ignorance one exposes one's vulnerability. One risks the possibility of criticism, of shame and perhaps of rejection because of one's admitted inadequacy. In addition, the supervisee faces the hazard of not being adequate to the requirements of the learning situation. His performance may fall short of the supervisor's expectations, intensifying a sense of inadequacy and incurring the possibility of supervisory disapproval.

Since the parameters of the supervisory relationship are often ambiguous, there is a threat that devolves not only from the sensed inadequacies of one's work, but also from the perceived or suspected inadequacies of self. This threat is exaggerated in the social work supervisory relationship because so much of self is invested in and reflected by one's work and because of the tendency to attribute to the supervisor a diagnostic omniscience suggesting that he perceives all and knows all.

The supervisor-supervisee relationship is evocative of the parent-child relationship and as such may tend to reactivate some anxiety associated with this earlier relationship. The supervisor is, in a position of authority and the supervisee is, in some measure, dependent on him. If the supervisor is a potential parent surrogate, fellow supervisees are potential siblings competing for the affectional responses of the parent. The situation is therefore one that threatens the reactivation not only of residual difficulties in the parent-child relationship but also in the sibling-sibling relationship.

The supervisor has the responsibility of evaluating the work of the supervisee, and, as such, controls access to important rewards and penalties. School grades, salary increases, and promotional possibilities are real and significant prizes depend on a favorable evaluation. Unlike previously encountered evaluative situations, for instance working toward a grade in a course, this is a situation in which it is impossible to hide in a group. There is a direct and sharply focused confrontation with the work done by the supervisee.
These threats, anxieties, and penalties are the losses that might be incurred in entering into the supervisory relationship. A desire to keep losses to a minimum and maximize the rewards that might derive from the encounter explains why the supervisee should want to play games in supervision, why he should feel a need to control the situation to his advantage. Supervisees have over a period of time developed some well-established, identifiable games. An attempt will be made to group these games in terms of similar tactics. It might be important to note that not all supervisees play games and not all of the behavior supervisees engage in is indicative of an effort to play games. However, the best supervisee plays games some of the time; the poorest supervisee does not play games all the time. What the author is trying to do is to identify limited, albeit important, sector of supervisee behavior.

MANIPULATING DEMAND LEVELS

One series of games is designed to manipulate the level of demands made on the supervisee. One such game might be titled “Two Against the Agency” or “Seducing for Subversion.” The game is generally played by intelligent, intuitively gifted supervisees who are impatient with routine agency procedures. Forms, reports, punctuality, and recordings excite their contempt. The sophisticated supervisee, in playing the game, introduces it by suggesting the conflict between the bureaucratic and professional orientation to the work of the agency. The bureaucratic orientation is one that is centered on what is needed to insure the efficient operation of the agency; the professional orientation is focused on meeting the needs of the client. The supervisee points out that meeting the client need is more important, that time spent in recording, filling out forms, and writing reports tends to rob time from direct work with the client, and further that it does not make any difference when he comes to work or goes home as long as no client suffers as a consequence. Would it not therefore be possible to permit him, a highly intuitive, gifted worker, to schedule and allocate his time to maximum client advantage and should not the supervisor, then, be less concerned about the necessity of filling out forms, doing recording, completing reports, and so on?

For the student and recent graduate supervisee oriented toward the morality of the hippie movement (and many students, especially in social work are responsive to hippie ideology, often without being explicitly aware of this), professional autonomy is consonant with the idea of self-expression—“doing your thing.” Bureaucratic controls, demands, and expectations are regarded as violation of genuine self-expression and are resented upon.

It takes two to play games. The supervisor is introduced to play (1) because he identifies with the student’s concern for meeting client’s needs, (2) because he himself has frequently resented bureaucratic demands and so is, initially, sympathetic to the supervisee’s complaints, and (3) because he is hesitant to assert his authority in demanding firmly that these requirements be met. If the supervisor elects to play the game, he has enlisted in an alliance to subvert the agency’s administrative procedures.

Another game designed to control and mitigate the level of demands made on the supervisee might be called “Be Nice to Me Because I Am Nice to You.” The principal ploy is seduction by flattery. The supervisee is full of praise: “You’re the best supervisor I ever had,” “You’re so perceptive that after I talked to you I almost know what the client will say next,” “You’re so consistently helpful,” “I look forward in the future to being as good a social worker as you are,” and so on. It is a game of emotional blackmail in which, having been paid in this kind of coin, the supervisor finds himself incapable of firmly holding the worker to legitimate demands. The supervisor finds it difficult to resist engaging in the game because it is gratifying to be regarded as an omniscient source of wisdom; there is satisfaction in being perceived as helpful and in being selected as a pattern for identification and emulation. An invitation to play a game that tends to enhance a positive self-concept and feed one’s narcissistic needs is likely to be accepted.

In general the supervision is vulnerable to an invitation to play this game. The supervisor needs the supervisee as much as the supervisee needs the supervisor. One of the principal sources of gratification for a worker is contact with the client. The supervisor is denied this source of gratification, at least directly. For the supervisor the principal source of gratification is helping the supervisee to grow and change. But this means that he has to look to the supervisee to validate his effectiveness. Objective criteria of such effectiveness are, at best obscure and equivocal. However, to have the supervisee say explicitly, openly, and directly: “I have learned a lot from you,” is the kind of reassurance needed and often subtly solicited by the supervisor. The perceptive supervisee understands and exploits the supervisor’s needs in initiating this game.

REDEFINING THE RELATIONSHIP

A second series of games is also designed to mitigate the level of demands made on the supervisee, but there the game depends on redefining the supervisory relationship. As Goffman points out, games permit one to control the conduct of others
and by influencing the definition of the situation. These games depend on the ambiguity of the definition of the supervisory relationship. It is open to a variety of interpretations and resembles, in some crucial respects, analogous relationship.

Thus, one kind of redefinition suggests a shift from the relationship of the supervisor-supervisee as teacher-learner in an administrative hierarchy to supervisor-supervisee as worker-client in the context of therapy. The game might be called "Protect the Sick and the Infirm" or "Treat Me, Don't Beat Me." The supervisee would rather expose himself than his work. And so he asks the supervisor for help in solving his personal problems. The sophisticated player relates these problems to his difficulties on the job. Nevertheless, he seeks to engage the supervisor actively in a concern with his problems. If the translation to worker-client is made, the nature of demands shifts as well. The kinds of demands one can legitimately impose on a client are clearly less ostentatious than the level of expectations imposed on a worker. And the supervisee has achieved a payoff in a softening of demands.

The supervisor is induced to play (1) because the game appeals to the social worker in him (since he was a social worker before he became a supervisor and is still interested in helping those who have personal problems), (2) because it appeals to the voyeur in hum (many supervisors are fascinated by the opportunity to share in the intimate life of others), (3) because it is flattering to be selected as a therapist, and (4) because the supervisor is not clearly certain as to whether such a redefinition of the situation is not permissible. All the discussions about the equivocal boundaries between supervision and therapy feed into this uncertainty.

Another game of redefinition might be called "Evaluation Is Not for Friends." Here the supervisory relationship is redefined as a social relationship. The supervisee makes an effort to take coffee breads with the supervisor, invite him to lunch, walk to and from the bus or the parking lot with him, and discuss some common interests during conferences. The social component tends to vitiate the professional component in the relationship. It requires increased determination and resolution on the part of any supervisor to hold the "friend" to the required level of performance.

Another and more contemporary redefinition id less obvious than either of the two kinds just discussed, which have been standard for a long time now. This is the game of "Maximum Feasible Participation." It involves a shift in roles from supervisor-supervisee to peer-peer. The supervisee suggests that the relationship will be most effective if it is established on the basis of democratic participation. Since he knows best what he needs and wants to learn, he should be granted equal responsibility for determining the agendas of conferences. So far so good. The game is a difficult one to play because in the hands of a determined supervisee, joint control of agenda can easily become supervisee control with consequent mitigation of expectations. The supervisor finds himself in a predicament in trying to decline the game. For one, there is an element of validity in the claim that people learn best in a context that encourages democratic participation in the learning situation. Second, the current trend in working with the social agency client encourages maximum feasible participation with presently undefined limits. To decline the game is to suggest that one is old-fashioned, undemocratic, and against the rights of those on lower levels in the administrative hierarchy—not an enviable picture to project of oneself. The supervisor is forced to play but needs to be constantly alert in order to maintain some semblance of administrative authority and prevent all the shots being called by the supervisee-peer.

REducing Power Disparity

A third series of games is designed to reduce anxiety by reducing the power disparity between supervisor and worker. One source of the supervisor's power is, of course, the consequence of his position in the administrative hierarchy vis-à-vis the supervisee. Another source of power, however, lies in his expertise, greater knowledge, and superior skill. It is the second source of power disparity that is vulnerable to this series of games. If the supervisee can establish the fact that the supervisor is not so smart after all, some of the power differential is mitigated and with it some need to feel anxious.

One such game, frequently played, might be called "If You Knew Dostoyevsky Like I Know Dostoyevsky." During the course of a conference the supervisee makes a casual allusion to the fact that the client's behavior reminds him of that Raskolnikov in Crime and Punishment, which is, after all, somewhat different from the pathology that plagued Prince Mishkin in The Idiot. An effective ploy, used to score additional points, involves addressing the rhetorical question: "You remember don't you?" to the supervisor. It is equally clear to both the supervisee and the supervisor that the latter does not remember— if, indeed, he ever knew what he cannot remember now. At this point the supervisee proceeds to instruct the supervisor. The roles of teacher-learner are reversed; power disparity and supervisee anxiety are simultaneously reduced.

The content for the essential gambit in this game changes with each generation of supervisees. The author's impression is that currently the allusion is likely to be to the work of the conditioning therapists—Eysenck, Wolpe, and Lazarus—rather than to literary figures. The effect on the supervisor, however, is the same: a feeling of depression and general malaise at having been found ignorant when his position requires that he know more that the supervisee. And it has the same payoff in reducing supervisee anxiety.
Another kind of game in this same genre exploits situational advantages to reduce power disparity and permit the supervisee the feeling that he, rather than the supervisor, is in control. This game is “So What Do You Know About It?” The supervisee with a long record of experience in public welfare makes references to “those of us on the frontiers who have struggled with client with multiple problems,” exciting humility in the supervisor who has to try hard to remember when he last saw a live client. A married supervisee with children will allude to her marital experience and what it “really is like to be a mother” in discussing family therapy with an unmarried female supervisor.

The older supervisee will talk about “life” from the vantage point of incipient senility to the supervisor fresh out of graduate school. The younger supervisee will hint at his greater understanding off the adolescent client since he has, after all smoked some pot and has seriously considered some LSD. The supervisor truing to tune in finds his older psyche is not with it. The supervisor younger than the older supervisee, older than the young supervisee—never having raised a child or met a payroll—finds himself being instructed by those he is charged with instructing: roles are reversed and the payoff lies in the fact that the supervisor figure is a less threatening figure to the supervisee.

Another more recently developed procedure for “putting the supervisor down” is through the judicious use in the conferee of strong four-letter words. This is “telling it like it is” and the supervisor who responds with discomfort and loss of composure has forfeited some amount of control to the supervisee who has exposed some measure of his bourgeois character and residual Puritanism.

Putting the supervisor down may revolve around a question of social work goals rather than content. The social action-oriented supervisee is concerned with fundamental changes in social relationships. He knows that obtaining a slight increase in the budget for his client, finding a job for a client, or helping a neglectful mother relate more positively to her child are not of much use since they leave the basic pathology of society undisturbed and unchanged. He is impatient with the case-oriented supervisor who is interested in helping a specific family live a little less troubled, a little less unhappily, in a fundamentally disordered society. The game is “All or Nothing at All.” It is designed to make the supervisor feel he has sold out, been co-opted by the Establishment, lost or abandoned his broader vision of the “good” society, become endlessly concerned with symptoms rather than causes. It is effective because the supervisor recognizes that there is some element of truth in the accusation, since this is true for all who occupy positions of responsibility in the Establishment.

CONTROLLING THE SITUATION

All the games mentioned have, as a part of their effect, a shift of control of the situation from the supervisor to the supervisee. Another series of games is designed to place control of the supervisory situation more explicitly and directly in the hands of the supervisee. Control of the situation by the supervisor is potentially threatening since he can then take the initiative of introducing for discussion those weaknesses and inadequacies in the supervisee’s work that need fullest review. If the supervisee can control the conference, much that is unflattering to discuss may be adroitly avoided.

One game designed to control the discussion is called “I Have a Little List.” The supervisee comes in with a series of about his work that he would very much like to discuss. The better player formulates the questions so that they have relevance to those problems in which the supervisor has greatest professional interest and about which he has done considerable reading. The supervisee is under no obligation to listen to the answer to his question. Question 1 having been asked, the supervisor is of on a short lecture, during which time the supervisee is free to plan mentally the next weekend or review the last weekend, taking care merely to listen for signs that the supervisor is running down. When this happens, the supervisee introduces Question 2 with an appropriate transitional comment and the cycle is repeated. As the supervisee increases the supervisor’s level of participation he is, by the same token, decreasing his own level of participation since only the supervisee controls both content and direction of conference interaction.

The supervisor is induced to play this game because there is narcissistic gratification in displaying one’s knowledge and in meeting the dependency needs of those who appeal to one for answers to their questions, and because the supervisee’s questions should be accepted, respected, and, if possible, answered.

Control of the initiative is also seized by the supervisee in the game of “Heading Them Off at the Pass.” Here the supervisee knows that his poor work is likely to be analyzed critically. He therefore opens the conference by freely admitting his mistakes—he knows it was an inadequate interview, he knows that he have, by now, learned better. There is no failing on the supervisor’s agenda for discussion with him to which he does not freely confess in advance, flagellating himself to excess. The supervisor, faced with overwhelming self-derogation, has little opinion but to reassure the supervisee sympathetically. The tactic not only makes difficult an extended discussion on mistakes in the work at the supervisor’s initiative, it elicits praise by the supervisor for whatever strengths the supervisee has manifested, however limited. The supervisor, once again, acts out of concern with the trouble, out of his predisposition to comfort the discomforted, out of pleasure in acting the good, forgiving parent.
There is also the game of control through fluttering dependency, of strength through weakness. It is the game of “Little Old Me” or “Casework à Trois.” The supervisee in his ignorance and incompetence, looks to the knowledgeable competent supervisor for a detailed prescription of how to proceed: “What would you do next?” “Then what would you say?” The supervisee unloads responsibility for the case onto the supervisor and the supervisor shares the case load with the worker. The supervisor plays the game because, in reality, he does share responsibility for seeing that the client is not harmed.

Further, the supervisor often is interested in the gratification for carrying a case load, however vicariously, so that he is somewhat predisposed to take the case out of the hands of the supervisee. There are, further, the pleasures derived from acting the capable parent to the dependent child and from the domination of others.

A variant of the game in the hands of a more hostile supervisee is “I Did Like You Told Me.” Here the supervisee maneuver the supervisor into offering specific prescriptions in spiteful obedience and undisguised mimicry. The supervisee acts as though the supervisor were responsible for the case, he himself merely being the executor of the supervisory directives. Invariably and inevitably, whatever has been suggested by the supervisor fails to accomplish. “I Did Like You Told Me” is designed to make even a strong supervisor defensive.

“It’s All So Confusing” attempts to reduce the authority of the supervisor by appeals to other authorities—another supervisor, another supervisor in the same agency, or a faculty member at a local school of social work with whom the supervisee just happened to discuss the case. The supervisee casually indicates that in similar situations his former supervisor tended to take such and such approach, one that is at variance with the approach the current supervisor regards as desirable. And “It’s All So Confusing” when different “authorities” suggest different approaches to the same situation. The supervisor is faced with “defending” his approach against some unnamed, unknown competitor. This is difficult, especially when new situations in social work permit an equivocal answer in which the supervisor can have a categorical confidence. Since the supervisor was somewhat shaky in his approach in the first place, he feels vulnerable against alternative suggestions from other “authorities” and his sense of authority vis-à-vis the supervisee is eroded.

A supervisee can control the degree of threat in the supervisory situation by distancing techniques. The game is “What You Don’t Know Won’t Hurt Me.” The supervisor knows the work of the supervisee only indirectly, through what is shared in the recording and verbally in the conference. The supervisee can elect to share in a manner that is thin, inconsequential, without depth of affect. He can share selectively and can distort, consciously or unconsciously, in order to present a more favorable picture of his work. The supervisee can be passive and reticent or overwhelm the supervisor with endless trivia.

In whatever manner it is done, the supervisee increases distance between the work he actually does and the supervisor who is responsible for critically analyzing with him the work done. This not only reduces the threat to him of possible criticism of his work but also, as Fleming points out, prevents the supervisor from intruding into the privacy of the relationship between the worker and the client.5

SUPERVISOR’S GAMES

It would be doing both the supervisor and supervisee an injustice to omit any reference to games initiated by supervisors—unjust to supervisees in that such omission would imply that they alone play games in supervision and unjust to the supervisors in suggesting that they lack the imagination and capacity to devise their own counter games. Supervisors play games out of felt threats to their position in the hierarchy, uncertainty about their authority, reluctance to use their authority, a desire to be liked, a need for the supervisee’s approbation—and out of some hostility to supervisees that is inevitable in such a complex, intimate relationship.

One of the classic supervisory games is called “I Wonder Why You Really Said That?” This is the game of redefining honest disagreement so that it be psychological resistance. Honest disagreement requires that the supervisor defend his point of view, present research evidence in support of his contention, be sufficiently acquainted with the literature so he can cite the knowledge that argues for the correctness of what he is saying. If honest disagreement is redefined as resistance, the burden is shifted to the supervisee. He has to examine his needs and motives that prompt him to question what the supervisor has said. The supervisor is thus relieved of the burden of validating what he has said and the onus for defense now rests with the supervisee.

Another classic supervisory game is “One Good Question Deserves Another.” It was explicated some years ago by a new supervisor writing of her experience in an article called “Through Supervision with Gun and Camera”:

“I learned that another part of the supervisor’s skills, as far as the workers are concerned, is to know all the answers. I was able to get out of this very easily. I discovered that when a worker asks a question, the best thing to do is to immediately ask for what she thinks. While the worker is figuring out the answer to her own question (this is known as growth and development), the supervisor quickly tries to figure it out also. She may arrive at the answer the same time as the worker, but the worker somehow assumes that she knew it all along. This is very comfortable for the supervisor. In the event that neither the worker not the supervisor succeed in coming up with a useful thought on the question the worker has raised, the
IN RESPONSE TO GAMES

Before going on to discuss possible constructive responses to games played in the context of supervision, the author must express some uneasiness about having raised the subject in the first place, a dissatisfaction similar to the distaste felt toward Berne's *Games People Play*. The book communicates a sense of disrespect or the complexities of life and human behavior. The simplistic games formulas are a cheapening, caricature of people's struggle for a modicum of comfort in a difficult world. A perceptive psychiatrist said in a critical and saddening review of the book:

> It makes today's bothersome "problems" easily subject to a few home-spun models—particularly the cynical and concretely aphoristic kind that reduces all human experiences to a series of "exchanges" involving gain and loss, deceit or betrayal and exposure, camouflage and discovery.²

There are both a great deal more sensible sincerity and great deal more devious complexity in multidetermined human interaction than is suggested by *Games People Play*.

However, the very fact that games are a caricature of life justifies discussing them. The caricature selects some aspect of human behavior and, extracting it for explicit examination, exaggerates and distorts its contours so that it is easier to perceive. The caricature thus makes possible increased understanding of the phenomenon—in this case the supervisory interaction. The insult to the phenomenon lies in forgetting that the caricature is just that—a caricature and not a truly accurate representation. A perceptive caricature, such as a good satire, falsifies by distorting only elements that are actually present in the interaction in the first place. Supervisory games mirror, then, some selective, essentially truthful aspects of the supervisory relationship.

The simplest and most direct way of dealing with the problem of games introduced by the supervisee is to refuse to play. Yet one of the key difficulties in this has been implied by discussion of the gain for the supervisor in going along with the game. The supervisee can only successfully enlist the supervisor in a game if the supervisor wants to play for his own reasons. Collusion is not forced but is freely granted. Refusing to play requires the supervisor to be ready and able to forfeit self-advantages. For instance, in declining to go along with the supervisee's requests that he be permitted to ignore the agency administrative requirements in playing "Two Against the Agency," the supervisor has to be comfortable in exercising his administrative authority, willing to risk and deal with supervisee's hostility and rejection, willing to accept and handle the accusation that he is bureaucratically, rather than professionally oriented. In declining other games the supervisor denies himself the sweet fruits of flattery, the joys of omniscience, the pleasures of acting the therapist, the gratification of being liked. He has to incur the penalties of an open admission of ignorance and uncertainty and the loss of infallibility. Declining to play the games demands the supervisor who is aware of and comfortable in what he is doing and who is accepting of himself in all his "glorious strengths and human weaknesses." Less vulnerable the supervisor, the more impervious he is to gamesmanship—not an easy prescription to fill.

A second response lies in gradual interpretation or open confrontation. Goffman points out that in the usual social encounter each party accepts the line put out by the other party. There is a process of mutual face-saving in which what is said is accepted at its face value and "each participant is allowed to carry the role he has chosen for himself" unchallenged.³ This is done out of self-protection since in not challenging another one is also insuring that the other will not, in turn, challenge one's own fiction. Confrontation implies a refusal to accept the game being proposed by seeking to expose and make explicit what the supervisee is doing. The supervisory situation, like the therapeutic situation, deliberately and consciously rejects the usual rules of social interaction in attempting to help the supervisee.

Confrontation is, of course, a procedure that needs to be used with some regard for the supervisee's ability to handle the embarrassment, discomfort, and self-threat it involves. It needs to be used with some understanding of the defensive significance of the game to the supervisee. It needs might be of importance to point out that naming the interactions that have been described as "games" does not imply that they are frivolous and without consequence. Unmasking games risks much that is of serious personal significance for the supervisee.

Interpretation and confrontation here, as always, require some compassionate caution, a sense of timing, and an understanding of dosage. Perhaps another approach is to share honestly with the supervisee one's awareness of what he is attempting to do but to focus the discussion neither on the dynamics of his behavior nor on one's reaction to it, but on the disadvantages for him in playing games. These games have decided drawbacks for the supervisee in that they deny him the
possibility of effectively fulfilling one of the essential, principal purposes of supervision—helping him to grow professionally. The games frustrate the achievement of this outcome. In playing games the supervisee loses by winning.

And if all else fails, supervisee’s games may yield to supervisor’s counter-games. For instance, “I Have a Little List” may be broken up by “I Wonder Why You Really Asked That?” After all, the supervisor should have more experience at gamesmanship than the supervisee.


Sample Weekly Feedback Form

Student/ Supervisor Weekly Review Form
(Adapted from Washington University School of Medicine/OT Program)

Week#: _______ Student: ________________________ Fieldwork Educator: ______________________

Areas of Strength:

Growth Areas:

Goals for Next Week:

Meetings. Assignments Due, etc.
READING LIST

Occupational Therapy Code of Ethics

Occupational Therapy Ethics Self-Assessment Index
Coffey, Margaret S., (1988), O.T. Ethics Self-Assessment Index, AJOT (42)5, p. 321-323.

Summary of Ethical Issues
This is a summary of the major philosophical schools of thought and ethical principles.


What to Expect During Your Fieldwork, Suggestions for Students, Essential Professional Behaviors
Reprinted from Michael Reese Hospital and Medical Center, Department of Rehabilitation Medicine, 1984.

Games People Play in Supervision

Occupational Therapy Licensure Law
This document reviews the educational and license requirements for practicing as an occupational therapist in New York State.

Service Delivery and the Role of the Occupational Therapist
This is a descriptive summary of various treatment settings and the role of therapists working in these settings.

A Patient’s Bill of Rights
This document summarizes patient rights in treatment settings.

Working with Children with HIV and Their Caregivers
This document answers the questions: What you need to know? Right to know? Who needs to know?

Developmental Stages in Clinical Reasoning
This is a summary of the stages that therapists and students experience when developing clinical reasoning skills.
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