2 The 'Therapeutic Use of Self' in Occupational Therapy

Lindsey Nicholls

Much of this chapter has been taken from the introductory section I wrote for my PhD research (2002–2010). As my doctoral studies were within the disciplines of psychoanalytic sociology and political studies, the initial chapters were used to orientate the readers to the art and science of occupational therapy. As such, the 'therapeutic use of self' attempted to outline the concerns I had about occupational therapy's loss of 'wonder and delight' (Nicholls, 2007, p. 56) in the unconscious. I felt this loss particularly affected the therapist's ability to recognise the multilayered communication that was part of working with clients by paying attention to what was said, not said, done and felt (by the therapist). This mixture of conscious and unconscious communication could offer containment (i.e. a deep level of understanding) for the patient and provide the emotionally honest support needed for clients to begin to consider making changes.

Finding a language and practice examples that would describe and explore occupational therapy for sociologists, psychoanalytic psychotherapists and political scientists was hard enough, but what I had not anticipated was the resistance I would experience when talking to occupational therapists ~~(OTs)~~ about these concepts.

The professional imperative to be positive (part 1)

In my role as an academic staff member I had a 2-hour 'debrief' session scheduled with a group of undergraduate occupational therapy students. It was a Friday and they had just returned from 12 weeks of clinical placements to hand in their practice evaluation forms, attend the debrief session and hear about their future taught modules. The students were excited to see each other and there was a buzz in the workshop room as they shared stories of

Psychoanalytic Thinking in Occupational Therapy: Symbolic, Relational and Transformative, First Edition. Lindsey Nicholls, Julie Cunningham Piergrossi, Carolina de Sena Gibertoni and Margaret A. Daniel.

what they did on placement. I joined them, and after outlining that the debrief was a way of extending their shared learning, I asked them each to describe one situation they would like further thought and reflection on by the group.

Many of students raised the same concern: that of managing their relationship with the client. They said they wanted to be respectful, show concern (be client centred) and not overstep the 'boundaries'. What they didn't know was how to answer clients who asked personal questions, invited them to visit after they had ended their placement or told them a 'secret' (i.e. something they asked them not to share with other staff). They all agreed that these were difficult situations and many of the students felt they should be 'honest' and tell patients that they did not share 'personal information' with clients. When I asked what their reasons were for not disclosing 'personal information', they could only state, somewhat defensively, that they had been told not to. While this 'rule book' approach was being explored, a mature female student said she did tell her clients certain things about herself because she thought it would help them. She told clients that she had teenage children and believed would help them feel they were 'normal' when they struggled with their children. She didn't want them to feel there was a difference between her and them.

When I suggested to the students that boundaries protect the patient from the therapist's less helpful intensions, the students seemed confused. They could not imagine that their goodwill and positively stated goal of enabling clients to achieve independence was not sufficient to establish a good therapeutic relationship. What they seemed to deny was that in any relationship there are many conflicted and unconscious layers of interaction and that they may have needed to consider the client's sense of shame and/or humiliation at needing help. These hidden or unconscious feelings could have been communicated by clients as an intrusive question or subtly seductive comments.

Had I known of the psychodrama work that Carolina Gibertoni had undertaken with occupational therapy students (described in Chapter 12), I might have asked the students to role play their interactions with clients, but I suspect that for this group it would not have been possible. They could not conceive of a less than perfect way of working with clients, and in their clinically reasoned narratives they positioned themselves as therapists who were conscious, well intentioned and full of hope for the client. What could not co-exist with these positive views of care work was the notion of an unconscious, something that is part of us all and affects our every interaction and choice of activity.

As Main (1957), in his seminal article 'The ailment', based on the observation of a long-term care facility, stated: 'there can be never be certain guarantee that the therapist facing great resistant distress will be immune from using interpretations in the way nurses use sedatives – to sooth themselves when desperate, and to escape from their own distressing ailment of ambivalence and hatred . . . The temptation to conceal from ourselves and our patients increasing hatred behind frantic goodness is the greater the more worried we become' (1957, p. 130).

Conscious and unconscious communication

In our considering a title for this book, it was suggested that if we used the words 'psychodynamic thinking in occupational therapy', it might be more palatable to the intended occupational therapy market, but it was a unanimous decision to keep 'psychoanalysis' as part of our focus in this book. Psychoanalysis, perhaps more than any other discipline, incorporates the notion of an unconscious into all that we say, do, believe, feel and think. Each of the authors has used psychoanalysis as a way of understanding patients, clinical situations, social environments and themselves. During my ethnographic research into the relational (i.e. emotional) work undertaken by occupational therapists in acute care clinical settings (Nicholls, 2010), it was deeply reassuring that therapists were acutely aware of clients' layered communication, which was difficult to access through standardised assessment techniques.

Clients' narratives had to 'felt', intuited and sometimes confronted so that a robust therapeutic relationship could be established between the occupational therapist and their patient. This relationship was based on the therapist being emotionally available for the client to locate their distress (or unconscious projections) in the therapist until they were ready to consider what these feelings could mean for their future life. This emotionally complex and rewarding work, while being tacitly understood in many clinical settings, had not been articulated in many profession-specific (occupational therapy) academic texts. The psychoanalytic occupational therapy model presented in this book (MOVI, Chapter 7) does consider the unconscious communication between client and therapist within the medium of 'doing'. The book has many examples of how clients' verbal and non-verbal communication is taken in by the occupational therapist and held (contained) until the patient can tolerate understanding it for themselves. The process of containment is central to the work that is done with clients using the relational model, the MOVI.

> *Containment as a psychoanalytic concept involves the analyst keeping a space inside their mind that allows for the patient's projective identifications to be 'taken in' and processed. This act may allow the patient to feel understood, and if given sufficient thoughtfulness (a mixture of personal experience, theoretical knowledge and tolerance of these painful experiences) can be brought to bear on these projections, meaning may emerge.*
> (Nicholls, 2000, p. 42)

Perhaps what is unique in an occupational therapy response, and different from an analyst who uses words, is that the occupational therapist communicates through doing and words.

This book, using the MOVI, explores how psychoanalysis, as a theory and practice, can allow occupational therapists to work with clients' thoughts, feelings and words through understanding their 'doing'. The emphasis of this chapter is on the occupational therapists' use of themselves in the therapeutic relationship. This 'use of self' pertains to a sensitive receptive capacity that therapists are able to develop towards clients. It often requires (as stated in Chapter 1) that the therapist has been able to explore difficult and painful areas in their past and present life. In other words, the therapist has had or continues to have therapy for their emotional well-being; it is this that allows them to do the demanding work with clients.

The professional imperative to be positive (part 2)

To return to my earlier example of the debrief with the OT students, when I suggested to the group that what may enhance their communication with clients would be a period of therapy for themselves, it seemed to be the final straw in my attempts to allow this group to think about themselves and the client. Students looked at me with a mixture of anger and dismay; it was as if I suggesting that there was something 'wrong' with them. They retreated into a sullen silence and the workshop limped to an unsatisfactory end.

It was only much later, in trying to think through what had gone so wrong in this teaching session, that I realised I had missed a vital step in the process: I hadn't first listened to them. I had expected the students to be able to hear and respond to the clients' unmet needs, identify with their disappointments and feel their pain. How could they perform that transformational role . . . if no one had offered that to them?

'The important thing is to connect'

Ormont (1988), in an article on the role of therapist in assisting clients in group therapy to recognise their need for (and unconscious defences against) intimacy, stated: 'In E. M. Forster's words, "The important thing is to connect." Nothing has caused more suffering over the millennia than people's inability to do just that. Psychoanalysis has from the beginning sought to help people overcome barriers towards themselves and others' (p. 30). Psychoanalysis uses the relationship established between the analyst and the patient as its primary method of therapy (Bateman and Holmes, 1995; Layton, 2008). It is within this relationship that the patient can gain an understanding of themselves and thereby begin the process of change. The therapeutic relationship can bring with it all the struggles, complexity and rewards of any close relationship. The responsibilities in this intimate relationship are both mutual and separate; the analyst maintains a constant thoughtfulness about the patient through a process of containment and interpretation (Ogden, 1979), while the patient investigates their inner world through free association and

an exploration of transference phenomena. Although both are changed by the experience of (the relationship with) the other, it is the patient who is desirous of change, and the analyst who offers their capacity (self) for this intense engagement in a process of transformation or change for the patient (Craib, 2001).

Fidler and Fidler (1963) discuss how the relationship between occupational therapist and patient is *as valuable* as the activity undertaken in treatment. They refer to the transference and projections that patients may have with the therapist and encourage occupational therapists to consider what these relationships may represent for the client, and to consider this understanding in their interactions and use of activities in treatment. They employ the notion of an occupational therapist using the relationship established with the client as a legitimate therapeutic agent of change in treatment; they call this type of intervention 'the use of self in treatment' (Fidler and Fidler, 1963, p. 71).

Fidler and Fidler (1963) also expressed a concern that this emphasis on the relationship between therapist and patient may take precedence over the significance of an engagement in occupations as part of the treatment. Perhaps 40 years on we can see that this pendulum has now swung to an overemphasis on activity as the only real (valid) therapeutic agent of change, and the relationship between therapist and client has been underplayed in occupational therapy literature as a need for 'client-centred' approaches (Reberio, 2000; Sumsion, 2006; Townsend and Polatajko, 2007). The MOVI (Chapter 7) offers a rebalancing of the conscious and unconscious interplay between therapist, client and the doing of an activity. (Chapter 6 covers the development following this initial Fidler and Fidler (1963) work, incorporating the relational thinking behind the MOVI.)

Client-centred practice in occupational therapy

In the past decade a 'client-centred' approach to practice has been a basic premise in all occupational therapy applications. Its underlying assumption, which comes directly from the work of Carl Rogers (1902–1987), is that the patient (known as 'client') is best able to identify their problem areas and performance deficits and thereby indicate their therapy goals (Thorne, 1996). This type of approach is often framed in idealistic terms, but recent literature points to the difficulties in implementing these theoretical concepts in practice (Wilkins, Pollock, Rochon and Law, 2001; Reberio, 2000; Sumsion and Smyth, 2000).

The relationship established between client and occupational therapist is seen as having the essential qualities of a Rogerian approach to client-centred practice: the authentic response of the therapist, an unconditional acceptance of the client, and an empathetic response to what is brought into the situation of therapy. 'It was Rogers' contention – and he held firmly to it for over 40 years – that if the therapist proves able to offer a relationship where congruence, acceptance and empathy are all present, then therapeutic movement will almost invariably occur' (Thorne, 1996, p. 135).

This approach to working with patients was developed as a reaction to the more pessimistic and deterministic view of human nature that psychoanalysis was purported to suggest. The replacement of the term 'patient' by 'client' gave an

emphasis to the self-responsibility the person (client) had in the relationship with the therapist. The value of the therapy was placed in the relationship that the patient established with the therapist, and this was linked not to the therapist's techniques, but to the quality of their interaction. This capacity of the therapist to be fully aware of and in tune with the client's world was the method of the therapy undertaken.

Before his death, Rogers accepted the shift of the term 'client-centred' to 'person-centred therapy' as a description of the nature of the interaction between therapist and client. He wrote about the feeling of 'presence' that he experienced when with a client. This, he maintained, was an experience of himself and the 'other' that was spiritual and existential in its quality, and allowed him a spontaneity of action and association that was often powerful and meaningful for the client (and himself) and led to fundamental changes in the relationship. Rogers maintained that he was able to offer people a 'space in which to find themselves' (Thorne, 1996, p. 123).

Rogers' approach was phenomenological in nature and practice, and although focused on the conscious experience of the client, his description of 'presence' echoes the discussion by therapists who work within an analytic framework and who are attentive to their 'countertransference' (Ogden, 1997; 1994) – that is, their internal response to the patient. I have wondered if Rogers' account of presence carried an echo of the experience of an analysis which leads to a deeper understanding of the patient/client by using ever more sensitive listening skills, including listening to one's inner dialogue as well as the words spoken by the client.

In Rogers' explanation of presence he described it as getting in touch with something that is not fully conscious: 'the unknown in me, when perhaps I am in a slightly altered state of consciousness in the relationship, then whatever I do seems to be full of healing' (Rogers, in Thorne, 1996, p. 136). This altered state of consciousness may be similar to the analytic description of maintaining an attitude of 'evenly suspended attention' (Craib, 2001, p. 203) to the communication of the patient, where the analyst's unconscious is able to comprehend the unconscious communication from the client. The importance of the therapist paying attention to their countertransference will be discussed more fully in the subsequent section, 'Concerns with client-centred practice'. My unease with an absolute adherence to a client-centred approach is that it does not include the notion that a client's communication is not wholly conscious, or that we (as therapists) are less than perfect in our ability to tolerate the relationships with some of our patients. In other words, the client may be either unwilling or unable to tell us what concerns them, and for our own inner reasons, we may not be able to hear them or respond with sensitivity and/or an acknowledgement of their hurt or shame.

Telling myself first

A friend of mine, who had been through a period of considerable distress many years earlier, said to me one day, as if in passing, that ~~a~~ period of depression she had experienced had been precipitated by a rape. I was shocked and asked why she had never told me at the time. She looked taken aback and said, 'Don't you understand? I had to tell myself first.'

Concerns with client-centred practice

I think that a client-centred approach to occupational therapy has many merits, and when used in a context of disempowered communities and/or individuals it may well provide an equality in relationships which allows for enablement and transformation: for example, Watson and Swartz (2004) have written an account of this approach in South Africa. It was eloquently described in Townsend's account of her research into a clubhouse model introduced to a mental health facility (Townsend, 1997). My concerns with the overemphasis in occupational therapy on a client-centred approach as the only way of establishing a relationship with a patient is that it does not account for the way clients structure their stories to be understood by professionals, the layers of meaning and intent in what is said by the clients, the potential misuse of empathy in the relationship, and finally the importance of acknowledging the patient's unconscious communication as a way of understanding their life and experiences.

The illness narratives

In their book *Introduction to Psychotherapy*, Brown and Peddar (1991) describe different levels of psychotherapy, from the supportive and sympathetic listener (level one) to the resolution of conflicts through the use of the therapeutic relationship (level nine). Their description of the 'intermediate level' (1991, p. 92) describes the capacity of the therapist to see beyond the patient's words to their layered meanings. Balint (1896–1970), a psychoanalyst, ran a series of seminars for general practitioners (GPs) in the 1960s and said that the patient quickly learns what is expected from them and shapes what they bring to the consulting room: 'Patients learn the doctor's language' (Brown and Peddar, 1991, p. 97). Balint was suggesting that clients may tell us stories about their lives that they think we will understand.

The following example, which comes from my clinical experiences in South Africa, demonstrates the sensitivity needed to understand the patient in an area fraught with the potential for cultural misunderstanding and/or unspoken personal shame. The clinician was a sensitive occupational therapist, Elaine, who worked in the 1980s with 'burns' patients.

Sensing the shame

Elaine worked with patients admitted to hospital who had sustained severe burns. Many of these patients were black men and women who came from financially impoverished and politically disadvantaged backgrounds and had been living in informal settlements (i.e. squatter camps). These shanty towns were built from bits of wood and scraps of corrugated iron and were often heated with open fires or paraffin burners. The potential for accidental fires existed alongside the warfare that frequently broke

out amongst rival gangs seeking to control the different sections of the squatter camps.

Elaine noticed that when she asked patients how a burn had occurred they often looked blankly at her and said they didn't know. She thought what was preventing them from telling her about the cause of the fire resulting in their devastating burns was the belief that she, a white middle-class person, would not understand what life was like for them. She said she learnt to ask her patients, in a conversational way, if their burns had been caused by 'a paraffin stove being knocked over . . . or an attack by "skollies"[1] . . . or . . .' and she would suggest the different ways that the fires could have been caused. By doing this she removed any sense of judgement and blame, and showed she understood the experiences of their lives. She said that when she did this, the patients, often with some relief, could then tell her how the fire had started, how they had been burnt and how traumatised they felt.

The stories of our patients' lives are layered with meaning, and this is especially true when the patient is experiencing a period of illness, disease or distress. Clients may come to us with a legitimate physical complaint, but its symbolic nature can create a window into their lives that, with careful attention, may help us discover the meaning of their illness. This was eloquently described in *The Illness Narratives* by Kleinman (1988). In a phenomenological study he explored the meaning behind patients' physical illnesses, many of which were devastating chronic conditions. In one chapter he described a man who had a chronic bowel complaint that was exacerbated during periods of stress. Although there is no space here to give a full description of the man's life story or the density of the understanding that Kleinman brought to bear on the situation, it seemed that the man, who would never fully recover from his illness, used it to communicate some of his loneliness and remoteness in relating to others. 'The pain was not a minor theme, however; it had the quality of a distraction, a part of experience that broke into his isolation by proving that he was real. And it brought him into contact with the only caring human beings in the city with whom he had developed a relationship: his nurses and doctors, and now a pain researcher' (Kleinman, 1988, p. 81).

Kleinman suggested that we look at symptoms within the context of the person's life. He described it as the interpretation of symbol and text, 'where the latter extends and clarifies the significance of the former; the former crystallizes the latent possibilities of the latter' (Kleinman, 1988, p. 42).

Communication between therapist and client is a richly textured encounter, and it may be beholden on the therapist to understand the symbolic and manifest content of the interaction. Therapists are encouraged to listen to the illness event within the client's life story, and not see the client as a 'hand injury' or 'right-sided stroke'. The

[1] 'Skollie' was a slang term used for local (often violent) gangsters.

patient's description of their life, interests and occupational performance problems will be lost on the therapist who sees them as a symptom without a context. The following example comes from some of my clinical work in London, in 1996.

The meaning of hearing voices

A patient of mine, who was living in the community and who had a long-term enduring mental health illness (she had been diagnosed with schizophrenia), once said to me that when she went to the community mental health team for her monthly appointment with the psychiatrist, he asked her if she was hearing her voices again. She said if she replied that she was, he often then prescribed an increase in her medication. She said, 'The thing is, no one asks me what the voices are saying.'

Her voices were very important to understand because, during significant periods of her illness, they were heard as her dead mother imploring her to kill herself and join her on the other side as her mother said she was very lonely. It was during these periods of hearing this particular voice that my patient became suicidal and battled to maintain her routines of caring for her children and maintaining her home.

A story without animals

In the novel *Life of Pi* (Martel, 2003) the author presents us with a fictional account of a young Indian boy (Pi) who, following the sinking of an ocean liner, is left adrift on a lifeboat with a Bengal tiger for 227 days. This story carries the reader through a series of adventures between the boy, the Bengal tiger, a zebra, an orang-utan ape and a hyena when suddenly, near the end of the novel, it gives us an entirely different account of what occurred on the ocean. This alternative narrative has no animals; the boy is adrift on the lifeboat with his mother, an ill sailor and a psychopathic cook. Both stories carry a similar plot: in the first account the zebra and orang-utan are quickly dispatched (eaten) by the hideous hyena, who is in turn eaten by the tiger. Boy and tiger then co-exist on the boat until they finally find land. In the second, shorter version of what occurred on the raft, the cook kills and eats his victims, until Pi kills him.

The reader is left wondering which account was the 'real' one and may have been challenged by a need to have a story that was comfortable to read and easier to understand (the one with animals) – certainly not one that includes murder, cannibalism and possible matricide. By doing a simple correlation between the animals identified in the first version of the story and the people described in the second, the orang-utan could have symbolised Pi's mother, the zebra becomes the disabled sailor and the hyena is the murderous cook, but what of the tiger? Was it representative of an alter ego in Pi, so full of rage and fear that he was finally able to defend himself and kill the psychopathic chef?

I was left wondering if the moral in the story was that the reader (or someone who listens to narratives) may only want to hear the things that are palatable to their minds. The question for me in the book became: on whose behalf was the story being told? In other words, if I could apply it to our work with clients, do patients alter their stories because they sense that as therapists we are unable to tolerate the reality of their experiences? Does some of this take place on an unconscious level, where both patient and therapist feel an unease, but may ignore the disjuncture in feeling by using platitudes of comfort and surety; and when the client withdraws from therapy, is it seen as 'their choice'?

In the book *Individuals in Context* (Fearing and Clark, 2000), occupational therapists are encouraged to lead the multidisciplinary team in the arena of client-centred practice, humming the tune (of client-centred practice) softly so that others 'will join in harmony' (2000, p. 7). These are strong and stirring words for occupational therapists who find they are a lone voice when speaking up as a patient advocate in a team discussion. But I would like to make a more personal observation of the difficulty in remaining client centred, which has to do with the therapist *not wanting* to experience the feelings of the patient.

The therapist, in being with the patient in a real and authentic manner, may come into contact with feelings that are disturbing and frightening. In order to protect themselves from those feelings, the therapist may unconsciously avoid any further contact with the patient, or make a remark that prevents the patient from saying anything further. Some patients are unable to verbalise their inner feelings and experiences, and by using a mechanism of projective identification place those feelings inside the therapist for containment and translation. Ogden (1979) explains 'projective identification', drawing our attention to the fact that the mechanism is first and foremost an attempt at communication. Like the baby whose cries need to be taken in (heard) and understood by the mother in order for her to respond to its pre-verbal need for food, comfort or warmth, we as therapists may need to take in and translate the messages from our patients.

Understanding this process does not only lie in the realm of psychoanalytic psychotherapy, and occupational therapists may do well to examine their countertransference responses to patients, as it is within the mechanism of projective identification that the patient can communicate their feelings and experiences that may not yet be fully conscious. Book (1988), in an excellent article on 'Empathy: Misconceptions and misuses in psychotherapy', states that 'empathy is particularly important in gaining access to the patient's inner world – a world the patient may be unaware of or, if aware, unable to conceptualize or verbalize' (p. 420). The response of being empathetic, he states, is being able to communicate to the patient an understanding of their inner experience. However, for some therapists this inner world carries a confusion and painfulness which the therapist attempts to avoid by using what can appear as an empathetic remark, but which the patient experiences as patronising or hurtful and therefore becomes silent.

Book (1988) uses a clinical example where a new registrar (doctor) encounters a paranoid patient on an in-patient ward. The patient is enraged at his incarceration and is shouting abuse at the registrar. The doctor, in an attempt to be empathic, says, 'I am glad to see you can get your anger out.' The patient hesitates, looks

perplexed, and then angrily roars, 'You bastard! To be so happy that I am this upset!' (1988, p. 422).

As Book points out, the registrar had equated being empathetic with being unquestioningly accepting. This had blocked the registrar from hearing that underneath the patient's anger was his fear and helplessness. It was only later in supervision, when the registrar could look at his own feelings of fear and helplessness, that he could begin to understand the patient's unconscious communication.

It may be this equation of client-centred care with compliant acceptance of a patient's behaviour or requests that has created some of the difficulties that therapists find in the new culture of 'client-led' services. I believe it is this lack of understanding of the difference between 'client-centred' and 'client-led' therapy that has caused some of the misunderstanding in occupational therapy and prevented therapists from taking a more active intervention in patient care. Therapists must remain involved in thinking both 'with' the patient and 'about' the patient. It is the capacity to both feel the feelings of a patient and wonder about these feelings that can allow the therapist to make an appropriate response and a therapeutic intervention.

In teaching client-centred practice to occupational therapy students, I often ask them to analyse the following scenario that I took from an advice column in a woman's magazine in 1993 (a period when HIV and AIDS had become a new anxiety for many patients).

Julia's problem or the problem with Julia

> ***Julia:*** *Last year I had a very brief love affair with a guy at varsity after a long-term relationship broke off. I did not expect anything to come of the affair, so I wasn't at all upset when he disappeared back home during the holidays and never so much as sent me a Christmas card.*
>
> *The problem is that now I have discovered he is bisexual. I am terrified that I may have caught a disease from him. I don't have any symptoms, but the mere thought of it is making me unhappy. I wonder if I should try to find out where he lives and write to him – but what would I say? Please help.*

When students start to describe what they have 'heard' being said in this brief communication, it quickly becomes obvious that what Julia is requesting – advice on writing a letter to the supposedly bisexual man – is just the surface of a deeply layered message. Students begin to consider if 'Julia' is angry with the man with whom she had a brief affair; they look again at her statement that he '*never so much* as sent me a Christmas card' as a sign of her disappointment and frustration at his ignoring her. They then wonder if he may have been a replacement for her unresolved pain at the ending of the long-term relationship she mentioned.

Beneath this hurt may be her fear that she is unlovable, and the feared infection could symbolically represent a deep flaw that she fears she carries into each new relationship. Through using association and reflection, the students are able to 'hear' much more than what is actually said by 'Julia'. This leads into their considering how they could or should respond to her 'request'; after all, she wasn't asking for an analysis!

The student class exercise described above has been a useful tool in looking at the limits of a client-centred practice where 'client-centred' implied staying on the superficial (or manifest) level of a client's 'request'. Responding to what someone has communicated in their between-the-lines or beneath-the-surface narrative can be deeply reassuring. Joseph (1983) said that as therapists we need to be able to distinguish between a patient's capacity to understand (i.e. seeking to know about something) and their desire to be understood (i.e. acknowledged for feeling a certain way) by their therapists. The same patient may desire these mechanisms at different times in the progress through therapy. My experience in analysis was that when I had been deeply understood by another feeling receptive mind, I could go on and try to understand myself.

On not liking a patient

In recent occupational therapy literature there are few references to therapists struggling with negative feelings towards clients. The discourse of client-centred practice makes it impossible to dislike a patient, let alone experience any kind of hatred or rage towards them. And yet we know, as partners, carers or parents, that it is quite natural to feel a wide range of feelings in response to another, and many of the less acceptable feelings we have towards caring for others involve disgust, hatred and envy (see Menzies Lyth, 1988). Finlay (1997), in her article on 'Good patients and bad patients', described how difficult it was for the occupational therapists she interviewed to say anything 'bad' about a patient or even state that there were patients they disliked. In our loss of a psychoanalytic discourse in occupational therapy, we have lost a language to describe, and thereby understand, our experiences of working with clients.

In a small qualitative study I undertook,[2] I was struck at the number of optimistic comments occupational therapists made about their work with clients and how positive they felt about their professional identity. It was as if there were no experiences of awkwardness with clients, no occurrence of professional unease and certainly no feeling of failure. It was this overwhelming affirmation that made me reflect on the loss of thinking about the 'other side' of experiences in the profession.

[2] Part of a postgraduate qualitative methods research course.

> *. . . what had been lost in the modern occupational therapy discourse is the incorporation of a shadow. With hope comes despair, with love hatred and with pragmatism a sense of bewilderment and confusion in day to day life. The researcher is not suggesting that occupational therapists now slump into the mire of depression and hopelessness, but perhaps acknowledge that in all situations, in the profession and in themselves there are unanswered questions, difficulties and periods of unease. By discussing the 'other side' of our experiences we may be able to engage in further critical thinking, and learn from each other.*
>
> (Nicholls, 2003)

Some professionals working in health care have expressed a concern that if we (as therapists) were to recognise the extent to which we feel with and about our patients, we would no longer be able to do the work. Fabricius (1991), in an article called 'Running on the spot or can nursing really change?', said it was the number and intensity of projections given to nursing staff by patients in an acute care ward that made the thinking about the work very difficult. Theodosius (2008), in her work on emotional labour in health care, uses the term 'therapeutic emotional labour' (p. 144) to describe the interpersonal and deeply reflexive work that nurses undertake to understand and respond to their clients' emotional behaviour or outpouring. This is particularly important when clients are seemingly irrational or abusive and/or make complaints, as presented in the clinical vignette of 'The complaint' (Theodosius, 2008, p. 142).

However, if we are to work as therapists with clients, to consider all that they do and say as well as investigating our response to them (i.e. our countertransference) as another form of their communication, then it is beholden on us as therapists to reflect on our experiences (or what Theodosius terms 'reflexive emotion management'; 2008, p. 201) to understand and help our clients. Daniel and Blair (2002a; 2002b) have promoted the use of a psychodynamic model of supervision in occupational therapy, emphasising the need for the clinical therapist to use their 'feelings to inform practice' (2002a, p. 237). The loss of explicit teaching (and evaluation) of the interpersonal skills necessary for this deeper level of communication in occupational therapy (or 'emotional labour' in the terminology used by Theodosius (2008) and Smith (1992)) is an area of development addressed in Chapter 12 and Chapter 13.

Although I have focused on feelings that are difficult to tolerate, such as hatred and envy, working with patients who suffer can bring us closer to an understanding of ourselves and improve the nature of relationships we have in all aspects of our lives. Supervision and reflection may also allow the therapist to remain in touch with the very desire that brought them into the profession in the first place. The hope that, by reaching out to the other, a measure of comfort, understanding and/or change is possible is surely the core of all the helping professions. I sometimes wonder if it is the capacity to endure the pain of living that can give some measure of reassurance to those who face the darkness alone.

> *Most patients with chronic illness, like the rest of us, live quietly and unremarkably in the daily struggle of living. Our pains, like our joys, are small, interior, simple. There is no great moment to the illness or the life. Yet illness, together with other forms of misery, sometimes brings a kind of*

> *passion and knowledge to the human condition, giving an edge to life. And for some patients with chronic illness pain and suffering have more to do with life – and specifically with that aspect of life which is dark and terrible and, therefore, denied – than with a disease process. Perhaps the healer and the family, like the historian of human misery, must allow themselves to hear – within the symptoms and behind the illness, especially for the complaints of those of us who are most ordinary – the wail.*
>
> (Kleinman, 1988, p. 86)

On becoming a therapist

Hoggett (2006) uses the word 'compassion' to describe the robust emotional commitment that public sector youth workers showed towards their 'subject(s)' (p. 154). Benjamin (1990) uses the word 'love' to describe a process which occurs between two people (e.g. mother and child) that goes beyond a (fantasy of) destruction or need for reparation: 'The outcome of this process is not simply reparation or restoration of the good object, but love, the sense of discovering the other' (1990, p. 192). I know my current university occupational therapy students are very suspicious of the word 'love', as they believe it is unprofessional to feel too much for and about the client. In the short story 'The Little Prince' (de Saint-Exupéry, 1974) the narrator speaks about love, but calls it another name; to 'tame'. This concept is discussed between the 'Little Prince' and the fox, who explains to the Little Prince that to tame meant to establish 'ties' (establishing a unique link with him) and that this was an art that had been 'often neglected' (1974, p. 66). He (the fox) says that if the Little Prince were to establish ties, they would have a need of each other.

This story provides a salutary lesson for all therapists to maintain the boundary of time as a function of 'holding' (Winnicott, 1956). The fox tells the Little Prince that he must come at the same time each day, so that the fox can anticipate (and look forward to) his arrival. He says to tame him (essentially a reciprocal process) they needed to recognise their differences (as fox and boy) and make a link through an appreciation of each other's needs. This seems to mirror Craib (1994), who stated that psychoanalysis allows for 'the formation of relationships based less on the illusion of common identity than on the reality of individual separation, difference and dependence' (p. 198).

This chapter may frustrate readers who were seeking a procedural approach to working with clients and I suspect this feeling is frequently shared by my students (as described in the early example). When teaching 'assessment techniques' to students, I suggest that they invite the client to sit with them in a quiet, private room and invite the client to tell them about themselves. I say that this will be sufficient for them to learn all they will need to know about the client, but more important than this gathering of facts and impressions is that it will start the relationship between the two because they are truly listening. This is not a simple process and many mistakes are made by new therapists who may wish to 'make the client feel better' or not worry as much, etc.

What these therapists may find harder to acknowledge is that these wishes are more to do with wanting to be liked by the patient than really engaging with what

prevents the patients from getting better. This conflating of therapeutic goals with personal needs is explored by Casement (2006) and he has many examples of how his seemingly well-intentioned approach to 'helping' clients was patronising and prevented them from learning about themselves. What I have hoped, in this chapter, is to suggest that using oneself in therapy is an attitude of listening that allows the therapist to hear the real concerns and hurts that are often hidden in the client's talking and doing. As Foulkes and Antony (1984) so eloquently expressed: 'The language of the symptom, although already a form of communication, is autistic. It mumbles to itself secretly, hoping to be overheard . . .' (pp. 259–260).

Conclusion

One of our motivations for writing this book was to try and capture the complexity of working with the client in a therapeutic relationship through a process of: emotional understanding (offering containment), making interpretation (developing insight) and having sufficient space/time for working through conflicts. This holding relationship requires the therapist to become more aware of themselves and thereby the many layers of conscious and unconscious communication from the client (what was said, not said and done). Our concern was that in the recent renaissance of reclaiming the word 'occupation' in occupational therapy theory (e.g. Wilding and Whiteford, 2007; Whiteford, Townsend and Hocking, 2000) what may have been neglected was the process required to become a therapist and to offer 'therapy', which allows for a change to take place over time. We are hoping this book will address some of the aspects of this lifelong process of learning to be an occupational therapist.

References

Bateman, A., and Holmes, J. (1995) *Introduction to Psychoanalysis: Contemporary Theory and Practice*. Hove: Routledge.

Benjamin, J. (1990) Recognition and destruction. In S. A. Mitchell and L. Aron (eds), *Relational Psychoanalysis* (pp. 181–210) New York: Analytic Press, 1999.

Book, H. E. (1988) Empathy: Misconceptions and misuses in psychotherapy. *American Journal of Psychiatry*, 145 (4), 420–424.

Brown, D., and Peddar, J. (1991) *Introduction to Psychotherapy* (2nd edn). London: Routledge.

Casement, P. (2006). *Learning from Life*. Hove: Routledge.

Craib, I. (1994) *The Importance of Disappointment*. London: Routledge.

Craib, I. (2001) *Psychoanalysis: A Critical Introduction*. Cambridge: Polity Press.

Daniel, M., and Blair, S. (2002a) A psychodynamic approach to clinical supervision: 1. *British Journal of Therapy and Rehabilitation*, 9 (6), 237–240.

Daniel, M., and Blair, S. (2002b) A psychodynamic approach to clinical supervision: 2. *British Journal of Therapy and Rehabilitation*, 9 (7), 274–277.

De Saint-Exupéry, A. (1974) *The Little Prince* (translated from French by K. Woods). London: Pan.

Fabricius, J. (1991) Running on the spot or can nursing really change? *Psychoanalytic Psychotherapy*, 5 (2), 97–108.
Fearing, V., and Clark, J. (2000) *Individuals in Context*. Thorofare, NJ: Slack.
Fidler, G., and Fidler, J. (1963) *Occupational Therapy as a Communication Process in Psychiatry*. New York: Macmillan.
Finlay, L. (1997) Good patients and bad patients: How occupational therapists view their patients/clients. *British Journal of Occupational Therapy*, 60 (10), 440–446.
Foulkes, S., and Antony, E. (1984) *Group Psychotherapy: The Psychoanalytic Approach*. London: Maresfield Library/Karnac.
Hoggett, P. (2006) Pity, compassion, solidarity. In S. Clarke, P. Hoggett and S. Thompson (eds), *Emotion, Politics and Society* (pp. 145–161). Basingstoke: Palgrave Macmillan.
Joseph, B. (1983) On understanding and not understanding: Some technical issues. *International Journal of Psycho-Analysis*, 64, 291–298.
Kleinman, A. (1988) *The Illness Narratives*. New York: Basic Books.
Layton, L. (2008) Relational thinking: From culture to couch and couch to culture. In S. Clarke, H. Hahn and P. Hoggett (eds), *Object Relations and Social Relations* (pp. 1–24). London: Karnac.
Main, T. (1957) The ailment. *British Journal of Medical Psychology*, 30, 129–145.
Martel, Y. (2003) *Life of Pi*. Edinburgh: Canongate.
Menzies Lyth, I. (1988) *Containing Anxiety in Institutions*. London: Free Association Books.
Nicholls, L. (2000) Working with staff groups: Containment as a prelude to change. Unpublished master's thesis. Tavistock and Portman NHS Library, London.
Nicholls, L. (2010) 'Putting it into words': A psychoanalytically orientated ethnographic study of hospital based clinical occupational therapy departments in the UK and South Africa. Unpublished PhD thesis. University of West of England, Bristol.
Nicholls, L. E. (2003) Factors in mental health multidisciplinary teamwork that impact on the professional identity of occupational therapists. Unpublished research project. Department of Health Sciences and Social Care, Brunel University.
Nicholls, L. E. (2007) A psychoanalytic discourse in occupational therapy. In J. Creek and A. Lawson-Porter (eds), *Contemporary Issues in Occupational Therapy: Reasoning and Reflection* (pp. 55–85). Chichester: John Wiley & Sons, org.
Ogden, T. (1979) On projective identification. *International Journal of Psychoanalysis*, 60, 357–373.
Ogden, T. (1994) The analytic third: Working with intersubjective clinical facts. *International Journal of Psychoanalysis*, 75, 3–19.
Ogden, T. (1997) Reverie and metaphor: Some thoughts on how I work as a psychoanalyst. *International Journal of Psychoanalysis*, 78, 719–732.
Ormont, L. (1988) The leader's role in resolving resistances to intimacy in the group settings. *International Journal of Group Psychotherapy*, 38 (1), 29–45.
Reberio, K. (2000) Client perspectives on occupational therapy practice: Are we truly client centered? *Canadian Journal of Occupational Therapy*, 67 (1), 7–14.
Smith, P. (1992) *The Emotional Labour of Nursing*. London: Macmillan.
Sumsion, T. (2006) *Client Centred Practice in Occupational Therapy* (2nd edn). London: Churchill-Livingstone Elsevier.
Sumsion, T., and Smyth, G. (2000) Barriers to client-centeredness and their resolution. *Canadian Journal of Occupational Therapy*, 67 (1), 15–21.
Theodosius, C. (2008) *Emotional Labour in Health Care: The Unmanaged Heart of Nursing*. Abingdon: Routledge.
Thorne, B. (1996) Person centred therapy. In W. Dryden (ed.), *Handbook of Individual Therapy* (pp. 121–146) London: Sage.

Townsend, E. (1997) Occupation: Potential for personal and social transformation. *Journal of Occupational Science*, 4 (1), 18–26.

Townsend, E., and Polatajko, H. (2007) *Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-Being, and Justice through Occupation*. Ottawa: CAOT Publications ACE.

Watson, R., and Swartz, L. (2004) *Transformation through Occupation*. London: Whurr.

Whiteford, G., Townsend, E., and Hocking, C. (2000) Reflections on a renaissance of occupation. *Canadian Journal of Occupational Therapy*, 67 (1), 61–69.

Wilding, C., and Whiteford, G. (2007) Language, identity and representation: Occupation and occupational therapy in acute settings. *Australian Occupational Therapy Journal*, 54 (3), 180–187.

Wilkins, S., Pollock, N. Rochon, S., and Law, M. (2001) Implementing client-centered practice: Why is it so difficult to do? *Canadian Journal of Occupational Therapy*, 68 (2), 70–79.

Winnicott, D. (1956) Primary maternal preoccupation. In D. Winnicott, *Through Paediatrics to Psychoanalysis* (pp. 300–305) London: Karnac, 1985.