‘PUTTING IT INTO WORDS’: A PSYCHOANALYTICALLY ORIENTATED ETHNOGRAPHIC STUDY OF HOSPITAL BASED CLINICAL OCCUPATIONAL THERAPY DEPARTMENTS: IN THE UK AND SOUTH AFRICA

LINDSEY ELIZABETH NICHOLLS

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol
for the degree of Doctor of Philosophy

Centre for Psycho-Social Studies
Faculty of Humanities, Languages and Social Sciences

September 2009

Abstract

This study seeks to understand the psycho-social work of occupational therapists (OTs) in two hospitals; one in London, United Kingdom (UK) and the other Cape Town, South Africa (SA). Within these medical environments the OTs work involved establishing empathetic relationships with clients, encouraging and assessing the client's self-care skills, which would enable them to return home.

The research was inspired by the seminal work of Menzies Lyth (1988) and aimed to understand the social defences OTs employed in their work. These unconscious mechanisms may have protected OTs from the anxiety of working with vulnerable clients but could have thwarted therapists' fulfilment of reparative desires. A psychoanalytically informed ethnographic study was undertaken in the two clinical departments using three linked data gathering methods; participant observation, free association narrative interviews and inquiry groups. Twenty one OTs took part in the overall study, eleven from UK and ten from SA; all were women, had a range of professional grades (based on clinical expertise) and came from diverse cultural backgrounds. The analysis of the data incorporated reflexive accounts by the researcher, including researcher's and participants' dreams. The happenstance of using two different countries as fieldwork sites highlighted how the personal (i.e. therapist's biography) and contextual (i.e. social/political) history affected the OT work undertaken.

The study reveals that OTs, although busy 'doing' tasks with clients, were emotionally sensitive to communication and able to reflect on the reciprocal exchange (recognition) that occurred when working in intimate care situations. The emphasis of the relational work undertaken by OTs shifted from the 'psycho' to the 'social'; UK data emphasised how OTs early family histories may have influenced their need to care for others and/or express their less conscious reparative desires. The SA part of the study highlighted the importance of understanding the social political context of OTs and clients' lives and how this influenced, consciously and unconsciously, their work.

The emotional and practical work of OT incorporates the psycho-social elements of an intersubjective relationship and occurs within the shared time of undertaking an activity. This work is essentially one of compassion, creativity and transformation but OT may need to incorporate the psychoanalytic language of social unconsciousness, hidden desires, emotions and relationships to explain itself more fully; OT needs the words to say it.

Acknowledgements

First and foremost I want to thank the occupational therapists in London and Cape Town who have allowed me to observe their work in all its intimate complexity. Their compassion and insights have helped me find my way back to a shared professional home. For this I am deeply grateful.

My thanks also go to my two supervisors, Professors Paul Hoggett and Simon Clarke. Without Paul's generosity, thoughtfulness and encouragement this work would never have started, and without Simon's critical and considerate comments it would never have finished. I have been very lucky to be in a group of psycho-social research students – Lesley Boydell, Rumen Petrov, Haralan Alexandrov, Antoaneta Mateeva**,** Sue Jervis and Sheila White (alongside the newer members) – establishing a community of practice in psycho-social research methods.

Throughout this period of study my partner, Angela Byers, has provided many additional thoughts, some key articles and relevant criticisms of my work. She has been more than tolerant of my absorption in the work, often making me a dull companion in our day-to-day lives. I am very grateful for her loving presence in my life.

In this time (2002-2008) my widowed mother became very forgetful and frail, moving from her home in Zimbabwe to live in South Africa, first with my sister and her family, later with Angela and I, and finally into a care home. She died on 18 November 2008, aged 84, and it is to her love and vulnerability that I dedicate this work.

Then I think how, at eight-five,
My mother's mind is a castle in ruin.

Time has raised her drawbridge, lopped her bastions.
Her balustrade is crumbed, and she leans.

Yet still you may walk these ramparts in awe.
Sometimes when she speaks, the ghostly ensign flies.

Time cannot hide what once stood there,
in all its glory.

Do not think that we are good
Or merely tourists.

That which detains us
Was once our fortress.

Mrs Barbara Nicholls, June 2008

Notes from a Dementia Ward
Finuala Dowling (2008) 'At eighty-five, my mother's mind' (pp.7-8)

Contents

Chapter 1: Begin at the Beginning

> '*Begin at the beginning*', the King said, very gravely, '*and then go on until you come to the end: then stop*.'
>
> *Carroll, 2006, p.114*

An Invitation to an Interpretation

This research project is an invitation to think about what occupational therapists do, feel and think about in their work. In thinking about this project I realised that every piece of work has an author, a subject and a reader. I wanted to keep this triangular space open to allow the reader to form their own opinion based on what is written. To create this space I have written about the project and about myself and held a reader in mind as an ongoing process. In writing about 'Reading Winnicott', Ogden (2001, p.301) said that Winnicott wrote as he worked: with an element of 'playfulness' that allowed the reader to form their own thoughts in relation to what he was suggesting. It seemed to me that in describing the research project and process I had undertaken I needed to write about what I was thinking in response to what I saw and did, as my viewpoint was contextual and influenced all that occurred. What I saw and felt and chose to represent needed to hold a space open for readers to reflect on the project and discover moments of truth for themselves.

> '…the most distinctive feature of Winnicott's writing is the voice. It is casual, and conversational, yet always profoundly respectful of the reader and the subject matter under discussion. The speaking voice gives itself permission to wander… has the compactness of poetry… is genuinely humble and well aware of its limitations… the voice is playful and imaginative; but never folksy or sentimental.' (Ogden, 2001, p.301)

I wanted to represent the work of occupational therapy and of the individual therapists who spoke about themselves in a respectful and empathetic manner and I have written about myself as researcher and occupational therapist. I wanted to use this work to discover my own thinking through the writing process; as Denzin (2001, p.23) stated, 'we know the world only through our representations of it'. In using the process of discovery through writing I have found myself thinking anew about the research, and it has been an ever deepening iterative reflexive cycle.

> 'Antonia S. Byatt in *Possession* has described certain kinds of readings that seem to be inextricable from certain experiences of writing, "when the knowledge that we *shall know* the writing differently or better or satisfactorily runs ahead of any capacity to say what we know, or how. In these readings a sense that the text has

> appeared to be wholly new, never before seen, is followed, almost immediately, by the sense that it was *always there*, that we the readers, knew it was always there, and have *always known* it was as it was, though we have for the first time recognised, become fully cognisant of, our knowledge".' (Morrison, 1992, p.xiii)

The first difficulty was to know where to begin. In trying to describe when and where this project was conceived I cannot find a clear timeline, as the idea of the project occurred over a period of time when I was in a professional and personal limbo. I had completed a Masters degree two years earlier and had begun a new job in a university department that encouraged staff to do research – all valid reasons for wishing to pursue a doctoral study. But in truth I think the reason I wanted to do the study was a search to find something to 'do' to replace the void I found after leaving psychoanalysis. I wanted to be more fully occupied when my three times a week appointments came to an end and I thought a study of a professional group that I belonged to, but had always felt apart from, would give me an understanding of my sense of personal disjuncture – perhaps in the same way my analysis had allowed me to feel closer to and more connected with the people around me.

Leaving my analyst was painful; it was seven years ago and it was yesterday. In my final appointment I spoke of my love of walking up mountains and my analyst made a remark about needing to look at what this activity symbolised. I retorted that that was what occupational therapists did, then I felt a little unsure of this statement and said 'well that is what they should be doing' and then, feeling even more unsure of everything and wondering how I would find the courage to get up and walk away from him (and this time together) as the session was near its end I said, 'well that is what I would do.'

Throughout this research project I have used psychoanalytic theory as a base which has informed the use of the research methodology and the understanding of the material within the process. I have reported on observations, interviews and groups with occupational therapists, and incorporated their reported dreams (from the interviews and/or inquiry groups) and my own dreams and reflections in supervision as part of the data. The project has allowed me to return to this professional group with a renewed sense of belief in the efficacy of occupations (that is, the things that we do in our daily lives) as a medium for communication with clients. I have also felt a compassion for the therapists who, like me, sometimes find it easier to act than to think, to do something

rather than to be with someone and who measure their self-worth by seeing the 'other' achieve more than they believed they could.

> *Dream 1: Running Through Walls (July 2002)*
>
> *I was in a hotel room with Paul Hoggett. It was an ordinary room, like the ones that certain chain hotels have. They offer consistent budget type accommodation for people who are in town on business and only stay for short period. The room was in a corridor of similar rooms. Paul said that if you ran at a wall and believed you could pass through it – then you would. I was intrigued at the idea and said I would try it. We both then ran at the wall of the hotel room and to my surprise and delight we passed right though it into the next room. I then began to run at the wall of this new room, Paul running next to me, and again we passed into a new room. This continued for about five rooms until we got to a room which had a man standing in it. I tried to run at this new wall but it didn't give way to let me through. I looked at Paul to enquire what to do; he indicated that we should go out to the corridor. This corridor ran straight down between rooms on the left and right (all looking exactly the same) and this corridor was quite a few floors above the ground. I began to run down this corridor and Paul kept pace with me. As we approached the end of the corridor I looked at Paul and he gave me a conspiratorial wink and I looked forward and threw myself at this final wall. We passed through this into the night sky beyond.*

At the time of having this dream I had just met Paul Hoggett to discuss registering to do a PhD in his department. He was interested in the study that I outlined to him in which I wanted to look at the unconscious processes which occurred in the professional group to which I belonged: occupational therapy. He said his department had simultaneously collected three other students who wanted to undertake research using psychoanalysis as a base for their projects and he would welcome my application. This meeting and the dream reiterated my sense of him (Paul) – that if you could imagine something then it was possible.

I had also found the work of Lawrence (1998, 2003a) on 'Social Dreaming' and was intrigued at the notion of dreams revealing what we do not yet know and that through the act of having and remembering the dream we have additional information to use in our thinking. The dreams (which have been recorded throughout my study) have amplified the data and through the use of associations (my own, from my supervisors and close colleagues) have allowed me to think further about my thinking. As Lawrence (1998, p.136) stated, we constantly take in images from our surroundings, hence the concept of dreams having a 'social content' where we capture and code social metaphors. At the time I had the dream outlined above (July 2002) there was an advert on British television in which a man (wearing Levi jeans) was able to run at walls and

burst through them[1]. He, like in my dream, was joined by an 'other' (a woman in the television advert) and they both ran through a wall at the end of a building into the night air. The Levi jeans advert ended with the words 'freedom to move'. My dream had captured this social and/or cultural symbol of breaking through barriers but also spoke to my deeper feelings of taking courage from Paul Hoggett to embark on a research journey, the purpose of which has been to break through and interrogate the rhetoric of the overwhelmingly positive descriptions of 'caring work' within the discourse of occupational therapy .

But what of the part in the dream where I found a man in one of the rooms and the wall became impenetrable? Who was this man, why could I not pass through the wall? In my dream I seemed to overcome this obstacle by finding another route (the hotel corridor) and the sensation of leaping out into space at the end of this avenue of rooms has stayed with me all this time; it has a quality of liberation and fearlessness that I think Erica Jong (1973) tried to describe in her book 'Fear of Flying'. What then of this man in the room? The man was a shadow character, not recognisable to me and not threatening either, just in some way ending our onward journey through the bedroom walls. Was he the figure that appears in my unconscious, the one that seeks recognition for his place in my internal world? Was he there at the beginning – before I had even begun to think of a research study, before I had begun my academic studies or professional training, was he the reason I wanted become an occupational therapist and work with people who had disabilities?

Because of this shadow presence in my first dream (prior to undertaking the study) and as a matter of respect to all the participants who shared their stories with me in relation to their choice of career, I have wanted to write about my reasons for choosing to be an occupational therapist. This is something I develop (from p14 onwards), it is the beginning of the beginning, and my reflexive account may also assist the reader to hear the voices of participants within the research process.

> 'As researchers, therefore, we cannot be detached but must examine our subjective involvement because it will help us to shape the way in which we interpret the interview data. This approach is consistent with the emphasis on reflexivity in the interview, but it understands the subjectivity of the interviewer through a model

[1] I found a copy of this advert on YouTube: http://www.youtube.com/watch?v=_rkvUEtbM1w&feature=PlayList&p=5F9FE5412D4F32DD&playnext=1&playnext_from=PL&index=6

> which includes unconscious, conflictual forces rather than simply conscious ones.' (Hollway & Jefferson, 2000, p.33)

This thesis has seven chapters and follows a logical progression of the study from its inception (and idea for a study) to its conclusion, the research findings. Chapter 1 explains how the idea of the study began, Chapter 2 looks at what a psychoanalytic discourse in occupational therapy (OT) could offer this professional group, and Chapter 3 describes the how and why of the ethnographic research methodology. Chapters 4 and 5 cover the analysis of the London and Cape Town fieldwork sites respectively and Chapter 6 returns to consider how the research methodology evolved while doing it. The final Chapter (7) returns to explore how some of the social defence mechanisms used in OT prevent therapists from experiencing the emotional fulfilment that is potentially part of the (intersubjective) care relationship: it is, after all, what love has got to do with it.

Occupational Therapy: a Brief Overview of the Profession

> *Caitlyn and I went to the ward where Simon had returned to his bed and Caitlyn asked if she could do a washing and dressing assessment with him. He was waiting to wash himself and Caitlyn filled a basin of warm water and took it to his bedside. She drew the curtain round Simon's bed and suggested that I stand outside as it would be more discreet for the patient; I was relieved as I didn't want to see him naked. Simon was a tall, elderly, dignified man who looked unwell; he was stooped, thin and sallow. He had long pyjamas and a catheter with a urine bag emerging from his trousers. He moved and talked slowly.*
>
> *Caitlyn observed his washing and dressing and gave him various long-handled sponges to use to reach his back and legs. She did not assist him unless he asked her e.g. to reach for his clean pyjamas from the bottom of the cupboard. I was aware of how hard it is to watch someone and not help or do it for them, especially if it looks like an effort on their behalf. I realised how much Simon wanted to do these actions for himself. There was a quiet dignity in his actions, he used his crutches to get to the sink, scrubbed out his dentures and placed them in his mouth, then used a brush to scrub the denture dish. He moved slowly back to the bed and seemed relieved at being able to rest. Caitlyn left the two sponge sticks for him to use.*
>
> *I asked Caitlyn how she had learnt to manage a washing assessment, particularly the aspect of a patient's nakedness. She said it [nudity] wasn't discussed at university and that she hadn't found it easy. She tried to protect clients' dignity by letting them keep their pyjama tops or bottoms on. She smiled at my question.*

Occupational therapy is a health related discipline (like nursing, physiotherapy, medicine and psychology) and its members are employed in a variety of public services and private organisations, e.g. remedial classes at schools, hospitals and social care or

insurance companies that process claims for disability. It is a professional qualification which is bestowed on graduates who have successfully completed a period of study at a university or college. Occupational therapists work primarily with people who have disabilities and through their analysis and use of therapeutic activities (called occupations) therapists aim to enhance the overall 'wellbeing' of the person with a disability. OTs work with people across a wide age range (from babies who have developmental delay to frail older adults who are being assessed for their 'indepenedent living skills'). OTs work in the areas of mental health and physical disability, sometimes parodied as the health professionals who 'make baskets' with bed bound orthopaedic patients or who organise the 'Christmas Variety' show in mental health institutions[2]. As the vignette which starts this section shows, OTs assist clients in finding ways they can manage self care tasks thereby being seen as 'independent' and ready for discharge.

The World Federation of OT's (WFOT) website describes OT as

> '… a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation…. Occupational therapy is practised in a wide range of settings, including hospitals, health centres, homes, workplaces, schools, reform institutions and housing for seniors. Clients are actively involved in the therapeutic process, and outcomes of occupational therapy are diverse, client-driven and measured in terms of participation or satisfaction derived from participation.' (wfot.org)

The majority of occupational therapists would agree that it has been difficult to articulate what it is that occupational therapists 'do'. There have been ever more complicated and lengthy definitions of occupational therapy from different authors and in different countries (Reed and Sanderson, 1983; Wilcock, 1998c; Townsend, 1999; Whiteford et al., 2000; Wilcock, 2001b; Creek, 2003), each one claiming to be the definitive definition – but none has seemed to remove the predicament that occupational therapists experience: that, when asked by family, friends or potential clients what is it that they 'do', no answer seems to be sufficient or succinct enough to convey what the work of an OT **is**. This difficulty in finding a comprehensive and succinct description of the work of an occupational therapist has been the subject of many articles (Creek,

2 There is a wonderful film 'Cosi' (1997) that tells the story of an OT assistant who involves the patients in a mental health institution in performing the opera 'Così fan tutte'.

2008; Wilding & Whiteford, 2007; Mackey, 2007; Fisher, 2003; Breines, 1995, Mosey, 1985).

Mackey (2007, p.95), in reporting on Finlay's (1998b) thesis based on in-depth narrative interviews with occupational therapists, stated that 'the diversity of occupational therapy practice contributes to a profound sense of confusion about the nature of occupational therapy (Finlay, 1998).' Other authors have found that the lack of focus on 'occupation' has contributed to the identity crisis in OT (Fisher, 2003; Breines, 1995), and Hooper and Wood (2002) thought that the difficulty OTs had in defining their work was related to the difference in two competing paradigms in the professional discourse – structuralism and pragmatism. One of the potential consequences of this professional 'dis-ease' is that occupational therapists can sound defensive when speaking or writing, as if they are anticipating not being understood; and this could prevent them from engaging in critical debates with other professional groups to explore different theoretical approaches to understanding people.

In a public lecture which I was invited to give to the students of a South African Medical University (Nicholls, 1992), I attempted to analyse my professional sense of inadequacy when working with doctors and other members of the multidisciplinary team. This rather tongue-in-cheek exposé about OT did help me explore the early history of the profession, where the initial theory about occupation and its therapeutic effect on the mind and body was seen as the remit of the medical profession (often men), and occupational therapists were the 'craft instructors' or adjuncts to the doctor's prescription of an 'occupation' (and they were most often women). Etzioni et al (1969) highlighted that a similar fate faced nurses, social workers and teachers who were considered 'semi-professions' (p.v). In his seminal text, the 'The Semi-Professions and Their Organisation' (published in 1969) Etzioni et al described how the female dominated professions (e.g. nursing and social work) were not considered real (or full) professions (such as medicine or law - groups dominated by men) as nursing lacked a 'scientific base' and did not require a university education or qualification. This lack of authority in a work role and professional status was reinforced by notions that the nurse's '"knowledge" has been assumed to be the knowledge of the heart' (Katz, 1969, p64). This 'heart' knowledge (or emotional work) was thought to be less important than the scientific rationality of medicine (medial knowledge). It was thought to be in the best interests of nurses (and clients) not to have a 'full scale induction into the scientific

outlook'(Katz, 1969, p.65) as it may have prevented her from having 'considerable emotional openness to the patient' (ibid, p65). In other words 'scientific' knowledge would have made her more rational and therefore unable to relate on human (feeling) level to her patients. Adding to the trivialisation of the emotional work that nurses undertook (simultaneously seen as women's work), was that it was considered 'satisfying' (i.e. rewarding) in itself. In other words; the work done was seen to be a payment in itself – thus obviating any further monetary compensation. Position and power in the medical hierarchy was held (and held on to) by men as doctors.

> '…physicians generally hold the nurse in low esteem: they are willing to see nurses receive income infinitely smaller than their own, and frequently treat the nurse as a non-person….To be sure, physicians often acknowledge individual competence and are find of individual nurses, But this is still in the character of a caste system, just as southern whites in the Unites States traditionally held specific Negroes in fond regard and treated them kindly, even lovingly.' (Katz, 1969, p.70)

In OT, similar to the assumption in nursing that the intimate care tasks undertaken for patients was 'women's work', the use of activities with clients was seen as gender (i.e. female) specific. For example, the use of handicrafts (e.g. weaving) or self care activities (e.g. cooking) used in the rehabilitation of patients. was thought of as 'women's work'. Mead (1949) wryly observed;

> 'Men may cook or weave, or dress dolls or hunt humming birds, but if such activities are appropriate occupations of men, then the whole society, men and women alike, votes them as important. When the same occupations are performed by women, they are regarded as less important'. (Mead, 1949, p.159)

Many of these early professional struggles for recognition and autonomy were achieved through changes in medical and dental council rulings (related to prescription and referral), alongside the recognition of a university degree qualification and the use of research-based evidence to support theoretical models in occupational therapy. But these changes do not seem to have assuaged the OTs profession's anxiety or struggle to articulate its identity. As Katz (1969) observed; 'Few professionals talk as much about being professionals as those whose professional stature is in doubt' (p.71) and it has seemed to me that OT has been caught in this particular defence or defensiveness about its professional / theoretical status.

> 'Occupational therapy is a diverse profession that assists people in all age groups and who have difficulties in many areas of function. There have been repeated attempts to define precisely what occupational therapy professional identity is, or should be, by aligning identity with paradigmatic constructs or specific bodies of

> knowledge. These observations often introduce an effort to clarify the professional identity of occupational therapists either by means of theoretical and philosophical discussions, or as a result of empirical study. Despite these efforts, however, what is apparent is that occupational therapy identity remains as elusive as ever. Each author attempts to bring order to the confusion only to be followed by another author offering a different perspective, or sociocultural changes to the content, terms and conditions that occupational therapists work in.' (Mackey, 2007, p.2)

Over the past ten years I have had a nagging concern that the anxiety I experienced as an occupational therapist – in trying to explain what I did to potential clients, multidisciplinary colleagues or friends – was related to something far more primitive than a lack of social acceptance by more dominant and/or gendered professional groups (i.e. men and medicine). Although I had never felt that what I did was glamorous, exciting or particularly clever, I had thought the lack of acceptance (even ridicule[3]) by colleagues was because of their misunderstanding of the symbolic value of 'craft work' or their lack of appreciation of the functional value of a 'tap turner'[4]. I had been previously been comforted by the often used Reilly (1962[5]) quote:

> 'The wide and gaping chasm which exists between the complexity of illness and the commonplaceness of our treatment tools is, and always will be, both the pride and anguish of our profession.' (Reilly, 1962, p.88)

But my use of this quote to students studying occupational therapy or in public talks about occupational therapy never completely removed my nagging sense of professional self-doubt about what occupational therapy **was**. It always seemed as if something was missing, and as I lacked a certain amount of personal self-confidence I assumed it was me who was 'missing' something. Was my anxiety caused by the thin theoretical foundations that OT rested its newly found laurels on or the lack of acceptance from other professional groups? Griffin (2001) examined the reluctance that OTs seemed to show in learning how to manage their newly acquired political and professional 'power' in health care. She encouraged OTs to less formal routes (e.g. by establishing networks) to influence decisions in multidisciplinary team work and for OTs to become 'partners in prevention and treatment' (ibid, p.27). This 'informal' route of gaining professional legitimacy may belie the less conscious aspects of group membership and belonging.

[3] There have often been jokes about occupational therapist being 'basket weavers'. I used to enjoy one slogan I saw which said 'Support your local hooker… buy a rug today'!
[4] This is a simple metal or wooden device which looks like an elongated letter F, but which can be used to open and close taps by someone who has limited hand grip strength (e.g. neurological condition or arthritis).
[5] This article, which is often quoted by current OT authors, was first published in the American Journal of Occupational Therapy in 1962 and is in a collection of 'Eleanor Slagle lectures (1955-1984)'.

> ‘the development of a profession involves more than developing a distinct body of knowledge…[professions] have social links not only to their clients and colleagues in their profession, but also to other groups with whose activity their skills must dovetail; and that the legitimacy of their professional contribution must be acknowledged by these other groups.’(Katz, 1969, p.72)

In September 2001, while attending a staff seminar at Brunel University (London), where Ann Wilcock (a prestigious scholar and author in occupational therapy) was talking about the research she had done on the history of occupational therapy (Wilcock, 2001a), I found myself becoming increasingly anxious, almost on the verge of panic. I began to wonder if the deep unease that was reflected in much of the professional literature and within less formal gatherings (like the one I was attending) was in relation to a fundamental flaw in the formation of the profession. Was there a false foundation in the original thinking about what an occupation was and how it was involved in the lives of human beings? If there was an early failure in understanding the link between occupation and human beings, would this have caused the extensively documented professional anxiety which contributed to its identity crisis?

It was following this seminar and my intense experience of unease that I wanted to put occupational therapy under a research scrutiny. Because of my interest in psychoanalysis as a treatment, a theory and as a research methodology (Bateman & Holmes, 1995; Kvale, 1999) I wanted to use an organisational (psycho)analysis of the professional discourse to see if I could discover some of the unconscious processes that may have contributed to this identity crisis (or bewilderment).

Wilcock (1998b, 1998c, 2002), a leading occupational philosopher, has said that human beings are ‘occupational beings’ and that ‘doing’ (i.e. being involved in activities) is a fundamental human need (or drive). She stated:

> ‘People spend their lives almost constantly engaged in purposeful “doing”; even when free of obligation or necessity. They “do” daily tasks including things they feel they must do, and others they want to. Human evolution has been filled with ongoing and progressive “doings”, which, apart from enabling the species to survive, has stimulated, entertained and excited some people and bored, stressed, alienated or depressed others according to what was done.’ (Wilcock, 1999, p.3)

By placing ‘doing’ as a primary need or drive, similar to Freud’s notion of an id impulse (Bateman & Holmes 1995), I think she was also implying: I do, therefore I am. What is done (by a person) has always been more eloquently described by OTs than the more complicated discussion as to why it has been done. Occupations (or doing) always have

a context and this was conceptualised by Law et al. (1996) as an intersection between the occupation (what is done), the person (who is doing it) and the environment (the context in which it occurs). This is depicted below (Diagram 1) and indicates that the area of specific interest to OTs is the ability of the person to perform the occupation competently (i.e. occupational performance).

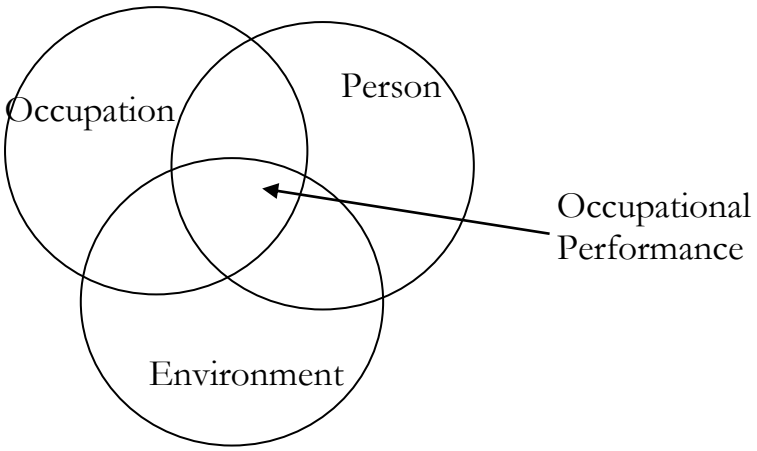


Diagram 1: from Christiansen and Baum (1997, p.74)

However, I do not subscribe to the emphasis on the central role of occupation as a motivator, or basic drive in human beings, and have followed the work of the object relations theorists (Klein, 1988; Segal, 1988; Winnicott, 1971) in believing that a primary drive in human beings is to be in relation to (i.e. contact with) other human beings (Orbach, 2008; Ormont, 1988) and that people can express this need through their use of occupations. This is similar to Winnicott's notion of playing and space (see Winnicott, 1971, p.38), where the playing takes place in the space between the mother and the child. This space is created by the mother's ability to be psychologically and/or physically present (and not intrude on the playing) and it is also a description of the time in which the playing takes place. This 'time' is the actual time of the play, e.g. ten minutes or after lunch, and it reflects the time of the social-political culture, which is a description of the 'environment'.

A diagrammatic representation of this relationship is shown at Diagram 2 below.

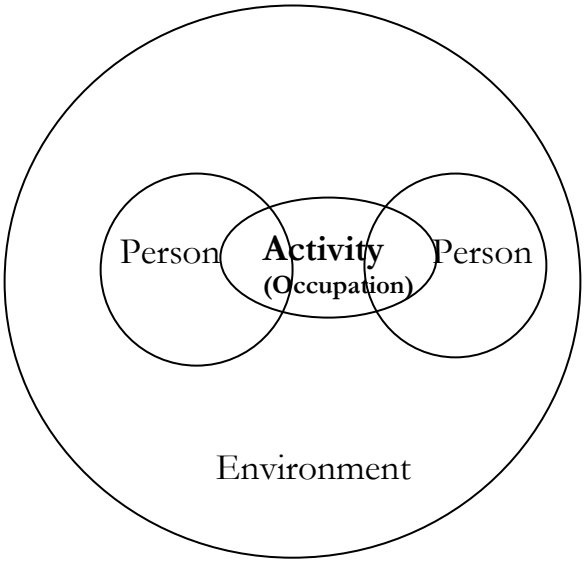


Diagram 2: Activity/Occupation[6] as Communication/Connection

Here 'doing' occupies the space between people and represents the way in which people connect to each other; at its essence it (an activity) can be a symbolic expression of desire for connection and love of the other[7]. The choice of occupation is influenced by the internal world of the individual and external realities of the environment. The 'internal' world of the individual includes their state of mind, the way in which their internal objects are represented and thereby symbolised, and the external realities which permit or restrict their choices. These include the time in which the occupational engagement takes place (i.e. social-political cultural history of that time) and the concrete objects available for expression (e.g. a violin to play music or a bag of compost to dig into a bed of roses).

Since starting the study I was very fortunate to meet and learn about the work of two Italian OTs (Julie Cunningham-Piergrossi and Carolina Gibertoni) who use (and have always used) psychoanalytic theory in their work. Their clinical descriptions of working with children or adolescents in a therapy room full of 'activity choices' have been an inspiration to me. As Julie said, when a young child from a refugee family is

[6] There is an on-going debate in OT about the difference between and distinction of an 'occupation' and an 'activity' and I have used the terms interchangeably throughout this thesis. I think the client's personal meaning (both consciously felt and unconsciously driven) in relation to the doing or not-doing of something is more central to a discussion of what they do than which term we may use to define it

[7] I have written about occupations that can defend the self against a recognition of its need for the other. See Nicholls, 2008.

constructing a wooden toy house, it may represent his need to make sense of where he is from, but if the saw breaks, the OT also needs to know how to replace the blade. That is what I love about being an OT; the mixture of the practical and symbolic value of the tasks. After all, woodwork was one of my best subjects at university!

Occupation: Meaningful Activity or Defence Against Anxiety?

In the last 15 years there has been a focus in the professional journals on the 'nature of occupation' and its relevance in the understanding of (assessment) and intervention (therapy) with clients. Words such as activity and occupation are debated in ever decreasing circles, some authors stating that all occupations involve activities but not all activities are occupations (Christiansen & Baum, 1997). However, in these debates about the term occupation and the use of activity in therapy what has been lost is any thought about occupation as representing an underlying (unconscious) desire by an individual to connect with the world around them. Psychoanalytic thinking in occupational therapy, which was once present in the literature and teaching of the profession (Fidler & Fidler, 1963), has lost its presence. There are a few authors/clinicians who continue to work with the symbolic value of activity within their practice (e.g. Cunningham-Piergrossi & Gibertoni, 2005). Eklund (2000) invited OTs to consider an object relations model in their work, but such authors are few and far between. Overall there has been a profound loss of wonder and delight in the value of the unconscious and the importance of activities as a form of communication that can represent what cannot be said or known.

I have also wondered if occupational therapists may have been using activities with patients as a defence against (i.e. an avoidance of) the experience of the client's neediness and/or suffering. This overvaluing of the activity element in occupational therapy may serve to forestall an emotional connection with the client, and prevent an understanding of the possible use clients have made of activities to defend themselves against anxiety (see Nicholls 2008). In other words, some activities can be a displacement activity (i.e. a defence against anxiety) and although this may be helpful and useful to the individual client (e.g. a grieving widow may spend much time cleaning the house) it could also indicate an avoidance of a more painful insight or life adjustment.

The nursing profession has kept alive a thoughtfulness about its vocation and possible unconscious defences since the early work of Menzies Lyth (Smith, 1992; Fabricius, 1991, 1999; Dartington, 1994). Recent publications in nursing journals refer to the importance of being aware of countertransference in understanding a patient's communication (Winship et al., 1995; O'Kelly 1998) and the usefulness of staff support groups as a way of thinking through and managing work-related stress (Bolton & Roberts 1994; Winship & Hardy, 1999). The field of 'emotional labour', initially identified by Hoschschild (2003) in the specific work roles of airline stewards, has been extended into nursing practice by Smith (1992) in her book on 'The Emotional Labour of Nursing' and her later publications, (Smith & Lorentzon 2005; Hunter & Smith, 2007). The work on emotional labour in nursing has been extended by Theodosius (2008) who gives careful consideration to the application of Hochschild's (1983) work on emotional labour to an acute care nursing setting and extends the understanding of emotional labour into identity, collegial relationships, reciprocity and 'reflexive emotional management' (Theodosius, 2008, p.201). Jones (1997), who writes about his work as a nurse, gave a moving description of the use of poetry to communicate with patients who are dying and Moreau (2008) believed that the experience of reciprocity in the relationship between the nurse and patient was one of mutual 'healing' (ibid, p.128).

Occupational therapy has not developed such an analysis of its own professional culture and/or the legacy of being one of the 'semi-professions' (Etzionzi, 1969). Although lists have been drawn up of what assumptions underlie particular models of OT (Reed & Sanderson 1983), these do not attempt an explanation of these assumptions by incorporating any psychoanalytic thinking in a coherent theoretical whole, such as in the manner used by Menzies Lyth (1988). Such an analysis of the profession, similar to the one undertaken by Main (1957) with nurses, may provoke a level of debate and discussion that may deepen the profession's understanding of its essentially human endeavour to relate people to their world of 'objects[8]', which are expressed in their relationships with each other and through meaningful endeavours.

[8] An 'object' is a term used in Kleinian theory that refers to the attachment made with the carers (most often parents) in the baby's life. These 'objects' (i.e. people) are real and internalised by the baby, called internal objects. Winnicott (1971) used the term for animate objects (e.g. the mother) and inanimate objects, e.g. a teddy bear which represented the mother (i.e. a transitional object).

Occupational therapy as a profession is less than 100 years old, although some authors have stated that the belief in occupation as a means to good health has been present since the Hippocratic oath (Wilcock, 2001a). There has been a substantial growth in the profession over the last 50 years. It has moved from being an adjunct to medicine (occupations being prescribed by doctors for patients, the occupational therapist acting as a craft teacher) to a professional body within its own right (Serrett, 1985). During this period a few OTs have charted the progression of the profession and identified turning points in its history (Kielhofhner & Burke 1977; Serrett 1985; Wilcock 2001). The emphasis in these developmental histories has been on the need for the OT profession to establish a solid theoretical foundation related to the quest for scientific and professional credibility alongside the trends in general medicine for evidence-based practice.

Occupational therapy has often found itself in opposition to the 'medical model' of prescriptive remedies, but has not established itself as a social model of care (Green, 1991). Clinically-based occupational therapy roles in multidisciplinary teams have been described as 'gap fillers' (Fortune, 2000) and are often determined by that team's theoretical orientation. Occupational therapists have frequently described a sense of insecurity in relation to their professional identity and this has provoked a somewhat defensive attitude towards other professional groups, preventing robust and critical debates between persons within the profession (Farnworth & Whiteford, 2002). Although this may be typical of the developmental stages or processes that any young professional group undergoes in establishing its unique identity in the multidisciplinary market of health care professionalism, my concern (as I have stated earlier, see page 8/9) has been that the defensive nature of the OT profession may also link to the use occupational therapists have made of activities in therapy.

Personal Journey and a Place of Revelation

One of the central questions I asked the participants in the study was, 'why did you choose this profession?' Later in the interviews I tried to explore whether the OTs found that, at times, they identified with certain clients and in that way felt they were part of the process, as if the client were part of them. In thinking about their responses to the project, the observation of their work, the narrative interviews and the group

discussions, I found myself identifying with some of what was shared and found that I would lose a place from which to speak; I would say 'we' and 'us' as if my experience were also part of the research process. I was both outsider (a researcher) and insider (an occupational therapist) with my own story of how and why I chose this project and this profession.

But what was my story? Could I know it and make it known by writing it down? In using psychoanalysis as a theory base in the project and in my analysis of the data, I have wondered whether, when I write an account of my process, would I be discreet (i.e. highly selective) about it in order to seem like a reasonable person. But what defences would I employ to keep any unbearable anxiety at bay? I have reassured myself that I can only know what I know and to begin there, with the thought that what is not yet known can be revealed in the process of writing and in the attention brought to bear on it by the reader. As such it is a triangular process, one that Winnicott (1971) Britton (2004) and Ogden (2001) have outlined.

The triangle of researcher (author), project (research data) and reader creates the space for thinking and thereby for knowledge to emerge. Lawrence (2003a) stated that it is our not knowing that allows us to learn. This knowledge is 'won from the void and formless infinite' (ibid. p.619) and occurs at the edge between the conscious and unconscious. He quotes from the Symingtons' (1996) book on 'The Clinical Thinking of Wilfred Bion':

> 'Ultimate reality can be thought of a vast reservoir of infinite possibilities, of thoughts awaiting a thinker, from the derivatives of which, the transformations, we cull from time to time elements that seem to belong together, that form a pattern or constant conjuncture. These elements we bind together by a name or number so that they become available to be filled with meaning, so that we come to understand the emotional significance for us of this particular bit of reality. This understanding can then join up with another constant contention to accrue further meaning and so on indefinitely.' (Lawrence, 2003a, p.620)

Lawrence, in using the work of Armstrong (1994) within the tradition of the Tavistock consultancy service, has expressed a 'commitment to revealing the "unthought known"… [which is] …grounded in the "politics of revelation" rather than those of "salvation".' (Lawrence, 1998, p.127). He was suggesting that organisations can learn about their unconscious process through reflecting on their actions, dreams, and associations to the dreams. Within this process they could be held less in the sway of unconscious processes and take responsibility for their functioning. It was with this in

mind that I began to write, and thereby think, about my own personal-professional journey.

I was introduced to occupational therapy in my final (A level) year at school through my mother. She had met an occupational therapist at a social event and was impressed with the description the therapist gave of 'doing things'. My mother was quick to tell me that she thought it would be an ideal career for me as I seemed to enjoy 'working with my hands' and I was always busy constructing things in the garage. My mother had made an appointment for me to spend a few days observing an occupational therapist at work in the local day care centre to see if I would enjoy this field of health care. At that time I had planned to study geology as I loved rocks and their different formations, but had been advised by the Rhodesian[9] government that there was little chance for women to do field work! I wasn't keen on an office-based job and so I was happy to explore other work opportunities. My mother was correct, I did love 'doing things' and would spend most of the school vacations constructing various models or toys to use, e.g. go-karts, tree houses or a maze for my two pet rats to find the cheese.

What I hadn't remembered, until the shadow man appeared in my first dream about the research project, was a critical encounter that occurred on my first day of observing an occupational therapist at work. The appointment for me to attend the occupational therapy clinic was at the end of the April school holidays and occurred just after my return from an Outward Bound course run in the Chimanimani mountains (in north-east Zimbabwe) by the internationally based Outward Bound organisation. This course gave me a certain physical confidence that I had lacked for most of my school career. I had always been a physically clumsy and somewhat socially isolated girl in my schooling and during the three-week Outward Bound course I discovered that I could read maps and enjoyed being outdoors with the challenge of finding my way in a new territory, and because of this I could offer leadership to the group of my fellow students.

I returned from Outward Bound with a new-found confidence in myself, and in the following few days went to visit an occupational therapy clinic[10] to observe an OT at work. On my first day I was pleased to see a roomful of craft activities; weaving looms,

[9] At this time (1974) Zimbabwe was called Rhodesia and the 'war' (i.e. struggle for liberation) had begun in earnest.

[10] This clinic was run by the St Giles charity and offered rehabilitation and respite care for people with disabilities. It was attached to a large hospital and day care centre but the programme was run exclusively by occupational therapists.

woodwork projects and basketry seemed to fill each table. Clients were engaged in working on these projects and the occupational therapist moved from person to person instructing them on what to do next. I was thrilled to think I would learn each of these crafts if I were to study this discipline.

The occupational therapist asked me to sit opposite an elderly man who she said had difficulty in speaking and she asked me to play a game of draughts with him. The man must have had a dense cerebral vascular accident (i.e. a stroke) which affected his speech and coordination. He was an elderly white man who wore a sports jacket that carried the emblem of a club on its pocket. He was unshaved and had food crumbs on the sides of his mouth and food stains on his shirt and jacket. He was slumped in his wheelchair and wore glasses with thick lenses, which made his eyes seem bigger than they were. Although I tried to make some conversation with him – e.g. who would start the game, which colour he would like to use – I could not understand much of what he said, his words sounded strangled[11] and strange and he spat when he spoke.

When I had begun the game (the draughts board and counters had already been put between us by the OT) I noticed that he had a tremor when he moved his left hand and he wore a Masonic ring on his finger. I recognised the Masonic ring as my father was a Mason and he often displayed his Masonic regalia to us as a family prior to leaving for lodge meetings. I told the man I that I recognised that he wore a Masonic ring and he stopped playing draughts, smiled broadly and began talking to me (none of which I could understand) but he reached across the table to take hold of my hand and he began to cry. It was at that point I knew I wanted to be an occupational therapist. I wanted to work with people who were affected by illness or disability, I felt I wanted to do things with them that would show them they could still be recognised and useful members of society.

Who was this man that he could play such a central role in helping me decide on a future career? Did he symbolically represent the frailty and vulnerability I had felt as teenager in my physical clumsiness and social awkwardness? Was the time ripe for me to feel that I could assist (i.e. be of use to) others since I had just returned from a good

[11] This difficulty in speaking is often a result of a 'right hemisphere' stroke and is called disarthrea. The person may be able to understand what is said but cannot articulate their words because of spastic facial and tongue muscles. It is very frustrating for these individuals as they realise they can't be understood by the other person.

experience of realising my personal strengths? Perhaps he was all these things. I have often said that I became an OT because I realised I had enough energy to share it with others. I do know that when the man cried I feel a deep compassion for him and at the same time a sense of self-importance; it was my hand he was reaching for, it was me who could comfort him. I felt powerful in relation to him, important for his ongoing wellbeing. But why was that feeling so central to my life that I made a commitment to join this profession and to keep looking for opportunities to feel an important part of others' lives, as I had felt with him? Did he represent my father, and was this an opportunity to symbolically repair a relationship that had been fraught with hurt, rage and disappointment?

It was during my professional life as an OT, between 1995 and 1996, that two events took place in my life which forced me to reflect on my interest in 'doing things' and how that affected my relationships with people. These events transformed my understanding of why I had enjoyed outdoor activities and brought into focus the painful difficulties I had always had in relationships with men, particularly my father.

In February 1995 my father died unexpectedly of a heart attack, pitching me into a period of frenetic activity which resulted in my moving countries and living a fast-paced life in a new job in London, cumulating in my attempt to do a 21-day walk in the Himalayas[12] to see Everest. This hike literally brought me to my knees. I undertook it in the monsoon season (July 2006), alone except for a young guide who spoke very little English, and when we arrived in Lukla my swollen knees would not allow me to walk further (and thereby get a glimpse of Everest) or return to Jiri. Because of the monsoon weather no flights were operating to or from Lukla to Kathmandu. The daily flights had been cancelled for the past three weeks and seemed unlikely for the foreseeable future. I was stuck, in physical pain from my swollen knees and I was alone, the only guest in a large hotel (my guide had taken lodgings with the hotel staff and I seldom saw him).

I experienced a breakdown. I withdrew into my room, I didn't bath, change my clothes or brush my teeth for three days and nights, and although I was called to the meals (set for one in large dining hall) I ate very little. I spent much of my time in a state of near panic and I was unable to organise my time to do anything constructive e.g. going into

[12] This route from Jiri to Lukla was described by Chris Bonington (1997) in his book 'Everest the Hard Way'. He said the walk into Lukla gave the climber a chance to get fit and acclimatise to the conditions.

the village to find other trekkers to talk to. After ten days of waiting I did leave Lukla (the scheduled helicopter flights arrived during an unexpected break in the weather to collect passengers) and I was able to return to Kathmandu, London and finally South Africa (my home) but the memory of this mental collapse haunted me. My previously busy life (full of outdoor adventures in canoeing, mountain walking and social engagements) had not protected me from a collapse which had occurred inside me. In fact in some ways my frenetic lifestyle and ultimate physical challenge may have even precipitated it.

It was following this event that I sought help and was able to enter into psychoanalytic psychotherapy between 1999 and 2001. I remember that in recounting the story of my time in Nepal, my analyst used the word 'breakdown', and for the first time I was able to acknowledge the full extent of my experience of fragmentation and my terror at it ever occurring again. This period of analysis allowed me to question my previously held assumptions about my life, my profession and wider society. Many of the insights I gained during this time have been a guide to me as I engage with people, situations or theory, but perhaps the most useful aspect was never to quite believe that my experience of something was the only valid experience – and so I have questioned, and continue to question myself in relation to my experience of others. This has given me a freedom of thought I never fully enjoyed before and it was this method of questioning that I wished to use in my research project.

My analysis also focused on my feelings towards my father and my deep pain and sorrow at his early rejection of me, particularly my gender. My father, an only child whose father was 60 when he was born, had longed for a son. I was the second and last child to be born, my sister being three years older. My father's longing for a son was part of my life and I attempted in many ways to fulfil his wish – although I was genetically destined to fail him in this quest. I have often reflected on my father's vulnerability and difficulty in owning his masculinity, his love of men's clubs (e.g. the Masonic society), his pride at being in uniform as an army reservist during the Zimbabwe conflict, and his somewhat patronising remarks about women. But this rejection of my birth and its concomitant denial of my real self, in an attempt to gain his affection, had influenced my early choices of activities (I enjoyed fishing, camping and hiking) and it also affected my choice of career.

In returning to the moment where the man (the patient in St Giles) wearing a Masonic ring reached out for my hand, I experienced myself as caring for him – and being able to care for him. It was probably an unconscious attempt to repair and reconcile my disappointment at my own parent's neglect. By caring for others I could feel close to people whom I identified as myself and/or as my distant and emotionally aloof father. What I hadn't realised, until my analysis, was that this need, when unconsciously enacted, seldom brought any sense of comfort (resolution) or change inside myself.

I began to think about the notion of occupations within the profession of occupational therapy: what were they and what did they represent? Were they representative of the cultural and social customs of the time? Did they provide a sense of connection to the world of work and people or were they (as I had found) symbolic representations of need and loss? Did they, as Winnicott (1971) suggested, link the internal (i.e. unconscious) world with the external (conscious) world? My question then, for occupational therapists, became: how do you 'distinguish between occupations that enable the self to express its innermost needs, and those that defend or deflect the self from the expression and fulfillment of those needs?' (Nicholls, 2008, p.253).

At the same time I wanted to discover if occupational therapists, as a professional group, had developed a group of unconscious professional defences (as described by Menzies Lyth's study of nurses (1988)) which would make exploring the underlying (i.e. less conscious) motives for doing something, including the choice of profession, more difficult. Asking why someone does what they do does not easily reveal less conscious or unconscious motives; in fact, the very asking of the question may create such anxiety that the possibility of exploring hidden motives is lost in anxiety defensiveness. I began to look for a methodology that would mirror the study that Menzies Lyth undertook with nurses and explored the narrative interview (Hollway & Jefferson, 2000) as a legitimate place for understanding unconscious processes and concerns through the use of the researcher's reflexive accounts of their countertransference (Finlay, 1998a, 2002; Birch & Miller, 2000; Holland, 2007).

There was one last event, prior to the start of the project, which helped me to think about how I could possibly engage the therapists and organisations in the work I wanted to explore. I had initially called the project 'Occupational Therapy on the Couch' and I even wrote a short piece for the UK 'Therapy Weekly' newspaper on my thoughts about

the possible unconscious defence in occupational therapy (Nicholls, 2003b). But this title seemed to me to place the 'other' – i.e. the occupational therapist or organisation – as the object of the study rather than as an active participant or co-contributor(s) and I needed to find a title that included therapists in the uncovering/exploration of this unknown area in the discourse of the profession.

I returned to two pieces of writing that had had a profound effect on my thinking: Cardinal's (1993) autobiographical account of her recovery through psychoanalytic psychotherapy 'The Words to Say it', and Gosling's (1999) discussion of Winnicott's theory of playing and reality in which he described language (i.e. words) as 'the most ubiquitous of all transitional phenomena' (p.80). In my reading of Cardinal's autobiographical novel and numerous academic papers I began to think that an inner healing seemed possible through a process of talking and reflecting deeply on the past. Gosling's description of words as transitional objects made me realise that words can only represent what we try to communicate to each other, but can never fully be that thing. In that way they are like the occupations (or activities) that I had found so hard to describe or articulate my understanding of.

> 'Trying to use words, and every attempt
> Is a wholly new start, and a different kind of failure
> Because one has only learnt to get the better of words
> For the thing one no longer has to say, or the way in which
> One is no longer disposed to say it. And so each venture
> Is a new beginning, a raid on the inarticulate,
> With shabby equipment always deteriorating…
>
> *T. S. Eliot, 1963, in Palmer, 1999, p.171*

If 'doing' was central to the profession of occupational therapy, and if 'doing' took place in the space (as mentioned earlier in the Winnicott (1971) notion of playing) between therapist and client, how could this 'doing' be spoken about? I wanted to find a way that would encompass a description of conscious and unconscious communication, incorporating the real and symbolic exchange between client and therapist. Perhaps what I was trying to do was to find a way of articulating what was happening but hadn't yet been given (or had lost) a legitimate voice in the discourse of occupational therapy. The new title became: 'Putting it Into Words: A Psychoanalytically Orientated Ethnographic Study of a Hospital Based Clinical Occupational Therapy Department'.

Overview of Project

The project, located in two separate large inpatient general hospital occupational therapy departments, had three separate and linked phases: a period of participant observation, a sequence of interviews and a series of inquiry groups. Because my previous clinical work experience had been in mental health and community teams, I thought it would be useful if I studied an area of occupational therapy in which I would be relatively naïve. I thought this lack of experience of inpatient work in the acute wards of a general hospital would help me to observe occupational therapists at work and enquire about events without having a predetermined view of what the clinical area may be like (based on my own experience of that area). What I hadn't anticipated was how much I would feel that I actually did know what was expected from occupational therapists, and that much of that internal demand for knowing came when I put on the OT uniform or when I was in the presence of a patient or multidisciplinary team member. This 'needing to know' became part of my reflexive account of the difficulty of managing myself when faced with overwhelming vulnerability, and echoed with my early experience of the man with the Masonic ring, i.e. I was convinced I could help him.

The project took place in two clinically matched departments in different countries. The project began in the UK, where I was working as a lecturer in a health science university department, and after completing a period of data collection from an inner London general hospital a serendipitous development occurred when I was offered a teaching post in Cape Town, South Africa. I began to consider what a similar study would reveal if I was to undertake the same methodology in a clinically comparable department in South Africa. I thought this may foreground the role of the social political history of a country (and profession) that influenced the therapist's clinical reasoning and thereby affect the cultural norms within the profession. A South African study alongside the UK project could offer an understanding of how context (social environment) influences unconscious action.

The principle research questions were:

1. Does an understanding of psychoanalysis (i.e. the concept of the unconscious, the importance of the relationship between client and

therapist and the role of symbolisation) help occupational therapists in their work with clients?

2. What symbolic role does the activity used within occupational therapy have for the therapist and client? In other words, does the current language used by occupational therapists acknowledge the symbolic aspects of a client's occupational choices?
3. To what extent does the professional culture of occupational therapy encourage an awareness of the emotional and relational dimensions of work with clients?

The aims were:

- To examine the culture of the profession of occupational therapy, looking at the underlying assumptions and unconscious defences that inform clinical decision making and training.
- To investigate the use that occupational therapists make of activities (or occupations) in working with clients.
- To explore the relevance of an object relations model in occupational therapy.

A copy of the research proposal which was used for the research and development (R&D) committees of both fieldwork sites can be found in Appendix 1. A full description of how the study was undertaken is covered in Chapter 3.

Dreaming as Reflexive Exploration

From the beginning of the research project until its completion (i.e. the writing of the thesis) I kept a record of my dreams. This has been an additional reflexive account of the process and has assisted me in thinking through the experience through the use of association and amplification, terms that Lawrence (1998, p.125) used in his work with the matrix of social dreaming. Some of these dreams have been about the clinical therapists and the work undertaken in the hospital, some have been about my identity as an occupational therapist and some have been about my supervisors and supervision. This final section of this chapter explores the two dreams I had prior to starting to write an account of the whole research process. They helped me locate a major theme within the work and are an example of the reflexive cycle I have used throughout the study.

In the months prior to the dreams occurring I had known of some personal events that had affected the lives of my supervisors. Simon's brother had died and Paul had undergone treatment for cancer. Although I was conscious of my feelings of concern for them and I fretted over how I could communicate my thoughts to them, the dreams precipitated the disclosure of some of my fears and desires. Ogden (2003) writes about the dream as the beginning of a symbolic language where the unconscious is able to find a form and shape that can be recognised, but he also draws the analyst's attention to the possible purpose the clients may have in telling the dream. After all, many people don't mention the dreams they have, yet I wrote to my supervisors about these dreams. Their responses created a place for further reflection because they replied to the dream in which they had been portrayed and then to the dream in which the other supervisor had been present.

Dream 2: The Paul 'Driving' Dream (2 April 2007)

Paul was driving me somewhere. He told me that he and Rose [his wife] had decided to foster a child as their children had all grown up and he and Rose felt they wanted to have one more child. In the dream I looked at Paul and I was worried as he looked thin and unwell. I worried about the decision he and Rose were making. I had the thought that if we had sex I could give him some of my vitality. I felt that having sex with him was inevitable and I became impatient with him talking and driving.

Dream 3: The Simon 'Driving' Dream (7 April 2007)

I am travelling in a car with Simon driving. I look at him and don't really recognise him, he has ginger hair, a thick beard and freckles and he is thin with a checked shirt tucked into his jeans – he smiles and talks in a Scottish accent. I was thinking that it just didn't look like the Simon I knew – I wondered if he had been ill and so had lost quite a bit of weight. I also didn't think Simon would ever wear a checked shirt and I knew he didn't have ginger hair – still I talked and laughed with him in the car, but it felt as if I didn't know him.

My initial association with the two dreams was one that came from the start of my analysis in London (1999-2002). In the initial interview I told my analyst of my tremendous struggles with my father – one of them was over who would drive the car – and I proudly announced that after I had my own car I never let my father drive if we travelled anywhere together. The analyst said to me that it sounded like I was telling him that I would not allow him to drive my car. I said of course I wouldn't! These were very early days in my analysis; in fact I had to give up the 'driving seat' and become dependent on my analyst. This exposed me to many anxieties and one of them was my sexual feelings towards men. It was also the point of the most profound change in my

analysis and one I am deeply grateful for as it felt as if a part of me that was always denied could be given life. It did change me – but I also lost an identity and with it a known way of being. It was terrifying at the time – and still anxiety provoking at times now.

Paul replied to the dream saying that it seemed I had been anxious about his health and wanted to give him something back. Simon also echoed this sentiment but said in an email to me that sex and love had not been fully explored in the analytic literature. He wrote, 'even analysts are more at home with the theoretical notions of love, which they talk of as sex, rather than the in your face bodily reality of everyday life. Sex with your analyst, or love for someone who seemingly cares for you?'

Simon's comments about love have helped me explore intersubjectivity and the concept of love that goes beyond 'doer and done to' (Benjamin, 2004). This theme I have developed further in the final section on reciprocity and recognition in therapeutic relationships. I was grateful to think further about the dream and I have considered that the dream may also speak of my desire for a conception that will result in a genuine product, not an 'adopted' one, speaking to my creative desire for a research project that is original; although a product of all that has been before, it is still an act of love (sex) that brings it into being.

The 'Simon dream' is more difficult to ponder; it seems to be a parody of Simon and I am bemused in the dream about how I should respond to him – I appear to be 'going along for the ride'. Simon's response to this dream was illuminating; he said the person I had described in the dream was like his twin brother who had died the previous year. When I said that I had heard that his brother had died (from a fellow student) but in fact I had never asked him about it, he apologised and said he thought he had told me. He said he had spoken a great deal about his brother's death and he felt people identified more with the pain of the person who survived a death than with the person who was facing death; he said he thought people felt it was wrong (taboo) to say so.

What Simon offered me was an authentic response to what had happened between the three of us. The dream about Paul was an attempt at oedipal triumph and excluded not only his wife (Rose) but also Simon (my other supervisor). In Simon writing to me about his loss and suggesting that the dream was about love, I began to think of the

vulnerability of love and how it exposed the 'lover' to the constant presence of loss. To love was to be vulnerable and to need, the very feelings that occupational therapy (and myself as occupational therapist and researcher) may be defending itself against.

> '…we are, none of us, able to do everything ourselves, we, all of us, need help. Being able to accept this and not feel oppressed by the idea that being helped is a sign of weakness is, I believe, the secret to true independence. As soon as this 'fact of life' is truly accepted we find ourselves valuing others, we move into a state of mind in which it is the concern for the object rather than our own survival which dominates. Of course none of us remain in this state of mind continually, we move between states of mind, but the discovery of the concern for the object will help us to return to that state because we always have a shadow of it within us.' (Stokoe, 2000, p.33)

This thesis, at its core, explores the nature of the relationship in OT by examining what occurs in the space between the client and the OT. This therapeutic engagement potentially provides a place for recognition and reciprocity that can form a bond of love between client and therapist. It may be that within the frame of time, activity and relationship losses can be acknowledged and new ways of being can emerge. It is a place where people learn to cope, heal and change.

Ogden (2004), in distinguishing between Winnicott's concept of holding and Bion's theory of containing-contained, draws our attention to the importance that Winnicott gave to time. I have been puzzling over the strangeness of time – a matter I return to in the section on the 'Curious Concept of an Occupation' in Chapter 2 – and how activities can be used to structure time. In some senses time is a concept full of subjectivity (what is a long or short time?), it is a social construction of reality (whose time is it?) and yet the ageing process of our body measures the finiteness of time, we all end in death.

The lines from Eliot's (1959) poem (below) remind us of the responsibility we carry to make use of time; it is, as he says, 'unredeemable' (p.13). Alongside Eliot's lines are ones from the poet Robert Graves, chosen by a young woman dying from cancer (see Jones, 1997) who discovered through her illness a profound love for her husband and children.

'Time past and time present
Are both perhaps in time future,
And time future contained in times past.
If all time is eternally present
All time is unredeemable'
Four Quartets: TS Eliot, 1959, p.13

In time all undertakings are made good,
All cruelties remedied
Each bond resealed more firmly than before -
Befriend us, Time, Love's gaunt executioner.
Robert Graves, in Jones, 1997, p.243

Chapter 2: A Psychoanalytic Discourse in Occupational Therapy

This chapter aims to describe some of the foundational concepts in object relations psychoanalysis and embed them in a thoughtful occupational therapy practice. After a brief introduction to the potential value of psychoanalytic theory in OT, the chapter covers three main areas in OT literature in some depth: the therapeutic use of self in OT; the concept of an occupation; and a reflection on possible social defences employed by OTs in their work with clients. I have frequently used the term 'us' to include myself as part of this professional group, although in truth I have felt neither inside nor outside, but on an edge, a borderland of belonging.

As stated earlier (footnote p.10) there is a convention in occupational therapy literature that I have chosen to contravene, which is the interchangeable use of the terms activity and occupation. I have no justification other than to say I think the client's personal meaning (both consciously felt and unconsciously driven) in relation to the doing or not-doing of something is more central to a discussion of what they do than the term we may use to define it. Occupations are essentially psycho-social activities.

The Heart of the Matter

> "It is only with the heart that one can see rightly; what is essential is invisible to the eye"
>
> *The Little Prince, de Saint-Exupery, 1974, p.70*

Psychoanalysis gives us an understanding of people and their relationships with themselves and others, as well as the occupations they invest time and interest in. This can offer occupational therapists an awareness of, and way of working with, clients that is rewarding and enriching. At the same time psychoanalysis can make us (client and therapist) more aware of our vulnerabilities and our ongoing struggle to be honest with ourselves and concerned for the wellbeing of others.

I have had an interest in and involvement with a psychoanalytic view of occupational therapy for so much of my professional life that I can no longer see clearly without

these conceptual lenses[13]. This frame of reference has influenced how I have engaged with clients, understood their choice of occupations, and helped me reflect on my relationships with colleagues and multidisciplinary team members within the context of care. It has been a concern to me that over the past 40 years a psychoanalytic discourse in occupational therapy has almost completely disappeared from our professional literature, except for a few voices (Collins, 2004; Daniel & Blair, 2002a, 2002b; Cole, 1998; Banks & Blair, 1997, 1997b; Creek, 1997b; Cunningham-Piergrossi & Gibertoni, 2005; Eklund, 2000) and it has been my wish to persuade occupational therapists to consider (or reconsider) what psychoanalysis can offer us in our endeavour to alleviate the suffering of our clients and support their sense of purpose in day to day life.

Psychoanalysis, rather being than an archaic language that refers to mankind's predetermined sexual drives and/or perversions, speaks to the heart of what it means to be human. Any serious study of the analytic theories and theorists will reassure occupational therapists that they are probably already somewhat aware (if not fully cognisant) of the emotional significance within the concepts, either inside the experience of their own lives or as they have come to understand the life world of their clients. Psychoanalysis is a language of understanding one's feelings through the process of thinking, a process that I have termed being concerned with 'matters of the heart'.

Craib, a sociologist and psychoanalyst, has written a very accessible text on psychoanalysis (2001), which I have drawn from heavily in this chapter, but it is his earlier book, 'The Importance of Disappointment' (1994) that so eloquently speaks to the heart of the matter. He wrote the book after he had been diagnosed with cancer, and so the book's introduction, as quoted below, is particularly poignant, as the reader can feel he is talking about himself, but within his words we recognise ourselves.

> 'I had never before allowed myself to recognise the fear of death that must be common to us all, and neither had I properly understood its implications: that life is immensely precious and the links we have with people, in all their dreadful complexity, are all that we have, and if there is such a thing as evil it lies in the deliberate breaking of those links … there is much about our modern world that increases disappointment and at the same time encourages us to hide from it: to act as if what is good in life does not entail the bad – for example, that we can love and be loved by another person without having to give up other aspects of our lives; that we can have children without sacrifice; that we can love without ambivalence

[13] The idea of theory (structure) being used as a lens through which to view the world – 'a pair of spectacles with a specially tinted filter' – comes from Hagedorn, 1992, p.14.

> and hatred; that we can take decisions about our lives without being bounded on all sides by the needs and actions of others; that we can grow without the pain and loss, and in the end we can grow without dying.' (Craib, 1994, p.vii)

It has seemed that in recent years occupational therapists have pursued professional credibility through their allegiance to models of practice espoused by modern (current) thinkers in occupational therapy or occupational science (Zemke & Clark, 1996; Christiansen & Baum, 1997; Wilcock, 2002; Duncan & Watson, 2004; Townsend & Polatajko, 2007; Wilding & Whiteford, 2007; Hammell, 2009) and what has been neglected is the early contribution of psychoanalysis to the profession. A psychoanalytic view of activity and the therapeutic relationship which was promoted in the early work of Fidler and Fidler (1963) has been subsumed by authors who maintain a view of the world that is wholly conscious, socially and/or culturally motivated and responsive to clear explanations and good intentions.

Perhaps the most profound loss in our current discourse has been an appreciation of the unconscious and the effect it can have on the actions and choices of individuals and within society. In the current climate of evidence-based practice and measurable outcomes that are reliant on positivist views of science and therapy, there has been a loss of wonder and delight in (appreciation of) the imaginative potential of the unconscious, with its capacity to repair, reconcile and recover. The unconscious carries within it, not only instinctual drives and their concomitant anxiety, but a capacity for connection, knowledge, wisdom and creativity (Milner, 1999; Segal, 1986; Banks & Blair, 1997; Fidler and Fidler 1963; Cunningham-Piergrossi & Gibertoni, 2005).

Psychoanalysis does not seek to explain events to or for people, but to offer them a way of understanding themselves and thereby others. The theory and therapy can offer, at its simplest level, holding and containment[14] for the individual client or group (see Ogden, 2004), but on a more profound level can bring about a resolution of conflicts and thereby a release from symptoms (or symbol) of constant suffering (Cardinal, 1993). However, understanding oneself, as anyone who has spent time in reflection knows, does not necessarily lead to measurable change, or an ongoing experience of happiness, but it can offer a sense of integration. Craib (2001, p.182) writes that psychoanalysis

[14] 'Holding' is a Winnicott term which refers to the mother (or therapist) keeping the baby's (or clients) needs foremost in their mind, a holding environment can refer to a mental space in the mothers mind that the baby 'occupies'. 'Containment' refers to the mother's (or therapists) capacity to take in projected material from the baby (or client) in order for the experience to be metabolised and put, at an appropriate time, into words.

does not offer a 'cure' – in fact he frequently advises patients that they may well feel worse long before they begin to feel better, and anyone who has put themselves through the agony of an analysis knows this all too well – but it does offer a capacity for thinking and thereby thoughtfulness that can sustain the self during times of emotional turmoil. A patient described the outcome of her psychotherapy:

> '… for the first time I can remember a feeling of solid confidence in myself to face life itself, still confusing but not so frightening any longer. The feeling of being able to be and exist and give of myself without feeling the threat of an infinite void, of falling off a very high roof, but rather of having myself, and contact with the world all around, continues.' (Brown and Peddar, 1991, p.201)

What distinguishes psychoanalysis from other forms of psychotherapy is the belief in the existence (and powerful influence) of the unconscious. Craib (2001) said that Freud's notion of the importance of unconscious in all our actions and interactions was as important and discomforting as Galileo's discovery that the earth was not the centre of the universe! His point is draw our attention to the very real possibility that we are not in control of all that we think, do and say, and that if we are to understand the nature of what it is to be human we must look beyond explanations that reinforce the view we are 'masters or mistresses of [ourselves]' (Craib, 2001, p.21).

I have never doubted the existence of the unconscious; in fact it was quite a relief when I realised during my first experience of an analysis, at the age of 23, that my dreams, thoughts and feelings were a language that I had not yet learnt to understand, but that were available to me as a guide to my internal life. Perhaps it is this investment in one's own internal life that is the most daunting and fulfilling in working within a psychoanalytic framework with clients. Bion (1991), an analyst who is considered a prodigious and original thinker, wrote in his autobiography that having recognised his most primitive self, capable of almost any heinous crime, he could better understand his clients and their struggles.

Craib (1994) writes about the contribution of psychoanalysis to everyday life and he offers the reader these words to ponder over:

> 'Integration is the acceptance of a process of being unintegrated, of depression, internal conflict and a normal failure to contain these within the boundaries of the personality. Perhaps another way of putting it is that integration involves a madness, a disorder, an internal division that for the most time remains within reason.' (Craib, 1994, p.176)

This recognition of emotional complexity may enable occupational therapists to lessen their hold on a wholly functional approach to work with clients and return to a thoughtfulness about their relationships with clients and the meaningfulness of activities. Occupation, i.e. what people chose to do with their time, could then be considered as a symbolic representation of a client's need for a connection with others and an opportunity for a method of reparation though action.

The 'Therapeutic Use of Self' in Occupational Therapy

> '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.' (Ormont, 1988, p.30)

Psychoanalysis uses the relationship established between the analyst and the patient as its primary method of therapy (Bateman & 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 the importance of the relationship between occupational therapist and patient to be **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' (ibid. 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 have seen that this pendulum has swung now 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 & Polatjko, 2007).

Client Centered 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 et al., 2001; Reberio, 2000; Sumsion & Smyth, 2000).

The relationship established between client and occupational therapist is seen as having the essential qualities that are part 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 term of client replaced that of patient, and 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 the patient established with the therapist, and that was not linked to the therapist's techniques, but to the quality of their interaction. This capacity of the therapist to be fully aware 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 centered' to 'person-centered 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 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 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 contertransference will be discussed more fully in the subsequent section, 'Concerns with Client Centred Practice'. My concern with an absolute adherence to a client centered 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.

> 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 first tell myself.'*

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 (Watson and Swartz, 2004, have written an account of this approach in South Africa). It was also 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 lives and experiences.

The Illness Narratives

In the book 'Introduction to Psychotherapy' (Brown and Peddar, 1991) the authors 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' (ibid. p.92) describes the capacity of the therapist to see beyond the patient's words to their layered meanings. Balint, 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 they shape what they bring to the consulting room: 'Patients learn the doctor's language' (Brown & 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 a cultural misunderstanding and/or an unspoken personal shame. The clinician was a sensitive OT, Theresa, who worked in the 1980s with 'burns' patients.

> Theresa 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 often heated with open fires or paraffin burners. This 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.
>
> Theresa noticed that when she asked the patients how the 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 stove or an attack 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 in doing this, the patients, often with some relief, could then tell her of how the fire had started and 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 so 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 not the time to give a full description of the man's life story or the density of the understanding 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 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' (Klienman, 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 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 (1996).

> 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 she [her mother] said she was very lonely. It was during these periods of 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, 2002) the author presents us with a fictional account of a young Indian boy who, following the sinking of an ocean liner, is left adrift on a lifeboat with a Bengal tiger for 227 days. This story, which carries the reader through a series of adventures between boy and tiger, suddenly, near the end, gives us an entirely different account of what occurred on the ocean. 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 easy to understand, certainly not one that includes murder, cannibalism and possible matricide.

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 we as therapists 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' (ibid. pg.7). 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 themself 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 verbalize 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' where he draws 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 counter-transference 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' (ibid. 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 patronizing or hurtful and therefore becomes silent.

Book (1988) uses a clinical example where a new registrar (doctor) encounters a paranoid patient who is enraged and shouting abuse at him.

> '[The registrar said] "I am glad to see you can get your anger out." The patient hesitated, looked perplexed, and then angrily roared, "You bastard! To be so happy that I am this upset!" When asked about his comment the resident [registrar] stated, "I was just trying to be empathetic".' (Book, 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 centered 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 has been this lack of understanding between 'client centered' 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 both as thinking '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 South African woman's magazine in 1993.

> **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 is being requested (by Julia) for 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 whom she had a brief affair with; they re-look 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 that 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 actually said – e.g. when my analyst said the story of my journey to see Everest[15] sounded like a 'breakdown' – can be deeply reassuring. Joseph (1983) said that as therapists we needed 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 was that it wasn't until I had been understood (his use of the word 'breakdown' made it real for me) that I could go on and try to understand myself.

On Not Liking a Patient

In recent occupational therapy literature there are no 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

[15] This is described in more detail in Chapter 1.

psychoanalytic discourse in occupational therapy, we have lost a language to describe, and thereby understand, our experiences of working with clients.

In a recent study I undertook[16] 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.

> '… 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, 2003a)

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, 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 (what Theodosius, 2008, terms 'reflexive emotion management' p.201) in 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

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

the need for the clinical therapist to use their 'feelings to inform practice' (ibid. p.237) but the loss of explicit teaching (and evaluation) of the interpersonal skills necessary for this deeper level of communication in OT (or 'Emotional Labour' as used by Theodosius, 2008 and Smith, 1992) is an area I return to in the final chapter.

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 can be possible is surely the core of all the helping professions. I sometimes wonder if it is our 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)

I have chosen to emphasise the importance of the relationship between the client and occupational therapist by placing the section on the therapeutic use of self before the next one, which looks at the symbolic use of activities and/or occupations that clients engage in. In reality they exist alongside each other, but as writing has something of a linear limitation, I have chosen to put the one before the other.

The Curious Concept of Occupation

> Many years ago a patient, in a drug detoxification unit, asked me, '*What **IS** an occupational therapist*?'
>
> Her tone was somewhat unfriendly, and I suspected that she already had an idea about my role, and so I somewhat playfully replied that it depended on what she thought an occupation was. She answered, '*I didn't ask you for a ******* lecture, I asked you what you **DID***.'

In some ways the client in the vignette above expressed the exasperation I think many of us feel in trying to explain what it is we 'do', and the ever recurring and increasingly elaborate definitions of occupational therapy attest to that reality, as described in Chapter 1. The question of what we do is more easily answered than the question of why we do what we do – both as human beings and as therapists using occupations as a therapeutic medium. Reilly (1962), in her much quoted article, talked about the 'complexity of illness' (p.88) and I have used this next section to look at the contribution psychoanalysis has made to understanding the concept of occupations, which at their simplest level of description, are the things that people do with their moment to moment in time.

Occupations are difficult to capture in their essence, because they are an empty category until the ideas of meaning, purpose and motivation are added to their understanding. On the surface, occupations can be descriptions that portray the external reality of 'doing' (for example fly-fishing, meditation or cooking maize meal), but without examining the inner processes that drive the person to do that thing there remains only a possibility of doing, what I have called an empty category, but one we (as a profession) are very curious about.

Many recent authors have included the dimensions of meaning and motivation in eloquent books (Hasselkus, 2002) and research papers (Christiansen, 1999) and a new branch of study has developed to examine the notion of occupation, that of 'Occupational Science' (Zemka & Clarke, 1996). Very few of these studies or papers carry the idea of the unconscious as contributing to the understanding of why people do what they do – and in the next section I will consider occupations as representing an unconscious defense against vulnerability, a way of coping with existential anxiety, and a means of expressing reparative desires and/or creative endeavours.

'Because it's There' or a Disavowal of Dependency

> 'How much of the appeal of mountaineering lies in its simplification of interpersonal relationships, its reduction of friendship to smooth interaction (like war), its substitution of an Other (the mountain, the challenge) for the relationship itself? Behind a mystique of adventure, toughness, footloose vagabondage – all much needed antidotes to our culture's built-in comfort and convenience – may lie a kind of adolescent refusal to take seriously ageing, the frailty of others, interpersonal responsibility, weakness of all kinds, the slow unspectacular course of life itself…' ('Moments of Doubt' David Roberts in Krakauer, 1997 p.145)

Since my own modest but personally harsh experience of walking in the Himalayas (in 1995) I have been fascinated by written accounts of mountain climbing by the mountaineers themselves (Bonington, 2001; Krakauer, 1997; Simpson, 1997a, 1997b,) and biographers who have given descriptions of the lives of climbers who have died in their endeavours to summit world's highest mountains, e.g. Rose and Douglas (2000) who wrote about Alison Hargreaves and her death after summitting K2. It was while doing this adventure reading that I came across the above quote and began to think about these physical endeavours as being a defence against the internal experience of human vulnerability (see Nicholls, 2008).

Object relations theory, which places the relationships we have with each other as the 'primary motivational drive' (Banks & Blair 1997, p.89), proposes that it is the very nature of this fundamental dependence and connection that we have with each other which causes us such inner conflict and turmoil (Ormont, 1988). Segal (1998), in her book an 'Introduction to the work of Melanie Klein', makes an important distinction in a person's capacity to acknowledge and manage their connection to (reliance on) others, and these are divided into two mechanisms: the manic defences which are organised against **any** experience of need (vulnerability) and guilt; and the desire for reparation – which can 'lead to further growth of the ego' (ibid. p.82).

The object relations theorists, (e.g. Klein, 1988; Winnicott, 1971; Bion 1984b) and the more recent inter-subjective theorists and therapists, (e.g. Ogden, 1994; Benjamin, 1990; Craib, 2001; Clarke et al., 2008) place the relationship with others as central to all that we are and do in life. Their understanding of our dependence on others as a necessary and problematical part of us has much merit in occupational therapy theory. Craib, (1994), in writing about the value of psychoanalysis, states: 'dependence is inevitable, and of course it is inevitable not simply when we are very young or very old: it is necessary, and is a fact throughout our lives, economically, politically, physically and psychologically' (ibid. p.187). There is much in our modern culture which denies this dependency (Hoggett, 2000) but on a deeper (psychic) level each person must struggle with their feelings of dependency on others and this can be expressed in their choice of occupations, e.g. using mountain climbing as an unconscious defence against (denial) of dependency.

If we are to explore the reasons why people do what they do (i.e. their choice of occupations) there is much to be gained by understanding the object relations school of thought in psychoanalysis. I will be using the concept of a 'reparative drive' in a later section as a possible explanation of creativity and change, but in reading the accounts of the mountaineers I was struck by their similarity to the description of a manic defence:

> 'The infant discovers his dependence on his mother, his sense of valuing her and, together with this dependence, he discovers his ambivalence and experiences his intense feelings of rage and fear of loss, mourning, pining and guilt in relation to his object, external and internal… It is against this whole experience that the manic defence organization is directed. Since the depressive position is linked with the experience of dependence on the object, manic defences will be directed against any feelings of dependence which will be obviated, denied or reversed.' (Segal, 1988, pg.83)

The idea of an occupation as representing unconscious needs and defences was evident in the work of Fidler and Fidler (1963) who drew our attention to the occupations chosen by the patient as potentially reinforcing 'their psychotic or neurotic defences' (ibid. p.74) and argued that we need to analyse their actions and choices in order to encourage different activities that could promote growth and maturity.

> 'An hypothesis exists that since action is the natural antidote for anxiety, any action or activity will relieve anxiety. It has been further hypothesized that the nature of the activity is far less important than the fact the patient is doing something. … Involvements in an activity can be either therapeutic or damaging to the patient, and therefore it is essential that we become more aware of and more carefully evaluate the psychodynamics of activities.' (Fidler & Fidler, 1963, p.72)

Many of the ideas Fidler and Fidler's original work show an understanding of psychoanalytic concepts and draw our attention to understanding the symbolic content of the choice of occupation. Unfortunately, the authors move from this interpretation of the need some patients may have for what are termed 'regressive' activities, to becoming highly prescriptive in recommending certain activities for these problems (e.g. doing clay work for someone with regressive tendencies). In this prescriptive approach to pathology lies the problem with their theory. They suggest that by choosing a different activity the person's inner turmoil will be alleviated and/or changed for the better. What they have ignored is that the original choice (by the client) of their occupation is a symbolic representation of inner and outward processes, and the change (or substitution) of the overt manifestation of this struggle will not change the impulse (drive) for the activity.

It may be easier to contemplate the 'madness' of high risk sports (like base jumping or 'free climbing'), but ordinary activities could also represent hidden needs or unresolved conflicts and /or grief. I recently went to see the Tom Kempinski (1980) play 'Duet for One', at a theatre in London[17]. The play is a fictional account of the psychotherapy session of a world renowned concert pianist, Stephanie, who is no longer able to perform her music as she has multiple sclerosis. In the feisty exchanges she has with her introverted and somewhat eccentric analyst it becomes easier to see that her cheery exterior of 'getting on with it' covers a deep and dangerous depression. But as the play unfolds, the audience realises that it is not the loss of her music which is tragic, but that her playing the violin had been in response to the early death of her beloved mother, and by no longer being able to play music, she was exposed to her unresolved grief. It is with this revelation that the therapy can truly begin, and the play ends.

What we do with our time may be a displacement activity, for example cleaning windows rather than sitting down and finishing a difficult piece of work (or writing). It can bring the pleasure of distraction, like watching a film after a busy day at work, and it can be a way of relaxing by pushing thoughts to one side. The doing of something (i.e. an activity) is not necessarily pathological, but it can represent hidden needs or fears, and when these remain unacknowledged, like Stephanie in the play/story above, doing that activity can become compulsive (like high risk sports, see Nicholls 2008), or when unexpectedly halted can expose the actor to their grief-without-end, i.e. melancholia.

The Tyranny of Time

In Mark Haddon's book 'The Curious Incident of Dog in the Night' (2003)[18], which he writes as if he is a 15-year-old boy (Christopher) who has Asperger's Syndrome (considered a mild form of autism), he gives a wonderful description of time.

> 'When I used to play with my train set I made a train timetable because I liked timetables. And I like timetables because I like to know when everything is going to happen.' (Haddon, 2003, p.192)
>
> 'Because time is not like space. And when you put something down somewhere, like a protractor or a biscuit, you can have a map in your head to tell you where

[17] This play was first performed in 1980 to great acclaim, and in this revival was beautifully acted by Juliet Stevenson and Henry Goodman in the Vaudeville Theatre, May-August 2009.
[18] Awarded the 2003 Whitbread Prize for Literature.

> you have left it, but even if you don't have a map it will still be there because a map is a representation of things that actually exist so you can find the protractor or the biscuit again. And a timetable is a map of time, except … time is only the relationship between the way different things change, like the earth going round the sun … and day and night and waking up and going to sleep…' (ibid. p.193)
>
> 'And this means that time is a mystery, and not even a thing, and no one has ever solved the puzzle of what time is, exactly. And so, if you get lost in time it is like being lost in desert, except that you can't see the desert because it is not a thing. And this is why I like timetables because they make sure you don't get lost in time.' (ibid. p.195).

Occupations are what we do with our time, and they provide a structure and sureness in the void of time, as the character of Christopher describes above in his hatred of unorganised time. But time also provides us with a conundrum: it is essentially empty and therefore potentially infinite, and yet we can measure time though our own body's growth and decay – a very finite experience of reality. The existential analysts (Frankl &Yalom in Hasselkus, 1997) use this very nature of time to comment on the existential anxiety that each person must face, the most fundamental being: if I am to die, if I am essentially alone (no other person like me) and if everything I do carries the ultimate responsibility of choice, then why am I here?

One of founders of the profession of occupational therapy, Meyer (1992, reprinted in 1977) wrote: 'Man learns to organize time and he does it in terms of doing things' (ibid. p.642). A person's capacity to use (organise) time is a core belief in the profession, such that each person's use of time is considered unique and carries a mixture personal meaning, cultural significance and social sanction. In an occupational therapy analysis a patient's inner world could be explored in trying to understand what they do with their time. Activity may be an expression of our connection to the world and provide us with our sense of personal integrity and belonging. Understanding what we do in the space and place of time is the heart of the profession's endeavour.

Much of the profession's recent discourse has been focused on the restrictions placed on individuals, groups or societies in participating in occupations (Townsend & Wilcock, 2004; Whiteford, 2005) and draws our attention to the social model of disability, which proposes that individuals are excluded from participation in many activities by society's attitude towards difference and/or disability. These issues are important and well argued by these authors, who call our attention to the need to take action on issues of 'occupational justice' (Whiteford, 1997).

The narrative accounts of individuals who have been imprisoned and held in solitary confinement for periods of time (Sachs, 1990; Keenan, 1992) demonstrate the value of activity as a way of establishing a sense of personhood though routines which occupy time. In the book 'Jail Diary of Albie Sachs' (Sachs, 1990) he describes his daily routine, which included polishing a plastic water jug (one of the few objects in his prison cell) with toilet paper.

> 'My need for activity is desperate, but there must be some element of usefulness in what I do. If the work is completely senseless, I feel even more demoralized at its completion than if I had done nothing at all. I put the jug on the floor near the door, and start to get my clothing ready for exercise time. The procedure is similar. Each item – the sandshoes, the shorts the vest – is dealt with separately and meticulously. From the tiniest bit of work, the sort of thing one does normally and casually and without thinking, I construct a methodical and conscious labour.' (Sachs, 1990, p.55)

The harrowing accounts of the effects of occupational deprivation have given therapists a renewed interest in issues of inclusion, choice and empowerment which have taken many therapists beyond their individual work with clients and into larger political and social arenas (Townsend & Wilcock, 2004; Townsend, 2003; Whiteford, 2004, 2005). Whilst I welcome this understanding of the wider realms of occupational engagement, I am concerned that the language of empowerment may neglect the shadow side of disability, dependency and care.

Hoggett, in a chapter titled 'The Hatred of Dependency' (2000) warns us that the pursuit of rights for individuals may blind us to understanding the inner conflicts that exist in each of us, and which are not mitigated or removed in the discourse of empowerment. He brings to our notice the tension between the 'commitment to individual liberty …[and]… an equally passionate commitment to an ethic of care' (ibid. p.174). The need, in some clients, for complete dependency, and their inability to embrace or consider change are part of our considerations of the 'ethics of care'. This capacity to care brings with it the responsibilities of concern for those individuals whose choice may be to hurt others or harm themselves – unconscious urges acknowledged in psychoanalytic work but frequently denied in the rhetoric of empowerment. Hoggett uses the following example to highlight his concern with the potential loss of an ethic of care in health services.

> 'People may wish to make choices that are harmful to themselves. Joan Riviere (1936) in a powerful description of suicide, reflects on the feelings of despair and worthlessness that accompany acute depression. She illustrates how some individuals become gripped by the idea that everything they touch turns bad, they

> are so convinced of the actuality of their own overwhelming destructiveness that they choose death in a desperate attempt to protect those that they love and care for from themselves. This is the most extreme example of self-harm, but at what point does passionate commitment to individual liberty give way to an equally passionate commitment to an ethic of care?' (Hoggett, 2000, p.174)

My concern with the recent trends in the discourse of empowerment is the potential neglect of the difficult and highly charged emotional field of care for the individual patient, whose occupational choices may be an indication of their inner distress, not a result of a lack of resources or society's disapproval. I have wondered if this loss of thinking (and feeling) about the possible experiences of fear, envy, humiliation or shame of being dependent is avoided by the stirring words of emancipation and achievement that are so prevalent in OT literature.

The choices an individual makes about how to use (spend) their time can provide us with a rich tapestry of potential meaning about their life and inner world. We may wonder, for example, why Ellen MacArthur wanted to sail round the world, or what helped Sir Ranulph Fiennes in his successful 2009 (third) attempt to summit Everest? OTs (Townsend and Wilcock, 2004) have acknowledged that 'choices' can be deeply affected by the limitations imposed by a society which ignores people with disabilities (e.g. physical access to schools or sports facilities for people who use wheelchairs). Society can also create a 'class system' in which certain people are denied social and economic access, e.g. the use of race classification in apartheid South Africa denied the majority of black South Africans a choice of where they could lived, schools they could attend, language they used and the jobs they could apply for. The social-political environment which affects occupational choices has been discussed in some excellent work by Kronenberg et al (2005), Townsend and Wilcock (2004). What is not discussed (or seemingly considered) in current OT literature is that activities (e.g. keeping busy) can also used be a defence against the difficulty of being alone with ones thoughts, in a place without a clear and purposeful structure, that of our unconscious minds.

Karpf (in Milner, 1999) wrote about the psychoanalyst and artist Marion Milner; saying that it wasn't until she delved into her inner mind, with all its contradictions of envy, 'murderous rage and fear of retribution' (ibid. p.iix) that she was able to contact her 'still small voice – an alive an intuitive part, which seemed to express her real, deep needs beneath the noisy clamoring of her will and social norms' (ibid. p.iix). This relinquishment of busyness was not easy and she became aware of 'her fear of

engulfment and annihilation. But the rewards were abundant' (ibid. pg.ix). The rewards of this delving may well be the capacity for creativity and reparation.

Occupations as Reparation, Reparation as Creative Expression

In October 2002 I was listening to the author Philip Pullman (1998) being interviewed on the BBC Radio 4 programme 'Desert Island Discs' (6 October 2002). I was intrigued by his answer to the interviewer Sue Lawley's question, *'Have you always wanted to be a writer?'* He replied, *'No, I wouldn't say that I have always wanted to* ***be*** *a writer, but I have always* ***wanted to write****.'*

It seemed to me that this was one of the indications of the creative process, that the person had a desire to enact a certain process that resulted in a substantial piece of work, such as a book, painting or political activity. Although I have been critical of occupations that may represent (for an individual) a defence against their feelings of dependence, occupations can also be a result of an emotional commitment to a relationship(s) and represent the value of relationships with others. Milner (1950) writes about the creative process in her seminal work 'On Not Being Able to Paint', and she describes having to let go of wholly conscious processes in order to find a wonder in the unknown. What she is referring to is the exploration of the unconscious as a source of creativity and pleasure.

Segal (1988), a Kleinian analyst, writes that one of the sources of creativity is the capacity of an individual to feel guilt and a sense of responsibility towards others. This is in part a result of the individual being able to enter 'the depressive position' (ibid. p.69), which is highlighted by their appreciation that their primary object (usually the mother) is both a source of pleasure and frustration. In other words, it is a whole object, and is the person (an object) whom the baby can both love and hate in equal measures. This realisation that the mother is both the object who feeds the baby (i.e. the good mother/breast) and the object that may frustrate the baby by not responding immediately to a cry for food or comfort (i.e. the experience of the bad mother/breast), puts the child in touch with its guilt at the bad feelings towards the (bad breast) mother and the possibility that it could have harmed her.

> ‘In the depressive position, anxieties spring from ambivalence, and the child’s main anxiety is that his own destructive impulses have destroyed or will destroy, the object that he loves and totally depends on.’ (Segal, 1988, p.69)

This description does not only belong to the child’s realisation that the person it loves and depends on is also the person who it is angry with or feels hateful towards; it can be seen in many adult relationships. Craib (1994) refers to this when he speaks about the ‘dreadful complexity’ (p.vi) of relationships that are often charged with ambivalence. A person, in accepting that they can love and hate the same ‘other’, also realises that they can potentially harm and may have hurt (damaged) their loved ‘other’. It is at this point that the desire for reparation is most strongly felt, and this can lead to actions which result in creative endeavours such as works of art or maybe in actions towards the restoration or promotion of social justice.

> ‘The reparative drives bring about a further step in integration. Love is brought more sharply into conflict with hate, and it is active in both controlling destructiveness and in repairing and restoring damage done. It is the wish and capacity for restoration of the good object, internal and external, that is the basis for the ego’s capacity to maintain love and relationships through conflicts and difficulties. It is also the basis for creative activities, which are rooted in the infant’s wish to restore and recreate his lost happiness, his lost internal objects and the harmony of his internal world.’ (Segal, 1988, p.92)

Craib (1994) uses the Kleinian concept of the depressive position and its concomitant defence of a reparative drive in a common sense way that speaks to the reader of everyday concerns. He writes about the difficulty people have in managing the ambivalence (the love and hate) they feel in any loving relationship, and how this ability to manage our feelings creates an inner morality ‘concerning our ability to maintain and re-establish good inner objects in the face of anxiety and rage … In practical terms, it seems to me to involve holding onto our ability to put the others’ interests before our own…’ (ibid. p.173).

My interests in occupations are related to the opportunity they present to us to be creative, and our desire to engage in them may come from this need to make reparation. Segal (1986) uses the examples of authors and artists to describe this process in her book on ‘Delusion and Artistic Creativity’. She says that the artist is ‘primarily concerned with their restoration of his objects’ (ibid. p.214) and that the creative process is both the creation of the object and the making amends for past ‘enormities’. She writes of the author Proust, who said:

> '…a book, like memory, is a "vast graveyard where on most of the tombstones one can no longer read the faded names." To him writing a book is bringing this lost world of loved objects back to life: "I had to recapture from the shade that which I had felt, to re-convert it into its psychic equivalent, but the way to do it, the only way I could see, what was it was but to create a work of art".' (Segal, 1986, p.214)

OTs may want to give more thought to the creative potential of the unconscious and perhaps encourage the use of symbolic activities in what people (e.g. clients) do. Collins (2001) wrote an article in the Journal of Occupational Science that encourages therapists to explore the 'edge' between the known and unknown. Although he does not call this edge the interface between the conscious and unconscious, he is critical of the way we have used consciousness to restrict our capacity to change.

> 'The whole question of human adaptation not only rests on whether one has the physical, psychological, spiritual, social, economic or practical resources and skills to meet change, but must also reflect the ways in which individuals can be creative or sufficiently empowered to consider a range of options for action … Human occupation is concerned with many facets of life and inevitably involves meeting edges, struggles, conflicts and disappointments.' (Collins, 2001, p.27)

His emphasis on the self and its capacity to explore the edge of its experiences of disappointment comes close to what Craib (1994) had articulated[19], but Collins (2001) lacks the depth and drama of the unconscious described Craib by (2001). Lawrence (2003b) writes about the 'positive aspects of the unconscious, which is the source of thinking and creativity' (ibid. p.621) and he describes it as the source of mankind's wisdom – we can only know it through its symbolic representations, one of which are our dreams. Collins (2004), in his recent article on 'Dreaming and Occupation', encourages therapists to listen to their clients' dreams as a way of anticipating and encouraging change, but he does not propose a fuller involvement in a psychoanalytic discourse within the profession. Perhaps if he had called his article 'Dreaming **as** an Occupation' he would have motivated a discussion about dreaming as an activity – and activities as a symbolic expression of the unconscious.

Collin's article (2004) does provide us with a window into other ways of seeing, and perhaps if we could look at our own dreams about our work as well as those of our clients, we would be embarking on a voyage of discovery that has been inhibited in the recent emphasis in occupational therapy on evidence-based practice and measurable outcomes.

[19] The full Craib quote was given earlier this chapter, pp.27-28 (1994, p.vii).

Pullman, in his children's book 'Northern Lights' (1998), introduces to the story a wondrous instrument, the alethiometer, which, when used correctly 'tells the truth' (ibid. p.127). Its purpose is to answer the questions of the reader and thereby provide guidance on the possible consequences of action. It is depicted as a circular object (like a compass) with a needle that moves in response to the focused thought or inner (unspoken) question of the reader. The needle rests momentarily on a certain pattern of symbols arranged around the perimeter of the face. To understand the meaning of the answer, the reader must allow themself to loosen their focus on the reality of the moment and see beneath the surface representation of the symbol to the possible underlying meaning. Each symbol carries many potential meanings (e.g. the sun may symbolise day, authority, truth, kingship etc.) and these meanings can only be understood in relation to the other identified symbols and the intention of the enquiry.

The complex process described in the book of reading the alethiometer may show a way of looking at the meaning of an activity (occupation) for our patients. It would start with the purpose of the question and the pointer, which moves from symbol to symbol, could identify potential meanings within the person's social, political cultural and unconscious life, and these meanings could only be understood in relation to each other.

The use of activities in our work with clients is a valued and distinguishing aspect of our work as occupational therapists. Understanding the possible meaning of an activity for someone can deepen the relationship we establish with a patient as well as provide us with a therapeutic agent of change. Fidler and Fidler (1978) wrote: '… when an activity relates both realistically and symbolically to an individual's needs and personal characteristics it is an agent for learning and growth' (p.306).

Occupational Therapy on the Couch

This last section is an attempt to consolidate some of my thoughts on occupational therapy with respect to the work of the psychoanalytically orientated organisational consultants who have examined the culture of institutions and/or professional groups in order to understand the influences that impact on these groups' endeavors. Their interest has been in how institutions both conceive of their tasks and manage their workloads by considering the conscious and unconscious mechanisms that can impact on the

individual worker and context of care. The book 'The unconscious @ work' (Obholzer & Roberts, 1994) described the psychoanalytic theory behind this way of thinking, and its predecessors (Menzies Lyth, 1988; Miller, 1993; Trist & Murray, 1990) helped me understand why some institutions, which had been created to provide care and rehabilitation for vulnerable individuals, often seemed to do quite the opposite.

> In 1993 a friend of mine was involved in a serious car accident and sustained an incomplete lesion to his (C5) cerebral vertebrae, leaving him paralysed from his shoulder girdle down to his feet. I visited him several times in the specialist spinal rehabilitation hospital and was concerned to observe several aspects of uncaring towards the patients whose mobility was severely restricted through their spinal injuries.
>
> The hospital, built in a series of single story wards, was sprawled over a large area and linked by a series of concrete pathways. These paths showed signs of neglect, many of the grass verges had grown over or through the concrete, making the intricate webs of paths impassible to any person using a wheelchair. This forced patients onto the narrow roads, whose one way traffic system left clients vulnerable to hospital and public transport.
>
> A hospital whose aim was the rehabilitation of patients with spinal cord injuries was at the same time providing significant obstacles to this stated aim. There may have been many conscious reasons (e.g. budget constraints) as to why the grass hadn't been cut but I wondered if the neglect of the environment communicated something an institution that unconsciously denied the full extent of the disability in their clients. It was as if the institution itself had become paralysed and unable to respond to the needs of its clients.

The notion of an organisational culture that is partially created and influenced by unconscious anxieties evoked by the nature of the work was highlighted in the study Menzies Lyth (1988) undertook with nursing staff in her seminal work 'Containing Anxiety in Institutions'. She said that the culture of an institution, which can inform the policy and procedures of that institution and influence its primary task, may be established as a defence against the primitive unconscious anxieties that arise from the workers' direct contact with clients. Occupational therapists may be employing a similar mechanism of a social/professional defence against the intimate contact with clients who are, by virtue of a trauma, illness or hereditary disorder, temporarily or permanently dependent on heath care and often viewed by society as 'disabled'.

A Significant Dream

I have been an occupational therapist since 1979. I began my training after my last year at school and have not done any other professional work. Most of my endeavours with clients have had a focus on activities that would encourage and/or return them to health.

I held a strong belief in the efficacy of 'doing' as a way of restoring wellbeing, and in many respects it echoed my personal life which involved many outdoor activities and social engagements.

In 1996, following a sabbatical in the UK where I was introduced to the work of Menzies Lyth (1988) through a course I had undertaken at the IGA[20], I had the following dream. It unsettled me greatly because it questioned the assumptions I had made about my professional role and identity. Although the dream indicated that I needed to pay attention to my own psychic soul, it was its reference to my professional work that made me think differently about the professional discourse of occupational therapy.

> *Dream 4: An Amputated Life (October 1997)*
>
> *I had a deep wound on my lower leg, and I went to a doctor to ask for his help. He said that the wound was serious and that I would have to have my leg amputated. I said that if that were the case, I would do it myself. I went home and planned to cut off my own leg with my grandfather's sword* [a family heirloom]. *However, I didn't have the courage to do it and so I returned to the doctor and asked if there couldn't be any other way of saving my leg. He asked a female colleague to see me, and after her consultation she said that it was good news, my leg did not have to be cut off, but that it would take a long time to heal. While I was relieved at the news, I felt guilty because I thought that I was an occupational therapist and although I had encouraged people who had undergone an amputation to walk again with am artificial limb, I did not want one.*

The dream put me in touch with my terror of loss, my shame at not being able to help myself (even if that meant cutting off my own leg) and my realisation (on waking) that I had kept up a form of pretense of my being 'independent'. I wondered if I had tried to do the same with my patients, where I had (unconsciously) ignored their fear and shame? Since that time I have been aware of the optimistic discourse used by occupational therapists when working with or writing about clients. It has seemed to me that the pain of illness and the reality of social exclusion for those who have profound disabilities was denied by a professional group who saw it as their job to encourage, equip or enable clients to engage again in their lives. In a research project (Nicholls 2003b) I suggested that this positive view was paramount to a dismissal of clients' real experience and the profession's need to maintain a comfortable distance from the very personal pain that clients bring into treatment situations.

[20] 'Work Group Seminars' Institute of Group Analysis, 1 Dalham Gardens, London, UK.

> ‘In the mid-1990s there was series of jokes told which began: “How many xxxx’s does it take to change a light bulb?” This recipe was applied to occupational therapists, and so the joke became: “How many OTs does it take to change a light bulb?” The answer was: “Only one, but they don’t change the light bulb, but teach you how to cope in the dark.” In this simple joke lies the inherent discomfiture in a ‘coping’ response to the world of darkness, some people may not want to ‘cope’ with the dark because it may require of them to deny that there is any dark at all.’ (Nicholls, 2003b)

The Culture of an Institution

Menzies Lyth (1988) undertook a study at a large teaching hospital to examine the problem, at that time, of student nurse training and retention. Her seminal work used a psychoanalytic perspective on the work situation. She described nurses’ work as having to confront situations that are extraordinary and distressing and may also resemble early unconscious anxiety.

> ‘Nurses face the reality of suffering and death as few lay people do. Their work involves carrying out tasks which by ordinary standards are distasteful, disgusting and frightening. Intimate physical contact with patients arouses libidinal and erotic wishes that may be difficult to control. The work arouses strong feelings: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse those feelings; envy of the care they receive’ (Menzies Lyth, 1990, p.440).

In order for nurses to undertake these tasks on behalf of patients and their relatives Menzies Lyth suggested that they needed to develop a professional repertoire of practices and procedures designed to protect them from excessive personal anxiety and enable them to undertake their caring role. However, the observations that Menzies Lyth made attested to the fact many of these procedures did not serve that function and seemed to add additional and excessive anxiety into the nursing situation. It was with these observations that Menzies Lyth drew our attention to the unconscious aspect of work and the role of institutional culture.

Menzies Lyth (1990) drew the parallel between the nursing tasks and ‘the phantasy[21] situation that exists in every individual at the deepest and most primitive level of the mind’ (p.440). She said that because the objective features of the actual task so closely represented the symbolic phantasy of destruction and decay in the person’s inner world the nurse was both exposed to excessive anxiety and unable to master it. It was the symbolic equation of the real events with the imagined ones that threatened the nurses’

[21] The use of ph in the word fantasy was chose by Menzies Lyth to make the point that this ‘phantasy’ was part of the unconscious life of a person and not a consciously chosen, and controlled, fantasy.

psychic world most profoundly. It was against this threat of overwhelming anxiety that nurses constructed a social/professional defence, and this defence became encoded into the culture and task performance of nursing, influencing how and where work was done.

> 'the culture, structure and mode of functioning are determined by the psychological needs of the members … A social defense system develops over time through collusive interaction and agreement, often unconscious, between members of the organization as to what form it will take. The socially structured defense mechanisms then tend to become an aspect of external reality with which new and old members of the institution must come to terms.' (Menzies Lyth, 1990, p.443).

The socially constructed defence which operated in professional groups or work situations was an unconscious mechanism, and could be seen to be operating only by examining work procedures and processes and questioning their underlying assumptions. In doing this Menzies Lyth was able to analyse the procedures undertaken in the hospital both as defending the nurses from anxiety and preventing them from progressing beyond it. She identified various practices that in theory were espoused as poor nursing care, but in practice were commonplace, e.g. splitting the nurse from patient, objectifying patients into conditions and ritualising the performance of tasks to avoid the feeling of emotional responsibility for the clients.

Menzies Lyth placed the relationship between client and health worker with its concomitant unconscious anxiety as the primary influence on professional and institutional culture. Although Menzies Lyth's study (undertaken in the 1960s) has been used to alert nurses to the ways in which their work can be subverted through the lack of attention to the relationship with the clients and its concomitant anxiety, authors such as Fabricius (1991, 1995, 1999) - who have followed the thinking of Menzies Lyth, do not think much has changed in the nursing culture.

Fabricius (1991) said although there have been significant changes in the professional status of nurses, they are still exposed to the raw emotion of clients' projections in the close daily encounters that are part of their caring work. She said that it is 'the sheer quantity, as well as force, of the projections that are thrust on them that are too much for any ordinary human…' (ibid. p.103) and make it impossible for the nurses to work through the emotional impact of their work. Because of this 'sheer quantity' she maintains that nurses continue to employ a socially structured (professional) defence mechanism that curtails contact with patients and denies the emotional impact of the work that Menzies Lyth had originally identified.

Fabricius (1999), in a later paper, wondered if the 'low self esteem' (p.203) in nursing was caused by its own members and not the political or social pressures from outside the profession. She said nurses devalued themselves and thereby each other. She linked this with the devaluing of the original nursing role, that of a mother suckling her baby. She encouraged nurses to resume their psychological care of patients as the real task of nursing and not overvalue the technical skill and academic knowledge that nurses seemed to be pursuing for internal validation and professional recognition. Her suggestion was that nurses had chosen to perform a certain kind of work, perhaps for deeply held beliefs and/or unconscious needs for reparation, and they should be supported in their endeavors by structures that allowed for their fulfillment of this need.

Some of the difficulties in describing nurses as needing (unconsciously) to care for others, can place an emphasis on a gendered identity (i.e. women) as being 'naturally' caring and therefore gaining an emotional reward for doing the emotional work. (This was discussed earlier, see pages 7-9). I have not wanted to ignore (or deny) the political and social history of gender relations in care work and their relevance in understanding the potential exploitation of women in these roles. It has been my belief that the consideration of the internal (unconscious) motivation to become a nurse, OT or mountain climber is as relevant to the exploration of a lived professional identity as are the social forces which play a part in emotion management (Hochschild, 1983) and structures of care (Etzioni et al, 1969). As Theodosius states;

> 'Although emotion is communicative, it is not always understandable because it is not always linked to processes of cognition…partly because emotion can be unconsciously experienced and partly because individuals are not always cognizant of their emotions (Craib, 1995, 2001). …Emotion therefore can be unmanageable and may be the impetus behind irrational acts or patterns of behavior an individual might consciously wish they could overcome.' (Theodosius, 2008, p.203)

In this study I have, perhaps, emphasized the less conscious (i.e. internal symbolic) aspects of relationships (e.g. between therapist and clients or between researcher and participant) more than the external social political forces which have shaped these interactions. This emphasis has been explored more fully in Chapters 5 and 6.

As mentioned in Chapter 1, occupational therapy as a professional group has not had the same psychoanalytic scrutiny that the professions of nursing, medicine and social work have undergone in recent literature (e.g. Obholzer & Roberts, 1994; Foster & Roberts, 1998; Smith & Lorentzon, 2005). If we were to examine the culture of our profession and its assumptions about health, the value of independence and activity, would we discover that there are unconscious anxieties that affect our relationships with patients, and that we may have used activities as a defence against these anxieties?

Finlay (1998a), who wrote about the value of reflexivity in the research she did into the life worlds of occupational therapists, looks at her 'unconscious responses' (ibid. p.453) to the clients she observed and the transference and countertransference she experienced with the occupational therapists she interviewed. She described how, when observing a therapist treat a patient who was dying of lung cancer, she 'could not stop herself from getting involved' (ibid. p.454). She reflected on her difficulty in maintaining an observer role and linked it to the therapist's need to 'do things' for the patient.

> 'When I reflected on my behavior, I understood that it was due to my active need to be involved, to do something. I also recognized my own sensitivity as an asthmatic, witnessing someone with breathing problems dying of lung disease. Once I recognized this, I could then see that the occupational therapist was experiencing similar identifications with some of her other patients. Previously I had interpreted the therapist as being involved with fairly superficial, irrelevant tasks. Now I could see that these tasks had a meaning for her – they were as much for her as for the patient.' (Finlay, 1998a, p.454)

Understanding the value and meaning of occupation and incorporating its use in treatment is one of the core tenets of the profession; it is, after all, in our professional title. Activities (in all their forms and complexity) have been used with clients to achieve aims as diverse as increasing muscle strength, building self-esteem or learning to cope with a diminishing memory. Some of the activities used with clients have been criticised as being reductionist and lacking in personal and cultural relevance, e.g. the wire twisting machine that may have increased the range of shoulder movement for the client, but had little personal meaning in their life (Nicholls,1992). The changes in how and which activities are used in therapy have been in part of the evolution of the profession (Serrett, 1985; Mattingly, 1998; Creek, 1997b) and there is more sensitivity towards using activities that may have personal meaning for the client, but the concern in my dream remained. Were we, by using games and activities, teaching patients to

cope through a denial of their feelings, and with our emphasis on being busy do we get away from time to think and reflect on their experiences which may offer them an opportunity (time) to heal?

Roberts (1994a), in writing about a consultation she did for an organisation, suggested that occupational therapists employed a socially structured defence in their work with older adults in a long-term care institution. She used a term that was initially coined by Miller and Gwynne (cited in Roberts, 1994) called the 'horticultural model of care'. This, she said, meant that occupational therapists believed that **all** patients wanted to 'grow', do more and become independent of the care that was part of the residential institution. She said that there was 'excessive praise for minor achievements' and an accompanying 'denial of disabilities' (ibid. p.80) and that in the end the patients were sure to disappoint the therapists as they could not maintain this level of independence: 'A good inmate here is one happy, fulfilled, active and independent. Eventually, of course nearly all of them fail' (ibid. p.80).

Another example of the denial of disability was given by Obholzer, 1994, where the teachers and physiotherapists at a school for profoundly disabled children would encourage the children's ambitions to be train drivers or bus conductors (ibid. p.88). Although occupational therapists were not directly mentioned as promoting the view the children held of their employment aspirations, I think it stands as an example of the defence system that therapists employ to protect themselves from the full force of the anguish of a profound disability. There was a temptation to deny the painful reality of a social exclusion that would face these children when they left the safe confines of a school that was specially adapted for their needs.

Occupational therapists have seen their work as synonymous with promoting 'independence' (Reilly, 1962; Mayers, 2000). Alongside this belief in the individual's desire for self-efficacy and independence is the clear distinction between the professional role and the client's experience. In my earlier study (Nicholls, 2003a) and in recent literature, therapists did not see themselves, as requiring the help they so readily offered to their patients. This denial of the need for dependency in others (clients) or oneself could be a symptom of the profession's unconscious defence against vulnerability and thereby affect its professional role in health care. Hoggett (2000)

draws our attention to the 'hatred of dependency' that has been reinforced in modern cultural assumptions about interdependence.

> 'Vulnerability and dependence are not just things which are imminent, i.e. potentially waiting round the corner for us. These things are also immanent, i.e. dwelling within each of us. Inside each of us there is a small child which is open to wonder and yet so easily hurt. Inside each of us there is a drifter and nomad, a failure, a non-survivor and all the persons that the passive internal voice can assume. A good society would be one which could provide a place for such selves to be, without always seeking to empower them or thrust cures upon them. Sometimes people just want to rest and be taken care of, sometimes people just want to drift along without having to think too much.'(Hoggett, 2000, p.169)

In my dream I decided to cut off my own leg, not because I was strong and brave but because I was mortified at needing the help from another. When (in the dream) I realized I didn't have to live an adapted life (with an artificial leg) I was ashamed that I had expected so many of my clients to enact that very denial of a wound that may require time to heal.

In the earlier section, 'The Curious Concept of Occupation', I discussed the Kleinian theory of the unconscious mechanisms that are employed by individuals to cope with the realisation of their dependence on, and thereby the possibility of their damaging, others. These defences fall under two headings: the manic defence and the reparative defence. I have wondered if the 'doing' part of occupational therapy was at times a manic defence, as if the client should not (and thereby doesn't) experience the painfulness of loss and social exclusion. Many of our clients do not have sudden remissions, or a return to a 'healthy functioning', and there is no possibility of work, social networks or leisure pursuits that occupational therapists so enthusiastically seem to promote. Reparative defences, which acknowledge the responsibility that we have for our actions, allow the individual to mature, but it is a 'slow process and it takes a long time for the ego to acquire sufficient strength to feel confident in its reparative capacities' (Segal, 1988, p.82). The following example comes from an OT conference I attended in the UK.

> At a 2003 conference for occupational therapists a keynote speaker, an OT, spoke of her psychotic illness and showed a film taken of her during her illness. It showed her doing art work and narrated the experience of her 'voices', what they said to her and how it affected her difficulty in trusting the help she was given. When there was an opportunity for questions I asked what had helped her heal and what had helped her to cope. She replied that the skills groups (mainly run by occupational therapists) helped her cope again, but she thought her healing had been in the periods she had in art therapy, where she could express her madness.

I wonder if we have lost too many of the original ideas that Fidler and Fidler (1963) used when they described the use of creative activities with clients, which they said could enhance the client's communication process. Banks and Blair (1997), in writing about the use of activities in a group with older clients, say that activities such as art and music, 'provide an alternative to verbal means of expression of the unconscious through the process of the activity through to the end product' (ibid. p.89). Perhaps in neglecting the importance of the unconscious, we have lost a range and depth of creative activities that may allow clients to express and experience themselves in a way that allows for insight, emotional expression and healing. These aspects of work within the creative process that can promote healing are essentially reparative activities, stemming from the unconscious need to make sense of the world and express the self.

Ubuntu: A Person is Only a Person Through Other People

I want to return to the conclusion I came to in my study (Nicholls, 2003a) of the professional identity of occupational therapists who worked in multidisciplinary teams. The occupational therapists interviewed certainly had the capacity and eloquence to give a coherent account of their work with clients and of their professional role. The overtly optimistic emphasis they gave to their work may have been in response to the research inquiry process, or an indication of a more latent defence against the years of the profession's lowly position in the hierarchy of health care (Etzioni et al, 1969, Serett, 1985, Griffin, 2001). However, the 'imperative call' for therapists to maintain this optimism and positive attitude may have prevented a deeper exploration and thereby understanding of a valued professional group.

> Perhaps what the profession needs are more opportunities to articulate their understanding of their work with clients. But it may not only be opportunity that occupational therapists require, but other words (and meanings) in their language. The dispossession of psychoanalytic thinking in the profession has been a particularly painful loss for the researcher. The analytic discourses give a richness of description and understanding to people's life pain and dramas that seems to have been lost in the language of clearly stated goals and outcomes that have been part of the occupational therapy literature today. (Nicholls, 2003a)

Psychoanalysis, with its theory of the unconscious, libidinal drives and the importance of object relationships, gives us a powerful and varied language to express and explore the nature of what it is to be human. It allows for contradiction and uncertainty and thereby for new knowledge to emerge. Perhaps what may encourage occupational

therapists to (re-)engage in a psychoanalytic discourse in their work as therapists would be the discovery for themselves of this way of working through the use of a reflexive clinical reasoning (i.e. an examination of their unconscious responses to patients) within a 'containing' supervisory relationship as suggested by Daniel and Blair (2002a, 2002b) and in the work (related to the emotional labour of nurses) that Smith (1992) and Theodosius (2008) have undertaken.

The language of psychoanalysis can also provide us a way of understanding ourselves, the relationships we establish and the society in which we live. In 2004 I was listening to Archbishop Desmond Tutu (on Radio 4, BBC) discuss the importance of the Truth and Reconciliation Commission in healing the psychic wounds of South Africa. He was asked for his opinion on the war in Iraq and on the Palestinian Israeli conflict. His strong anti-war views may not be easily appreciated in times of conflict, but he used the African word 'Ubuntu', which means that a person is only a person through his relationship with other people, to describe the responsibility he felt we all carried towards each other. It was following this radio discussion that I came across the following section in Craib's (1994) book on the 'Importance of Disappointment' and understood it again and for the first time.

> '… the straightforward rejection of the insights of psychotherapy does not help, because it denies one of the few areas where a separation from the system can be achieved: the complex internality of the individual, comprehension of which can enable him or her to take a critical and analytic distance from what is happening, and enable the formation of relationships based less on the illusion of common identity than on the reality of individual separation, difference and dependence. But this achievement means recognition of the real internal pain of fragmentation, of internal conflicts and of our manifold limitations. This, perhaps, is the most important message of psychoanalysis.' (Craib,1994, p.189)

What I think he is saying is that psychoanalysis gives us an opportunity to think about ourselves, our capacity to feel concern for others and a critical ability to see through rhetoric and cultural assumptions about what is right or good for oneself or others. It is this ability to think about our feelings and experiences that emancipates us and allows us to love the 'other' as a separate and important part of our lives.

Chapter 3: Methodological Mapping of the Research: Route and View Points

> 'A point of view is inevitable; and the naive attempt to avoid it can only lead to a self-deception, and to the uncritical application of an unconscious point of view.' (Popper, 1966, p.261)

This chapter gives an account of the four-year psychoanalytically informed ethnographic research project 'Putting it into words'. The research was aimed at exploring the conscious and unconscious relational dynamics in two acute inpatient occupational therapy services and followed the method initially described by the Menzies Lyth's (1988) study of nurses: observation, individual interview and group discussion. The project, from its inception to completion, has been much longer than four years and this section describes the actual methods of the data gathering, theoretical considerations of the methods chosen and processes used in the analysis of the information collected[22].

The chapter is divided into two sections that, simply put, could be described as the 'what' and the 'why' of the research. The first part is an outline of the practical processes that were used to gain entry into the clinical areas, methods used to gather material about and from participants, and a description of the reflexive cycle used in the analysis of the data. The second part covers a discussion of the theoretical underpinnings of these methods, i.e. the use of interpretation in the free association narrative interviews (FANI) (Hollway and Jefferson, 2000), the use of dreams to enhance reflexivity and the ethical considerations of representation in ethnographic studies which use psycho-social methods.

Clarke (2006), in writing about the use of psychoanalysis in sociology, described so elegantly what I have learnt in the process of this study: that we are all products of our psycho-social worlds and they influence what we see and do in our lives and in our research. Any attempt to separate (or hide) them renders the research empty of an authenticity and personal meaning for the participants, the researcher and the readers.

[22]Pseudonyms for the staff (participants), patients, departments and hospitals have been used throughout this thesis. The London General Hospital is referred to as LGH and the Cape Town General Hospital is referred as CTGH.

> There is something quite distinct about a psycho-social approach to social research; it is an attitude, a position towards the subject of study rather than one methodology… These may entail the analysis of group dynamics, observation, or a detailed reading of the co-construction of the research environment between participants (we are all participants) and researchers … the most important element of psycho-social research is that it does not reduce social or psychic; there is no duality, the two are so related they are inseparable, or at least we cannot talk about one without the other. (Clarke, 2008, p.113)

Timelines: Practical Implementation

The research was initially planned for only one site (an OT department in a London based hospital), but this changed when I was offered a post at a university in Cape Town. I began to consider doing the same study in two areas, both OT departments in large general hospitals, but in different countries. This move from one to two sites for the project was a serendipitous event, as it foregrounded the role of the social (i.e. context) in psycho-social research methods. If I had only done the UK part of the study, I would have concluded that the relational work OTs did with clients was a result of their conscious and unconscious **personal** needs. These were related to their need for recognition, identification and/or a wish to repair or reconcile a relationship from their past (i.e. reparation). A description and analysis of these themes is more fully explored and described in Chapter 4. By undertaking the same study in South Africa, I was forcibly struck by the equal importance of the social-cultural background of each of the participants and how this influenced their conscious and unconscious relational work with clients and each other. It also brought into view my own social-cultural background of white colonialism, and these dynamics are described and explored in Chapter 5.

Many of the practical aspects of the study were similar in both places; for example, it took a full year from my first meeting with the managers of a potential 'site' to starting the data collection. Much of this time was taken with gaining permission from the various authorities, e.g. the NHS COREC[23], Research and Development (R&D) and ethics committee in each hospital. The documents related to gaining permission for this project, the R&D application for London General Hospital (LGH), information for potential participants (PIS-1) and clients (PIS-2) are at Appendix 1, 2 and 3. Although

[23] COREC Central Office for Research Ethics Committee. This office was incorporated into NRES (National Research Ethics Service) in April 2007.

this section attempts a clear (i.e. linear) description of the process undertaken in the research using time (i.e. days and dates) as a guide, I have also added some of the dreams which occurred during this time that indicate a strong undertow which was taking place in my thinking. This internal change influenced the choice I made to use two sites for the project and it affected the way I explored and interpreted the material from the London and Cape Town areas of fieldwork.

> '… the researcher is a central figure who influences the collection, selection, and interpretation of data. Our behaviour will always affect participants' responses, thereby influencing the direction of findings. Meanings are seen to be negotiated between researcher and researched within a particular social context so that another researcher in a different relationship will unfold a different story. …As part of laying claim to the integrity and trustworthiness of qualitative research, it is vital for researchers to find ways to analyze how subjective and intersubjective elements influence their research. Reflexivity offers one such tool. Here, the researcher engages in an explicit, self-aware meta-analysis of the research process. Through the use of reflexivity, subjectivity in research can be transformed from a problem to an opportunity.' (Finlay, 2002, p.531)

I found that during the years of doing the research project I was changing, and doing the research changed me.

Excess Baggage

I began the data collection part of the study feeling rather confident (arrogant may be a better word) that I already knew, more or less, what I would find. I had completed my 'literature search[24]', had already begun to think about the defences that OTs employ in their work – after all, I was one of them! I had been able to analyse my own use of occupations as a possible means of deflecting my anxiety or, at times, as a way of avoiding intimacy. What I hadn't realised was this 'knowing' made me appear rather arrogant (to the participants) and was in itself a defence against knowing. Learning can only occur through allowing oneself to have experiences, and that means letting go of what one thinks one knows (Palmer, 1999; Lawrence, 2003a).

The following dream occurred in response to completing the cumbersome NHS COREC research approval forms. It indicates the changes which began to take place in me during the five-year research process. These events (dreams and reflections) were deeply unsettling for me as I questioned my authenticity as a researcher (i.e. my role in doing the research) and as a person (a citizen with a particular social-cultural history).

[24] This literature search is reflected in Chapter 2.

The dreams did help me think about what I was doing, feeling and thinking (i.e. experiencing) in the project and this aspect of using dreams to enhance reflexivity in research is more fully discussed later in this chapter.

> *Dream 5: On Becoming a Citizen (20 Feb 2004)*
>
> *I am about to give a presentation to a large group of people in a tiered lecture theatre. Many of my colleagues from the University* [my UK work place] *are there, I recognise LW and AW. The purpose of the presentation is to become a UK citizen – i.e. you are allowed to become a citizen if you pass the presentation.*
>
> *As I look through the form (that looks very much like the R&D form that I have had to complete for my research) I realise there is a section I have not yet completed. It is too late to complete it and I realise I will have to speak about the question without preparation.*
>
> *The section asks about my thoughts and conclusions from my most recent clinical work. I talk about my work with drug addicts and I say that when I began working with them I thought that drug taking was a matter of individual choice, but now I consider that society and its marginalisation of certain groups plays a role in why people take drugs. I said that my understanding of the social in the psyche had shifted from when I first started working on the ward.*
>
> *As I was talking I realised how much I had changed. I wondered if I thought I had to say those things in order to gain admission to the UK or if I really did believe what I had said. Had I just come to say what I thought was expected of me?*

When I began the research I was a South African (SA) citizen living in the United Kingdom (UK) and working at a London University. During the seven-year process of the research I became a British citizen, moved to SA to work and live (engaging in the second part of the research project), and I have now returned to work and live in London. This movement between countries, and living again in South Africa for a three-year period, has provided a rich tapestry of contextual events which have shaped and informed the study. Some of these events were consciously chosen and others became opportunities (or accidents) along the way. During this time of change the research project became the one constant feature of my life and the decision to return to the UK was difficult and painful because I was finally saying farewell to my African home.

It had always been my intention to return to South Africa, and when I was offered a post at a university in Cape Town I took the opportunity to develop the ethnographic study I had begun in London to include a second 'matched' department in South Africa. I hadn't realised how significant this would be in helping me see how our personal and cultural background influences the way in which we perceive the world and that this perceiving then creates the world we find ourselves in. Moving between cultures helped

me see them more clearly, Stratton (1998) had said that culture is to us what water is to fish (p.157), and in both the UK and SA I did often feel like a 'fish out of water'. What was unexpected and very painful for me was to feel that I didn't fit in when I returned to SA; the country had changed, but so had I (this is described more fully in Chapters 5 and 6).

The project took place in two occupational therapy departments that were part of large general medical hospitals; one in London, UK (London General Hospital – LGH) and one in Cape Town, South Africa (Cape Town General Hospital – CTGH). The data collection was undertaken in the UK first, from Feb 2004 to August 2005, and the South African data collection took place from Feb 2006 to November 2007. The ethnographic study used the same three-step method of data collection: observations, interviews and inquiry groups. Each of these methods were underpinned by psychoanalytic approaches to gathering data: the observations were reflexive participant observations (Hinshelwood, 2002); the interviews used the FANI (Hollway & Jefferson, 2002) and the inquiry groups used Reason's (1988) co-operative inquiry groups as well as looking at transference material with the researcher and group members. These methods are more fully described and explored later in this chapter in 'Seeing ↔ Believing'.

The differences between the two departments were far less stark than I initially thought they would be: many aspects of the therapy work with clients were similar and the most notable difference was in my thinking and approach. This change becomes evident when reading the two subsequent chapters, 'The Privilege of Burden' (an analysis of the UK study) and 'Another Country' (the SA data). The UK study privileges the position of the therapist's early family life history in understanding their need to care for others, i.e. the personal is professional. The SA study integrates this need to care for others into the wider context of the therapist's life: their gender, age, racial group and socio-economic history, i.e. the political is professional.

Getting Started: Gaining Entry and Recruiting Participants

The process used to gain entry (i.e. research and ethics approval and the participants' acceptance of the project) into the organisation/department was similar in each country. In each setting the route included acceptance of the project (in principle) by the OT

manager and staff, application for R&D permission, a meeting (again) with staff to find volunteers and establish observation, interview and group timetables.

The fieldwork was divided into three discrete and separate periods; the participant observation, interviews (the FANI) and inquiry groups. Each period took approximately six weeks. Most of the individual staff who participated in the initial observation period went on to be interviewed and become members of the inquiry groups. In the final stage of the project (the inquiry groups) all staff who were members of the OT department were invited to participate, even if they had not been part of the observation or interviews

Information about the project, used for potential participants, was called a 'Participant Information Sheet' (PIS). There were two PIS documents: one for the primary participants, the OTs, (PIS-1 – see Appendix 2) and one for the clients whose treatment may have been observed (PIS-2 – see Appendix 3). These documents outlined the purpose of the research and gave an explanation of each process (e.g. interview or group). All participants who agreed to take part in the project were given a signed copy of their consent form.

The following table outlines the process used.

	London, UK study 2004-2005		**Cape Town, SA study 2006-2007**
Feb 04	Letter to heads of department of large hospitals outlines purpose of project.	Nov 05	Email to head of department with brief outline of project asking for meeting.
March 04	Initial meeting with Jessica (Head of Department) London General Hospital (LGH).	Jan 06	Initial meeting with Alice (Head of Department) Cape Town General Hospital (CTGH) and two senior staff.
June 04	Application to research and ethics committees of local trust.	Apr 06	Application to university and hospital research and ethics committee.
Oct 04	Re-submission following advice on incorporating more current literature in OT and rewording of the aims of the project.		No resubmission required.
Dec 04	Meeting with staff to discuss the project and to discuss their thoughts, ideas and/or concerns.	Nov 06	Meeting with staff to discuss the project and to discuss their thoughts, ideas and/or concerns.

Dec 04	Letter to staff as a response to the initial meeting and to request volunteers for the project.	Dec 06	Letter to staff as a response to the initial meeting and to request volunteers for the project.
Jan 05	Observation period: five OTs volunteered to be observed. (See below for further detail).	Feb 07	Observation period: four OTs agreed to be observed. (See below for further detail)
Feb 05	Information sent to participants about interviews.	Feb 07	Information sent to participants about interviews.
Mar 05	Interviews: the initial interview was followed by some written thoughts on the themes which arose and a second interview scheduled. (See detail below)	Mar 07	Interviews: the initial interview was followed by some written thoughts on the themes which arose and a second interview scheduled. See detail below)
May 05	Information sent to all staff on inquiry groups.	May 07	Information sent to all staff on inquiry groups.
Jun 05	Inquiry groups: four groups were held, each a week apart. (See detail below)	Jun 07	Inquiry groups: three groups were held, each a week apart. (See detail below)

Table 1: Timelines for Research Project

Within the whole study (UK and SA), 17 OTs volunteered for different parts of the research process. All were women and their ages ranged from 23 to 48 years. The OTs had different work roles: some were newly qualified (called basic grade in the UK), and some had a number of years of clinical experience and held mid level management positions. In both LGH and CTGH there were three women who became central to the process by participating in all three stages of the project (observation, interview and group). Their sustained contribution facilitated many of the insights and new thinking that has emerged as part of doing the research.

Participant Observation

The observation periods took place in mornings or afternoons and were each between three and four hours long. They took place by my following the participant in their 'normal' work day and this involved a number of different activities – e.g. team meetings, ward rounds, administrative time at the team base – but the majority of the observation time was spent watching the participants working with clients on the wards. I had initially thought I could remain in the background, allowing for my observations

to be silent as I concentrated on the external reality (i.e. what was occurring) and my internal experience of feelings and associations. However, I began to realise that the participants were anxious about being under such scrutiny and so I started to share some of my thoughts when we walked from place to place. This was useful in the later interviews, as the participants and I had already begun to establish a reciprocal (thoughtful) relationship.

The following is an extract from the first observation period of the project with a senior OT, Alison. My break in role of being a silent observer is placed in **bold** and the response by Alison to my sharing these thoughts in placed in ***bold italics***.

> Alison used a great deal of interaction with everyone around; she seemed to notice people and greeted them. She helped a social worker find a programme that she could download onto her computer so she could receive faxes and she also greeted an OT on the ward and asked her how her day was going. I was aware that Alison has quite a bit of pressure on her – a number of referrals to deal with, each involving different levels of assessment and decision making and she also needed to assist new staff … All of this was done through her interactions and as they occurred, she moved from one situation to another with a high degree of flexibility. **I said that I was impressed at how much she communicated with everyone around her and I didn't realise how much it was needed.** She said that she finds that she also does the nurse's work … and the physiotherapist's job ... ***She said she hadn't realised that she made that number of decisions under pressure and it was good to hear my observations, she said she wouldn't mind the next observation, she would be less anxious.***

I wore an OT uniform (white tunic top and bottle green trousers) while involved in the observation part of the project. This had been suggested to me by Jessica, the head OT of LCH, so that I would blend in more easily into the ward environments. This putting on and taking off of the uniform became a theme throughout the project. For example I noticed in the UK the staff had a change room in their work premises where they could change into their uniforms. In SA the staff arrived at work already wearing their uniforms and they travelled home in them.

Table 2 below outlines the participants who volunteered for the observation period and the number of observations undertaken.

LGH		CTGH	
Alison	2 periods (am and pm)	**Joanne**	2 periods (both am)
Caitlyn	1 period (am)	**Mina**	2 periods (am and pm)
Diane	2 periods (am and pm)	**Nassrin**	2 periods (both in pm)
Fiona	2 periods (both am)	**Azar**	0 period (absent on arranged days and then took leave)
Heather	1 observation period (am)		
	Total: 30hrs		**Total: 27hrs**

Table 2: Participants for Observation and Number of Observations

Interviews

The interviews took place in the workplace, in a room that was quiet, comfortable and set aside for the interview period. Each interview had been preceded by an observation period where I had established a link with the participant through watching them working actively with clients and sharing some of my initial thoughts on the observation period with them. Hunt (1989) had described how important the initial period of observation was for 'development of sufficient rapport with subjects to ensure their trust and co-operation' (p.13).

The first interview with each participant began with my inviting them to tell me about their work and the dialogue developed from whatever the participant spoke about. At times, the direction of the interview was clearly influenced by my own interest in the topic more than that of the participant. I have highlighted some of the difficulties in maintaining the 'evenly balanced attention' of the analytic attitude in the next section of this chapter on the use of the FANI. I have described how an apparent misdirection was related to an association I had to the unconscious material and sometimes provided a deeper (or more personal) discussion between myself and the participant.

Following the first interviews I made notes on the events and my reflections on what had been said. I then listened to the recordings to gain an understanding of what the dialogue had revealed and I wrote to the participant with some thoughts on the interview and suggested further areas of exploration for the second interview. This email also served to confirm the time and place of the next interview and allowed the participant to withdraw from the process if they wished to. Two participants did not have a second interview: one was leaving the hospital after the first interview (Fiona) and Heather, after cancelling the second interview, could not commit herself to a future

time. I thought she may have been surprised at how much she had said in her first interview and she may have felt exposed and unwilling to explore her work further.

Each interview took between 50 and 70 minutes. They were digitally recorded and the participants were all offered copies of the recordings (on a CD). The box below specifies the names of participants who were interviewed, and the number of interviews per person.

LGH		CTGH	
Alison	initial and follow-up interview	**Joanne**	initial and follow-up interview
Caitlyn	initial and follow-up interview	**Mina**	initial and follow-up interview
Diane	initial and follow-up interview	**Nassrin**	initial and follow-up interview
Fiona	initial interview, left post		
Heather	initial interview, did not commit to follow-up interview		

Table 3: Participants for Interviews

Inquiry Groups

The inquiry groups were held in the team base of the departments. In the UK study different staff came to each of the four groups, and so the same themes for the group were kept as a starting point. These inquiry groups were difficult, staff seemed to be pushed into them, either by their team leader or by the OT manager, who would see me arrive, realise that a room had been booked for a group and would ask OTs to join the group.

In SA the same staff came to each group and so issues that came from one group could be taken into the subsequent one. The themes for the first group were circulated to all staff (prior to the group) and the issues that arose from that group were circulated to all the members before the second and final (third) group. This seemed to increase the commitment to the inquiry process and the group membership grew from six to eight members in three weeks. (Appendix 4 is a copy of the email sent to all staff at CTGH to encourage their attendance of the Inquiry Groups).

The table below indicates the members of the inquiry groups. Participants who had been part of the observation and interviews have been put in **bold** and new participants to the study are in *italics*

LGH					CTGH			
Group	1	2	3	4	Group	1	2	3
Alison	**x**	**x**			**Joanne**	**x**	**x**	**x**
Caitlyn			**x**		**Mina**	**x**	**x**	**x**
Heather			**x**		**Nassrin**	**x**	**x**	**x**
Chetna	x	x			Azar	x	x	x
Beverly				x	*Elizabeth*	x	x	
Janet				x	*Pamela*	x	x	x
Lee	x	x			*Shanaz*			x
Lisa		x			*Vida*		x	x
					Zarrin		x	x
total	**3**	**4**	**2**	**2**		**6**	**8**	**8**

Table 4: Members of the Inquiry Groups

Possible Benefits of Participating

In giving information (in the PIS-1) to the potential participants, and having warned them of the possible negative consequences of taking part, I also wanted to say what I thought they may gain through their involvement.

> … you will be encouraged to put your thoughts about your work into words, you may find that you are able to articulate an understanding of the 'whole' situation (i.e. the client, their illness experience and the therapy offered) that reflects an understanding you bring to each clinical situation. This opportunity to articulate your experiences in working with clients may allow you to reflect on the hidden (less conscious) aspects of your work. This 'telling the story' of your work with the client would include the intuitive responses you may have had to an implicit understanding of your clients' life events and needs. This may generate a renewed appreciation of your work with clients, your role in the multidisciplinary teams and reinforce the value of supportive collegial and supervisory relationships. (PIS-1)

Although I had encouraged the potential participants to consider what they might gain by taking part in the project, I had not considered what it would mean for me. In doing the study, in supervision and in using my dreams I have tried to look at what was hidden from view, in conscious and unconscious processes. The project began as an investigation into the 'well meaning-ness' within the OT discourse and I was quite sure I would find many examples of 'defences' that OTs used in their work. The dreams I

have had have nudged me into looking at how I may judge the very aspects (in others) of a self that I cannot bear to see.

In doing the research I realised that when I looked for defences, that is all I found, and it was a judgemental position. I needed to develop a deeper reflexive gaze and wonder what the defence was defending against. From the tongue-in-cheek 'OT on the Couch' I did change the title (as described in Chapter 1), and in trying to find words to describe the relational world of OT I discovered the importance of a shared place in learning and relationships. These insights were supported by my finding and reading the thinking of Winnicott (1971), Benjamin (1990, 2004) and Clarke et al. (2008) on these matters.

Data Analysis

> 'By going beyond the modern cult of rules and facts, and recognizing the social construction of psychological knowledge, therapeutic research could be freed from an obligation to either remain silent about its methods, or to imitate the technical data-reifying methods of the experimental and psychometric traditions.' (Kvale, 1999, p.97)

The data collected in this research project, as in many similar qualitative studies, was extensive and it was hard to know where to begin in making a coherent whole from the jumbled pile of collected work. The data included observation material and reflexive notes, audio recordings of the interviews and inquiry groups (so necessary in checking all the transcripts for accuracy), verbatim transcripts of these interviews and groups, dreams and notes from supervision sessions. As Kvale (1999) observes that there is much in the way that a psychoanalytic interview is used that can stand as a valid research method, and he describes how the knowledge which emerges about the 'subject' (in this case the client) is a result of the inter-view between the therapist and client. '… there is an emphasis on knowledge as interrelational and structural, interwoven in networks. Knowledge is neither inside a person nor outside in the world, but exits in the relationship between person and world' (ibid, p.101)

The subjective data (i.e. my reflections and dreams) were valued as 'instruments of understanding' (Hollway, 2008, p.140) and led the way into the first level of analysis. I used the themes which arose from the observations and reflection I had made of the fieldwork sites (LGH first and CTGH later) and placed them on a large sheet of paper as a 'mind map'. I then read and re-listened to the interview material, until it became part of me, until I could 'feel' it. Menzies Lyth (1988), in describing her methodology, wrote

that ‘the data have to be ‘felt’ inside oneself; that is, one has to take in and experience the stress in the organisation, much as one does in individual and group psychotherapy’ (ibid, p.128). I added the additional insights (thoughts) to the themes originally identified on the mind map. The additional interview material amplified the themes and provided new avenues for exploration. I used the same process for the inquiry groups and this became the third layer of the mind map. The raw material from the data was then identified to use in thick descriptions in the chapters on the UK study (Chapter 4) and the SA study (Chapter 5).

Kvale (1999, p.105) warns that ‘Current interview research is often subject to the tyranny of verbatim transcripts and formalized methods of analysis’ and he says that if these methods had been used at the time of Freud they may not have allowed for Freud’s theories to be promoted or accepted as ‘researchers might still have been reading and categorizing their transcripts, and discussing their reliability rather than emphatically listening to the many layers of meaning revealed in the embodied therapeutic interrelations.’ (ibid, p.105). Listening to and understanding what has been said requires an attention to the ‘ “whole” narrative, to the meanings produced in the researcher-participant relationship, links between parts of the account, to conflicts and tensions within accounts, and the unsaid as well as what is said.’(Hollway, 2008, p.140).

In using this form of examining the “whole” I have tried to be explicit (for the readers) about what I have focused on and why these themes had relevance for the participants within the culture of that environment. These reflections on the themes are within the written accounts of the two clinical areas, LGH (Chapter 4) and CTGH (Chapter 5). The emphasis of the study shifted from considering how the OTs personal stories of family and early childhood (in UK) had influenced their work as an OT - to the political social realities of the lives of OTs in SA, and how this influenced what they did and felt about their work. Because of this shift in emphasis/balance from the ‘psycho’ to the ‘social’ in the research I have reflected on the complexity of using this method and holding a point of view in Chapter 6, ‘Journey without Maps’.

As Hammersly (1992) and Burawoy et al (1991) discuss the difficulty with ethnography is in establishing its validity (truthfulness) and relevance, or as Burawoy explains, its application from ‘micro level’ exploration to ‘macro level’ (ibid, p.273) understandings. The fact that I was (am) an OT and was undertaking the research within my professional

group made me an insider, i.e. I had knowledge of the professional discourse (ways of working, clinical terminology). This may have helped in gaining the trust of the OTs who spoke openly about their work and frustrations with the demand for rapid discharge from medical wards. But this insider role was also potentially 'blinding' as I assumed (or anticipated) certain experiences and may have steered the interviews to areas of work which preoccupied me; for example how OTs manage (emotionally) the nakedness of male clients (as described in clinical vignette with Caitlyn on page 5).

By assuming an empathic stance in the interviews, which felt congruent and unrehearsed for me, led to a deepening exploration of the OTs work and lives, but it may have left the participants wondering what would become of their disclosures. The semi-intimate (reciprocal) relationship that can develop in certain feminist approaches to ethnographic methods was discussed by Huisman (2008) as potentially betraying a trust that participants have in the researcher. This she described as an implicit understanding that some 'good' will come from their disclosures and/or the relationship would continue after the project was over.

The limitations of establishing the usefulness of the study (i.e. relevance) and the use of interpretation in the data analysis, which provided a 'voice' for the data and its meaning (validity), will be discussed at the end of this chapter. Kelly (1999) described 'qualitative research [as]…concerned with making sense of human experience *within* the context and perspective of human experience' (p.398) but these descriptions contain (or some would say be contaminated by!) the unique perspective of the researcher. I have endeavoured, in this project, to make the theoretical position and personal perspective that I have taken as explicit as possible to allow the reader to use these for a process of 'distanciation' (i.e. distancing oneself from the material). Kelly (1999) described 'Distanciation' as adding meaning 'not by imposition, but by pointing to the subjective and contextual *limits* of understanding' (p.400).

In thinking about the difficulty of representing the 'voice' of individuals and groups in ethnographic research, I am reminded of the different qualities that portrait painters bring to their work. Some artists are able to reveal such an essential quality in their subject that the friends and lovers (of the subject) immediately recognise that part of the person, and other painters seem to superimpose (perhaps merge) themselves onto the face of the object portrayed, leaving the viewer wondering who it is they see.

Establishing View Points for Researching Below the Surface

As mentioned earlier, the research I undertook examined the social defence mechanisms of occupational therapists in their everyday work with clients in an acute hospital department. The study used the three processes Menzies Lyth (1988) had described in her seminal study of the nursing profession: observation, interviews and inquiry groups[25]. In doing the practical part of the study I began to question how the method could help me explore what I didn't know and what, because of the unconscious, I could not know. I used psychoanalytic theory as a basis for the study, which is the belief in the work of the unconscious in all that we do, say or think.

I realised that if the unconscious were active in the participants' and researchers' lives it may generate defensive patterns of engagement within the research process. How could I discover something 'new' if I could only be aware of (or observe) what I already knew? What research methods would uncover the areas of the 'unthought known' (Bollas, 1987) within the qualitative methods of interviews, observation and reflexivity.

Hollway and Jefferson's (2000) understanding of 'defended subjects' (p.45) and 'free associate narrative interviews [FANI]' (p.37) were key methodological resources and I explored two further lines of reasoning within this process: interpretation as intersubjective creation of knowledge (seeing ↔ believing) and the use of dreaming as a reflexive tool for thinking (dreaming ↔ thinking). In this section I have kept these two developments in separate parts of the writing, but hope that the reader can appreciate how the strands are related to each other .The dream material created new opportunities for dialogue with and between participants, the observation and interviews evoked dream material. To know about something I needed to experience it by observing the external events and internal 'events' (including dreams). These observations (and insights) then provided a fertile ground for the intersubjective dialogues that took place in the FANI and inquiry groups.

[25] I have termed the groups 'inquiry' groups as Menzies Lyth was not explicit in how she had structured and managed the groups in her study. Her descriptions show that the groups were used by the nurses to reflect on their work. Menzies Lyth would add her thought from her observations and reflections of their work. This method seemed to assist in an exploration of the observed events and illuminate some of the defences that nurses had unconsciously used to do their work.

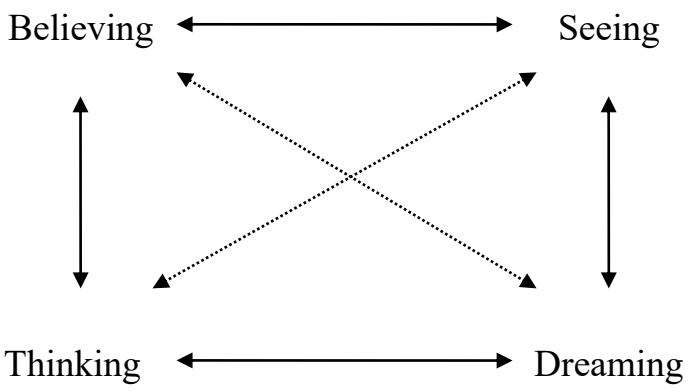


Diagram 3: Process used to Develop View ↔ Points

Seeing ↔ Believing

Menzies Lyth's (1988) study of ward-based nurses was able to identify the social defence systems that operated within the institution (a large general hospital) to protect the nurses from the experience of 'raw' unconscious anxiety. This study created a bridge between social sciences (anthropology) and psychoanalysis and had inspired me to inquire about the professional defences that occupational therapists may employ in their work with clients.

In the research process, the action of observing or interviewing the participant brought my viewpoint into focus alongside that of the participant. Anais Nin (1903-1977) said, 'we do not see things as they are, we see things as we are' (cited in Blenkiron, 2005, p.49); and this 'seeing' what we already expect to be there can make the conscious discovery of something new very difficult. The current thinking about reflexivity (Finlay & Gough, 2003; Pillow, 2003) suggests if the researcher is able to explore their own view of the world and describe their motives for doing the study (a kind of self-analysis) then the reader is able to decide for themselves what 'truth' may lie in the research report. These self-disclosures are an effort at transparency and increase the trustworthiness of the study undertaken, but considering the active ongoing work of the unconscious these self-disclosures are frequently beset with difficulties. I have used the story of the 'emperor's new clothes' to uncover the difficulty with not knowing what you don't know and the imaginative use of interpretations in the FANI as a way of creating a dialogue with the participant in which meaning may emerge.

The Emperor's New Clothes

The story of the emperor's new clothes (Andersen, 1993) illustrates how powerful (i.e. blinding) a cultural belief can be: people – the townsfolk, ministers of government and the emperor himself – will believe what they are told, if the cost of not believing would make them appear stupid or deficient in some respect. In other words, people 'believed' what they 'saw'. This difficulty of seeing what is 'there' (or not there - in the case of the emperor's clothes) mirrors the current thinking in social construction theory (Burr, 2003), that what we see is mediated by what we expect to see. These beliefs are created through a series of social interactions that are encoded in a complex web of political, cultural, social and family relationships. As I embarked on participant observation methods I wondered if what I saw would have been influenced by what I thought I should see – making me 'blind' to what may have been visible.

A second part to the story has always intrigued me: the role played by the young boy who called out that the emperor had 'nothing on at all'. I have been interested to know how the boy was able to see his nakedness and the tone of his declaration, an interpretation. It seemed to be the same kind of statement that a therapist might make to a client – that they 'saw' something different to the narrative (verbal presentation) of the client, and this interpretation could sometimes expose the client to a hidden part of themselves with an accompanying sense of shame and/or relief.

The **intention** behind the boy's statement becomes crucial to understanding the use of an interpretation in the research process (using FANI). If the boy's intention was to shame the emperor (by demonstrating his 'superior' knowledge) he may have evoked such anger (defensiveness) in the emperor (and crowd) that it would have destroyed any possibility of thoughtfulness. If the boy wanted to say what he saw as an inquiry and interpretation of events, then it may have been possible for the emperor to consider his role in the sham and simultaneously the townsfolk's role in this pretence.

Although Hollway and Jefferson (2000) are explicit about not using 'interpretation' in the FANI, I found that saying what I had been thinking about in the groups and interviews allowed the process of understanding to evolve. Hoggett (2006a) described interpretation as a kind of 'thinking aloud' and it seemed to me the boy in the fable was

thinking aloud, allowing for the Emperor and the crowd to reflect on their combined folly.

Developing 'In-Sight'

Social constructionists warn us that our perceptions may be altered by what is deemed important by a society and its culture (Burr, 2003), but we have another theoretical source for understanding human subjects: psychoanalysis and the use of projective identification and the role of the unconscious (Ogden, 1979). The possibility of 'seeing' something can be an internal one; through taking in the projections (raw experience) of the other (a client or participant) we can create an internal place for these feelings that may allow us to put them into words or take some form of action. This deep therapeutic encounter may bring about a change in the client, and at times the therapist (Casement, 2006).

Menzies Lyth (1988) described how she used a process of 'internalising the data' (p.128), mentally and emotionally sifting the data until meaning could emerge. This meaning was often in the form of a hypothesis which was then posed to a group of nurses to check its validity (or usefulness). As Menzies Lyth stated, 'this understanding of the data is also a stressful task for the consultant [i.e. researcher] … The data have to be felt inside oneself; that is one has to take in and experience the stress in the organisation, much as one does in individual and group psychotherapy.'(Menzies Lyth, 1988, p.128). The real evidence of the effectiveness of the hypothesis occurred when discussions of its possible meaning created changes in work routines that lessened the stress on the individual nurses.

Menzies Lyth's (1988) study was 'called sociotherapeutic or 'clinical'' (p.115) and was motivated by an ongoing difficulty that had been identified by the organisation. She described an action learning intervention but added that 'one's understanding of a social organisation, as of a person, is likely to be seriously limited if one cannot gain access to unconscious or implicit elements as well as to more overt ones.'(ibid. p.119). As a psychoanalyst she brought these theoretical constructs and clinical skills in gathering data and discussing the results. She said her in-depth access to the nurses was made possible by the invitation from senior management and the intention in her study was to 'communicate the diagnostic findings to the client organisation' (ibid. p.121), i.e. to

effect change in that organisation. Unfortunately, not all research is by invitation and mine was motivated by being an occupational therapist and concern with the positivist emphasis in research methodology (used in OT) and the overtly optimistic descriptions of occupational **therapy**. Occupational therapists seemed to ignore the relational realm of care and deny the possibility of their using activities (also called occupations) as a defence against the clients' vulnerability (Nicholls, 2003).

*Participant Observation: Creating an Internal Map of the Psycho-social Wor**k***

To create an awareness of the work undertaken by occupational therapists, I spent several periods immersed in observations of their work: with clients, in meetings and at the team base. This was to familiarise myself with the culture of the environment by observing their interactions with clients (relational and tasks performed), creating an inner experience by observing my feelings. This period gave me an internal landscape of the work and became crucial in developing relationships with the participants (as mentioned in the earlier section of this chapter using the work of Hunt, 1989). I reflected on what I had seen and felt and was able to refer to these events later in the FANIs.

Participant observation comes from a long tradition of ethnographic fieldwork studies (Hunt, 1989; Hammersley, 1992; Hammersley & Atkinson, 1995; Gilbert, 2001) and what is 'seen' may be affected by what the observer expects to see (or can cope with seeing, or judges from their social-political world view), while participants may be affected by the act of being observed. My recording of events involved a mixture of external and internal events, like the tradition of infant observation that Bick (2002) had required. The following example from an acute medical ward and described my thoughts and feelings about the client, their family, the staff and hidden beneath that my own sense of awkwardness at being an observer, i.e. without a 'helping' role.

> *…. I saw that the bed opposite had an elderly man lying in it, he was connected to monitors and machines, he had a mask over his nose and mouth and a drip. There was a younger man and woman standing either side of the bed, the patient was either asleep or unconscious. He showed no recognition of them and his eyes were closed. The two figures seemed to be keeping a silent vigil. I wondered if the man was dying and if they were his children. I thought hospitals were very public places; this scenario was in full view of the ward with the usual traffic of nurses, equipment suppliers, technicians, doctors and admin staff walking past without any glance towards them – or them towards the passing staff. I wondered if the noise was a comfort in this still scene (a tragic tableau). It felt as if the movement of the*

staff was at least a sign of life – the patient in bed showed little sign of being alive, he looked old, thin, pale and his mouth hung open.

The work of Esther Bick (1964) on infant observation and its inquiry into the experience of observing has been incorporated into many new disciplines of study that use psychoanalysis in their research work, e.g. organisational analysis (Hinshelwood, 2002; Skogstad, 2004; Mackenzie & Beecroft, 2004). The 'Bick' method encouraged the researcher to observe the details of events which took place between the child and their mother (or father/caregivers), including an uncensored description of their thoughts and feelings during these observations. These were transcribed into detailed field notes that were used in seminar group discussions for further analysis.

In this way the researcher relied on their internal experiences (projective identification) to understand the unconscious communication which took place between mother and child. In a similar fashion the experience of the fieldwork in the research study with OTs provided me with an internal awareness of the emotional work undertaken by therapists. Some of this awareness was in thoughts (or as questions), dream images or associations with events in my life. The creation of these internal images and reflections were important in engaging in the next stage of the study, the interview.

The example used below presented me with an insight into possible social defences employed by OTs, protecting them from the anxiety of working in an acute care setting. The observation took place in a general medical ward; the newly qualified OT (Fiona) was assessing an older adult patient (Sydney) for his readiness to return home. Assessments often involved asking patents to discuss or demonstrate how they would perform their 'self care' routines; washing, dressing and using the toilet.

Fiona asked Sydney if she could do an assessment. He was sitting on his bed in a six-bedded ward with male patients. The ward was large with a sense of camaraderie between the men; a few smiled and greeted me. Sydney was an older man (perhaps late 70's), with a large (swollen) torso and thin legs crisscrossed with varicose veins. He was wearing pyjamas and his unbuttoned top left his chest and stomach visible. His hair was thinning and his face ruddy, I wondered if he was a smoker or heavy drinker to have such a deep red pallor.

Sydney said he had met occupational therapists before – during the war when he did things with his hands to 'get better' and go back to the fighting. Fiona didn't respond to this information – she asked him some questions about his home and if he could get to the toilet on his own, if he was able to wash and dress himself. … she asked him to demonstrate his walking to the toilet (on the ward). He walked there and the physiotherapist asked him why he wasn't using his sticks. He seemed to have forgotten that he had any and then he began to get irritable.

When he returned to his bed Fiona asked him to show her how he washed himself. Sydney took off his shirt and I became quite concerned as I didn't know if he would strip down to his naked body. I found myself thinking about my father – Sydney's body was similar to my father – and a similar age to when my father had been in hospital. I wondered what my role would be to watch this man in such a vulnerable naked state. It felt partly voyeuristic and partly painful as I had no role in it – nothing to do except watch.

Fiona asked Sydney who was at home with him he started to get more irritable. He said she couldn't phone his wife and he couldn't understand why she had to ask him all these questions. Fiona said she would be back in a while and asked me to come out with her. She told me she was shocked at his questioning her and I said it seemed he didn't want to let her know how things were at home and I wondered if he was coping and perhaps her questions were making him irritable.

Fiona returned to Sydney but he was wouldn't do anything further. As we walked back Fiona she said she was feeling scared. I didn't respond to that (in fact I cut across with my next comment). I said I thought Sydney was protecting himself from questions by being irritable with her, perhaps he felt ashamed. I was thinking of my father who could be charming but cover his sense of humiliation with a blustering aggression. I wasn't listening to Fiona – I was thinking about my father and imagining that Sydney's irritation was similar.

This observation brought several areas of inquiry which I could explore in the interviews. Some of themes were; the difficulty of working with older male clients, physical frailty and the fear clients expressed (overtly or covertly) about the 'power' OTs had in deciding their future (i.e. discharge plans). In managing this anxiety OTs would sometimes seem to only assess the physical capability of clients (walking, toileting, washing), allocating equipment to assist them in these tasks and not acknowledging the clients' emotional experience of being in hospital. This 'giving of equipment' seemed to be the defence OTs used to protect themselves from the responsibility of decisions that altered a client's (often an older person's) life, where they would live after leaving the hospital. I wondered, by keeping tasks practical, if there was a denial of the horror of becoming old, the loss of one's bodily integrity (e.g. incontinence) and increasing physical dependence on others.

An unexpected outcome of these 'accompanied' observations was the connection it established between the participants and me. Fiona, following the period of observations, described many of her negative experiences of work in the interviews and I wondered if she could trust me as she knew that I had seen some of what she described. Perhaps as I had already made an active intervention in observing her difficulty with 'Sydney' we had begun a reflective space between us.

The observation also evoked reflections and associations with my father, who had died in hospital (many years previously) after an elective surgical procedure. I wasn't expecting to find it painful to observe the older men in the wards, and although the associations helped me think about the anxiety of these clients in hospital I would sometimes cut off from listening to the therapist's description of their experience because I was too full of my own. By using my associations during the observations (e.g. Sydney's irritability) I could ask the OTs during the second part of the research – the interview process – about something I had felt or thought about as a 'thinking aloud' (i.e. interpretation) to what they had been saying.

The Use of Interpretation in the FANI

Using the work of Hollway and Jefferson (2000), based on the notion of a defended subject and the experiences of countertransference as part of the data, as a guide for the interviews I undertook with the participants there were three aspects of the process which began to intrigue me:

- What was heard was not always what was said.
- The response of the researcher was critical in developing the interview.
- Responding to what the researcher thinks they have 'heard' is potentially fraught with misunderstanding and/or unintentional exposure.

I considered the 'layers' of this interaction as an intersection between conscious, hidden and unconscious communication. The diagram below attempts to outline the different elements in this exchange. (A similar discussion of this layering of the messages from a participant can be found in the analysis of Julia's problem in Chapter 2). Perhaps as a caveat to the inclusion of this diagram I wanted to acknowledge that in many ways is not adequate in portraying the complexity of any one exchange between a client and therapist, or researcher and participant. As with language that can only use a linear progression (except perhaps for poetry that uses words as symbols and spaces or punctuation for artistic emphasis) the diagram has only two dimensions. Interviews are complex processes and I would often find unexpected material in the transcripts or listening to the recording of interviews (i.e. not what I had remembered having been said). The diagram aims to separate out what is mixed, muddled and sometimes quite chaotic in any one interview. As Frost (2007, p.245) said in discussing the need for a

psycho-social discourse in social work education; 'The necessarily linear trajectory of words on paper makes it difficult for this boundary-less, interacting, multi-dimensional process to be captured.'

Participant	Researcher	Layers of consciousness
What is said	What is heard	Conscious
What is meant	What is said in response • Inquiry (clarification) • Reflection (empathy) • Interpretation (selected fact or overvalued idea?[26])	Conscious
What can't be said (e.g. shameful or unethical)	Intention to create a space for meaning to emerge or for 'misunderstandings[27]' to emerge?	Hidden from view – **Subconscious**
'Un-thought known'	Countertransference e.g. identification with defence structures and/or dreams	**Unconscious**
What is not known	What is not known	**Unconscious**

Diagram 4: Layered Interaction between Researcher and Participant

The FANI method described by Hollway and Jefferson (2000) attempts to create an agenda-free space for the interview to occur. The researcher is an integral part of what can be known from the interview – in other words, what can be known occurs within the relationship between the participant and researcher, and both are objects of analytic scrutiny.

> '… tracking this relationship relies on a particular view of the subject: one whose inner world is not simply a reflection of the outer world, nor a cognitively driven rational accommodation to it. Rather … research subjects whose inner worlds cannot be understood without knowledge of their experiences in the world, and whose experiences of the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world. The research subject cannot be known except through another subject; in this case the researcher.' (Hollway & Jefferson, 2000, p.4)

The response of the researcher to the participant is crucial in developing insights into the experience of the subject. These responses include the psychoanalytic concepts of containment, projective identification, identification and interpretation (see Ogden,

[26] These terms come from the Britton and Steiner (1994) article 'Interpretation: selected fact or overvalued idea?'

[27] Fabian (2001) reminds us that it is better to have a 'misunderstanding', which the researcher can clarify, than 'not understanding' (p.33) which means it may pass without notice by researcher or participant.

1979, 2004). Alongside more technical discussions of how responses or interpretations are made (or not made) I thought there was a less obvious area of inquiry – the intention behind the response of the researcher.

The researcher may hope that their conscious intention in responding to the participant is to clarify or illuminate the material being discussed, but be unaware of an unconscious enactment which could include narcissist identification, attempts to prove superiority by using sophisticated terminology, or an envious rivalry with sadistic remarks. This possible unconscious enactment by the researcher (e.g. rivalry or narcissistic identification) can be a neglected area of inquiry if the researcher only emphasises their conscious intentions. While notions of projection, projective identification and interpretation allow us to consider how meaning may emerge within a FANI, Fabian (2001), in his discussion on 'ethnographic misunderstanding and the perils of context' (p.33), also draws our attention to things that are misunderstood (and so become available for understanding) and the things that we don't know we didn't understand, and so the possibility of understanding them sinks beyond sight (or insight).

On Understanding and Not Understanding and the Process of Containment

Joseph (1983) writes that analysts need to distinguish between patients wishing to be understood and those who wish to understand. The desire by the patient to 'be understood' was linked to the Kleinian position of paranoid-schizoid functioning (Segal, 1988; Steiner, 1993), where the patient gave the therapist their feelings as a way of being rid of them. As such, the patient experienced any verbal attempt by the therapist to understand these feelings as an attack. In other words, the patient wanted to be free of their experience and so found any attempt at an interpretation by the therapist as a negation of their communication. These patients did not wish to receive their feelings back, even though the therapist may have attempted to do so in a palatable form!

Joseph (1983) suggested that the patient at a later stage, having shifted into the (Klienian) depressive position of functioning, may be able to tolerate thinking about their feelings and the therapist's active interpretations could be helpful and necessary for the patient to make progress. This process of being rid of feelings (through projection) and tolerating interpretations between patient and therapist seemed to me to be preceded by the capacity of the therapist to contain the experiences of the patient

(Nicholls, 2000). Containment, a concept initially used by Bion (1962b), is clearly articulated in work with patients (Steiner, 1993; Odgen, 1979) and with organisations (Bolton & Roberts, 1994).

> 'Containment as a psychoanalytic concept, involves the analyst's 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, pg.42)

Hollway and Jefferson (2000) state that within the research relationship it is the intersubjective aspects of 'recognition and containment' that allows for 'trust to develop' (p.49). They mentioned how a verbal response by the researcher, which resonated with the depth of the emotional material of the participant, provoked further revelations of the material that were hidden from view. They hypothesised that the participant could be ashamed or had pushed it out of consciousness as it was frightening to recall. The researcher's response was described as an empathetic reflection where the researcher speaks back to the participant a feeling that they were in contact with (i.e. an emotional resonance) while listening to the interview, e.g. 'that sounds frightening', or 'that must have been very sad' etc.

Ultimately containment involves taking in the experience of the 'other' (client, participant or group) and attempting to understand what is being communicated. As Joseph (1983) and Steiner (1993) suggested it may be unhelpful or even harmful to speak these insights back to the 'other' and the act of containment may be sufficient for the person to feel understood. However, as the research interview aims to reach an understanding of what is being said, the researcher may risk an interpretation that aims to clarify or uncover the meaning within the communication. But these interpretations bring to light further concerns; are they valid and ethical? Britton and Steiner (1994) distinguished between interpretation as a 'selected fact or overvalued idea' (pg.1069), the latter being a noxious experience for the recipient. I wondered whether a researcher should risk an interpretation when the participant was not in an ongoing relationship with them?

Britton and Steiner (1994) considered it was the response of the patient to the analyst's interpretation that provided the evidence of its accurateness. They suggested that the analyst use their free floating attention until a 'selected fact' began to emerge, to which other facts or events seemed to be related. At this stage articulating this idea (or hypothesis) to the patient would confirm its usefulness if the process of therapy continued, i.e. it provoked insight and movement in the analysis. However, if the analyst had erroneously over-used a theoretical concept as a central tenet to their understanding of the patient there was a temptation to get the patient to fit the theory – resulting in an 'overvalued idea' (Britton & Steiner, 1994, p.1070). They said it was hard to distinguish between the two types of hypothesis but articulating them (and believing in them) was essential to the unfolding process of the analysis.

> 'In our view the distinction between a creative use of the *selected fact* and a delusional one which supports an *overvalued idea* may be small at the moment of its formulation, but becomes crucial in the events which follow the verbalisation of an interpretation. It is partly because of this we believe that an essential part of the work of interpretation takes place after it is given.'(Britton & Steiner, 1994, p.1070)

There may be opportunities in the FANI which allow for the researcher to test a hypothesis (a selected fact or overvalued idea) that they have been considering within the research and with the participant. I found this particularly useful in the second interview where I could explore notions that had occurred to me during the first interview and while listening to the recording. Britton and Steiner (1994) said that 'a great deal depends on the spirit in which this [i.e. the offer of an interpretation] is done' (p.1073). If the interpretation is taken up by the patient as something 'he is being asked to consider' then 'an atmosphere of inquiry is able to develop' (p.1073). This seemed to echo the very notion of a 'thinking aloud' that Hoggett had spoken about.

Britton and Steiner (1994) also warned that interpretations which are forced onto the patients and don't allow for any doubt cause a 'soul murder' (p.1073), and for this reason alone researchers may have become very cautious of attempting any interpretation in their interviews. I had thought that because the participant was not in an ongoing relationship with me, if my interpretations were clumsy and/or inaccurate they wouldn't be harmful but may cause the interview to come to an abrupt halt or the participant would be less forthcoming. In my experience the interpretations I used

assisted the interview more often than hindered it and what was not tolerated (i.e. thought about) by the participant was easily dismissed, often to my considerable chagrin!

Menzies Lyth (1988) in her chapter ‘`Methodological Notes on a Hospital Study’ (pp.115-129), described how not all the insights or interpretations were shared with the participants and only ones which maximised the therapeutic effectiveness of the client/consultant relations were used. The insights that were never shared were useful in helping the consultant understand the organisation. She discussed that during the interviews some topics were ‘too painful for certain informants [participants] easily to expose in a relationship which was basically fact finding and not therapeutic for them and where the consultant does not, therefore, have the therapeutic sanction to cause pain’(ibid. p121). This drew my attention to the ethical nature of the relationship established within the interview.

The participant was protected by the explicit information on the nature and purpose of the study given to them prior to their consent being sought for the project. But in agreeing to participate in the research, neither I nor the participants could have anticipated the painfulness of the research process: for example, witnessing the intimacy of an encounter between a therapist and client, interview material which emerged through an empathetic attunement to the underlying themes. These were part of the less conscious communication and were related to the participants’ unconscious communication and my motivation for doing the study (conscious and unconscious).

Ethical Endeavours: Expropriation, Emancipation or Enlightenment

The film ‘Capote’ (Miller, 2006) depicts the author of ‘In Cold Blood’ as manipulating the trust of the killers in order to learn their story and understand their motivations for killing a family in an isolated house in Kansas. The book made Capote famous but leaves the question of how interpersonal knowledge is gained and to what purpose it may be used. Capote exploited his relationship with the killers to write their biography and Capote’s identification with the killers (as suggested in the film) caused him considerable personal despair and contributed to his alcoholic demise.

I wondered how the ethics of consent and beneficence could be employed where the researcher does not expropriate the knowledge gained from the participant, creating an advantage for the researcher and leaving the participant somewhat diminished? The problem of whose 'voice' was being represented (and the ownership of information) was partially solved if the researcher explicitly shared their understanding of the research process and analysis of the social defences, with the participants. This may help researchers feel less like a manipulative 'Capote' figure and support the whole inquiry process by including insights of the participants to the hypotheses generated through the analysis. But is this sharing of psychological 'insights' ethical?

Sinding and Aronson (2003) describe what qualitative research interviews 'do' to the participants: 'At one extreme, interviews allegedly empower, generate self-awareness, or offer a kind of therapeutic release for the interviewees; at the other they draw reproach for feigning intimacy with, and then abandoning, the people they engage' (Sinding and Aronson, 2003, p.95). In the film 'Capote' the central drama occurred when he abandoned the younger killer (Perry Smith) after gaining his trust and account of the murder. This unethical abandonment after 'getting the story' is reflected on by Huisman (2008) in her account of her three year doctoral study with refugee Bosnian Muslim men and women in the USA. Huisman explores with some depth and considerable honesty the tensions she felt between forming research 'friendships' (ibid, p.386) and needing to get the job done (i.e. material for her doctoral thesis). She described her work with Mirsada, a lonely (isolated) woman and her ethical conflict of what these research meetings had meant for Mirsada.

> Hoping to get around to doing the one-on-one interview that she had agreed to when we first met, I always had my notebook, tape recorder, blank tapes, and extra batteries on hand. On many occasions, we would get started on the interview, but then one thing would lead to another and we never seemed to get very far. Then, on one cold and dreary winter day, Mirsada offered to finish the interview. Two hours later, after she had shared some of her most private thoughts with me, she looked at me and asked, "Does this mean that you are not going to come visit me anymore?"
>
> When Mirsada looked me in the eyes and asked if I was going to visit her anymore, I feared that what I was doing ran counter to my commitment to feminist ideals of equality, reciprocity, and improving the lives of women. (Huisman, 2008, p.388)

Like Huisman (above) some researchers describe being afraid of doing harm through the process of inviting intimate stories from participants (Birch & Miller, 2000), particularly when these interviews become 'emotional'. In my experience, when a participant became 'emotional' any offer I made of changing the topic or even

switching off the recording device was dismissed or ignored – the offer seemed like a rejection of their feelings.

Alison, who cried with a wrenchingly bitter sadness while sharing an account of abuse, seemed disconcerted when I offered to stop the recorder or change the topic.

> *'No … I actually … I feel quite safe with you because instead of leaving which would have been my usual … I didn't … so that's … you know that's just saying that I feel safe here which is good … I suppose …*'

An action learning research process (Reason, 1988) provided opportunities for participants to be involved in generating and responding to research data, promoting their development within the field of study. In some respects the Menzies Lyth (1988) study described that process, where hypotheses were taken back to study groups for consideration and response, including changing ward routines and procedures, a concrete example of an action learning outcome! Perhaps how her study was different from the recent use of action research (Reason, 1988) was the attention paid to unconscious social defence mechanisms in examining the 'unthought known' (Bollas, 1987) amongst the participants.

Following my period of data collection I began to wonder if what occurred – as moments of 'understanding' – took place in the space between me and the participant. Armstrong (2004) wrote about the 'analytic object' in work with organisations, using our countertransference as a way of understanding the unconscious communication. He said it was the space between the patient and the analyst that created the object of inquiry – a third position that was frequently full of 'muddle, confusion uncertainty and fear' (pg.80) and in this space meaning emerged.

Winnicott (1971) described the use the child made of the mother as an 'object', who over time becomes a 'subject' in the transitional space of 'playing'. He identified the child moving from a narcissistic use of the object into an appreciation of the mother having her own subjectivity and thus contributing to playing by introducing her own games. This movement of the object from being in the child's omnipotent control to being outside of its inner world (i.e. becoming a subject) involved what Winnicot (1971) and Benjamin (1990) described as a destruction of the object and the simultaneous emergence of love. It is also the theory upon which intersubjectivity rests: an appreciation of the subjectivity of the 'other' in which a third position can be shared,

a place where something new (creative) can emerge. Within this exchange the child and parent experience pleasure in the game and in each other's presence.

> 'Typical studies of mother-child interaction will formulate the mother's acts of independence as a contribution to the child's self-regulation but not to the child's recognition of her subjectivity. This perspective also misses the *pleasure* of the evolving relationship with a partner whom one knows how to illicit a response, but whose responses are not entirely predictable and assimilable to internal fantasy.'(Benjamin, 1990, p.186)

In the interviews and inquiry groups I sometimes found that the participant or I would articulate something 'new', an understanding of what was thought or being said. Participants would say they hadn't realised they were thinking about something until it emerged in the dialogue between us. The example below comes from an interview with Alison. I had asked her if she thought that being 'overly' self-reliant was a trait (defence) in the helping professions.

> **Lindsey:** *Maybe that is true of all health professionals – this –being in charge of the giving and of the thoughtfulness and the additional time … but to experience that in yourself as needing it feels threatening … difficult …. can't ask for help.*
>
> **Alison:** *Yes it's horrible to ask for help … it's actually forbidden* [laughs] *… I feel like it is … I used to feel like it is an admission of failure if you are asking for help*.
>
> **Lindsey:** *So there is something in OTs… maybe it's all helping professionals … but it seems there is something in the very practical nature of OT, the doing … the toilet seats, the stair rails, the inflatable mattresses that allow OTs to think in that very practical way but find it difficult to feel they might be in a position to need them …*
>
> **Alison:** *Do you think it might be about control? Because if you are in control you are the one doing - the deciding … but if you feel you need something there is a kind of lack of control there somewhere isn't there? …. so it's admitting that you are not in control and you need something … I feel that I need to be in control …*
>
> **Lindsey:** *mmmh, so it's the vulnerability …*

In asking Alison if there was a hidden fear of being 'dependent', she began to talk about her own sense of shame at needing help; an 'admission of failure'. I continued the conversation (thinking aloud) that all the practical help OTs gave (e.g. kitchen trolleys as a mobility aid) may reassure them that they would never need it. It was following this musing that Alison had an association about 'being in control' and how that may have concealed her (and perhaps other OTs') feeling of vulnerability in asking for help – something they would so readily offer others.

The use of interpretation to extend the narrative interview (through associations and reflections) is eloquently described by Hoggett et al's (2010) description of their biographical research into 'development workers'. They used the FANI and found, similar to my experience, that it was often in the response of the participant that confirmed (or not) the usefulness of their interpretations.

> '… when the epistemic alliance between interviewee and interviewer is working well, firm evidence of the value of an interpretation can be found from the ways in which interviewees respond. Here there is a precise parallel with psychoanalysis: a good interpretation produces new material, or it enables new connections to be made within what is already known and spoken of. This way of judging the value of an interpretation combines elements of pragmatism and realism: pragmatism, to the extent that the 'truth value' of a formulation can be judged according to its capacity to generate new insights, that is, its 'heuristic power'; realism, to the extent that, by deploying perspectives from psychoanalysis and critical theory, we endeavour to illuminate our interviewees' unique, personal experiences of the social relations that form them and are formed by them.' (Hoggett et al, 2010, p.183)

Dreaming ↔ Thinking

> 'The dreams were eloquent, but they were also beautiful. That aspect seems to have escaped Freud in his theory of dreams. Dreaming is not merely an act of communication (or coded communication if you like); it is also an aesthetic activity, a game of the imagination, a game that is a value in itself. Our dreams prove that to imagine – to dream about things that may not have happened – is among mankind's deepest needs. If dreams were not beautiful, they would be quickly forgotten.'
>
> 'The Unbearable Lightness of Being' (Milan Kundera, 1985, p.59)

This second part of describing the 'view points' within the methodology explores the use I made of dreams as part of a reflexive approach in the research method, which included observations, interviews and enquiry groups. I wanted to explore methods which could illuminate the 'hidden from view' dynamics in the study which were generated by my position (conscious and unconscious) within the research. I looked at extending the use of reflexivity in the process, using my unconscious experiences (i.e. dreams) as part of the data generated.

The problem for me was to find a way of exploring my experience that didn't repeat what I already knew and avoided the temptation I frequently felt to describe my internal world in a way that might be palatable to the readers of the study. I found I censured feelings or thoughts that may depict my intentions as unkind, selfish or – the worst for

me because of my past – a racist, and this self-censure often took place during the periods of observation or interview, as I knew I would be recording them at a later date. Pillow (2003) discussed how the real 'rawness' of reflexivity seems to be edited out in smug self-serving accounts by some researchers – losing its power to persuade the reader that what took place was real. Her article encouraged researchers to be unnerved (disquieted) by their reflexive experiences and not to try to explain what could be understood.

> 'My goal in asking these questions is not to dismiss reflexivity but to make visible the ways in which reflexivity is used, to be as Gayatri Spivak (1984-85) states, "vigilant about our practices" (p.184). This vigilance from within can aid in a rethinking and questioning of the assumptive knowledge embedded in reflexive practices in ethnography and qualitative research and work not to situate reflexivity as a confessional act, a cure for what ails us, or a practice that renders familiarity, but rather to situate practices of reflexivity as critical to exposing the difficulty and often uncomfortable task of leaving what is unfamiliar, unfamiliar.' (Pillow, 2003, p.177)

Although Pillow remained highly critical of the ways that reflexivity had been used in qualitative methodology, she did not offer clear guidance as to how researchers could avoid an edited self-serving narrative in their work. She also mentioned the potential difficulty researchers had in exploring events in their own 'community' (be that of cultural, socio-economic or profession-specific sameness), and how the researcher could have attempted a 'closeness' with the subject as a way of understanding their position. This assumed closeness, in fact, did not offer a way of understanding that individual (i.e. participant) and may have even been an unconscious wish by the researcher to avoid the sense of separation that is part of any research (and therapy) relationship.

It seemed that reflexive accounts were fraught with the difficulty of finding a voice that could recognise difference without assuming an 'ethnocentric' superiority to it or express (through a process of identification) an empathy and understanding for the participant that didn't succumb to a description of the researcher's own sense of pain and disappointment. The use of this self-description, on behalf of the research, has given rise to the concern that it has become solipsistic and self-referential, thus forgetting the true purpose a research project.

> '… some scholars see the proliferation of reflexivity talk at best self-indulgent, narcissistic, and tiresome and at worst, undermining the conditions necessary for emancipatory research.' (Pillow, 2003, p.176)

In thinking about how I could be more creative (and at the same time less defensive) in recording my reflections during the research process, I decided to include any dreams I had during the time of the project. This was in response to the work of Lawrence (1998, 2003a) who said that dreaming was a form of 'sustained thinking' (p.609) and can allow us to question taken-for-granted assumptions of how the world appears. I believe that dreams are essentially creative endeavours (as Kundera, 1985, describes in the quote at the start of this section), providing us with a rich source of metaphor that we can use to translate and interpret the world around us.

Segal (1986) said dreams were a form of communication, a symbolic structure: '…the dream is not just an equivalent of a neurotic symptom. Dream-work is also part of the psychic work of working through' (p.90). I thought they would provide glimpses into the unconscious aspects of the study which were more difficult to capture in the self-referring accounts of my self-analysis or feelings towards the participants. As Main (1957) stated, '…the need for the therapist steadily to examine his motives has long been recognised as a necessary, if painful, safeguard against undue obtrusions from unconscious forces in treatment; but personal reviews are liable to imperfections – it has been said the problem with self-analysis is the countertransference' (Main, 1957, p.130).

The dreams I recorded became one of the least comfortable ways I used to approach a description and analysis of the study. They were often in response to an event and seemed to fall into different categories: those about the methodology, about my supervisors, about the participants (therapists) and about the clients I had observed in intimate treatment situations. Having decided to use them as part of my reflexive account I could not ignore them and they would often disturb my equanimity, but they did draw my attention to something I may have ignored or overlooked in doing the work of the data collection or in trying to give an account of the project.

The following dream, 'a staff retreat with a hidden cat', illustrates the process I used, linking a research event, a dream, associations and its subsequent action. The dream occurred early on in the project and was provoked by a very difficult meeting I attended to discuss the research with staff. I had tried to explain the purpose of the project and encourage individual team members (i.e. the OTs) to volunteer to be observed and/or interviewed. However, after I spoke a small number of staff who began to dominate the

meeting said they did not agree with the process I was proposing to use as they didn't think I would be able to understand what I saw. I found that I quickly became confrontational (and competitive) and I tried to use many theoretical terms to prove that my methodology was sound and my work was so significant it would contribute to new theory in OT!

I left the meeting knowing something had gone wrong and that I had 'behaved badly' (i.e. been pulled into an argument), but I couldn't think about what had happened as I was still aggrieved at being ousted by the staff. That night I had the following dream which helped me understand the anxiety that the project proposal might have generated – and it provided me with a helpful understanding of the conflict that had occurred.

Dream 6: Staff Retreat with a Hidden Cat (December 2004)

The dream had two parts. In the first part I was in a day centre working with mental health clients. The staff were in a separate room from the patients, a staff room with a couch and comfortable chairs. Amongst the staff I recognised L. B. (a nurse and friend of mine from many years previously) and R. G. (a more recent South African university colleague who is an OT). The staff were saying they didn't feel well, some were lying on the couch and others sitting slumped on the chairs. The room was darkened and it felt as if the patients were being neglected, as if the hospital was refuge for the staff.

In the dream I was reminded of a day centre where the staff's illnesses seemed to dominate the culture of the unit and the patients were neglected. A senior nurse would come to work and lie in a darkened room avoiding any contact with the patients by saying she was 'unwell'.

It was time for me to go and I tried to leave the staff room by getting out of the windows in the rest room. It was on a horizontal hinge and opened by half the pane going outside and the half of the pane coming into the room.

In the second part of the dream I was in a room full of metal beds – they were old-fashioned, where the mattress was held on a framework of springs that were visible and supported by the metal rungs under the bed. I knew there was a cat hiding in the room but I couldn't see it. I realised that the cat was sitting between the springs above the bar under the bed. There were quite few beds in the room and it was difficult to move around the room.

In remembering and recording my associations to the dream, I began to think about the 'retreat' I had unconsciously seen the staff as enacting and my strong association of the atmosphere of the dream to a previous work experience. I also had known of Steiner's (1993) work 'Psychic Retreats' and Armstrong's (2004) use of this concept in organisational work.

I began to wonder if some anxiety had been stirred up in the team at my request to observe them doing their work. They may have been afraid that I, an academic OT, would see them NOT doing something they felt they should be doing. My reaction to their questioning of the project could also have mirrored (a countertransference response) the very anxiety they experienced in my request to observe them. Perhaps they felt that what they were doing in the acute care setting wasn't real, good or proper 'OT', similar to my feeling that my research (in their eyes) wasn't real, good or proper research.

The 'dream' window being half in and half out reminded me that every defence has another side, perhaps one of thwarted desire. A desire to care for clients that was fulfilling for the therapists, a theme I returned to in the interviews. The cat could have been a curiosity that was hidden from view (i.e. had not been awakened) in the staff group and/or myself. Perhaps I had seen the staff like the metal beds, difficult to move and old-fashioned.

As a result of the dream I was able to think about the confrontation that had occurred in the meeting and I wrote to the staff team the following day. I wanted to thank them for the meeting, and also try to apologise for the 'one-upmanship' that I enacted in the meeting and re-interpret what may have been some of their anxiety. I wrote the following:

> I have been reflecting on some of the concerns raised by some members of your team ... Perhaps I needed to say that all research .... will have a personal emphasis – and it will be that of the researcher as they (I) make sense of their (my) observations. This is a reflexive process including my actual observations alongside a research diary and supervision.
>
> The research is essentially my endeavour to understand occupational therapy for myself – and I am asking the staff in your establishment to help me with that. If the project does lead to an increased understanding within the wider academic and clinical community of the complexity and value of occupational therapy, that would be grand! ... but I will only know what outcomes there may be by doing it. Perhaps if all the staff could look though a copy of the research proposal they may view it within this context ... and feel less cautious about being viewed with a critical lens.

The project did go ahead and one of the themes that emerged from the study was that junior OT staff often felt a sense of failure for not working with clients in the way they thought an OT 'should'. They interpreted this as a personal failure rather than viewing the system, hospital and OT profession as not being able to accommodate the needs of the older adult clients who were approaching the end of their lives.

Conclusion

I have realised that the research process, observation, internal reflections, dreams, interviews and group inquiry sessions were all 'grist for the mill'. It was then up to me to turn these fragments and musings into a coherent account so the reader could reach their own conclusions; mentioned earlier (see page 78) as the concept of 'distanciation' (Kelly, 1999, p.400). There was never a single or correct interpretation of the events which occurred – but I thought if I could provide sufficient viewpoints along the methodological map, the reader may enjoy their own journey through the research process and share in some of the insights gained while developing their own. I did not want to impose any early conclusions on the process of discovery, but as Hammersly (1992), Burawoy et all (1991) and Huisman (2008) indicate, the potential usefulness of a study may not be in the qualification gained (or publications accepted) but in the changes the research brought about for those for whom it was intended. What relevance then did this study have for the OTs in the two departments I worked, LGH and CTGH? Did the study have further application for different clinical OT departments (e.g. long stay forensic mental health facilities) and were the struggles identified by therapists in UK and SA similar to those in other countries?

The move between a 'micro' examination of a context and its relevance for a 'macro' level environment (i.e. social / historical / political context) was discussed with the use of an 'extended case study method' (Burawoy et al, 1991, p.271). This need to move between what is learnt in the crucible of interpersonal (dyadic) care relationships to wider social issues became more evident as I moved the study from the UK to SA. I began to realise that what OTs did was a much a result of their social political histories (i.e. their racial, gendered, class and cultural identities) as it was their early experiences of home and attachment to significant others. I return to a discussion of the methodology in Chapter 6 'Journey without Maps', to deepen the discussion on issues from the psycho-social conscious and unconscious that became part of each research encounter.

In writing some of my reflexive descriptions I felt like a patient of mine who once said of a therapy group, *"the more I said, the more I realised I revealed. It felt like undressing in front of strangers."*' Like the earlier description of the portrait artist (see page 78) I was reminded of the difficulty of positioning myself in the research. Pillow

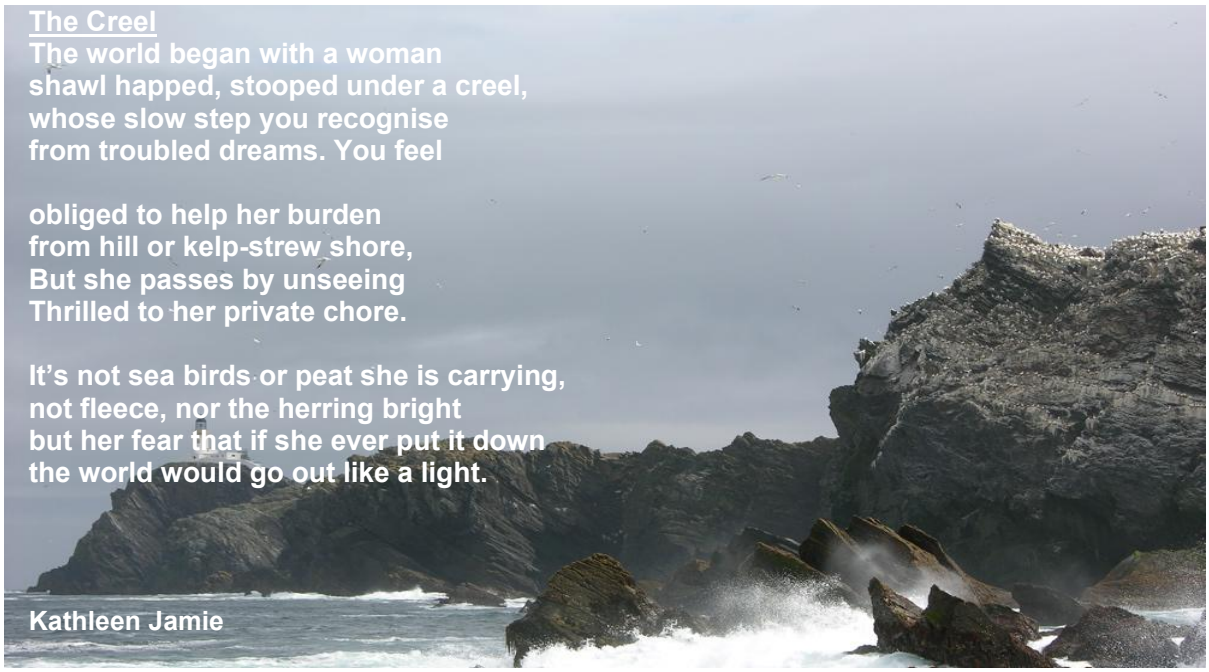
(2003) starts her article on reflexivity with the quote; 'All ethnography is part philosophy and a good deal of the rest is confession (Geertz, 1973)' (ibid, p.175).

Hunt (1989) wrote a helpful text on the methodological and epistemological challenges of undertaking a psychoanalytically informed ethnography study. Her highly reflexive account of the research she did into police work included the use of dreams, her countertransference with the participants she observed and those with whom she formed 'research relationships'. I have returned to Hunt's defence of this methodology in the final chapter (7) to consider the rigour (trustworthiness) of using this methodology (e.g. interpretations of unconscious material) to gain an understanding of the subjects' (participants') world. Hunt (ibid) stated that the choices made (or emphasis given) during the fieldwork and written analysis are often a complex weave of the researchers intentional reasons and unconscious motivations and this mixture of given purpose and hidden (i.e. unconscious desire) is present even **before** the study begins.

> 'The unconscious structuring of fieldwork begins prior to the initiation of the research. The choice of setting itself may reflect an inner dynamic. While any researcher's interest in a particular topic is structured by rational and instrumental factors, additional motives are often at work …My own curiosity about police culture…did not begin with a literature review. It grew out of a dramatic exposure to the subjects. …memories of the facts and fantasies which accompanied my first encounter with police represent only the surface of the complex threads which linked me to them…my romance with the police began long before I laid eyes on my fieldwork subjects. The unconscious fantasies which were mobilised in my first encounter served to fuel my curiosity and even direct the focus of my research.… There are few researchers whose object of study does not condense a richly colored prism of transferences.'(Hunt, 1989, p.29/30)

The fact that I had not considered the social political context of the NHS in the lives of the OTs I observed in the UK (more fully described in the following chapter) may have been related to the difficulty I had in making sense of a history that I hadn't lived. This emphasis was easier to consider in the SA part of the study as I had trained, lived and worked there for 20 years. But it may also have been that in trying to locate myself in a valid role with the participants, I (unconsciously) presented myself as their 'therapist', someone whom they could talk to about their inner lives and work. I had not considered this as a possible dynamic until I began to explore why I had neglected the social contextual area of inquiry in the first part (i.e. UK OT) of the study.

Chapter 4: The Privilege of Burden



(Photo of Muckle Flugga, Shetland, taken by Tom Wright)

'Poems on the Underground', Kathleen Jamie, 2004

A profession which has its central tenet the duty of working with (i.e. caring for) people who become physically or psychologically vulnerable through an accident, illness or change in social circumstances (e.g. redundancy), is often praised or admired by others for coping with the emotional demands of such a job. The personal rewards of working with vulnerable people (clients) have been difficult to separate into grouped themes; some relate to the individual therapist's personal (intra-psychic) needs, and some have been in relation to the context of care, e.g. enjoying the OT role with the assigned responsibility doing a 'discharge' assessment in the multidisciplinary team (MDT) settings. In reflecting on the overall experience of the UK study I found the above poem – 'The Creel' – seemed to articulate my sense that the work being done by the OTs was a burden which many felt was a privilege to bear. It provided some therapists with the possibility for reparative actions (which is in part based on unconscious feelings of guilt and responsibility for others[28]) and for others it legitimitised an identification with their clients' desire to be independent.

[28] My understanding of the unconscious desire for reparation grew throughout this research project, it moved from a pure Kleinian position of reparation as being a defence against anxiety (see Segal, 1988) to one of seeking 'mutual recognition' and the experience of love (see Benjamin, 1990, Winnicott, 1971).

This chapter describes the observations, interviews and group discssions which took place in the London General Hospital (LGH) as the first part of the ethnographic study. Each section is introduced with a general description of the themed area and significant dreams and the verbatim accounts are used as 'thick descriptions' (Denzin and Lincoln, 1994, p.399) of the area. This chapter also highlights an emphasis I gave to the individual motivations of the OTs in doing their work, i.e. I focused on their early life histories as a way of understanding the significance of doing care work. This perspective on the psychological profiles of the individual therapists followed the work of Menzies Lyth (1988) and my own analysis of the reasons why I had become an OT. This focus (viewpoint) changed as I moved to South Africa and began to realise the impact that race, gender, language and class had on the work done by the OTs and in the research relationships I established with them. These aspects of the work undertaken by OTs and the research relationships are described and explored in Chapter 5, 'Another Country' and Chapter 6, 'Journey without Maps'.

The Context of Care

A Potted History of OT in UK

Occupational therapy has been part of health and social care in the UK for the past 86 years. The start of the profession, 1924-1930, was attributed to Dr Elizabeth Casson (1881-1954) who had been inspired by the work (i.e. the use of activities) she had seen in long term care institutions (asylums) in New York, USA. Dr Casson introduced OT into her 'nursing home in Clifton, Bristol' (Turner et al, 2002 p.6) and was responsible for establishing the first OT training school in Bristol, Dorset UK. OT attracted middle class women who wished to be gainfully employed.

> 'Thus, by the beginning of the 20th century, the idea of using occupation in the treatment of the mentally ill had become widely established. Also at this time, it was becoming more socially acceptable for women to take up careers and join the professions; their traditional roles of caring for the sick could now incorporate the expanding knowledge related to that care and, along with the pioneering work taking place in nursing, these caring professions gained more respectability' (Turner et al, 2002, p.5)

The demand for OT and its focus on providing structured work activities in mental institutions changed with the 2nd World War; when a number of men with physical

injuries required long periods in hospital for recuperation and rehabilitation. OT began to incorporate activities (mainly craft projects) into hospital wards which would assist in muscle strengthening and/or mobility for their clients. Many early training courses in OT included teaching these craft activities to the students – hence the often quoted jibe that "OTs are just basket weavers".

There are now 31 recognised training programs throughout the UK and students, on completion of their university degree courses, are able to register with the Health Professional Council (HPC) (Creek, 2002, Turner et al, 2002, COT, 2010). Places at these university courses are currently funded by the NHS, which provides students with the financial support to train as OTs, but gives the NHS some control over the curriculum design and content. There is little mention in public information on OT that attests to its relational (i.e. emotional) work with clients. The recent College of OT (COT) website describes an OT as;

> '…help[ing] people of all ages who have physical, mental or social problems as a result of accident, illness or ageing, to do the things they want to do. These could be daily activities that many of us take for granted, from grocery shopping or brushing your teeth, to more complex activities such as caring for children, succeeding in studies or work, or maintaining a healthy social life.' (COT, 2010)

OT in the UK carried a similar legacy to that of OT in other countries (e.g. USA); it had been founded by doctors and the first OT texts (i.e. OT theory) were written by medical professionals (Serett, 1985, Paterson, 1998). '…occupational therapy was established as a treatment to be prescribed by a doctor, much as a medicine would be. Early occupational therapists were pleased, and indeed proud, that their profession was given credibility through the part it played in the rehabilitation of the wounded soldiers, and were at pains to emphasise the importance of adhering to the doctors wishes' (Turner et al, 2002, p.12). Although OTs, through the establishment of their own professional body (1960) and changes in the Heath Act of 1999 (Department Of Health, 1999), gained a professional independence from having their service 'prescribed' by doctors, an ambiguous relationship with the 'medical model' remains. This can been observed in OTs firmal and informal use of a medically based professional language (Wilding and Whiteford, 2006) and its seeming reluctance to own or use a professional 'power' in multidisciplinary health care teams (Griffin, 2001).

> Historically, occupational therapists have been accepting, non-assertive and have not wanted to rock the boat and this now detracts from their ability to create change. Occupational therapists are notorious for putting the client first and this unselfishness and dedication may not benefit the profession (Polkinghorne, 1982/1983)…. Miller (1992; p. 1017) suggested that occupational therapy is 'outside the mainstream of current power holders both because of philosophical differences and because it is predominantly a female profession when the mainstream professions are profoundly patriarchal'. Grayson (1993) challenged Australian occupational therapists in her Sylvia Docker Lecture by stating 'I put it to you that our behaviour and attitude as women have held back the profession and therefore allowed us to be accountable to males' (p. 57). If power is the ability to influence others and to have what you want then occupational therapists would seem to be powerless according to these authors and need to develop skills to enhance their power. (Griffin, 2001, p.29)

There are many 'potted' histories of OT in the UK (e.g. Dickinson, 1990, Paterson,1998, Creek, 2002, Turner, 2002, COT 2010). Paterson (1998) and Dickinson (1990) trace the UK history of OT to the present day providing highly descriptive accounts of what was done (i.e. activities) based on the philosophy of care of that time e.g. mental health clients working in their institution's kitchens as part of 'work therapy' treatment. There are very few critical accounts of OT as a profession in the UK that use a social / political analysis of its current concerns and debates in relation to its early history and/or the changes that have swept through the NHS over the past 20 years. Most accounts praise the advancement of OT (e.g. its improved status as a university degree profession, see Paterson 1998) or its increased range of work regions e.g. into voluntary sector services and/or 'return to work' government schemes (see COT, 2010).

At the beginning the study (UK) I had not been fully cognizant of the social and political forces that had an impacted on the OTs who worked in the acute care setting I was about to observe. Social and political changes in the health care system have been identified in studies such as Theodosius's (2008) work on 'emotional labour' in NHS nursing, or the potential loss of a thoughtful relationship when the NHS employed the terminology of a 'market based care system' (White, 1997) and the thoughtful scrutiny given to a new NHS term 'choice' by Greener (2009). The description and analysis of what I observed, learnt through the interviews and inquiry group process did not consider these wider social political issues. This neglect of a wider contextual analysis focused my understanding of the issues that OTs described as being related to their personal vulnerabilities (personality) and/or professional responsibilities (work role). For example when one of the UK therapists (Fiona) bitterly complained of her high case

load and pressure to discharge patients quickly, I had not understood her experience to be, in part, as a result of changes in the NHS since the introduction of the 'Community Care Act' in 1990.

> '…in the 1990's centralisation and rationalisation off acute tertiary services, and a shift towards care in the community, reducing the number of hospital beds available … all these factors have resulted in fewer resources and greater demand. Thus, the numbers of patients treated has increased while their stay in hospital has been reduced' (Theodosius, 2008, p.44)].

This regrettable oversight was remedied, in part, by the SA section of the study; leading to my understanding that the relational care work that OTs do is located in a conscious and unconscious psycho-social space (see Chapter 7 for a further discussion).

The UK Fieldwork Site: An Acute Care General Hospital

The London General Hospital (LGH) is located in a central part of London, surrounded by rail, tube and bus links. The whole complex comprises a jumble of buildings, each seeming to have been built with a different architectural emphasis, from old Victoria brick buildings to new high tech glass and chrome. The road to the hospital goes past a large garden centre which advertises flowers for funerals and marriages. I was struck by the irony of the offer of flowers for these two events. It symbolised two strong impressions I had while being in the hospital environment: that patients came to hospital because they were ill and could die, and that for many of the staff the hospital was a social environment where there was the possibility of meeting a romantic partner.

The OT department was in a large modern chrome and glass building that was linked to the adjacent wards through a confusing number of corridors, staircases and lifts. In following the OTs from the department to the various wards where they would assess the patients, I often felt disoriented and unsure of which building I was in or how to find my way back to the team office. The OT suite was comprised of administrative and team managers' offices, a changing room with bathrooms and lockers, a small kitchen, two seminar rooms, an equipment room and a number of team offices. Team rooms were shared between the OTs and physiotherapists, with the physiotherapy staff sitting on one side of the room and the OTs on the other.

Each OT staff member had their own computer, telephone and bookshelf above their work station, there were several printers in the rooms, one of which delivered referrals from the wards to the different teams. Teams were divided into neurology, medical, rehabilitation and orthopaedic/surgery. Each had between six and eight OTs: a senior I OT (i.e. team leader), two or three permanent staff (senior II), one or two junior 'rotation' staff (basic grade, newly qualified staff) and two or three OT assistants.

The first meeting I had with the staff at LGH, described in Chapter 3, became my first observation of the team. I was struck at how young, tired and white[29] the therapists looked, particularly the two team leaders, Alison and Diane. There was only one male OT in this large staff meeting. My impression was that this was a very busy department, the OTs carried a high caseload and they were anxious that I may judge them for not doing 'proper OT'.

I was grateful that the OT staff at LGH accepted the project and the individuals who participated in the project (observations, interviews and groups) were generous with their time and insights; many shared very personal stories from their lives. I was interested in the therapists' understanding of why they did the work of an OT. Because of this 'individual' focus I begin with a brief description of the OTs who took part in the project.

Participants in the UK study

Alison

Alison was a white British woman in her late 30s who was a team leader. She had a friendly and efficient manner and when meeting me for the first time she shook my hand in a firm grasp. She described herself as a 'mother hen' with 'her' staff. In accompanying her to the wards she walked at a fast pace and also greeted many of the staff, whom she seemed to know, in the corridors or wards. When reading or writing notes in a patient's folder at the ward clinical desk, she would engage the staff in conversation and she also answered the ward phone when it rang next to her. She said it helped everyone if staff who worked on the ward operated as a team and not as individual professionals.

[29] Although it may seem incongruous to comment on the racial group of the staff observed, as a South African researcher I found myself being aware of the racial groups of staff and clients. The importance of race, class, gender and language is more fully explored in Chapter 5 (the SA part of the study).

In working with clients Alison was warm and engaged, she often touched the clients and she would discuss treatment options with them, giving them time to consider how they might manage when they got home.

> Alison asked Margi [an elderly woman on the ward] about her home toilet and shower. Margi said previously she could get to the toilet and use the shower, but now she needed assistance and she wasn't sure how she could do it as her husband slept in another room and he was hard of hearing so if she needed assistance she wasn't sure how she could call to him. Alison asked how Margi thought she could do that when she returned home. Alison did not suggest any alternative, I kept thinking of a bell or whistle, but Alison remained discussing what Margi thought she could do. Margi said perhaps she could wake her husband when she got up and walked toward the toilet, so that he could be awake if she needed assistance to get up off the toilet and return to her bed.

I felt comfortable with Alison from the start of the project, she seemed able to care for all those around her and I found I was soon included in this warmth and concern. I felt close to Alison, sometimes I found myself identifying with her (I can also be a mother hen) and at other times I wished she could have been my therapist.

Diane

Diane was a white British woman in her late 30s and was also a team leader. She had worked in different hospitals and at the time of the study was not sure if she would remain at LGH. She had an exuberant personality and would often refer to her life outside of work, which included theatre work and socialising in the pub.

Diane offered guidance to junior staff on her team by using a mixture of seriousness (clinical advice) and humour. Caitlyn had a very unpleasant incident where a patient was verbally aggressive towards her. Caitlyn had become quite distressed and returned to the office to calm down before seeing other clients.

> Diane returned and Caitlyn told her that a patient was really abusive towards her. Diane said, 'Would you like me to take the patient off you or take him out and shoot him?' We all laughed at that.

Diane withdrew from actively participating in the study after the second FANI interview. In often referring to her social life she seemed to be defending against any feelings of loneliness or neglect.

> Diane had a slightly swollen face and seemed to have a blocked nose, I asked her if she was okay and she said that she had fallen on her face as she had fainted and it was quite bruised. She said she had been away for the weekend and had probably

> drunk too much … she had fainted and landed on her face … She said it in a light-hearted way as if 'girls will be girls'. Diane speaks quickly and often adds self-depreciating statements in what she says, as if to make a parody of her experiences.

After the end of the second part of the project (the interviews), when Diane withdrew from any further involvement, I had the feeling I had let her down and I have explored this dynamic later in this chapter by reflecting on a dream Diane told me.

Caitlyn

Caitlyn was in her early 20s, British, white and was a newly qualified therapist doing a rotation post. She spoke with a confidence that seemed to come from a good technical knowledge of the profession. She was an attractive young woman with a bounce in her step, she laughed when I asked her if she was engaged and said she was 'far from married!'

Caitlyn was formal in her approach to clients and followed standard assessment process (e.g. OT forms) for establishing if clients were able to return home 'safely'.

> The patient (Eric), an elderly thin white man, was having his hair brushed by a nurse as we arrived. He had had a skin graft (on a leg ulcer) and his bandaged leg was elevated on a stool in front of him. Caitlyn asked for detailed information and would repeat the questions in a number of ways to elicit answers, e.g. 'tell me again, when you approach your front door, are there steps which you must walk up to the house?, 'how many steps are there outside your house?', 'is your front door at pavement level?' etc.
>
> Eric was a quiet and dignified man, perhaps somewhat shy of the questions from a young attractive OT. Caitlyn asked what he did on the day he didn't go for a meal at the Age Concern project. He said he drives to see his 'lady friend'.

Although Caitlyn followed the written procedures of the OT assessments, she was sensitive to the circumstances of the individual clients and would observe them without stepping in and helping them, something I often found myself wanting to do[30]. In listening to the interviews with Caitlyn, I was dismayed to discover how frequently I mentioned her age, in relation to the clients or the other therapists. I wondered if I had been slightly envious of her youth and unconsciously might have made her feel that to be older was preferable for working with these clients.

[30] An observation between Caitlyn and Simon is described in Chapter 1 (p.5).

Fiona

Fiona was a young white British therapist who had completed a year of her basic grade rotation post. She was leaving the hospital to work in another city. She always looked tired (she had a pale face that showed up the dark rings under her eyes) and worried.

Fiona said she had thought that too much was expected from newly qualified OTs in the acute area and that she was constantly worried about the clients on her list that she could not get to see. Some of those were discharged from hospital before they had an OT assessment. Fiona said she felt drained by the demands of the work and that the families often needed counselling when their parents or partners could no longer cope at home, and all of that could take time, which she seemed always short of.

During her interview Fiona spoke openly about how stressful she had found her work and that she often felt as if she wasn't doing a good job and she was letting people down, particularly the other members of the team. When I asked Fiona why she had volunteered for the project, considering she had felt that she was not managing as well as the others, she said she wanted me to know what she experienced and that it had helped her to have some feedback from the process (she saw the interviews as a reflective space).

> **Lindsey**: Why did you volunteer … if inside you felt this job was not your best?
>
> **Fiona**: … to have somebody to come and observe your work and what you are doing … who has got you know you … has got more of an insight probably … that is why I did it, even though it is quite nerve-racking it is quiet scary.

I felt she wanted someone to witness her distress, perhaps with the hope that it would not get passed on to the new recruit for her post and perhaps, by telling me about it, she wouldn't carry it into her next job.

Heather

Heather was recruited into the project after Fiona had left. She was an older woman (in her mid 40s), white and British, who had recently qualified as an OT. She was familiar with the OT processes, she had been an OT assistant in the Trust while completing her degree. She was an attractive, slim woman with a quick walking pace and she would engage in lively conversations with the staff and clients on the ward. She seemed to have a 'working class' accent and although my ear is not finely tuned to British accents

I did notice that Heather had a different way of speaking to Diane, Alison and particularly Caitlyn, the other basic grade working with her.

Heather had agreed to being observed and to doing the two FANI interviews, but after the first interview she cancelled the second interview (for work reasons) and did not volunteer for another one. I worried that she may have felt she had said too much about herself in the first interview and she didn't want to re-engage in the process of reflecting on how her personal experiences had influenced her work with clients.

> **Lindsey:** I am interested in … about the way [you] process emotions … at work…
>
> **Heather:** I think a lot of it has come from myself … literally through experiences and although it sounds awful … actually now when I look back I think it has prepared me so much better … out of every negative you will get at least one positive … one learning… so I don't see very much in my life any more as negative…
>
> **Lindsey:** When you struggled … in your personal life … did you seek any counselling at that stage to … help you work with things…
>
> **Heather:** …therapy? When I was younger … no … there was lots of things that happened, never! It was offered to me, people came to the house … no … fine I can do it , pride, that's all it is … [I] became a widow five years ago … and I did something … and it was on advice from my manager … for about three months … I thought what was that all about … but … I think it just started a process that makes you feel it doesn't matter what you are feeling you are totally human … everything that happens is a process, a cycle, you may get stuck in it, but you will continue going through it … you know … you can't have a child, watch it grow up, watch it leave without any … without learning and getting something…

During the interview Heather spoke for long periods of time, barely drawing breath. I wondered if talking was her way of keeping her feelings (and me) at bay. She had told when she was a child 'people had come to the house' (I wondered if it was social services) and that when her husband died she had 'done something' (probably seen a counsellor), but it was after this interview that she decided not to have a second one. She had told me she liked to put things behind her, and perhaps I got put behind her!

Heather did come to the third inquiry group with Caitlyn. They seemed to gain confidence in each other's company and would complete each other's sentences, as if thinking with the same mind and speaking with the same voice.

Chetna, Beverly, Janet, Lee and Lisa

These therapists joined in one or two of the inquiry groups held at the last stage of the project (see the table presented on the UK inquiry groups in Chapter 3, p.71). They were co-opted by either Alison, who was their team leader (Chetna, Lisa and Lee), or by the acting head of the OTs who saw me arriving to run the scheduled inquiry group and suggested they join (Beverly and Janet).

I did not get to know them as well as those described above, although these OTs made useful comments on the themes which had arisen from the study to that point. Each inquiry group began with my giving a brief description of my 'findings' in the study as a way of inviting their comments and reflections.

Themes from the UK study

Too Many Demands and Not Enough of Me

The hospital, the wards and the OT offices were always places in which there was a great deal of activity. Staff often spoke quickly, meetings were efficient and timebound, assessments with clients were procedural and actions were decided upon and taken within one meeting with the client. This included navigating complex emotional areas such as eliciting descriptions of the care which may be provided (or not) by relatives, ordering equipment and communicating decisions with the client and staff.

> The patient (an elderly African-Caribbean woman) talked slowly and seemed to not always follow what Alison was asking. Alison was to assess if the patient could manage at home and asked what resources were there, particularly for getting to the toilet and back, as well as washing herself.
>
> The patient said she was cared for by her grandson, she was all right except she would like to be able to sit outside. When Alison asked how she would be able to do that, the patient began to cry and said that she had asked her grandson but it wasn't easy. Alison sat next to her, put her hand on the patient's arm and asked if things were difficult with the grandson. The patient nodded, and the Alison asked if the patient was ever hurt. The woman said no, but she didn't get to go outside.
>
> Alison asked if a wheelchair might help her. The woman said yes, then she could go outside and see what was going on. After asking if she could speak to the grandson, she phoned him and suggested where he could access a wheelchair and also suggested a home service to help his grandmother with bathing. Alison communicated all of this to the client while encouraging her to use the Zimmer

> frame to return to her bed and help her back in. This whole process took 40 minutes.

This assessment process was driven by the emphasis on 'discharging' the patient. The OTs felt this could place an unfair amount of pressure on them as the ward staff would seem to wait patiently for a technical procedure (e.g. an x-ray or the results of a blood test) but if the ward wanted an OT assessment before the patient could be sent home, they would complain that the OTs were 'behind'. This pressure to get clients 'home' was misinterpreted by Fiona, who thought that a patient who insisted on staying at home was 'one less' for the ward to manage:

> Fiona said it was hard in the beginning because she thought she needed to discharge the patients as quickly as possible. She told me of a home visit (with the patient) where he refused to come back to the hospital. She had tried to persuade him, but he said he wanted to stay at home. She came back to the hospital thinking she would be thanked for having 'got rid of a patient;' but the staff were angry, saying she should have contacted them She had misunderstood the messages of getting patients 'out' of the hospital, she thought the ward would be pleased he had gone! She said the ward wanted what was best for the patient, I thought the difficulty was in trying to manage the risk of a discharge.

Many of the OT staff felt under pressure to complete the assessment by the clients, who would anxiously ask when they could get home. This pressure (i.e. the time each assessment took and number of referrals) left some staff feeling they weren't doing their job well as they couldn't keep up with the demands. This placed them in an impossible situation which eroded their sense of professional confidence/purpose.

During an inquiry group the participants talked about how they managed their work tasks and how stressful it was when the patient was very ill and the family wanted someone to **do** something, help in the situation. Alison said there were times she felt that there wasn't enough of her to cope with these multiple demands.

> **Lee**: Some patients or families are very pushy. [We] Always try our best, some aren't satisfied, even when you are doing all that you can do.

> **Alison**: I had a lady, her son was dying, she used to phone me every day and say Alison you are such a good therapist … have you managed to get me that recliner chair yet, she would phone me every day. I can remember after a week of this, he was getting more and more ill, I was badgering the commissions, … we ended up purchasing it [the equipment] with her money. At one stage when she rang me and said this isn't good enough I ended up crying my heart out in the toilets, so embarrassing because they could all hear me. Sounded like someone was howling and it was just me saying there is not enough of me. Feel you just want two people because there is not enough of one person. He died recently.

I had wondered if the frantic pace of the work (e.g. the number of clients, the complexity of assessments and impact of the decisions made) were a manic attempt by the OTs to 'keep-death-at-bay' (Obholzer, 1994b, p.171), or at least to get the patient home or into residential care before they died in hospital. This was not only the case for the OTs but all the hospital staff (nurses, physiotherapists and ward managers) seemed to work at this pace. It reminded me of the description in the book 'The unconscious @ work' (Obholzer & Roberts, 1994) by Roberts in her chapter 'The Self-Assigned Impossible Task' where she described how care workers' 'inner needs and conflicts make them vulnerable to getting caught up in institutional defences arising from shared anxieties' (p.110).

Multidisciplinary Team Work: Chaos, Co-operation or Competition?

I was often amazed at how busy and noisy the hospital was. There was a continuous movement of staff walking from one place to another, unloading trolleys, pushing clients in wheelchairs, working at reception desks or cleaning ward floors. Clients sometimes seemed out of place in all this busyness because they were static (often in beds connected to monitors) or on trolleys or wheelchairs being taken from place to place. There seemed to be more staff than clients in wards or corridors, and much of the staff time was spent in talking to each other about the clients. At times this was to confirm and communicate information about a client or a brief reflection on an event concerning a client.

> I heard the ward sister talking to a junior nurse. She said a patient (Jake) had died, and in a hushed lowered tone, that he had died from an overdose. She seemed upset and looked distracted. She said Jake had come to the ward the previous week to say hello, she said they had all worked so hard on him. They had a call from the drug and alcohol liaison nurse to say he had died.
>
> While this was taking place I was aware (again) of how busy wards were. Next to the nurses' station a porter was unloading boxes into a store room, there was cleaner who moved down the ward with a mop and bucket, the physiotherapist came behind the nurses' desk to look at some folders and spoke to the OTs who were writing in the notes. Behind the nurses' station, two doctors were using computer terminals to write their notes. I was watching the number of interactions at any one time that were superimposed on the discussion about the patent who had killed himself. An older woman approached me to ask if she could visit her friend on the ward. I directed her to the ward clerk who told her which room her friend was in.

I observed a staff meeting on an acute medical ward. These were held twice a week for multidisciplinary team members (MDT) and focused on discharge planning for the

clients. The MDT comprised of nurses, OT and physiotherapist, no doctors or social workers were present. I noticed the potential for competition between the team members as clients were allocated for 'further assessment' or assigned to 'no further action' as they would be moving to a rehabilitation facility.

> The MDT was held in the 'quiet room' on the ward. It comprised a head nurse, OT, physiotherapist, staff nurse and a student nurse. The staff nurse and student nurse did not speak once during the meeting. The physiotherapist, wearing a stethoscope round her neck and blue trousers, spoke the most, giving feedback about the patients. I wondered if she was competing with Fiona (the OT) and if my presence had increased the sense of rivalry between them, after all I had another green uniform on! The physiotherapist seemed more familiar with medical terminology which made her appear more 'powerful' and her talking seemed to make Fiona more tentative.

This potential for MDT members to compete with each other may have benefited the clients, e.g. joint assessments and interventions would be done by the physiotherapist and OT. But there were other interactions where clients seemed to be used by staff who sought to position themselves as having more authority in relation to another category of staff.

> I watched an interaction between a porter, a nurse and a patient who was seated in a wheelchair. The porter had come to collect the patient for a procedure. The patient was a frail looking middle-aged woman who was smiling and talking with the porter and the receptionist. The receptionist asked the porter (who was a dark skinned man in his mid 40s) if he had the patient's notes. He said he didn't and she should give them to him. The receptionist (a middle-aged black woman) said he fetched the patient so he should get the notes. There was an argument developing and the patient began to look down, she didn't say anything. The receptionist went to get the notes, gave them to the patient, who then held them on her lap. The porter wheeled the patient out of the ward looking angry. The receptionist said aloud that the porter was 'ignorant'.
>
> I was struck by the patient's vulnerability (her nightwear, the wheelchair), she seemed to have so little power and staff conflict could increase her feeling of vulnerability. The patient had stopped any eye contact when the conflict began – she seemed to shrink into herself. I wondered if the porter could read, perhaps he was illiterate and was hiding it from the receptionist.

Much has been written about the benefits of MDT work in health care (Atwal & Jones, 2009, Hall & Weaver, 2001), but it seemed to me that when the status of the different staff groups was under threat, it was the patient who paid the price in the fight over who was right or knew more. I wondered who would mediate when these conflicts arose.

Vulnerability, Nakedness and Death

When arriving for my first meeting with Jessica to discuss the possibility of doing the research project at LGH I was struck at how the clients – elderly, fail and in hospital pyjamas – were the ones who looked out of place in the new building. The atmosphere of busyness, social interaction and administrative processes seemed to deny the reality of the clients' vulnerability. In going onto the wards and seeing the physically frail clients, I realised not all recovered in hospital, some died.

This contrast between the staff activity and the immobility of illness was also reflected in the difference between the OTs and their clients. The participants were young, female and often had an energetic walk and purposeful way of addressing clients e.g. asking them about their home circumstances or to demonstrate their self care routines. It seemed as if the OTs did not notice that their clients were much older men who may have found these requests, by a young woman, humiliating. (e.g. see Chapter 3, the interaction between Sydney and Fiona, p.78)

During an observation period (with Caitlyn) an older male client became angry with her as he felt she had not given him sufficient advice and help with his return home. His anger seemed to be a fear of returning home; he said there was no one there who would be able to care for him. I wondered if he was afraid of leaving the security of the hospital. I felt my presence as an older professional woman with Caitlyn created an audience for his anger, and it may have added to her sense of humiliation.

> Dennis, a black man in his early 60s with an African-Caribbean accent had a strong-looking compact body. He walked with two elbow crutches and was dressed in shorts and a t-shirt. Caitlyn asked how things were going for his discharge and he started to complain about his treatment. He said she wouldn't know about his difficulties as she had never been to his house to see what he needed. When she said she had called his wife to measure the height of the chairs, he seemed to become more agitated. He said that when his wife was unwell he had looked after her, he had to bathe her. He demonstrated how he had lifted her out of the bath (he cradled his arms as if lifting someone out of a bath) and asked who would do that for him?
>
> Caitlyn tried to reassure him, she asked about a chair he could sit on in the lounge, he became more agitated and said 'what chair…what chair', adding 'who will move my chair, who will help me'. With this he wasn't looking at her but seemed to be appealing to me to understand that the help he had been given up to this point had not been of any use – he also seemed to be asking Caitlyn to 'do something'. It seemed that it didn't matter what Caitlyn suggested it wasn't going to be good

> enough. He kept saying that she should have been to see his house for herself. I had an image of a small boy who didn't want to leave school as he had probably received a lot of praise from the staff for 'getting better' and that he didn't want to miss the special attention he got for his recovery.

Caitlyn was visibly shaken after this tirade and she went through to the nurses' office and began to cry. She said she didn't understand why he had been so upset and that she had done the same for him as she did with all the other patients who had had 'elective surgery', as if doubting her professional ability. When a nurse came in and saw she was crying she said that Dennis had been 'like that' since he had heard he was being discharged. She said she didn't think he wanted to go home.

During the observation period I had a dream about my father, who had died ten years earlier in a hospital. At the age of 65 he had gone for elective surgery on his femoral artery and following the operation had been allowed up to walk to the bathroom and he had died instantly from a heart attack, as a blood clot was dislodged and entered his heart. It had been a deeply shocking event for my family and I wasn't aware of thinking about it until I realised that with each of the older men I saw in the hospital, I would look for my father. I imagined how he would have been very irritable with any request from a female therapist to demonstrate his skill in being 'independent' in his self care.

Alison had done an assessment of a client (Phillip) who had cancer in his liver and pancreas and was to be sent home with a 'palliative care pack[31]' (i.e. to die). This observation evoked a strong emotional reverberation in me (and later dream) as I began to wonder how my father looked before he died and if the staff had cared for him.

> Phillip was sitting upright on his bed, he was in his late 60s and very thin. His shrunken face made his glasses seem even larger and he had an oxygen pipe in his nostrils, the clear plastic pipes hung below his chin. Although he was pale and thin I could see he had been a fit and active man from the shape of his legs and arms – they carried the feeling of muscles and fast movement.
>
> He spoke slowly and softly as if speaking was an effort, breathing in before he began a new sentence. His feet, which protruded from the blanket placed over the lower half of his body, were swollen at the ankles, puffy and bluish, and some of his toes had bunions and crossed over each other.
>
> I did not look directly at Phillip but found myself looking at his feet and remembering my father's feet, they looked very similar. When my father died in hospital I was in another city and my sister had gone to ward to speak to the staff. I asked her about all that had happened and she told me that she hadn't see my father's body, but saw his feet sticking out from the blanket. As she told me this I could imagine what it was like

[31] This included an inflatable mattress which prevented pressure sores and an oxygen supply.

> to see his feet; they were quite deformed from having worn incorrect shoes in his youth and his toes crossed each other, like Phillip's did.

The time that Alison spent with Phillip was deeply moving to watch. She was able to ask him, in an unobtrusive and natural way, about his concerns in moving back home. During this brief exchange she realised that he was anxious about dying as he felt his wife would not cope without him.

> Phillip said that in December (1 month earlier) his ankles had become swollen and painful and they diagnosed that he had cancer of the liver and pancreas and said it was also in his lungs. He was shocked and couldn't understand why he had cancer in his lungs because he hadn't smoked for 40 years.
>
> Alison asked how his wife was managing and he said that she was 'being cheerful'. He spoke about his two sons and became quite tearful, saying they were 'little gems'. He spoke more softly and seemed to struggle for breath, his oxygen had slipped out of his nose and Alison helped him replace the pipes, saying it would make it easier for him. Phillip said he was sacred of using the oxygen as it made him sleepy and, he said with a soft voice, that he was scared that if he fell asleep he wouldn't wake up.
>
> Alison said that he needed to have little naps because of his fatigue, even a small effort would tire him out and little rests were important. She said his energy was like a glass of water and when he used his energy it was like emptying the water out of the glass and he should have rests so the glass could fill up again. As she said this filled a glass next to his bed with barley water.

Phillip said he was afraid to die as he felt his wife would not cope with all the things that he used to do, he also said he wished they could talk, but they were seldom alone and he didn't want to upset her. Alison was able to offer some practical suggestions that would allow him to conserve his energy and do the tasks he needed to.

> Alison left Phillip's bedside because her bleep went off, I wasn't sure what my role was once the OT had left the patient's side. I was scared to be left with a man who was dying, I didn't know what I could say or do that wouldn't be an intrusion or meet my own need for reassurance. On the one hand I found myself looking for anything I could do that may ease his physical distress, e.g. moving a magazine closer for him reach so he wouldn't have to lean too far, but I was afraid of his vulnerability. I didn't want to be available for a request for information or even reassurance.
>
> Alison walked back into Phillip's cubicle and he had dozed off. She took his arm and he woke up and said, 'I am scared if I doze off I won't wake up.' His eyes were wide and his words were an effort to speak. Alison held his arm and said she thought he would wake up. Phillip looked at her and said, 'Do you think so?' 'Yes,' she said 'you will wake up from these sleeps.'
>
> This moment between them was very poignant, an older man who was resisting nodding off because he was afraid he may die, and a younger therapist holding his hand and saying 'naps' were important for him to conserve this strength and they weren't the end. All of this was communicated by her smile and touch (a firm

holding of his hand). I found myself become tearful and grateful that Alison could give comfort to this patient.

Alison contacted Phillip's wife to ask her about the arrangements for Phillip's return home and it was during this conversation that Alison realised Phillip's wife wanted time to talk about his illness and what to expect. Phillip's wife had felt her request had been ignored by the medical team and Alison said she would ask the consultant to speak to Phillip and his wife on their own.

Alison put Mrs P on hold while she called the consultant's secretary. During this conversation the secretary said that the consultant was very busy and didn't have time to speak to 'every relative'. Alison listened to this and said; 'I am sure Dr X has many patients, but you see Mrs P has only got one Mr. P and so she really wants to speak to Dr X about him. When do you think he will have some time to speak to her in a private place and not in front of the ward round.' From this explanation she got a time that the consultant could see Mrs P.

I was impressed at Alison's calm persistence with the consultant's secretary. She had communicated the urgency of Mrs P's request as well as showing her understanding of how busy the consultant might have been. When we were walking back to the OT department I asked Alison how she managed to keep her cool; she said that it may appear as if she is managing but inside she is 'raging'. Her neck was red and blotchy while she was talking to me and I asked how she coped with her rage. She said, 'I eat chocolate' and laughed. It was a pressurised laugh.

It was the night after this observation that I had the following dream. I hadn't been conscious of how deeply the observation of the interaction between Phillip and Alison had affected me. While in the hospital I had been aware of thinking about my father, and wondering how the staff (he had been in a South African hospital) had felt about him. In the dream I seemed to be preoccupied with items of furniture (objects) that seemed to have been taken from me. The objects (e.g. an antique desk) symbolised my father and the loss of him (his death) as if he had been stolen.

Dream 7: My father's desk (January 2005)

I was visiting Timothy's [a distant relative's] *house and noticed that he had some of my father's furniture. I was upset to see it there and I asked him if it would be possible for him to give it to me as he wasn't using it – I said I would pay him for it. As I was leaving I saw he had my father's desk (a beautiful old Sheraton desk) and I realised that Tim wouldn't agree to part with this desk. I was furious that he had it as it had been promised to me when my father died. I thought I could steal it – Tim didn't know where I lived and he wouldn't be able to get it back – but then I remembered what I really wanted was my father and his ashes were in the desk so I took them. They were in a large cardboard box with a painting of red poppies on it.*

The dream was provoked by my watching Alison's interaction with Phillip. She was able to respond to him with compassion and it had stirred a longing in me to have had such a good and close relationship with my father. His death had stolen any possibility of reconciliation between us, or recognition of each other, which could have extended beyond the disappointments and recriminations that had been part of our relationship. The theme of care work (i.e. relational work) being driven by an unconscious need for reparation and/or recognition is discussed later in this chapter.

Uniforms and Uniform Terminology

In making the initial arrangements to start the project at LGH, Jessica (the OT manager) suggested I wear a uniform so that I could blend into the ward environment. This uniform became part of my reflexive process as I realised that I gained an invisibility by wearing it – I became another member of staff that thronged the busy corridors of the hospitals – but it also made me feel like an impostor. I had no therapeutic function on the wards and so when approached by a patient or relative for help I could do nothing to assist them.

> A person stopped me in the corridor to ask where a ward was. I realised that the uniform I wore was a liability as it was a sign to others that I would be able to assist them. I wondered on whose behalf the uniform was worn (them or me). I had a College of Occupational Therapists badge on my uniform. I wondered if this additional symbol made me appear more knowledgeable.

The uniform seemed to symbolise my difficulty in maintaining an observer role when with the therapists on the wards. I would find myself asking them about their treatment or a diagnosis as if I knew what I would do or the diagnosis was familiar to me. My wish to appear competent and knowledgeable occurred more while I had the white tunic and green trousers on than when I wore my own clothes (e.g. doing the interviews and inquiry groups).

The uniforms also seemed to rank the professionals who worked in the hospital: nurses, physiotherapists and OTs wore uniforms, while the doctors and social workers didn't. Junior doctors (or registrars) would wear fashionable clothes (e.g. chinos and t-shirts) with an identity badge and stethoscope to indicate their role, and senior medical staff (e.g. consultants) wore a suit and tie. I had understood that uniforms were a mechanism of infection control, but doctors did not use any protective clothing (e.g. a white coat)

when examining a patient. I did find myself thinking about the 'super-bug' threat in the large hospital and how the doctors seemed to be fairly nonchalant about the possibility of carrying infection from one patient to another.

Jessica also never wore a uniform; she was a slim tall attractive older woman who dressed in tight-fitting fashionable clothes, at times appearing incongruent in the occupational therapy environment of green uniforms and assistive devices (e.g. Zimmer frames and toilet seats). While doing a period of observation in a team room, Jessica had walked into the room without seeing me, later saying she hadn't realised I was there. Her clothes and figure exuded an attractive femininity and when I was with her I often felt awkward and large and it seemed that wearing a uniform emphasized that aspect of me. I wondered if Jessica's insistence that I wear a uniform was an unconscious positioning of herself in relation to my role in the team, as if there were an unconscious rivalry between me, a researcher, and her, a manager.

During the period of the inquiry groups I had a dream about a person who appeared to be one person but, when they moved slightly, they were another.

> *Dream 8: Both Sides Now (June 2005)*
>
> *A woman, who was standing next to me, was telling me her name, she said it was one name, then she did a small movement with her hand and body (turning her hand over and moving to one side) and she said she had a different name, like a card that has a different picture on both sides – or a coin with two sides).*

My association with this dream was that the participants (therapists) may be showing one side of themselves (to me or the clients) but there was also another side they would tell me about (or I would see). I wondered what function the uniform played in helping therapists in their work. Heather and Caitlyn, in the third inquiry group, spoke of how they felt about wearing a uniform and I was intrigued by a comment that Caitlyn made, that a uniform 'keeps you in'. This insight began a series of associations by the OTs as to the value (and role) of wearing a uniform. I told them about my dream and wondered if they sometimes felt as if they had 'two sides'.

> **Lindsey:** You said that when you put your uniform on it 'keeps you in'.
>
> **Caitlyn:** [laughs] Yes!! you don't relax as you would do … or you are not as emotional as you would be usually.
>
> **Heather:** I think you are still you but it is almost as if it has a shell over it. You use all your attributes you have got to get a patient engaged but it is not on a personal

> level because they don't know Caitlyn, this uniform keeps that in. But you can use what you want. It's almost like going into a bag.
>
> **Caitlyn:** In the changing room in the afternoon we are probably the loudest … the most stupid and the most honest with each other. It is really strange because we are with each other all day… but we choose that time to be free to talk about what we want to talk about.
>
> **Lindsey:** Do you ever feel there are the two sides, so that one side is professional and caring and then there is the other side that just …
>
> **Caitlyn:** Actually a new assistant in team is finding that quite difficult with us because we have a joke in our office … and he finds it difficult to know when that stops and then when we are on the ward we act differently. People find that hard to begin with.
>
> **Heather:** For us it is second nature, from one thing to the other.

I returned to this topic in the fourth inquiry group and asked Janet and Beverley if they understood the comment that 'a uniform keeps you in'. They said a uniform provides a professional role making it possible to ask (difficult) personal questions of the client.

> **Bev:** I suppose it is a bit like that. It is like a role play. Me at work is really quite different to me out of work … like assertiveness …. I am very aware that I am very different in work especially when I am out with my family, [laughs] like a child again, a daughter, a sister.
>
> **Janet:** With some of the personal questions, I don't know that as just me I would be comfortable asking but as Janet the Occupational Therapist, that's part of my role and part of my job, maybe in that sense it keeps you, and in a hospital it is important because you are easy to identify … when people see you in a uniform and trust you in a way, you are a member of the hospital team, you are a professional.

In describing their work situations or experiences with clients the participants (OTs) often used words that were so familiar to me, I did not consider questioning them or even wonder if I had understood them. This shared language was part of the discourse in occupational therapy and the words used were central to how therapists spoke about and interpreted their work. There had been an appeal in the profession to develop a language that was a 'uniform terminology' (see Wilcock, 2002; Wilding & Whiteford 2007) with the idea that words would be used and understood in the same way by all occupational therapists.

In reading a publication 'Occupational therapy defined as a complex intervention' (Creek, 2003) I was struck at the uncritical descriptions of words such as 'independence' and the emphasis on the therapist's goodwill (i.e. intentions) when working with clients. There was no attempt to understand a client's fear or vulnerability

(like Dennis with Caitlyn described above) or the client's capacity for self-destruction (Hoggett, 2000). All was 'good': therapists' intentions were unambiguous, clients responded to being valued and if provided with an opportunity for action, all wanted to be independent.

> The client's engagement in the process of therapy is the most important aspect of intervention; therefore occupational therapy is most effective when it is a partnership between the client and therapist. The therapist-client interaction is a dynamic, collaborative process in which choice and control are negotiated and shared and in which the client participates actively in setting and realising goals. (Creek, 2003, p.29)

While doing the project I noticed that there were certain unquestioned assumptions about what 'independence' was; it was often interpreted as being able to 'do something for oneself' and it was assumed by the participants that every client would want to strive for this kind of achievement. In other words, to not want to be independent may have been a sign of illness (or moral turpitude).

Achieving 'independence' supposed that clients were able to (and wanted to) perform daily living tasks without another person's help, for example washing and dressing themselves. Many of the interventions with clients included encouraging them to use 'assistive devices' which would allow them to perform these tasks without help (e.g. a long-handled sponge for washing their back or feet, a trolley that could be used as a walking frame, a stool to sit on in the kitchen to conserve their energy while cooking etc.). These devices would be given to client as part of a discharge plan. Fiona, in describing her discomfort at the fast-paced work of the acute setting, said that she sometimes felt that they 'threw equipment' at the client as a way of getting them home, whereas if she had more time they may be able to do it for themselves.

Fiona said that on rehabilitation wards (where clients stayed in hospital for a period of time) the OT team would only give equipment (assistive devices) as a final resort, but in working on the acute medical team she found that giving equipment was something she felt she could 'do for them' (the clients) and so she would give as much equipment as she could as if this was treatment or therapy in itself.

The participants said that their written reports (patients' notes) on the assessment and interventions they had undertaken with a client did not reflect the internal processing or relational work between themselves and the client. There wasn't a 'medical' language that could explain the client's fear of dying or account for the time taken to listen to a

client. In the first inquiry group Lee described how she thought physiotherapy was easier to understand for a medical team.

> **Lee:** Physiotherapy is so much easier because you can see a patient do their exercises … seems to be so more cut and dried. In OT [you] try and encompass everything that we do and you can't, you can't write down all the things you do … can't write in the notes that the patient was discussing his will … that he was crying the next morning about that. Can't really write that down and quantify that as a treatment.

The participants said they would use 'medical language' when they wanted to distance themselves from a client because the client's injury was shocking or hard to imagine for themselves. Caitlyn spoke about how she managed her feelings when she worked with a younger man who had had a traumatic amputation (i.e. unexpected amputation, often as a result of an accident). I had noticed that Caitlyn, when asked about clients or her distress, would say that she 'doesn't think about it' and so I mentioned this to her.

> **Caitlyn:** I have an amputee, a chap who has a lower limb amputation and he is about in his 50s. I think I find it harder to relate to him I think than I do the elderly.
>
> **Lindsey:** When you talk to him … do you ever find yourself getting in contact with his shock, his shame, his sense of bewilderment about a loss of a body part …. [or] as you say 'you don't think about that'.
>
> **Caitlyn:** [laughs] Maybe … that is where I try to stop being an OT and start thinking more medical like, [laughs] … yeah and that's probably where being around the doctors in such an acute environment, you try to think about it just as a diagnosis … I know it sounds hard. Obviously when you are with the patient you are aware of how it affects them … but yeah … I do …

The use of this language in OT was very powerful, I found that I would sometimes speak as if I understood terms that would 'show' my knowledge (and perhaps status) to the participants. Although I had told them I wanted to observe an area that I had no clinical experience of in order to see it with 'fresh eyes' I found myself wanting to act as if I knew more than they did. I wondered if I was trying to show that I, too, belonged to their club. When I used words like 'countertransference', 'reparation' or terms like 'the envy of the care offered to clients', they seemed out of place.

Relationships: Identification, Repetition, Reparation and Mutual Recognition

This section aims to describe the relationships between the therapists and their clients. In organising the material I have used a layered / laddered approach (see below) by placing the categories below each other. I have tried to use this as a depiction of the move from the more consciously expressed or observed interactions towards categories which are less conscious or unconscious in relation to the acknowledged parts of the self and motivation.

These sub-themes with the relational field are not distinct (separate) from each other, they are layered and overlapping. The diagram below presents them as separate entities but they would be better portrayed as running into each other, like ink blobs on wet paper. The four terms I have used to try and describe the layers of the relational work undertaken by the therapists are: identification, repetition, reparation and reciprocity (or mutual recognition).

Identification (superficial recognition) **A**				Conscious of connection and/or association with client, seeing oneself in or as the other	CS
	Repetition **B**			OT aware of a possibility of repeating patterns but less conscious of enactment	CS + UNCS
		Reparation **C**		A need to work with /care for others not always consciously linked to the past – felt as a desire	UNCS
			Mutual Recognition (reciprocity) **D**	A deep sense of connection and becoming or being a subject for the 'other'	UNCS

Diagram 6: A Layered View of the Relational Work Undertaken by OTs

In many of the examples presented below there is the possibility of all four layers operating simultaneously, and I hope the areas I have chosen to highlight and the way in which they are presented does not preclude that perspective for the reader. Although I

have used a ladder I am also not trying to suggest that one layer is better or even more emotional 'mature' than the others.

I have tried to tease out the subtle differences between the reasons why therapists undertake and/or enjoy their work with clients. As I described in Chapter 1, I felt my own reasons for wanting to work with vulnerable 'others' was in part a manic defence against the painful disavowal of my gender by my father and was also a recognition of (i.e. identification with) the clients' struggle to overcome adversity. I also knew that in my clinical work with clients I had sometimes been irrevocably changed by their narratives; like Casement (1985, 2006) I had learnt from my clients. In exploring the differences between 'real' reparation and manic reparation I have drawn from the distinction made between the two by Segal (1988) and the discussion in Polden's work (2005) on 'Reparation terminable and interminable' (p.559).

Thinking about reparation and creativity has led me into the work of Benjamin's (1990) theory on intersubjectivity as the shared place of learning for client and therapists. This shared place of experience was first identified by Winnicott (1971) in his theory on playing (p.38) and heralds the entrance of the mother as a subject into the space of playing together (ibid. p.48). These ideas and their application in clinical settings and social milieux have been developed further by Clarke et al., 2008; Ogden, 1994; and LaMothe, 2005. Although there is a significant overlap between the descriptions of reparation and reciprocity (the term I have used for the intersubjective view of communication) I have tried to distinguish between them, as it is this that has lead me into the last chapter of this thesis: what love **has** got to do with it.

Identification: Seeing Oneself in the Other

The relationship between the therapist and client was a specific focus of the study and I asked the therapists what they 'got out of' working with people and why they thought they had wanted to be an occupational therapist. When the therapists were prompted to talk about a client that they always remembered, I would ask if they felt they perhaps had identified with that client. It could be a superficial form of recognition, e.g. I am like that person, or I understand them because they are similar to someone I know

In some of the interviews the participants had described events from their past (childhood and early adulthood) which they felt had influenced their personality – and these events seemed to have created a desire in the participants to assist others or work with vulnerable people (i.e. clients) to help them achieve 'independence'.

I asked Diane how she had come to decide on a career as an occupational therapist.

> **Diane:** I … took another job and I remember there was a lady there who, she had this awful corset that she could … I forget now if she could either put it on or could take it off, she could do one but not the other and I had watched her and I knew she could do this herself but that nobody had taught her how … and it suddenly occurred to me that I really wanted to be teaching people to do things for themselves. I had seen all of this when working with the OTs and realised that was it for me… so it was as much about facilitating people – not that I had that language then – to do things for themselves, that if somebody had taught them or given them the right bit of equipment that they could actually do things and then people could be more independent … get on with it … simple as that…
>
> **Lindsey:** Why did that make sense to you?
>
> **Diane:** Because this particular lady was very bitter and miserable and bossy and selfish … and partly I just thought she would be a happier person if she had her … self back again … and partly it would make our life easier if she was a bit more independent and she was nicer to us – so it was a two-way thing really…

In this narrative Diane described how she saw something in this woman's struggle with her corset that she could understand. I had wondered if the woman, in having to ask for help, felt diminished and so became irritable. I asked Diane if she identified with this struggle between needing something and sometimes feeling humiliated by asking for help. Diane said she often expected people to notice when she needed help. This had been a recurrent theme in a dream Diane told me in the earlier observation period. She said that she would do often things for others 'before they had even asked', i.e. she noticed if they needed something.

Caitlyn described working with a client and asking them a seemingly ordinary question about their being able to use the toilet, and how the person would look at her with wonder and delight (a recognition of her worth), as if she had asked them something that was the most important thing in their life (the million dollar question).

> **Lindsey:** What keeps you going?
>
> **Caitlyn:** [pause] … I like it when you go to a patient … you say the smallest [thing], like do you have problems getting on and off the toilet and the patient looks at you as if to say you have asked the most important question in the world because that is the one thing that they are having problems with and they never

> dreamed that anyone would ask them that question. You find that you have asked the million dollar question. It is really nice when you can … when you feel that you can solve these problems for people that another profession [can't], although they are quite simple things we know how to pinpoint them I guess.

Recognition occurred when therapists were able to see and help their clients; Diane saw the woman struggle with her corset and realised she would be happier if she could do it for herself; Caitlyn felt recognised when what she did seemed like having the answer to the 'million dollar question'.

Repetition

Some participants talked about a difficulty they had in managing their feelings towards clients or colleagues and said that this was a pattern that seemed to repeat itself in their own lives. It was as if they realised that they had been caught in a cycle of repetition but would be powerless to break it, except to take leave or wait for someone else to intervene. One example was the therapists' difficulty in acknowledging that they were ill and needed to stay at home to rest. The subject of 'sick leave' came up in the third inquiry group with Caitlyn and Heather. This group took place two weeks after the bombs in London[32] and it was on a day that people in London had been advised not to travel unless they had to (there had been several minor explosions earlier that day on public transport). I had felt anxious about my journey into the hospital but I was determined not to be a sissy and I was surprised to see a full complement of staff in the team offices.

> **Lindsey:** [during] periods of personal vulnerability, illness or sadness in OTs they seem to keep going … how much is the suppression of reality, or the need to be involved, committed to something?
>
> [short silence]
>
> **Heather:** … anyone I work with that something … has happened to them and they have just … put it aside … come into work, put their uniform on and just got on with their patients. Whereas if I saw that with a patient I would try to address it and say maybe that is not the thing to do, but as an OT I have done it, I am sure you have done it.
>
> **Caitlyn:** I noticed two Fridays ago [the day after the bombs] a lot of my friends [didn't] go to work, too much risk getting transport and last Friday, every one [OT staff] was here … because of the patients but you don't want to let your team down…

[32] 7 July 2005.

> **Heather:** I find it very difficult to be at home and be sick, I don't take very well to that role … if you are the one that was poorly I would say Caitlyn go home and I would feel I am doing the right thing by giving you this push but if you were saying it to me I would say, no, no I am fine.
>
> **Caitlyn:** You want someone to take responsibility away from yourself to say it is OK to be poorly and we will manage.

During the study I began to think about the participants as having a compulsive form of self-reliance. I wondered if their own sense of vulnerability was defended against through caring for others and thus avoiding any sense of their own need or neediness. Like the discussion above, OTs needed a therapist to tell them they were ill and give them permission to go home!

During the observation period Diane had told me a dream in which she said the themes were often repeated, in other dreams and in her waking life.

> In the dream she had hiked to the top of a steep mountain and as she was descending she saw something lying to the side of the path. She was with friends; she didn't recognise them but knew they were friends of hers. She went off the path and it was very steep and dangerous and lying on the ground was a kitten that was also a baby. She picked this kitten/baby up and it had broken bones, held it very still against herself and realised that if she moved it would die. She was wearing socks not shoes and it had started to rain, the path was very slippery and she tried to take off her socks without moving the bundle held against her chest. She walked down the mountain holding this kitten/baby. It was starting to get dark and she was worried that she would hurt this baby further.
>
> Her friends didn't help her, they didn't seem to notice that she was struggling. When she got to the bottom of the mountain she walked up to a building where there was light on and a swing door to get in. As she stepped up onto the veranda to walk through the door she missed the step and tripped, dropping the baby/kitten. As it fell to the ground she realised that the fall would probably kill it and she felt terrible (grief-stricken) and relieved at the same time. She woke up as the baby/kitten fell and she remained feeling this mixture of emotions.
>
> I said the dream seemed to be about her work, working with orthopaedic patients who often had broken bones. Diane said she hadn't made that connection. She asked me why I thought her friends hadn't helped her, I asked if in the dream she had asked them, she smiled and said no, she hadn't, it was like her not to ask for help.

Diane spoke, in the FANIs, about trying to change patterns in her life that she recognised were a repetitive cycle. She often thought people did not help her and when she felt particularly vulnerable (as she had in the dream above), or when she had a period of ill health, she felt alone and was convinced that people were ignoring her (albeit implicit) requests for help. As in the reporting of the dream above, she realised she had not actually asked for the help, but she expected people to be able to see a

situation and offer assistance. Like Caitlyn's and Heather's descriptions of being ill at work, these therapists wanted a person (another therapist) to help them or to tell them to go home.

This cycle of repetition for the therapists did not bring about change in their work patterns or relationships and sometimes deepened the participants' feeling of worthlessness. Like the earlier story of the woman and the corset, Diane believed that asking for help was sign of weakness and made others (like her manager) more critical of her. It was after the second interview with Diane that I realised she may have, implicitly, been asking me for help. I wondered if her volunteering for the project was an unconscious request for support. In her accounts of dreams and stories from her past and current life I began to feel concerned that she was not managing as well as her amusing accounts of falling down drunk indicated, that she may have been very unhappy.

I wondered if she had become angry with me (as the example she gave above) when this subconscious (implicit) request for assistance had been seemingly ignored by my not asking her more directly about the possibility of her being depressed and perhaps drinking too much. I thought I may have enacted a repetition in her life. She had given many examples of how she really felt (like the description of Julia in Chapter 2) and I had not responded to them by saying I was concerned or suggest counselling. Diane withdrew from the project after the interviews and did not attend any of the inquiry groups, although I would sometimes see her in the team room prior to the groups starting.

Reparation

During the in-depth FANIs the participants spoke about events from their lives that had deeply affected how they viewed themselves and which they felt had contributed to the reasons why they worked as occupational therapists. All the participants felt they had a need to help people, and in exploring these reasons they would recall upsetting events from their past which had left them feeling inadequate or vulnerable. Telling these painful stories became possible because of the ongoing relationship I had established with the participants during the observation period. In the week between the first and second interviews I would think about the next interview and consider which themes

may be explored further and I would email these thoughts to the participants prior to the second interview.

Alison said that she had been given feedback (from a health counsellor) that she did not need to 'mother' everyone and she needed to take better care of herself. With this in mind and following my strong association with my father when observing her with Phillip, I sent an email to Alison asking her, amongst other reflections, what she thought the role of the 'father' was in a family. This question evoked a painful recollection (in our second interview) of her childhood where she had grown up without a father and in later years had fought with her new step-father.

In her early childhood her mother, a single parent, found it difficult to cope with two children, Alison and her older brother. Alison tried to support her mother by doing the housework before she got home. This caretaking responsibility was further complicated by an aggressive response from her brother who resented her 'good work'.

> **Alison:** … I mean, well, we had to bring ourselves up really because my mum … had gone out to work and we also had to do all the domestic tasks so there was a big influx of responsibility … and that is when he started to hit me because I guess it was just the two of us there were no witnesses … so yeah I can relate to being very vulnerable as a child.
>
> **Lindsey:** … so he would hit you …
>
> **Alison:** uuumh. I would wind him up … (quietly ha ha), my mum would leave us lots of tasks and things and I would be doing them and he wouldn't and I knew she would cry when she got home and he … they hadn't been done so I would try and get him to do some stuff and … he would beat me up … and that was quite bad – but uumh – that took me – I struggled a long time with that … you know feeling of my brother … being the kind of controlling dominant … one … and Frank [Alison's partner] in some respects is quite like my brother but he isn't my brother and that is the bit I am just starting you know, I have to really take that in.
>
> **Lindsey:** … maybe you didn't make your brother like that …
>
> **Alison:** No … I've worked [it] out … I had some counselling last year … that my one way of controlling him was making him angry … that sounds weird – that was the only affect I had on him – uumh because otherwise he would just ignore me or call me horrible names or whatever so when I made him angry I got a response – a very negative response but still you know – a response.
>
> **Lindsey:** uuumh uumh
>
> **Alison:** I think he struggled allot with my granny going and … I think he was quite like my dad so she used to be nasty to him … so you know so there are always reasons for everything …

> **Lindsey:** uumh. It reminds me of why you said it is so important to you [to work with] families because if you can just get them to talk to each other … there is a chance they will change.
>
> **Alison:** [starts to cry] … I feel so upset
>
> **Lindsey:** What you are talking about is very sad … uuumh …

During the latter part of this interview Alison began to cry and although I offered to turn off the recorder she indicated that it wasn't necessary and she wished to carry on talking. I realised that the recording device was a way of being heard and so I found myself trying to find the link between what Alison was saying and her desire to work with families and how that offered her some sense of fulfilment. I tried to comfort her by saying I thought some people came into the caring profession because of the pain in their past and it could provide them with a sense of purpose.

The participants didn't necessarily connect their childhood experiences and feelings with their choice of profession and their need to help others. Nevertheless I found it was central to the project and the times when the participants described their childhoods were often key moments in the interviews where the emotional tone and depth of the interview altered, like the one described above.

The participants found they could offer their clients compassion and patience but could not give the same attention to their partners or families. In the second inquiry group Alison spoke about her partner's (Frank) serious illness and how intolerant she had been with him during his illness.

> **Alison**: As a therapist when my boyfriend got leukaemia, I could not put up with him being pathetic. I was really annoyed with him … and to this day he is angry with me for trying to motivate him when actually I was the only one who wasn't giving him any sympathy. The other side of the coin, every old person I meet, I think I am finding my granny in them, because she is my loved one. [starting to cry] … If I can find any similarity at all, I kind of look for it and it helps. If I don't like someone … I really find it difficult if someone is whingeing then I want to pull away, but I am actually more attentive and more helpful because I am compensating for the fact that I really can't stand this person.
>
> **Lisa**: You are just trying to not make them whinge again!
>
> **Alison**: No, I actually want to compensate for the fact that I am not feeling warm towards them.

Here Alison gives a lovely example of identification (with people who look like her granny), the difficulty she found in being compassionate with her partner (she was

scared of his vulnerability and the possibility of losing him) and the ethic of care (the 'deep acting' Hochschild, 2003, described) that protects the client when the therapist has a negative countertransference with them. As Alison said, she didn't like clients that constantly whinged, but she found she tried even harder with them to compensate for her feelings.

Polden (2005) described the difference between a false (narcissist) and true reparation, extending the work of Kleinian thinking (see Segal, 1988) on manic and true reparation. Although reparation begins at the point of separation (from the mother) and indicates a growing capacity for creativity[33] and love, Polden argues that if the child's sense of guilt and responsibility was not the child's fault but projected into them by an anxious mother, the reparation they perform is never-ending. She calls it an 'obsessional reparation' (Polden, 2005, p.564) evoked, not by the child's natural (or primary) destructive impulses, but by a depressed (or damaged) mother who cannot bear the child's assertion of self.

> 'If destructiveness is not primary, what looks like reparation is unlikely to be triggered by genuine remorse for damage caused by one's own aggression and is more likely to be an attachment-based attempt to stay attuned to and to try to make better an object experienced as damaged right from the beginning – the castrated mother who, out of anxiety or envy or both, is not easily able to respond to her child's healthy assertiveness, but needs instead to superimpose her own agenda. Conversely, this mother's child will never have the opportunity to explore and eventually to integrate his aggression but right from the beginning will be trying – hopelessly and interminably – to repair damage he did not cause (and therefore cannot mend). The desire to make better is triggered but cannot be fulfilled, if the mother's investment in her own depression makes her unwilling or unable to respond positively to her child's overtures. It is in these circumstances that obsessional and manic forms of reparation will arise. (Polden, 2005, p.562)

I had wondered if caring for others (in a professional role) was, in part, an enactment (like the compulsive caring that Polden, 2005, described above) by some therapists from unresolved mourning in their early childhood and/or past. I was reminded of the Sisyphean task (from Greek mythology) where Sisyphus was compelled to push a heavy stone up a hill, only to watch it roll down again before he could reach the top, whence he was bound to start the process again. It seemed that Alison's description of her early childhood had these elements, a depressed single mother and an angry (violent) older brother who beat her for being 'good'. It was no wonder she felt a deep need to repair others and what was remarkable about her was her reflexive ability to contemplate these matters and through this process consider alternatives. Unlike Diane she did not seem

[33] This aspect of creativity emerging from the stage of reparation is more fully discussed in Chapter 2.

trapped in a cycle of despair, her work wasn't a Sisyphean task but perhaps like Ulysses' journey to 'Ithaka' where the experiences from travelling enrich the soul.

> 'Keep Ithaka always in your mind.
> Arriving there is what you're destined for.
> But don't hurry the journey at all.
> Better if it lasts for years,
> so you're old by the time you reach the island,
> wealthy with all you've gained on the way,
> not expecting Ithaka to make you rich.'
>
> *Constantine Cafavy, 1911*

Reciprocity (Mutual Recognition)

Throughout the project I found myself wondering what the participants 'got back' from working with their clients. I had experience from clinical work that 'doing for' someone wasn't a one-way interaction and that something took place between the two people (client and therapist) that was essentially fulfilling for both. In undertaking the project I did not experience myself as 'doing it' for them (i.e. the participants) or for myself; through dialogue with the therapists a new viewpoint on the project emerged and my thinking about OT was challenged and expanded. The process of trying to make sense of what occurred between clients and therapists or between myself and the participants became a shared venture, essentially a creative one of thinking aloud. The insights emerged from the mutual exchange, one that Ogden (1994) described as the 'analytic third' (p.3) and Winnicott (1971) called 'the overlap of two areas of playing, that of the patient and that of the therapist' (p.38).

Many of the participants spoke about a sense of connection with their clients and this often made them feel their job was worthwhile. Fiona described this as the 'X' factor, a place where the work undertaken with the client was creative and emerged during the session.

> **Lindsey:** What do you think you get out of it?
>
> **Fiona:** [laughs] … [silence] … I think it is that little X factor really isn't it? … seeing a child being able to enjoy themselves or find something and absolutely loving it and at the same time knowing that they are getting such therapeutic benefit from that …
>
> **Lindsey:** What does that do for you?

> **Fiona:** … definitely that sense of accomplishment … and the thing is that sometimes … you don't set out thinking this is what I am going to do you know when you treat a patient it's a bit like going on … a bit of an adventure you don't quite know what you are going to find and so sometimes things can be a surprise you know …

Heather said caring for people was part of her life from a very early age, said that the work made her feel good about herself. She linked it to an early childhood where she cared for her brothers and sisters; but as an OT she didn't feel her patients would need her for the rest of their lives, but that like having children, they grew up and moved away.

> **Lindsey:** uuumh … have you ever thought why …
>
> **Heather:** I was around my mother, a nurse, and she had eight children and she cared … you know she was a carer so then when things got too much and she needed a hand, and being the eldest … I helped … and I did work from there and it made you feel good and … I had my children very young I married very young so … you know I chose a different path so … [she described her career path into OT].
>
> **Lindsey:** What is it about OT for you …
>
> **Heather:** I think as an OT … that I am actually relied upon … it sounds awful but it is very similar to me watching my children growing up and developing … and thinking okay one day you … I know you will go … you will be doing your own thing and that is what it's like with a lot of my patients, you know the end's not the same … but they are not always going to need me …

The work, with its emotional demands, made the therapists feel good about themselves. Lee, in the first inquiry group, spoke about working with 'palliative care' patients, people who were leaving hospital to die at home. She said that the work was hard, different from what she had done in the past, but it also gave a chance to feel close to the patient who may have been facing death alone.

> **Lee:** [palliative care] is quite different … I know when I am ordering things for certain people, that little package is like a death package. Terrible to think that way … [pause] … at the same time a special position because you do get to speak to people at a point in their lives which is quite unique. Often quite rewarding because you are with them when they are really on their own. Doesn't always happen. Sometimes they are just too distressed or they just want their family. Then you need to step back. I find that difficult because you want to be there to help.

In asking the participants in the inquiry groups how they felt about their clients, many of the therapists said how much they liked them. At times, they said, clients reminded them of a loved member of their family (a granny, an uncle or a longed-for absent father), or they would simply find that they 'clicked' with a client. Therapists questioned whether they were being unprofessional in liking a patient, and this

prompted me to reflect on one of the hidden aspects of the care work: that sometimes therapists enjoy feeling cared for (i.e. recognised) by the clients.

> **Lee**: I remember when I was in my final year I somehow managed to go on pracs [clinical practice placements] where I got patients I fell in love with. I was really lucky. Most of my friends at university with me used to say I got too emotionally involved and I always remember saying how dare they say that because they were things that gave me so much joy. I had wonderful times with my patients. I always thought, am I getting too emotionally involved? Definitely something instilled in us, keep a professional distance, not go beyond a point. I think it is probably right because you can take too much on and sometimes it is good to have set work times.
>
> **Alison**: I don't remember having any training to deal with my emotions at all and I remember them saying something about staying professional, making sure you don't get over-involved with a patient. I get told I get too involved. But I feel that the day that you stop being so involved is the day you stop caring and I don't want to be like that. What they don't do is say deal with all the caring, when you say goodbye to someone and they go home, it is a relationship that has ended, you say goodbye to them.

Later, in the same inquiry group, I tried to articulate what I had begun to think about in terms of the work of caring and the possibility of reciprocity, and how when the professional was personal it carried the risk of being hurt.

> **Lindsey:** I wonder sometimes about a need to care, need to reach out and make things easier and more comfortable for someone … and when that need is met by somebody who is willing to receive [it] … that a wonderful interaction … you grow inside … How much harder it is also when that is your need and a person cuts you off, blames you and then you feel a personal hurt … [like] the stories you are telling …
>
> **Alison:** When someone doesn't say thank you or when someone is rude, you then feel useless and worthless, what you do is no good and you want to go and cry. That's what we do … we go to the office and cry.
>
> **Lindsey:** So actually caring for clients is good news, it is not unprofessional. Clients care about us, nobody talks about it … as if it goes hidden … like it is not allowed, but in fact it is the very thing that makes the job worthwhile. The very thing that makes people go back the next day and keep trying.

But was this reparation or reciprocity and should there be a distinction?

Heather and Caitlyn, in the third inquiry group, said relationships with clients were the best part of the work and made them feel good about themselves.

> **Heather:** While I am getting close and finding this out the relationship is working, I feel positive, I feel good about myself, I am doing what I should do. Almost like gratification but … where … [the] patient is not forthcoming … and I feel saddened by that because I feel we could have done this or we could have got there, so I think for me, selfishly … that I like getting close to them.

> **Caitlyn:** Or else why would we be doing what we do … It is satisfying, when you first get a patient there are always complications and problems that you need to solve and what is great is when it all comes together. You are solving all these things.
>
> **Heather:** They become a person don't they? There are pink referral forms and a number and this person you see in a bed, then you get to know them a bit more and you think that is Aggy, or so and so. Then you walk past the ward and you no longer see them as you did at first, especially if you have done a home visit you see them in their home with the picture on the wall. I don't know. It just becomes real. See it all come together.

It seemed to me that the participants enjoyed the relationships they developed with the clients and in some of these relationships they became a person (not just a professional) to the clients as well. The recognition of the other was a two-way process. In the second inquiry group I found that I was trying to ask the group members about this process and in so doing began to say what I had been thinking about in relation to reciprocity. It seemed to me that there were moments that took place between the client and the therapist (like the one I had observed between Alison and Phillip) where something beyond professionalism that took place. Perhaps that was that the moment that a person seeks as a professional, i.e. a person in a professional role, it confirms that there desire for reparation has been received by the other and it is deeply reassuring.

Benjamin (2004, p.8) describes the value of being able to 'surrender' in a relationship, and in the intimate care situations that I observed and in the OTs descriptions of their work, there was a quality of interaction with their clients that left them feeling fulfilled. It is what I have termed reciprocity in the therapeutic relationship; Benjamin called it 'mutual recognition' (ibid, p.5). Surrender is not a form of subjugation to the other or a type of 'masochism' (LaMothe, 2005, p, 211), but one in which we encounter the other and are moved by them. Benjamin (2004) distinguishes surrender from 'submission' (ibid, p. 8) and says that 'surrender' refers to the acknowledgement of the experience of the other.

> '…surrender refers to recognition – being able to sustain connectedness to the other's mind while accepting his separateness and difference. Surrender implies freedom from any intent to control or coerce.' (Benjamin, 2004, p.8)

The OTs often responded to their clients with an authentic enjoyment of and/or concern for them. The OTs sometimes drew on their own life experiences to identify with the client (as Heather had done) and they were affected by the client's responses (as Caitlyn had been when the client was angry with her). They were sensitive and compassionate

in responding to the client's needs, as Alison had been when she was 'moved' by Phillips distress and not talking to his wife about his death, and she contacted the consultant about talking to Phillips' wife.

What I felt was absent in this part of the study wasn't a lack of compassion or ability to make clinical decisions by the clinical therapists, but support **for** them from the OT profession. This could be through a shared language (i.e. a discourse including research, published articles, seminars and policy documentation) that could acknowledge the emotional labour of the OTs. As Frost (2007) has argued for psycho-social teaching in social work, OTs may also benefit from understanding the same emphasis in their professional training.

> 'Unconscious processes and the unconscious dimension of people, organisations and social structures [that] are a fundamental tenet of such psychosocial theory. The internal world and its struggles, for example with anxiety, ambiguity and defence mechanisms, is a key site for enquiry' (Frost, 2007, p.245).

In the UK part of the study, what seemed to missing were the words (a psycho-social language) to express more fully what the OTs did and felt in relation to their clients. This is one of the themes I have identified in the final chapter (7); 'What love <u>has</u> got to do with it'.

Chapter 5: Another Country

the indigent

the poor are coming towards her
from the four corners of the earth
they crowd the plains
and climb onto the mountain terraces
whatever she does they will be with her
and her inability to live a life in proportion to them
even her smallest action will be without honour

(Bertolt Brecht said that it was only those who knew hunger
who would feed the hungry
- the rich feed only each other)

Antjie Krog, 2006, p.71

This chapter covers a description and analysis of the research undertaken in the Cape Town General Hospital (CTGH). The information presented highlights how the social, historical and political context became a focus (i.e. moved into the foreground) in the work that OTs did and in the research relationships I established with them. This was different from the UK study, where the individual therapists were introduced at the start of Chapter 4 and remained a reference point through the discussion of the UK themes. This change in focus was an unexpected part of the research, and I discuss why this might have occurred more fully in the next chapter, 'Journey without Maps'.

The poem which starts this section 'the indigent', written by Antjie Krog (a white South African Afrikaans woman, author and poet[34]), gives a brief portrayal of the experience of living and working in the ever widening rich/poor divide of South Africa. It also highlights one of difficulties I experienced in writing this chapter, which was trying to report on the research and provide sufficient contextual detail for the readers to hear and feel the material for themselves. But the words were hard to locate, each word potentially carried a different meaning in the separate contexts (i.e. UK and SA). 'Indigent', for example, is a word commonly used in SA to describe 'the poor' and is used as a category (in client's CTGH medical folders) to refer to a person who is unable to pay for their treatment. The slippery use of words which can define and/or offend remained a difficulty for me throughout the chapter and I used many reflexive accounts in an attempt to locate my understanding (or viewpoint) of the research events and

[34] Krog wrote the highly acclaimed semi-biographical account of the work of the TRC (Truth and Reconciliation Committee) in South Africa, 'Country of my Skull', 1999.

relationships which occurred. As Krog (2009) states in her paper, 'My Heart is on My Tongue – The Untranslated Self in a Translated World',

> I want to make the point that a narrative can be experienced as discriminatory and ethically problematic when read through a particular, in this case a western, perspective. But the moment there is an attempt to interpret the narrative via its embeddedness in an indigenous worldview, it becomes breathtakingly ethical, fair and logical. (Krog, 2009, p.641)

In 2005 I returned to South Africa to begin work at a 'previously disadvantaged[35]' university as a senior lecturer in the occupational therapy department. My sojourn of eight years in London had ended, and having felt I had never left South Africa (neither exile nor immigrant), I looked forward to my new teaching post, reconnecting with old friends and completing my research study in a different but previously familiar work environment. Although this second half of the study provided many interesting insights into the way occupational therapy is organised and thought about by therapists working in a different social context of care, I hadn't realised how much I had changed by living in the UK with its emphasis on social justice and access to all for health and social care.

All Change

> In November 2007 I was sitting with my mother in her room at the Lady Christians Home in Cape Town, South Africa and reading to her from a book I had brought with me called 'The Sunshine Settlers[36]'. This activity could occupy the time we spent together and prevented the repetitive cycle of my mother's questions; she had a progressive dementia and her memory was poor and attention span limited. She enjoyed being read to and could focus on short simple stories, and although I had not read the book for many years I remembered it as a series of adventure stories of a man who had attempted to establish a farm in Southern Rhodesia (Zimbabwe) around the time my mother was a young girl – 1930.
>
> Soon after I started reading I began to struggle as I had to keep substituting words for the ones that were written, I was quite shocked at the racist colonial language of the author and I was also acutely aware of the black nursing staff who were ever present in the home and who cared for my mother's needs in a way that I had found I could no longer undertake in my own home.
>
> My mother asked me what was wrong, her sensitivity to the emotional tone of a situation had never diminished, I said that the book had some old fashioned ideas about black people and I was trying to substitute the words that were written, like

[35] There were three universities in Cape Town: each carried its own political history of access by the different race groups in South Africa and financial resources allocated by the apartheid government. The university where I was offered a post had been established in the 1980s for 'coloured' and black students – it had not received the same funding as the 'white' universities and so had been earmarked by the new government for improvements.

[36] Crosbie Garstin, first published in 1935, reprinted 1971.

> 'Kaffir' and 'nigger' as I didn't agree with them. Yes, she said, times have changed and it isn't right to call people those words.

The vignette described above was one of many occasions when I was confronted with the post colonial awakening I encountered as I saw and felt the legacy of the racially oppressive apartheid past; a past that I, as a white person, had in so many ways, unwittingly contributed towards and continued to do so. I frequently found myself out of place (like the example above when I re-read what had been a favourite book of mine) and I would struggle to find other ways of speaking and thinking.

The study in the UK had brought to mind how the individual life histories of the therapists I had interviewed had contributed to their unconscious reparative desire to work with vulnerable clients. In South Africa I realised how the experience of the therapists' social-political background, i.e. their gender, race, language and class, had affected their understanding and commitment to working with patients who had accessed public health[37] care. In holding onto a view of people's actions as being a result of their early personal life history in a nuclear family, I had ignored the contributions of the wider society they had been part of, and that I had been part of. In the South African study I began to develop a dual focus: on the social structures which supported racism and the individuals' experience of their home and family. Gordon (1993) reminded us that racism is in both places at the same time, the social and the psyche.

> '…to understand racism, psychoanalysis is necessary but insufficient and must be welded to social and political theory. …Racism is in the material world as well as the psyche and our attempt to understand it – like our attempt to understand all other phenomena – must be in two places at once…' (Gordon, 1993, p.73)

I could not have anticipated how hard returning to South Africa would be. I frequently felt ashamed of my previous blindness[38] to the results of oppressive practices from the past, many of which remained encoded in current social relations. For example, my English partner (Angela) was told by many of my white friends not to 'give' anything to people who came to the house gate, as 'once you give them something they will never leave.' Prior to our moving to Cape Town Angela had told me that she would not come to South Africa if she had to roll up her car window and turn away from street children

[37] Healthcare in South Africa remains divided into those that have a 'good' income (i.e. middle class) and can use private health care through medical aid schemes and those that cannot afford health insurance and therefore use public health hospitals and clinics (such as CTGH).
[38] The word 'blindness' denotes a psychological blindness, like Steiner's 'Turning a Blind Eye' (1993, p.116), or Morgan's paper 'Between Fear and Blindness (1998).

who knocked on car doors to ask for money or food at busy intersections where traffic had halted. I had assured her I would not tell her what to do and I was often humbled by her natural generosity to all whom she met. When she was asked by her UK friends how she felt living in South Africa, she would say, 'I felt white – and I wanted to tell black people that I was not white like "they" were' ('they' meaning other white South Africans).

I also tried to locate myself in a new work place and amongst old friends and routines, some of whom (and which) I no longer had much in common with or enjoyed. In 2007 I was invited to speak at a Jungian international conference held in Cape Town, with my English friend (and Jungian analyst), Susanna Wright. I wrote the following:

> My return to South Africa (in 2005) after eight years away has been harsh. I have been confronted in my new workplace with certain junior colleagues who have viewed my thoughts and suggestions as an attempt to criticise or undermine their scholastic achievements (or worse still patronise and humiliate them), and by friends whose houses were bigger and whose gates and fences were higher, and my own sense of guilt at having more resources than many of the people whom I saw at street corners or who lived in informal settlements. At the same time I had a heightened sense of fear (bordering on hyper-vigilance) regarding my own personal safety, something I had not been aware of prior to my departure for the UK in 1998. (Nicholls & Wright, 2009, p.813)

Similarities in Hospital Structures and Culture of Care

Like the UK study, it took a year from first discussing the possible project with the OT manager, Alice, and three heads of the sections to doing the field work. I applied for research and ethics permission through the Cape Town General Hospital (CTGH) research and development board, and following their permission I applied for ethics clearance. Once I had gained their approval I arranged to meet with all the OTs at one of the monthly staff meetings to discuss the project and asked for volunteers for the participant observation, interviews and inquiry groups and their overall agreement to have a research project undertaken in their department.

On the surface the CTGH was very similar to the one I had entered and observed in London. Like the London General Hospital, the occupational therapy department was separate to the main hospital where the wards were located. Therapists saw clients on the wards where multidisciplinary team (MDT) meetings took place and they returned

to the OT department to write notes and/or collect equipment. The OT service had been integral to the hospital since its inception and it employed approximately 30 therapy staff. The OT department was managed by a head OT (Alice) and had four 'middle managers' (i.e. lead therapists), three of whom became involved in the research project: Nassrin, Joanne and Pamela.

In observing Joanne working in her office I reflected on the similarities in the work areas where OTs had their desks and wrote their notes.

> The files on bookshelves are similar to the ones I saw in the UK: referral forms, files for orthopaedics, spinal ward, etc. The desks had assessment forms and referral forms. There were two assistive devices (commodes) in the corner of the office – one to go above a toilet for patients who have had hip replacements and another which was to act as a commode for patients who had mobility difficulties (the frame had a hole which a bucket could be placed beneath). The same equipment was available in the UK, the difference was these assistive devices were wooden and had been made in the OT department by the technicians and clients. Equipment in the UK was ordered from specialist firms. Both could be given or sold directly to the patients.

Like the UK study, referrals for occupational therapy were made by the MDT members who worked on the wards and the work of the OTs was divided into the separate clinical areas of paediatrics, medical wards, strokes (known as 'neuro') and orthopaedics, which included hand therapy. OTs undertook short-term assessments and interventions with clients who had been admitted to the hospital and the emphasis (as in the UK) was in getting clients home or into rehabilitation facilities as quickly as possible.

There was an additional clinical section within the OT department – that of 'work assessment'. This area took clients who were being considered for a 'disability grant' and they attended OT daily for a period of four weeks, where their previous work skills (e.g. clerical skills, shelf packing etc.) were assessed or they were asked to complete new work tasks. Many of these work tasks were generated from the ongoing needs within the OT department, such as mobility equipment (wheelchair maintenance) or self care assistive devices, e.g. wooden commodes (mentioned above) or tap turners.

OT staff became part of the wards they worked in and contributed to the overall care of the clients. Mina, who had worked on the 'stroke' team for many years, enjoyed the challenge of working with complex neurological clients and the feeling that she was valued by the team for her clinical assessments and contributions in MDT meetings.

> As we were walking towards the ward Mina told me that she had worked on the 'neuro' ward for many years – although she had had a break for a period, when she returned all the same staff were there so it was if she hadn't left. The ward round took place on the neuro ward and she also did assessments on other medical wards. She said that the neuro patients were getting younger because there was a link between HIV infection and emboli (which are the cause of stokes). She was involved from the admission as they (the rehab team) assisted in the ward with the correct positioning of the client and getting the person to use their affected limbs in as many functional tasks as possible.

Relationships with clients were initiated through the initial assessment process. Clients who were in the wards were often given a quick orientation to the work of an OT before the therapist asked them to demonstrate their 'independent living skills', for example how they got on and off the bed or used a toilet. The therapist asked about the client's work and home circumstances, particularly if they were in casual employment (e.g. domestic work), which they risked losing through being in hospital. These enquiries were routine when therapists met clients, as they could, if necessary, contact employers on the client's behalf.

> Mina went to a woman patient (Pumza) who had just come out of the shower. She was a young (early 30s) black woman who had been admitted the previous weekend. She had gone to work but wasn't feeling well and the hospital suspected she had had a stoke. Mina asked where she worked and if they knew where she was. Pumza was a cleaner and made tea at a factory, her employer had come to see her the previous evening at the hospital. She was on contract at her work, had been there a year and would be able to return to her work.
>
> Mina tested the side of her body that had been affected by the stroke. Pumza's left eye and mouth seemed to be hanging and Mina stroked her finger down the left and right side of her face. Pumza said her left side felt different and painful. She said initially her left arm and leg had been weak but were now fine. She looked fit and healthy, she had just returned from the shower where she said she had done all her own ablutions. Pumza would go home soon and lived in a brick house in Langa, the house had one room with a separate toilet and basin. She lived there with her 20-year-old son and her boyfriend.

The OTs showed compassion and sophisticated clinical reasoning processes when working with clients; they seemed aware of the mixture of physical, social and personal consequences of an illness for the individual and their family. Zarrin described her work in a clinic for older adults where an assessment of a client's difficulties had helped modify the whole family's sense of shame of something for which he may not have been responsible.

> **Zarrin:** we had a 65-year-old accountant who was scrapped off the role of accountants because … at 62 he embezzled money. Why would an accountant be truthful and honest all his life and at 62 [change]? … functionally he comes across as being absolutely fine, he scores 30/30 on his MSE [mental state exam] but assessing him cognitively he does have fall out … we are trying to find out if he

> was dementing when he embezzled the money … So we need to sit down with the wife and even though its not going to get him back [to work] … it is restoring the sense of pride to the family, his sense of self-worth because we found that [he has] got frontal temporal lobe dementia … for the wife it has all the social implications … she was the wife of the accountant who was struck off the role … So it is giving that family that sense of pride … for us to facilitate that process, and find out from his medical history if he had dementia and they [medical team] said he should have covered his tracks a lot better … obviously it wasn't with malicious intent or it was just that he has lost the insight or the judgement.

Like the staff in London, the OTs spoke about enjoying the feeling of working with clients who, after a serious injury or illness, began to see a future for themselves. In reflecting on what they 'get back' from working with clients, some of therapists said they 'felt good' when they were able to help someone or remember successful work with a more difficult client to motivate themself.

> **Joanne:** I think if your treatment is successful what you have done with the patient is successful … or they come out better … when you discharge them with good results … that makes me feel good.

> **Mina:** I think it is what we spoke about last week – your self-worth, and self-esteem, knowing that you made something better or easier for an individual or a family. That's what we get out of it. At least that is what keeps you going. Because you often do have a difficult patient and you often reflect on … the more positive examples or more positive outcomes that you have experienced.

Nassrin said she wanted to work with people as an OT because it was part of her value system, that doing what she believed in 'recharged' her and she ultimately felt she was fulfilling her purpose [in this life].

> **Nassrin:** So when I work it almost reaffirms me … reaffirms my values and in that way gives back to me … I don't think it is always on a conscious level and maybe that is the recharge that happens when you are working … but it is around what you think your purpose is on earth … and how you are meant to engage with other human beings and interact with other people, being in a healing caring profession … I can't see myself doing any other type of work … I will always be [in] contact with people, always be a caring, nurturing, supportive role, because it comes back to what I value in myself, and what I think my beliefs and values are … and so in that way it gives back to me because it makes me feel that I am fulfilling a purpose, or a purpose that defines myself.

In response to my asking the therapists in the inquiry group why they thought they became OTs, Joanne said she felt she had a 'God given talent' and she needed to use it. Similar to Nassrin above, Joanne felt it was part of her 'higher purpose' and the deep religious belief she held.

> **Joanne:** I have got talent … with scissors [laughter] … putting things together, seeing things three dimensionally, building things, making things … Like a carpenter enjoys making cupboards … but maybe … because I can. I do it because

> I can, and because I feel that … I have a calling … it is a bit of a corny word … but … I want to help people, and to use my talents … in order to help people. If … I can do something or I have a skill that God has given me, or a talent that I have been given … that can be used towards helping somebody else then … I must do it … because I can.

Joanne had said she was a Christian and Nassrin was a Muslim; both therapists described working with clients as helping them feel that they had reached beyond themselves to fulfil a moral and/or religious calling.

The Borderland

When a person drives from Zimbabwe across to South Africa they enter a territory which is a borderland, it doesn't belong to either country (in this particular crossing it is the vast Limpopo River). Many aspects of the landscape (e.g. trees, sandy soil and weather) remain the same in the journey across the two cultures and the traveller may only be somewhat aware of the more fundamental changes, i.e. those of the social political realities, encoded in language and procedures. It is this borderland (i.e. the similarities and subtle distinctions between OT in the UK and SA) that I have described in the following section.

There were certain similarities between the two research contexts which also were examples of the subtle differences between them. The three I have highlighted below are about the relationships between the OTs and head of service, the thoughts the OTs had about their uniforms and the structure of ward routines and use of equipment.

Teamwork

Although the processes of gaining permission to undertake the study were similar, i.e. presenting research protocols to research committees with a separate submission to the ethics panel, and it took the same length of time, I felt it was overall an easier process gaining access to the CTGH OTs. I felt the team coherence and camaraderie in the department made my overture less threatening. Like my relationship with the UK head, Jessica, I had known Alice from our previous work at a university some years previously. She had been the head of the CTGH OT department for many years and provided a clear management structure with an obvious commitment to clients and staff.

The large staff room, where staff gathered to have tea and lunch, had the recognisable noticeboard but also pleasant oil paintings of the region and tastefully framed pictures of most of the current staff.

The staff who were part of the project had been working at CTGH for between six months (e.g. Vida, a new graduate) and 12 years (e.g. Nassrin). Most staff had been at CTGH for over five years and seemed to be settled in their work roles with opportunities to develop further services in their area of clinical interest.

Unlike the UK study, the inquiry groups were well attended, and each week more OTs came to discuss their work and insights. The therapists described reading my emails after each inquiry group and discussing amongst themselves what they had been thinking about in preparation for the next one. It seemed to me that the staff who had not been part of the observation and interviews wanted to be part of the study and could do so by joining the inquiry groups. Zarrin would begin her input in the inquiry groups by saying she had been thinking about the previous group or an email and then she would offer a thoughtful reflection on working with complex clients.

In thinking what the difference was in the OTs' feeling able to share their experiences with each other and with me in the inquiry groups, I thought it may have been generated by Alice's management style, which was welcoming and always inclusive of the staff who were heads of sections. Alice was easy to approach – and her primary concern for the clients was obvious.

> While waiting for Mina I sat with the staff who had gathered for their lunch. I asked who had taken the photos on the walls of the staff room. Alice said it was locum who they had last year and when she left she gave them a present of the framed photos. Alice asked the others how long she had been with them. Joanne replied 'four months three weeks and two days.' Everyone laughed and Alice said 'shame'. I wondered if that was because Joanne had really struggled with her or if she missed her – it wasn't clear to me…

Four of the nine therapists that participated in the project (observations, interviews and inquiry groups) had been students at a university where I had taught OT (1988-1998).

Uniforms

The OT staff all wore uniforms, white tunic tops and green trousers, but variations in the style were more evident in CTGH. I wore the same uniform that I had purchased for

the London study but in the Cape Town summer I found it hot and uncomfortable. I too began to dress in a more casual style and would wear a cotton t-shirt and green trousers with my white tunic top unfastened over the t-shirt. I felt uncomfortable in this style and reflected on my sense of nakedness.

Unlike the UK there was no strict adherence to a code where uniforms were only put on at work and taken off before staff went home – and this became a theme in the inquiry groups when staff reflected on their not having a clear distinction (boundary) between work and home. I mentioned in the inquiry group that I had noticed that London staff only wore their uniforms at work, whereas in Cape Town they did not have the same routine. I said I wondered if it made it harder for them to 'leave work at work'. Two therapists who had worked in London thought the London rule of leaving uniforms at work provided an 'end point' to work.

> **Pamela:** I certainly felt that way when I was working in the UK, the moment I put my uniform on I put my profession on and the moment I took it off, I took it off … I think because the role of the OT there is a lot more … defined, a lot more structured. You only do your little bit, you don't get involved in anything other than … orthopaedics, if you are working in orthopaedics … so it's a lot easier to leave work at work …
>
> **Joanne:** It is also different because you are not allowed to travel with your uniform … because of all the legal implications if someone has a heart attack … blah blah blah … it's just like the British are about everything, so you put it on at work and you take it off at work … so it is easier … forces you to make that distinction … it's not like here where you go from here to somewhere and you are still in your work clothes, and you still have your badge on …

Some staff felt that the lack of clear guidance on what colour or style was acceptable for the OT uniform had weakened the respect that it was given by those who wore it and caused a blurring of boundaries with other staff in the hospital. It represented the responsibility that the therapist carried (for others).

> **Nassrin:** I personally don't think that we value the uniform … It is changing with the universities changing what the uniform looks like … so the clothes that define … when you are an OT has shifted … for us … we wear black, we wear any shade of greens, there aren't colours that we only wear for work …
>
> **Joanne:** I am a uniform kind of person [laughter] ... I liked my school uniform … so I am the kind of person that likes the discipline and structure that goes with a uniform and the responsibility and the … purpose that goes with it.

I had once been a student OT in that department (1975-1979) but during the doctoral research project I felt lost, as if I should know the way around, and I found that things had changed and I didn't recognise where I was. I wrote to my supervisors and said that

‘in the two occasions I had been to the OT department to meet with staff I had found myself feeling as if I was in a dream where you think you know where you are but you also know you have never been there before.’ This feeling of being lost was echoed in a dream I had the night before I began the first period of data collection – the participant observation.

> *Dream 9: Downstream Without a Paddle (Jan 2007)*
>
> *I am at an adventure camp (which was at the hospital department) and I was following Joanne around. She took me to the top of a shed where she said we could sit and talk. The shed was unstable and I was afraid to sit down in case it broke. She wanted t know about my personal life – she seemed to think that as I was to get to know about her she could get to know about me. I said the place where we were sitting used to be place where they stored the wood.*
>
> *We went to a river and I told her about the rapids on the river as I had been down the river a few times and we both got into canoes. She was carried off by the river and I realised she didn’t know the way (she had never canoed before) so I went after her – but I didn’t have a paddle so I had to let the current take me. I was concerned as the river turned a sharp left and then there were a series of fast rapids – but when I got to the left turn I could use a paddle to turn into the bend and I had to use my body to move the canoe round the corner. When I was round the bend the river had changed from what I had remembered and had split into two smaller streams – I didn’t know where she had gone to.*
>
> *I was at a café and I met up two friends, Carol and Kathy. The waiter was walking from table to table handing out Christian Bible tracks and another man who was dressed in a grubby ill-fitting suit was showing a group at a table some magic tricks and he was using a chip packet which he folded up and made disappear into his coat but he was quite inept and clumsy (more like a clown) and as he moved his hands across his body I could hear the rustle of the chip packet in his coat pocket.*

This dream became part of my later reflection on how my identity and experience of the ‘other’ was shaped by the social political environment of my past. The shed I have recalled in the dream was in the garden of our family home in Zimbabwe – where I had spent my childhood. I struggled to understand how images of a distant past had become part of my present. Was it like Nassrin’s mourning of the loss of a clear structure – like that of a clear dress code guideline? Was I struggling to accept the many changes in the new South Africa, from where I had been absent for nearly a decade?

When I returned to South Africa friends said to me ‘welcome back’ – after a while I started to say it was really ‘welcome forward’ as so much was different. I had a sense of trying to run so I could catch up. In the dream’s second part – where two characters were working in a restaurant, one was a kind of pious ‘do good-er’ and the other a rather shabby inept clown. Were these the roles that I found myself steering between in this familiar/unfamiliar environment?

Relics and Residue from the Past

Walking round the hospital I noticed signs of times past. There were photographs of staff, some of whom I recognised as senior consultants from the past, many of whom had wielded great power in the hospital and frightened most health science students. I observed a ward round in which the consultant seemed to be enacting a parody of his own importance, with little acknowledgment of the patient's rights for information, dignity and respect or the MDT members' joint responsibilities in working with the client. It felt as if time had stood still and the democratising of health care had had little impact on these procedures.

> The ward round began with the consultant (a tall, older, largish white man dressed in a suit) talking about the film 'King Kong' playing on a TV in a large cabinet facing the patient. He said all that happened in the film was that Fay Ray screamed for two hours. (I noticed that the film showing was the recent version with Aden Brody.) No one in the group responded to the consultant, I wondered if they knew which movie he was talking about as it was a very old film. He moved in front of the TV and talked about the first patient.
>
> There were 13 staff standing around the bed of the patient (a 30 year old coloured woman who had suffered a sudden dense stoke) he was discussing. They were made up of doctors (white coats), physiotherapists (blue tunic tops), the OT, and nurses. A youngish black woman wearing a white coat with a stethoscope round her neck was reading from the files of the patients (I assumed she was a junior doctor). The consultant questioned her on the details of what she was reading and corrected her or asked about her clinical reasoning. No other professional was quizzed in the same way.
>
> At no time did the consultant speak directly to the patient, although he was physically closest to the patient. After the brief presentation by the junior doctor the consultant said what he thought, suggesting additional tests, medication or that the rehabilitation team could suggest when the patient was ready to go home. He seemed to show no interest in the patient's language or home circumstances.
>
> There were two large colour photographs of the 'rehab' team on the ward wall. There were staff I recognised from this ward round and consultants whom I recognised from ten years previously.

The OTs were responsible for the assessment, recommendation and distribution of certain items of equipment which would make that client's mobility or independence in self care easier. This was similar to the assessment undertaken by the OTs in the UK, but whereas the store room in the UK was full of off-the-shelf catalogue items, the OTs in SA produced many of the items in the department. Clients paid for these items on a sliding scale according to their level of income and if they were indigent they didn't pay at all. In the UK these items were 'free' for the clients and had (according to Fiona, see

p. 114) often been over used ‘thrown at the clients’ rather than considering their individual needs.

In the CTGH the responsibility for administering the allocation of the assistive devices was hampered by complex procedures related to which fund supported which assistive device. Nassrin discussed the difficulty OTs had in recommending and allocating wheelchairs for clients. She had inherited an administrative system from many years before and said she was one of the few people who could understand it, there were five different wheelchair systems each with their own sets of forms and procedures. For clients who may require a specialised (e.g. motorised) wheelchair there were budget constraints: one specialised wheelchair could cost their entire annual budget leaving other clients without any chairs. OTs were also required to deliver and collect the chairs which were no longer needed, and many of the chairs were lost to the system as some OTs were reluctant to visit clients at home.

> **Nassrin:** Things are changing now in the health care system with more therapists at community health centres … before we would actually do ‘pick ups’ … collect the chair and physically knock on the door and … take back the chair … people get them for an initial stage and once they get stronger and start mobilising with walking frames they no longer need the chair … and at the moment that doesn’t always happen … I mean home visits is part of our job description … but I know I have got colleagues that … they **don’t** feel safe, and they want to work at CTGH because they want to work in a hospital rather than to leave and go out in the community …The actual allocation of who gets and who doesn’t get is a tricky one … we have developed some criteria around it because we have had to make do with less than what we need … but when you read the national provisional guidelines around the issues, it say that everyone should get one … but we don’t have enough for everyone one – so that becomes difficult – try to prioritise in terms of how well they will use the chair, whether we can mobilise any loan systems … I think sometimes it is not just about who gets and who doesn’t get but who gets exactly what they need vs. … what is kind of second best.

I asked Nassrin if she thought that the issuing of equipment was an OT’s primary role; she said that she thought it was very important because if the person needed equipment there would be many other areas of their life that would be affected by their lack of mobility. She said the referral to OT for a ‘wheelchair’ from a clinic or ward would be the start of a full OT assessment and getting to know the client and their home circumstances. I thought the additional burden of the assessing who the ‘deserving’ were to be and having to fetch the equipment back was unquestionably accepted by the OTs. It seemed to shift the responsibility of funding and equitable resources from the health and social care management onto the health care worker (in this case the OT). Nassrin saw the usefulness in extending the request (for equipment) into developing a

deeper inquiry into the client's life circumstances but remained quietly accepting of the onerous process.

Differences in Context

South Africa does not have a National Health Service – a publicly funded health care service that is accessible to any citizen and paid for through the contributions of those who have a secure financial footing. It does not have a publicly funded grant for people who find themselves out of work (e.g. the equivalent of the UK job seekers allowance) and it has scarce resources to assist individuals who are disabled and thus temporarily or permanently unable to work. Although health economists in the post-apartheid period of reform (Wadee et al., 2003) have called for changes to tax structures and government spending, little has altered the divide between the wealthy class of citizen who use their health insurance to access private care and the poorer class of society who are funnelled through a series of public (i.e. government funded) local community day clinics to regional hospitals and, if necessary, on to specialist tertiary hospitals[39].

The gross inequity in public funding for different racial groups in the recent political history of the country meant that the wealth, education, access to health care and housing had been controlled by a 'white only' rule, deepening the poverty of those who were other than white. Although all the rules and policies of 'separate development' were eradicated with the new government (from 1994 onwards), the difference between those who access private care and those who attend public hospitals is marked by a visible racial divide.

Price (1986) wrote a caustic analysis of how public hospitals such as CTGH had been used to further the aims of the apartheid government; he described how, in the 1980s, the separation of a publicly funded health system into community centres, regional hospitals and tertiary specialist care institutions was an '*instrument*(s) of Apartheid' (p.158). The legacy of CTGH remaining a specialist hospital has been supported by its close proximity to a health science university faculty which uses the wards and clinics

[39] CTGH, a public sector hospital, was created as a 'centre for excellence' for specialist patient care, performing many skilled operations, cancer treatments and interventions for chronic diseases of 'lifestyle' considered by Price (1986) as part of the apartheid machinery which 'reinforced an ideology of racial superiority' (p.161).

as a training ground for the medical and allied health professional students. Since the late 1990s CTGH has offered outpatient and inpatient services to its geographical catchment area (acting as a regional hospital) and a specialist service to all South African regions. Its national and international status was a matter of some pride and ironic humour for the staff who worked there.

I asked the OTs in the second inquiry group if they considered that for many of the patients who came to CTGH it was a 'beacon of hope'. Joanne said it was also an indication of how ill they were!

> **Lindsey:** [The] client group … are people without medical funding, they might live in the area and I also imagine that CTGH is a beacon of hope … for many patients … I often think if they make it to the top of the hill[40] that is the first good sign [laughter].
>
> **Joanne:** I was walking up the hill one day and heard a patient say to another patient, 'are you coming to CTGH, oh you must be **really** ill.' [laughter] Like when they are at their last … it impacts a lot for me … this is the last … the last place where they could potentially be helped or seen to. There is nothing other than this. Especially … if they can't return to work or are unable to do what they used to do, then there is no alternative and that is quite scary …

I asked Joanne, who had worked in the UK and in SA in the same clinical area (orthopaedics), what differences she had noticed. She said the number and type of injuries were different, and in CTGH there were very few white patients. She said one of the registrars said if he saw a white patent in the clinic he assumed one of three things: the person was poor, ignorant or 'stingy'.

> Joanne said in the UK each patient was seen separately, here they are lined up, there could be up to 35 people in one room, it was a small room and all would be talking about their injury in front of the other patients. She said, with a smile, the type of injury in the UK was often related to using hedge clippers, or cutting a finger while cooking; here it was gunshots, stabbing, car accidents and violence from partners. In the UK a patient would often faint when they first saw their injury; here, she said, she had never seen someone faint. She laughed.

From the start of the SA data collection I was very aware of the difference in the client group; in the UK study clients, with few exceptions, were white older adults and the clients I saw during my observations in CTGH were young adults and most were black or coloured[41].

---

[40] The CTGH is at the top of a hill and the taxis which operate as a form of public transport are prevented by hospital security from going all the way to the top of the hill – they discharge their passengers half-way up the steep slope.

[41] Current racial classification in South Africa is a deeply contested area. For my purposes the distinction between white, black, coloured and Indian relates to how these communities were divided by apartheid

> … we walked past two beds being pushed by porters onto a ward. One bed had a black young male patient who looked as if he was in pain and a bit fearful of the bed being pushed around. I wondered if the man had come from surgery or had been admitted from an acute trauma unit. I was struck, again, at how young and black the patients were compared to the patients in the UK.

Crime and Violence

In visiting the wards for the first time I noticed that the bed arrangement and nursing station was very similar to the UK study, except that in CTGH all the bed sheets and covers had emblazoned across them, in large continuous print, the name of the hospital and statement that to take these items was against the law.

The types of injury sustained by the clients were also different. Clients in the orthopaedic ward were there because of violence, car accidents or the gang warfare that was part of prison culture and often continued when the recently released ex-offenders returned home.

> Antjie said the trauma and orthopaedic ward was made up of young men who were bored and could make you feel embarrassed. One of the young men called out to ask if he could still masturbate now he had a total hip replacement. I asked how she had replied, she told him he could provided he didn't flex his hip more than 90^{o}, we all laughed. Antjie said the men were bored and the only women they saw were the therapists who came to advise them on their walking or standing. She said she was lucky, she has chronic sinusitis so she can't smell, many of the injuries are septic and it would make it difficult to work with the patients if she could smell how bad their wounds were.

> Joanne said the trauma ward was different … the ward had a high security presence as many of the patients were victims of gang warfare and gang members would come to the hospital to 'finish the job off'. She said the patients were often reluctant to say how they got their injuries, they told stories of how they were innocent victims while going to or coming back from church.

The clients were a daily reminder of the level of trauma and violence in South African society. In observing a clinic for hand injuries I was impressed by Joanne's immediate compassion and help for a woman who, in discussing her painful hand, told Joanne of a previous attack by her partner who had broken her legs and locked her in a shack, making it impossible for her to seek help for her injuries.

---

policies (these were the four racial categories that were used for people living in SA), and how the distinctions between these groups continued to be reinforced through different social, cultural and policy initiatives. See Posel (2001).

> The next patient was a black woman in her mid-thirties. She had come for advice on her right hand … Joanne looked at both her hands and asked what had happened to her left hand … the woman said she had been attacked and her hand been broken. Joanne asked where she had gone for help with her hand and the woman said she hadn't. Joanne asked why not and the woman said because her husband had locked her in the house, he was the one who attacked her and he didn't want anyone to see her, she had her children with her.
>
> Joanne asked what had happened and the woman said her husband had beaten her with a doorpost, had broken her leg and crushed her hand. He kept her locked in the house and only took her to hospital a week after the attack. Joanne asked where he was now, she said she had left him, was working as a domestic cleaner and she was free of him. She had three children with her. Joanne asked if she had told anyone of the attack and the woman began to cry and said she hadn't told anyone, she had to rely on him as she didn't have any family to help her when it happened and she had to ask him to take her to hospital. While she was telling Joanne, Joanne had reached across the table and was holding the woman's arms with both her hands, an embrace with a table between them.
>
> Joanne suggested a counselling service and the woman said she would like to talk to someone. Joanne asked where her workplaces were and said she would send her the number of the counselling service in the city centre near to the second place where she worked.
>
> Joanne then made the resting splint for the woman's right hand and explained that because of her previous injury her right hand had probably been doing twice the amount of work and so it had become swollen. The woman agreed. Joanne asked if she was happy with her work, the woman said her employers (there were two sets of employers) were good people and she was happy. She told Joanne about her three children, one was working, one was in matric[42] and the other was still in junior school.
>
> After the woman had left I asked Joanne how often she heard stories like that, she said at least once a week. Many of the women had never told anyone before and she found that the counselling service of NICRO[43] could help the women. She said for people to get help the problem was with transport (getting to the service) and payment. As this woman was employed near NICRO she would be able to get the help.

During the free association narrative interviews (FANIs) Joanne told me about a taxi driver who had come to the clinic as he had been shot in the hand. She said it was a classic 'taxi shooting injury', as the victim would put their hand up to their head when shot at with a gun and the bullet would often pass through their hand. When she had offered this man a referral to a counselling service, he had laughed and said that it was the third time he had been shot, he didn't need it. That evening I opened the free weekly local newspaper delivered to our house and saw that a taxi driver had been shot in the road which ran next to the house earlier that day; he had sustained an injury to his head and hand. The crime and violence in South Africa was part of my daily reality and I

[42] End of school exam – equivalent to AS levels.
[43] NICRO is an organisation that works with people who have been in prison – but they also have a branch that works with victims of violence.

could feel its effects on my sense of personal safety and my constant appraisal of what an 'other's' intentions may be towards me.

I asked Joanne how she managed to sustain herself in her work when she saw so much violence; I asked her if she ever felt numb.

> **Joanne:** I think you do … some days more than others because then you just can't face another one. But it is a very strange feeling because … They all have got such … similar stories … but you can't afford to …
>
> **Lindsey:** You can't afford to….?
>
> **Joanne:** …to be thinking about it all the time … or to try and save them all … because you can't. So I think you probably do become a little bit numb … I think that is OK … I just think if your numbness is written all over your face – I think that is where the problem lies. Because … you can be numb to protect yourself but you must still engage with the patient. So I think maintaining that … is probably something … that could be difficult … [laughs] … at times.

Race Rules

OTs in Cape Town appeared to be separated along a racial divide between predominantly 'black[44]' therapists who worked in public service organisations (hospitals, schools and mental health institutions) and predominately white therapists who worked in the private sector (medical insurance funded hospitals, private practice clinics or insurance claim firms). Many 'black' OTs refused to join the officially recognised OT association of South Africa (OTASA) stating they believed it was run by 'white middle class therapists' who did not understand (or care about) the realities of the majority of people living in South Africa. The OTs based at public hospitals had formed their own organisation, the OTs Associated Hospital Group (OTAHG), and they met regularly to disseminate and discuss new government policy. I had been invited to facilitate three of these meetings and became aware of the tensions within the meetings between older white women (like Alice and myself) and the younger 'black' managers.

These divisions were not absolute; Joanne for example was a white Afrikaans woman who said she said she didn't like private practice. I was intrigued to read (in a report of an OTAHG meeting) that the white women who attended these meetings were referred to as the 'old white women', as if they no longer were able to make a contribution to the

[44] 'Black' in this instance refers to therapists who are Black African, Coloured, and Indian.

new South Africa. At the same time the OTASA committee (who were mostly white women) could not understand why 'black' OTs did not attend their professional meetings or social events. The new South Africa (i.e. post apartheid) was alive with the legacy of racial stereotyping and it created many barriers to any genuine dialogue taking place across the racial groups.

I found that I was very conscious of my race (i.e. whiteness) while doing the study. I found that in all my reports and reflections I mentioned race. I shrank from anything that implicated white people in the legacy of the past and I also felt burdened and guilty for the assumptions I had made about people's experiences that were located in my colonial personal past. I didn't want to consider that I could carry racist notions about the 'other' and yet I found evidence of them in many of the transcriptions and observations.

Joanne told me of her difficulty in finding a way to reprimand a junior colleague for her neglect of a client. I asked her if the difficulty she had in asserting her managerial role was because the colleague was from another race group. This may have been a reasonable interpretation in an institution where senior staff tend to be older white women and more junior staff black, but in truth my fantasy while doing the interview was that the OT who had neglected the client was black. It was only when I listened to the interview that I realised at no time had Joanne indicated anything about who (gender, age or race) the junior therapist was. I was mortified to find that my assumption had seemed to dominate the interview.

> **Lindsey:** Are there certain patients that … you can really understand where they are coming from because there is something about them that you … feel for. Is it the same with staff? … my fantasy is that this staff member [the person that Joanne said she needed to reprimand] is a different race group from you … which makes you feel cautious about how to manage your authority …
>
> **Joanne:** …probably not consciously … because I really don't distinguish in that sense. …You end up … I mean we all do it, you look at someone … I mean especially in the field of OT … it ends up that if you have gone to this university you are most likely white, or if you have gone to this university you are most likely coloured or most likely … I don't think consciously. Sorry what was the question?

I realised that I had attributed my own racial prejudice to Joanne – imagining that she would feel unable to confront someone who was from a different racial group from her own. It was no wonder that she asked 'what was the question?' During the study I found myself trying to be 'different' from the white people I saw round me, as if I would

otherwise be associated with them through a shared racial identity. I viewed them as selfish and insensitive, something I wasn't (or was at least trying very hard not to be).

> I became aware of a white woman lying in the bed opposite … who … spoke loudly and asked for the doctor to be called … The nurses seemed irritated at the request and said they would get to it when they had finished their other duties. The woman opened a plastic container and ate a muffin. She was a large woman and was lying on her bed with her head propped up on cushions. She offered the woman in the bed next to her a muffin from her plastic container – the woman next to her declined.
>
> I felt ashamed that I was white and may be seen to be like this woman. I imagined her as one of the patients who pretended that she didn't have an income and so could benefit from the reduced fee service of the hospital. A doctor walked past and she called to her … Again I felt that the white woman patient was a spoilt person who was unaware of the people around her and was demanding and selfish. I had not felt such antipathy towards a patient before and it seemed to be evoked mostly by the colour of her skin. Although I was aware it was in part my disavowal of my own whiteness and the privilege it had afforded me in South Africa, I couldn't stop myself from coming to the conclusions I had about her behaviour.

I had lived in South Africa, working in Cape Town for nearly 20 years (1980-1998) and had taught at a (predominantly white) university for a ten-year period (1988-1998). Four of the therapists who participated in the research study had been students of mine, three from ten years previously and one recent graduate from the university I worked at while undertaking the study.

In doing the narrative interviews Nassrin had said that she had enjoyed her training to be an OT as there were so many new things to learn, and she had particularly enjoyed the creative activities undertaken in the degree course (e.g. art, gardening and sewing). I asked Nassrin how she felt being one of the few black students in the class, she said it felt like she had to 'catch up' but there was a more poignant reflection which I became aware of later in re-reading the transcriptions: she felt as if she didn't have something the white students could learn from her (this statement has been placed in bold in the FANI below).

> **Nassrin:** … the first elections was my very first year at university, 1994, so my schooling was still very much segregated and separate, and so for me … being in the class with people that was so different I mean that was catch up … if I reflect on it I think that … people were schooled at different schools, and came from very different areas …There wasn't that much of integration happening … so some things [the traffic accident and death of a class mate] did help to bring the class together … but I think there were … subtle divisions or rifts that were very much what we had brought with us … and our experiences coming to university and where we started from were very different journeys … we were in the new democracy, and there is a level of tolerance which I did experience … I didn't feel as if I was on the outside … but I did feel I had a lot of catching up to do.

> **Lindsey:** … in some ways you are saying what … your experiences of coming to university was one of not being the same as … racially
>
> **Nassrin:** I want to think about this a little bit more … It is not so much the … that my experiences weren't acknowledged … it is from my perspective. I saw lots of people in my class as having more opportunities than me and I think that that exposes you … and learning so much about myself and discovering hobbies and things I never knew … I looked at what other people in the class that they had that on board already … art lessons, music lessons … that was all new to me. When I speak about catch up then I speak about the parts I discovered about myself … I'm not saying it took away from my experience and my childhood and that not being rich but … I don't think that was really engaged with … because I don't think others were aware that they had missed it … and so they didn't engage … **it didn't feel like I knew something that they were learning from…**

In the three-year period of living in South Africa (2005-2008) I found myself becoming irritated with the plethora of autobiographical accounts by white authors (e.g. 'Gem Squash Tokoloshe' by Zadok, 2005; 'Frankie and Stankie' by Trapido, 2004) who described their experiences of growing up in South Africa seemingly always aware of the gross inequities and injustices of the country. They wrote of how they constantly questioned their parents and other authorities about this visible discrimination, for example going into a shop and questioning the purpose of having two queues, one for whites and one for blacks. I had no such morally enlightened narrative from my past, I had participated, unthinkingly, in the privilege of the position I held as a white person growing up in Zimbabwe and then working in South Africa.

During the SA study I found and read the biographical accounts of Tsitsi Dangarembga, a black woman born in Zimbabwe at the same time I had been, who had written of her childhood and schooling in my home place. It was a profound awakening for me, because as I read her two books, 'Nervous Conditions' (1988) and 'The Book of Not' (2006) I found I could not recognise what she said and had seen. It was as if it was another country. I found myself confronted by a confusing 'other reality' and I read about the pain she experienced by the disavowal of her 'self' by whites. It was these biographical accounts that helped me see Nassrin's narrative (above) more clearly – she was saying that she felt ignored by the white students in her class, that what she knew was not 'needed' by them.

The Political is Personal

As I said when this chapter began, I began the study (in the UK) with a view that what may have motivated therapist to undertake work with vulnerable clients was an unconscious wish for reparation and recognition. The observations and interviews in London seemed to echo this, with therapists discussing their early lives of being neglected in large families and learning to become visible through 'helping' (Diane) or trying to assuage a mother's depression by keeping up the housework while ignoring her own abuse by a relative (Alison). This seemed to fit my own reflections of why I had become an OT and the use I had made of 'doing' in my life. The UK study also related to the work of Menzies Lyth (1988) and her descriptions of the nurses' need (motivation) to care for their patients as part of the unconscious defence of reparation.

The observations, interviews and inquiry groups in South Africa, alongside the reflexive cycle of dreams I had while living and working there, made me aware of the complexity of the interface between the social-political and personal history of the country as lived by each person in their home, educational institutions and workplaces. This was integral to the psycho-social research project, and as Orbach (2008) stated, it was impossible to separate out the different parts of a person, family, gender, race and place All played a part in how the person felt and acted in the world.

> '.. social movements such as feminism, the New Left … were engaging with psychoanalysis … [and] were contextualising the intrapsychic life of the individual as an outcome of relationship: relationship that was embedded in a set of classed, raced, religious, ethnic and gendered relations that was reflected in the particular nuances of psychological relations.' (Orbach, 2008, p.26)

This focus needed to include how the research study was conceived and undertaken alongside how the data was presented and interpreted. As Smith (1999) states in her book 'Decolonizing Methodologies', research could enact a further performance of colonisation.

Hope as a Dream, Reality a Burden

One of the participants in the second inquiry group reported a dream about one of the patients on the paediatric wards. I had asked if the group had any thoughts about the previous group, or if they had any dreams to report; there was much laughter, then Elizabeth shyly said she had had a dream.

> **Elizabeth:** Ya, I've tried not to analyse it [more laughter] – it's one of the kids we have in the ward who has severe traumatic brain injury and … I just had a dream that he improved … [laughs] which is not likely … and bladder and bowel continence is a big thing in our ward … and I dreamed that he was continent and that he could speak. [laughs] That is not likely to happen, ever.
>
> **Lindsey:** And when you wake from a dream like that … what is the sense?
>
> **Elizabeth:** I didn't think I really feel anything … [laughs] … you tend to lose hope because this kid has been the same now for months and months and to dream like that is just … strange, because you don't expect anything … really from this child any more.

This led the group to discuss their view of clients and the role of 'hope' in their work. Joanne spoke about feeling hopeful in the dream and then waking up to the reality, leaving her feeling sad. Zarrin said OTs don't have the right to confront the client with too much reality, because to do that would be to strip hope away from them.

> **Zarrin:** A patient I saw last week had a severe stroke and the possibility of him walking again is very slim. The referral for seeing the patient was 'improving insight' and I went in there … but saw I it from a very different perspective because the gentlemen said to me 'nobody has the right to tell me' … in all his rehab centres including here they told him he will never walk again … He said no one has the right to say that, only God has the right to make that decision … I thought that is true … because do I want to take the hope away, where I improve his insight [that] he will never walk again and he slips into a depression … and loses his sense of purpose or am I giving him false hope … and that was a very fine line to walk. He did have lack of insight, [but] it was that sense of purpose and sense of hope that was keeping him motivated … but how [do I] I communicate to my patients? So it is that sense of hope, but is it false hope?
>
> **Lindsey:** Very similar to the dream, what is the wish for the patient and what is reality … as you were saying Joanne, when you wake up … not just about sleeping and waking up but waking with a new realisation, waking up to the reality of somebody's life. And whose right [life] is it?

I asked the OTs if they felt that the reality of many people's lives in South Africa added an extra burden onto the professional commitment they made to their clients, as if there wasn't a boundary between the role of being a professional and being a person/citizen. (I asked this as a continuation of the OTs talking about their uniform and not 'taking it off'[45]). Zarrin said she couldn't separate what she was as a person and as a professional. She described taking the bus home and watching street children at the traffic lights sharing out the coins they had collected from a day's begging.

> **Zarrin:** I saw it as … there is poverty but I also saw it as … when I am in a car on a Saturday and I am not thinking about work, then they are naughty, they should be at home and they shouldn't be on the streets but … last night it was a completely

[45] See earlier description of 'uniforms' in section on the Borderland, p.136.

> different … it was already half past six, it was dark and I was thinking where are their parents … where are the adults who need to take responsibility, but look how responsible they are – these eight- and nine-year-olds … because they had quite a bit of silver money and they were probably going to eat and this was their meal for the day … but it was all those thoughts … I should be doing something, I should be alleviating poverty for kids … [laughter] and I thought no you can't do that, you have to go home now. [laughter] … and by the time I got home all I did was hug my children, it didn't make it right … but it kind of comforted me … It is always a battle of who you are … and where you are at.

Many of the OTs shared their awareness of the political social realties of their clients' lives and how they saw people outside the hospital (e.g. walking with crutches alongside the motorway) as part of an extended service they could/should offer. This was similar to their feeling that they never took their uniforms off (see p.139) that they were always, in effect, 'on duty'.

When Joanne spoke about her work she said she sometimes looks at the 'non-complaint' client – who smells of alcohol and has been in so many fights that he is blue from all the scars on his face and body – and she wants to sit in a corner with him and weep.

> **Joanne:** I … saw a guy yesterday … and he looked like he had been pulled backwards through a bush and he had a fracture because he was knocked over as a pedestrian and I thought … where have you gone, what has happened … any person who comes in this world has got the potential to be the best person that they can be … and something somewhere … pushed him in this direction and now his arm is not healing because he is drinking too much … and you just feel like you want to go and sit in the corner and cry with him … because what is there for him … there is nothing … he knows that he shouldn't be drinking … [laughs] … but that is not enough … and he knows that his arm is not going to [heal] which means that he won't be able to work because he didn't finish school … he has got a manual job … so you feel that … and then you just move on … because there is isn't much else you can do really … apart from that time that you spend with them I think.

A Stranger in Your Own Home

Of the three in-depth interviews I undertook with Mina, Joanne and Nassrin each shared something of their early lives which illuminated their commitment to working as an OT. The stories were powerful narratives of lives where their social political awakening took place with parents who were able to negotiate the racial discrimination in South Africa (Nassrin) or who represented a place they rebelled against (Mina) or who were always outsiders as they refused to participate in white conformity (Joanne).

The access into the meaning of their narrative often took place as the therapists spoke about their childhood and they were frequently surprised to see the link between their early experiences and the way they engaged with their adult work roles. Sometimes the observations they made of particular clients or events they observed in everyday society provided rich material for establishing links between their unconscious lives and their work. These understandings were sometimes quite unsettling for the participants.

> **Nassrin:** I must be honest I've just … I guess after our conversation last week I have been thinking about a lot around what you were saying about my childhood and … I never gave any thought that it's about using your whole self … and parts of your upbringing and all of those things contribute to your clinical reasoning that you use when you work with a patient … and what I decide is influenced by who I am. That has been on my mind this last week. It's been quite … I have been quite shaken up by it …

I had a dream during this period which unsettled me – it was of falling down a hole where there was no bottom, and what I was standing on to keep myself upright kept giving way beneath me.

> *Dream 10: Falling Down a Hole (April 2007)*
>
> *I was attending a conference and all the delegates were staying in a long corridor of rooms. As part of the events of the conference I was going to a performance of an amateur theatre company. The building where the show was to be held was built like a child's castle and I had to stoop down to get through the doorway (an open ornately painted door) to the theatre.*
>
> *The room I entered into was fairly dark and I fell into a deep hole – the hole was bottomless and I could feel myself slipping down. In the hole were several bolts of material – the material was the one they use to make pressure garments in the OT department. I tried to push these bolts of material under me so that I could gain a purchase on them and get out – but as I pushed them beneath me and they would wedge themselves - if I tried to stand on them they fell into the space below, leaving me hanging again.*
>
> *A person walked into the room and I tried to gain their attention to get some help – but they ignored me and walked away.*

The feeling of the dream was of being in familiar territory (conferences and research were part of my life) and on unfamiliar ground, literally, there being nothing below to support me. It was an anxiety-provoking dream. The bolts of material in the dream were used in the OT department to make 'pressure garments' for patients who had amputations (to prevent swelling in the affected limb) or with clients who had been burnt, to soften the skin and prevent contractions or keloid scarring. This emotional echo of being unnerved reminded me of Azar Nafisi (2004), an English teacher in Iran, imploring her students to explore their world with different eyes. The dream had an 'Alice through the Looking Glass' feeling.

> ‘I wrote on the board one of my favourite lines from the German thinker Theodor Adorno: “The highest form of morality is not to feel at home in one’s own home”. I explained that most great works of the imagination were meant to make you feel like a stranger in your own home. The best fiction always forced us to question what we took for granted. It questioned traditions and expectations when they seemed too immutable … I wanted them … to consider the world, like Alice in Wonderland, through different eyes.’ (Nafisi, 2004, p.94)

In the FANI interviews, Mina described how she observed the traditions of her religious culture (she was a married Muslim Indian woman) and also used her experiences of that culture to break from the past and be different to what she had seen her mother (and aunts) become. Mina had worked at CTGH on and off for a period of ten years and in talking about her background she said she was the first in her family (parents and grandparents) to attend university and in this way she ‘opened a door’ for her younger sisters and cousins to follow. She said sometimes she would look at how the women in her culture had accepted what they were NOT allowed to do or discouraged from doing and she would use that as an impetus to make sure she could do it. I asked if that was why sometimes she would push patients to do more than they thought they could; she laughed and said she hadn’t seen it that way, but perhaps she did.

> **Lindsey:** Would you say that you were an independent person?
>
> **Mina:** I think I am … I do have … limitations and boundaries set through my culture and through my religion … there are sometimes when I wish things could be a little bit different … [laughs] … what probably has made an impact on me … my mother, fits in with the norm and what society expects … and although … she is happy on most instances, I have seen she does become a bit frustrated through the boundaries that are set for her … that’s maybe … given me the little bit to try and see how much I can push those boundaries … when I think of doing something … it is odd because sometimes I don’t … how do I put this? … when I do things, on some occasions … I don’t do it in terms of I want to be **like** that one … I sometimes do it in terms of I **don’t** want to be like that …
>
> **Lindsey:** I hear you saying that you are quietly rebellious …
>
> **Mina:** mmmh [laughs] I think I am …
>
> **Lindsey:** Perhaps … when patients struggle with the limitations they have been given … and they defy it … you can connect with them … and [although you] accept the stroke does place … very real limitations, in the same way you say you accept that within your culture, there are certain limitations and … you will operate within them … but there are always those other parts that you know you can still do …

This ‘leading the way’ was echoed in a story Mina had told me about watching two young children help their disabled mothers enter a bank, which in South Africa has a complicated double door system to prevent crime (i.e. a quick getaway). She had been

watching how the children were extensions of their parent's needs, not really allowed to be children and the mothers seemed unaware of their use of their children.

> **Mina:** I remember we were in the bank … and … during that short space of time, there were two women that came in, one with those scooter things that you sit on … and another lady in a very sporty wheelchair and both of them came in with young children … between five and seven years old. I was fascinated with the way, the interaction between … mother and child and how the child almost took it in their stride to do the things that the mother couldn't necessarily do … like running ahead to open the door so that the mom could go through, holding it open, going through and then opening the door on the other side … and the one woman … the child was a lot more playful, he ran ahead and opened the door and walked in and he didn't hold the door open long enough … and she shouted at him … and I just thought … for any other child, they wouldn't have been expected to do things like that. I wondered … is she being unnecessarily harsh on him … or she probably sees that it is part of their roles together … and just as reprimanding a child who is doing something they shouldn't do … that is part of what she almost expects of him … and I just found that so fascinating … how the expectations can be put on children … in terms of what you are able to do and what you can't do.

Mina had not linked this story with her own narrative, which was one of leading the way in her family, holding the door open for her sisters and cousins to pass through. Mina had said that working had given her an independence from some of the cultural restrictions she felt were placed on Muslim woman.

Joanne's personal history and identity was one of being a white Afrikaner growing up in a small conservative town where her father's refusal to participant in the 'Broderbond'[46] had made the family an outcast in the small community. She said that for most of her youth she was unaware of the stigmatisation that her father experienced as he had protected his family from its full impact. She described her father as a wise, loving man, that her childhood had been in a secure, loving home and that all her siblings were in 'service' professions, mostly because of their strong religious beliefs.

She spoke of the different jobs she had done, including a four-year period of work in the UK, but said she didn't like the identity she was attributed by fellow South Africans of being a white who had left because she didn't agree with the new (ANC) government.

> **Joanne:** If you are South African and you have stayed beyond your working holiday visa time then people think that you are there because you have left the country for some reason … I am talking about South Africans now. Because I met so many older South Africans who have left the country because of politics and because they don't want to be part of the new South Africa, they just assume that this is why you are there. That is not the reason I was there. I was very excited

[46] This was a powerful secret society which operated amongst white Afrikaans men and was likened to the Klu Klux Klan in America.

about the new SA and I hated being labelled there, and I felt I needed to prove it and so I'll just go back …. ja …

Lindsey: So in some ways your return was …uumh…politically motivated …a commitment to SA and you didn't want to be associated with disillusioned white SA people who have moved across to the UK ?

She said was pleased to work at CTGH, she had applied for the job as she said she was unhappy in an orthopaedic OT private practice. She liked the type of patients who came to the hospital. I asked her what it was about 'these' clients that she wanted to work with.

Joanne: I just like the patient population at the hospital more because I think you can be more useful. I feel more comfortable and I feel more….that what I do is more meaningful here than what it would be somewhere else. In private you would get to see the patient more often and there is less of a challenge because they are literate and you can give them a home programme and off they go. Maybe I am what you call it in English a "smart fraat?" Do you know what that is? I like people who suffer. [laughs]

Lindsey: Like heartache?

Joanne: Yes, people who like to be amongst heartache [laughs] … I feel that I want to be in SA and I want to contribute in some way … to people's lives and especially people not so privileged … and I want what I do to be meaningful … I want to contribute to society and I didn't feel that I was contributing when working in private practice.

Joanne said she was brought up in a liberal home where she never heard derogatory terms used for 'other' people and she was shocked when she went to an Afrikaans university and heard her fellow students 'call people things'. I asked her how she felt about being Afrikaans and she said that she loved the language but didn't want to be associated with what the term had stood for in the past.

Joanne: so what I am trying to say is that even within the Afrikaans culture… I like the language and am proud to be an Afrikaans-speaking South African but I also wouldn't call myself an Afrikaner – that just sounds like Vervoerd.[47]

Joanne mentioned that she and her husband had deliberately chosen to live in a suburb commonly associated with English speaking whites, i.e. separate from the Afrikaans community[48] in Cape Town as they did not identity with the culture of the Afrikaans community. It seemed that they had chosen to live in the place where they would never feel at home; perhaps like Nafisi (above) imploring her students to always examine their

[47] Considered the architect of apartheid in South Africa.
[48] One of the legacies of apartheid was that distinct cultural groups lived together: Afrikaans-speaking white and 'Coloured' in the 'northern suburbs', English speaking 'Coloured' in Rondebosch East etc.

culture and beliefs, Joanne had chosen to be uncomfortable so that she did not become complacent – or feel complicit with the actions of the Afrikaners in the past. I said to her in the FANI it sounded like an 'identity dislocation'.

Towards the end of the second interview Joanne told me about a patient she often found herself thinking about; one, more than all the others, that stayed with her. She told the story of a man who had to flee Burundi (because of ethnic conflict) and had walked to South Africa. He had attended the orthopaedic clinic in Cape Town as he had fallen in front of a truck in Mozambique and had suffered an avulsion of his right arm. She said this man, who had survived so much, had arrived in their clinic with no money, no language to communicate, no papers (not even a photograph of his family in Burundi) and no understanding that his arm would never heal.

Joanne explained that an avulsion was where the arm had been torn away from its nerve roots at their origin (in the shoulder girdle); causing tremendous pain (because of the severed nerve roots) and the arm would have no functional use. It hung next to the body and was a potential hazard as it lacked any active movement or sensation. I asked why she had thought about this man in particular and if she had identified with him. She laughed and said she didn't think so.

> **Lindsey:** This may sound a bit strange … but was there anything about this man you felt was like you?
>
> **Joanne:** He was very short, very black. [laughs] Um … I don't know. I haven't really thought about it … I don't know what it was … It's just that same thing … this is going to sound really awful now, when you see a small little animal in the wild that is about to be eaten by a lion … that is already fat from all the other small little things that he has eaten … that is the kind of thing. You just want to take the little rabbit or whatever it is and take it out of that situation … It is so sad … I think this continent is just so sad. I mean there is lots of good … but … you just see the violence all the time… and you see … You very rarely see the guy who did walk from Burundi and made it, and is now good and well … you don't see those people … which makes you a little more cynical about the success stories out there.
>
> **Lindsey:** What comes across in your story is just your sense of hopelessness … sorry helplessness with him – because there **was** nothing you could do.

In working with the observations and interviews I had found myself being judgemental of Joanne's part in the project, reading her input as defensive or being 'in denial' until I realised I had attributed some of my own racist thoughts onto her, as seen in the earlier section where I assumed a colleague Joanne spoke about was black. After this revelation I began to read her interviews differently and I realised that Afrikaners, like her, had

experienced an 'avulsed' identity. The Afrikaners, more than any other white group, were attributed with the sins of South Africa's damaging and painful past. Antjie Krog, an Afrikaner, dedicates her semi-biographical account of the TRC[49] 'for every victim who had an Afrikaner surname on her lips' (1999, p.iii). I began to realise that Joanne may have felt dislocation of her identity like a tearing away of her right arm from her body – and that she would always feel the pain of this loss of her roots in her current life and identity. It was partly because of this pain that she chose to work with this client group, not in a pious patronising manner but because she wanted to help, as she said, because she could.

At no time did Joanne speak about a feeling of guilt or associated shame about her cultural background, but I felt it was encoded in many of the things that she said and did. It was as if it was an unconscious part of her that motivated her to work with the particular patient group and gave her the compassion and no-nonsense support I observed her offering.

The Political is Professional

Nassrin was a 'coloured' Muslim woman who had lived in Cape Town all her life. She said that she thought sometimes people chose to work in institutions (like CTGH) to protect themselves from seeing the realities of their clients' lives. When I asked how she had been able to move beyond that comfort zone she began to tell me about her life. She had grown up in a 'coloured' suburb which bordered a very poor area of Cape Town (Seaview) and she had attended the 'Afrikaans' medium school in Seaview, which her mother had especially chosen, even though the 'English' medium school was nearer to where they lived.

> **Nassrin:** I went to the school that was possibly one of the poorest schools … and I think my mother was quite conscious in placing us there … It was an Afrikaans medium school with one English class and we were English speaking so I was in the English class … lots of the children from Seaview went … And I guess having friends at school who lived in the area … I guess … it never struck me it was a safe and not safe area … it was just where people lived …

Nassrin said while she was growing up she was aware of the politics in the country from her family; her parents didn't often attend the political mass rallies as they had young

[49] 'Country of my Skull'

children but there was always talk about politics. She recalled a time (when she was still quite young) taking part in a protest about her school closing.

> **Nassrin**: I remember at the school we went to … it was dreadful and the principal chose to close the school before the government gave the law that it needs to be closed … but there was a protest about it … and I remember getting dressed in the morning for a week and a half and being in school uniform going and standing at the school gate with my mom until about 10am … because we should be at school … and school shouldn't be allowed to close. And we were ten kids who did it … and this is a primary school … so being different … taking a stand … has always been something I have been brought up with … For me it is part of life. [laughs]

She said that her parents chose a senior school that had a reputation for political awareness, although this meant that she had to be 'bussed' in to the school. It was a 'coloured' high school that was located in a newly designated 'white' area. It had been part of a group of 'coloured' buildings: a school, a church and mosque group that had not closed or relocated when the 1950 Group Areas Act was passed by the SA national government. Nassrin felt fortunate to have gone to that school, as friends who went to nearby schools were politically 'apathetic'.

> **Nassrin:** I think my parents chose my High School very carefully… I went to West Ridge High[50] … it's the school that wouldn't move, schools mosques and churches wouldn't move … so the residents were all white, it was in a white area and all the learners got bussed in … but it was a school that was a lot more political than … the schools closer to us … there was a kind of an apathy … because friends [who] went to the schools in the area … they were oblivious to what was happening … we would have awareness programmes and mass rallies and the SRC [Student Representative Council] was very active at school so I guess it has always been a part of me, I don't know where I learnt it or where I got it from …

Nassrin seemed to be saying (above) that her awareness of the political realities in the country (and in her life) had always been part of her and that she had never consciously thought about it in. She said her father had been a quite thoughtful man who had followed his conscience. She described a time when his brother (her uncle) had accepted a position in the 'new' tricameral parliament, which many white, coloured and Indian citizens opposed, and this had pulled her family apart from the extended family. She felt she had learned to be an independent thinker, her mother had often commented that she was a child who could 'play alone'.

> **Nassrin:** In the 80s the family structure was broken down … my uncles and aunts … whatever is said they go along with. But my dad is quiet, he kind of thinks … he reads a lot … we have always been different even from the family … it has given me … it is OK to be alone … and I am very independent in that way I can be without people … I think it is also my personality style … My mom always said I

[50] Pseudonym.

> could play alone as a kid whereas my sister always needed to be entertained. [laughs] … I guess if there is something that I think or should happen I can move with it without having support around me.
>
> **Lindsey:** … that is how you described yourself at work … as someone who can think things through and what frustrates you at times is OTs who simply do what they are asked to do without thinking about what else it means … so there is something about your childhood which has freed you … to be a thinker.

It was after this first interview that Nassrin said at the start of the second interview that she felt 'shaken up' as she realised that her past had contributed to her work as a therapist.

> **Nassrin:** I must be honest I've just … after our conversation last week I have been thinking … a lot around what you were saying about my childhood and I guess I have come to the realisation that … [I thought] OT [was] what you get trained as … it's the four years and I never went back and thought that although we use ourselves very much therapeutically … and we can't actually split parts of ourselves … I never gave any thought that it's about using your whole self … and parts of your upbringing and all of those things contribute to your clinical reasoning that you use when you work with a patient … It's been quite … I have been quite shaken up by it …
>
> **Lindsey:** Really?
>
> **Nassrin:** In a very good way – I think it has given me deeper understanding into myself.

Nassrin said she had thought of herself as having two lives: one at home (and school) and a second one of being a professional. She said going to university had felt like leaving something behind and moving on to another. I asked her if it was in talking about her past that she began to see the bridge between the two.

> **Nassrin:** … [pause] … it was very much like leaving something behind because it was two completely different experiences … in some way even through education continues … the framework in which you are doing it in is so different … so it doesn't feel like a continuous process … it feels like you are saying goodbye to one and moving on …
>
> **Lindsey:** …what you are saying in some way about my questions … made you think about the bridge between the two, how you grew up, what values and traditions, what your parents stood for … assisted you in being able to think … to see both sides of something …

It was in the second interview that Nassrin had spoken about feeling marginalised in the class of predominantly white students who seemed to know more about the creative activities in class than she did and they seemed unaware of their privilege. She felt she did not have anything they would want to learn from or about. In looking through the

transcripts I was shocked to see that with this heartfelt revelation, I seemed to have changed the subject abruptly by mentioning the men in the class, who would also have felt 'left out'.

> **Lindsey**: I think what you are saying is that the dominant culture in the class was one that … although not consciously … perhaps in some ways unconsciously … excluded your experiences … and the way you managed that or protected yourself was to keep those separate … going home each night to touch base with who **you** were as well as travelling in to this … land that was different …
>
> **Nassrin**: [pause] Yes …
>
> **Lindsey**: …the other thing I remember from the class is it had a tremendous number of men …
>
> **Nassrin**: … I think there were four … but I think they were still very much in the minority… [laughs]

Why couldn't I have kept quiet after what seems to have been a sensitive interpretation of the way she coped with her time of being 'alone' in the university class? Why did I immediately mention another group of 'minority' students? What was I avoiding (or afraid she may say) that made me want to turn away from that moment. Was it because I had been her lecturer and in all the time I had taught at the university I had never realised how she had felt. In thinking about this part of the interview I think it was my guilt and shame at my ignorance of her at this time that made me want to avoid any further knowledge.

I had one last 'research' dream during this time which seemed to uncover this sense of culpability and guilt I carried during the research process. It ends this section and resonates through the next chapter on a journey without maps.

> *Dream 11: Burying the Past (June 2008)*
>
> *I am in my house in Zimbabwe (*it is not a house I have thought of for many years*) where my partner and I are packing all our things to take to somewhere else. I realise that there are two black men in my neighbour's garden who are hiding and planning to attack us and steal our things. I tell my partner I will climb over the garden wall and deal with the., I climb over a brick wall into the neighbour's garden, come up behind the two men and kill them both by hitting them on the head with a metal pipe.*
>
> *I put their bodies in a large green trunk and lock it up. My partner is worried and I say that they won't be found until after we leave and so not to worry. But I find that I feel awful. It is a Friday night and I can't forget what I have done, I keep worrying about being found out – and then I think of the work of the TRC and how the mothers wanted to know what had happened to their children and so I decide go to the police and let them know.*

> *On the Monday I go to the police station and I ask to speak to someone about a crime. The person at the desk asks if I would like to speak to a duty sergeant or the inspector, I say the inspector. I am left to wait for a long time. The inspector was a middle aged woman (smart and bright) with red hair. I told her what I had done and she asked if the bodies had started to decompose. I said not – and that I couldn't bear to keep the bodies hidden, even though I knew I was leaving as I wanted the men's mothers to know where they were and what had happened to them.*

Nassrin had said she didn't realise that her past had influenced how she thought about and did her work. Like her, it was through the process of my research that I began to realise how my social-political past had affected me in what I was able to understand and do in the work I had undertaken in this project. In 2003, when I began the project, I was eager to include some of the work of the South Africa OTs in a study of the unconscious defences used by OT, but I was unaware of how my own colonial racial past would affect of those explorations. I had neglected to consider how the social unconscious, that we all have and carry, influences the choices we make, the assumptions we use and the relationships we form.

The study at CTGH drew my attention to how the multiple conscious and unconscious layers of our past affect our needs and aspirations. The UK study was focused on the therapist's early life (family) experiences and how these may have affected their need to care for others, (as described in Chapter 4; identification, repetition, reparation and mutual recognition). In the SA part of the study this inquiry broadened out to include therapists 'culture' background, e.g. racial group, religion, home language, gender and class. For example Mina had explained that her university degree and work role allowed her a freedom and independence of mind that her mother (who observed the traditions from the past) had not enjoyed, and she thought she sometimes used this example when 'pushing' patients to do more than they thought they could. Nassrin explained how her early political education (by her family) made her aware of the wider social issues (particularly their access to education) that affected people's health and Joanne felt a strong commitment to working with 'these people', although she had never seemingly considered that this need may have been in response to a deeply felt cultural guilt and shame at the past.

These 'hidden' motives were mostly unspoken, and seemed to be part of the social unconscious (Brown, 2001, Dalal, 2001) of the OTs working at CTGH. The uncovering (and thinking about) of the layers of conscious and unconscious 'social' material I have

developed further in the following chapter, ‘Journey without Maps’. As Hopper (2001), in discussing the duel focus required in group and individual psychoanalysis said;

> An analyst who is unaware of the effects of social facts and social forces cannot be sensitive to the unconscious re-creation of them within the therapeutic situation. He will not be able to provide a space for patients to imagine how their identities have been formed at particular historical and political junctures, and how this continues to affect them throughout their lives.’(Hopper, 2001, p.9/10)

In the SA part of the study the socially fractured and violent nature of the South African society seemed to permeate the work undertaken by the OTs at CTGH. This placed different type of demands on their emotional response to the clients, one that included an ethical reflexivity (about the historical, social and political circumstances of the client) and a need to guard themselves from being overwhelmed by this work.

Chapter 6: Journey Without Maps

Mapping

As travellers, drawing
lines from place
to place, we copy
the nervous conceit of mapmakers.
We crop the edges of our worlds
like failed photographs,

but our discarded parts,
with their uncertain shifts from
inside to outside,
show that definiteness
is only the edge
of desire.

Gabeba Baderoon, 2005

Baderoon's (2005) delightful poem, 'Mapping', draws our attention to the fact that a map cannot always reflect how things are, the poet enfolds thinking from social construction theory about how the interpretation of a context changes according to the person who 'views it' (see Burr, 2003) and the nature of time in which things change. This is echoed by the narrator (Christopher) of the story 'Curious Incident of the Dog in the Night Time' (Haddon, 2003), who realises that maps are not like time. The difficulty of his linking the changes that occur with time and using a timetable as a map maps is described in Chapter 2 (see p.45). Baderoon's poem says that mapmakers can ignore (or unconsciously deny) these things, and so they have a 'nervous conceit'.

This chapter, which revisits the methodology that I have used in the study, looks in more depth at the 'off the beaten track' moments in the research; times when I deviated from the route of the identified process and discovered something unexpected. Like a traveller who sets out on a journey with a clear itinerary, it is often the unexpected events – when flights are cancelled and trains halt – that the tourist finds out something that is quintessential to that place.

Mapping

I have a love of maps, like novels and poems; they can reveal their hidden depths, secret caves and watercourses with careful study and reading. My partner is well aware of this penchant of mine for 1:50,000 printed contours and tells friends that I will take a map to bed with me to read 'like a book'. I can't think of a country, town or mountain I have visited without first equipping myself with several versions of maps of those places. At the same time I have an aversion to guides which describe popular or local routes, like a walking guide for the Glen Coe region, or worse, a 'route finder' guide that tells you which motorways to use to get to your destination directly. I have resisted buying a 'sat nav[51]' for my London driving, although I can appreciate that it would warn me of traffic jams ahead, something a map can never tell you, because a map is a description of the roads without people (in cars) on them. When asked why I like maps so much I have said it's so I can find myself when I get lost.

This love of maps is similar to my love and, at times, defensive use of theory. When I began my analysis in 1999 I began to read as much as I could on the process of analysis (e.g. Steiner 1993; Joseph, 1989; Segal, 1986) so that I could assist my analyst in case he got into difficulty with knowing where we were. He seemed irritated and amused at my attempts to correct him or direct him! What I hadn't realised was how frightened I was by the unknown parts of myself that were revealed in dreams, associations and the powerful transference I had with him. I hated feeling vulnerable and lost in this conscious/unconscious world. Like being afraid of the dark, I didn't realise that if you wait for a period of time your vision in a dark place can adjust to the minimal light and you can see some things. I am not sure I will ever relax into not knowing something, and the best advice Paul Hoggett gave me (after I had begun my data collection) was to try and allow myself to be surprised by it. I am sure he had become all too aware of my defence against vulnerability – which was to (arrogantly) assume I already knew something and thus not allow myself to discover something new.

Many events have helped me be surprised by the data; some have been during the collection of the material when things didn't go to plan (e.g. the confrontational meeting with staff at London General Hospital, described in Chapter 5), or when I was emotionally overwhelmed by the poignancy of the intimate care offered to clients by the

[51] Satellite navigator, e.g. brand name 'TomTom'.

OTs. Several insights and revelations have come from books I have read during the study, like Tsitsi Dangarembga's (2006) description of being a black teenager at a predominantly white girls' school in Zimbabwe at the same time I had lived and was at school there; in poems that have followed after me demanding to be better understood; and in the disquieting and disturbing dreams I have had since the study began.

I can imagine that many people write of their research as a journey (it is a popular metaphor used to describe the process of therapy, learning to live with a disability or being in a long-term partnership!), but in thinking about my research 'journey' and my proclivity for maps (i.e. theory) but my resistance to the use of route finders (methodologies which I interpret as prescriptive 'go this way'), what could I say now, in looking back on the period of the research, about what I have learned? Perhaps the most accurate title would be 'not quite finished' or as the 85-year-old Diana Athill (2008) called her award-winning biography, 'Somewhere towards the end'. The reason for this is that what has been done continues to be understood in new ways as different theories and perspectives take precedence. I began the thesis by inviting the reader to make their own interpretation of the events described and I hope that this open style has continued, but like maps that join onto (or overlap with) other maps, this map has its edge and thereby its end.

The poem which starts this chapter says so much of what I have found and come to know in doing this research project. By using this poem I want to revisit the methodology which has underpinned the data gathering and sense making process (i.e. hermeneutics/interpretation) of the research project, which I have termed the 'nervous conceit of mapmakers'. I used the second part of the poem, which considers that the discarded parts (of photographs) are the 'edge of desire', to think about the work that OTs undertake with clients and consider if it is about giving and receiving love (a mixture of reciprocity and reparation) which relational theories have termed recognition (Benjamin, 1990; Hoggett, 2001). This leads into the final chapter which re-looks at Winnicott's (1971) notion of the transitional space as a potential conceptual 'map' for understanding the intersection between personal and social dynamics when OTs are working with clients.

The 'Nervous Conceit of Mapmakers'

> 'I shall not first give an historical survey and show the development of my ideas from the theories of others, because my mind does not work that way. What happens is that I gather this and that, settle down to clinical experience, form my own theories and then, last of all, interest myself in looking to see where I stole what. Perhaps this is as good a method as any.' (Winnicott, 1945, p.145)

From early in the project, after my first meeting with the potential participants of the hospital in London, I realised (prompted by the dream I described in Chapter 5) that I would be in danger of finding only what I was looking for. Having been influenced by Menzies Lyth's (1988) writing on social defences, I had begun to see everything that OTs did as a potential defence against 'envy, shame and disgust', and it was no wonder that the OTs were more than a bit suspicious of my motives! It was after my first meeting with the UK OTs (a full description and analysis of this dream is in Chapter 3, pp.91-92) that I realised I needed to 'know' less and be 'surprised' more. The cat (symbol) in my post-meeting dream also suggested that I needed to be more curious about what I saw and felt. I had to be, in the words of the oft quoted Bion directive, 'without memory or desire'.

I needed to uncouple my past theoretical reading from my 'naive' observations and interviews. It seemed from what Winnicott described in the above quote, I could do the work and then look through the theories to see what I had 'stolen'. In this process of reading about psycho-social methodologies I found that what I thought I had 'discovered' was in the writing of Morgan (1997), Kvale (1999) or Clarke (2002)! Perhaps the 'conceit of map makers' in Baderoon's poem referred to my own arrogant refusal to read more and follow the guidance given. At times my mistakes (clumsy attempts at interpretation or talking too much during the participant observation period) did prevent the participants from saying more, but I can't honestly say that theory would have stopped me, as it was often my unconscious anxiety that drove me to slip and trip in the data gathering process. These misunderstandings became part of the analysis of the themes in the research and, at times, assisted the process of opening up a new area of inquiry.

In the earlier chapter on the methodology[52] that I have used in this study, the two developments were in my use of interpretation within the narrative interviews and incorporating the dreams of the participants and myself as a way of increasing the

[52] Chapter 3: Seeing ↔ Believing and Dreaming ↔ Thinking

reflexive stance that developed over the course of the research process. It was hard to know if the dreams precipitated the shifts in my thinking or occurred in response to the changes in my thinking, i.e. they mirrored new thinking. I have explored this use of dreaming in more detail after considering the role of the inquiry groups in the research process.

In looking for a way of undertaking the group discussions, which Menzies Lyth (1988) mentioned in her study, I explored the description of focus groups in substantive texts such as Morgan (1997) and Gilbert (2001) and in the use of the co-operative inquiry groups in Reason's (1988) book on action research. The descriptions did not match what I wanted to do – which was to extend the free association narrative inquiry method into a group setting where participants could reflect on each other's contributions through free association and further inquiry. I wanted to create a space for playfulness in the group, where participants could be spontaneous (creative) and thoughtful (reflexive). Being able to create this way of working in a group was a mixture of Winnicott's (1971) notion of playing that allowed for a creative (novel) response to the world and Lawrence's (2003b) work with establishing a (group) matrix in his exploration of social dreaming. Lawrence spoke of not using interpretations of the dream material presented in a group matrix, but allowing for 'amplification' and 'association' (ibid. p.610). This seemed to me to allow the group to be 'playful' and acknowledge both an internal (unconscious) and external world, one in which the therapists 'did' things.

> 'My idea of play…is not *inside* by any use of the word…Nor is it *outside*, that is to say, it is not part of the repudiated world, the not-me, that which the individual has decided to recognise (with whatever difficulty and even pain) as truly external…To control what is outside one has *do* things, not simply to think or to wish, and *doing things takes time*. Playing is doing.' (Winnicott, 1971, p.41)

I couldn't find an exact description in the literature on focus or co-operative inquiry groups of how the work of Hollway and Jefferson's (2000) approach to interviews could be taken into a group setting. I decided to ask the potential participants to explore both the conscious and unconscious aspects of their work in a group setting where the presence of others, and me, may assist them in their exploration of what things may mean.

Treading on Cultural Toes; learning through 'Misunderstandings'

The groups were a complex field of inquiry because of the relationships that existed between staff members and the relationships that had been established with me during the research. On a few occasions when tensions arose in the group, I was conscious that if I ignored them they could have caused difficulties for staff who would continue to work together long after I had gone (i.e. when the project was over). When these potential misunderstandings arose I would try to draw the group's attention to them by asking if I had correctly understood what was being said (or implied). I had learned to do this from facilitating staff groups – and rather than making an interpretation of a possible unconscious communication it was an attempt to gain some clarity on the meta-communication. These interactions often brought some surprising insights and did seem to help the group to talk to each other about their work and themselves.

The example I have used below occurred in the first of the inquiry groups at Cape Town General Hospital (CTGH). I had become, as described in the previous chapter on the SA data, very aware of race as an ongoing dynamic in all of the interpersonal exchanges that took place, between me and the participants, between therapists and clients and now, potentially, in the group. There were six OTs in this first group: three had already been part of the project and three other staff had decided to join the group. Of these six women, three were white (Joanne, Elizabeth and Pamela), two were 'coloured' Muslim (Nassrin and Azar) and one was an Indian Muslim (Mina). The participants worked in different clinical areas but shared the same departmental offices and procedures. Joanne and Nassrin held middle management positions, although all staff had senior roles (i.e. been in post for over five years).

Pamela was different from the other group members as she worked in a clinical area where she assessed clients for their 'work readiness'. If she found the client's disability prevented them from performing a work role, she could recommend they be awarded a state funded disability grant[53]. The group began with Pamela describing her work and how she felt more like a policeman than a therapist, as she often had to make harsh judgements about people's ability to perform in a work role, although she was

[53] This grant was one of few state funded grants for the population. The disability grant was highly valued as it could provide a family with an income when the unemployment rate in SA was over 45%. The grant, in 2007, was R820pm (approximately £54.60pm) and has been used for 'poverty relief' (Nattrass, 2006).

frequently aware that they may not be able to find work. She said that she felt that they had a 'social' disability not a physical disability.

> **Pamela:** I find that … the disability is not medical, it is a social disability – but the legislation that governs my role is based on a medical model so I cannot make judgements based on social disability within the legal framework … so in a sense I am not fulfilling my role as an OT, but if I don't practise within the medical model then I am not fulfilling my legal obligation, so it makes it really hard sometimes … medically they are not disabled … so you can't award a disability grant based on their medical condition … but you can't send them out to work either. So you bend the rules a little bit. [laughter, researcher and group]
>
> **Lindsey:** Can you give an example? I don't want to jeopardise your future career … [laughter from group]
>
> **Pamela:** … a female who has never been employed … whose husband has always been the sole breadwinner who then passes away… She has hypertension and diabetes but both are well controlled…. medically she is not disabled but she has **no** work experience, has maybe a sub B education, has always just looked after her family, and is … 52. So at the end of the economic lifespan … she is not medically disabled, but realistically there is no chance she will be able to find a job or do anything apart from domestic work.

While listening to this account I began to assume that the woman she was describing was black and from a rural area where the access to schooling and employment was very poor, predominantly as a result of the previous apartheid policies of 'homeland' development (see Price, 1986). When I asked Pamela if that was the case, she replied that it was more likely the woman was local and Muslim.

> **Pamela:** It's not necessarily that but … the groups that we most often see … are Muslim women where family is a very big part of the culture so it is not that generation … it is much more about looking after family, cooking, being at home.

This statement by Pamela made me acutely aware of the three Muslim women who were in the group and also of the interviews I had undertaken with Mina, who had described how she was the first person in her family to achieve a university degree and professional qualification. Her parents, who had come to South Africa from India as economic migrants in the late 1930s, were intensely proud of her and she had used working as a way of avoiding the harness of her cultural history. I was struck by my own cultural stereotyping of Pamela's example (my assumption was of a black woman); what would Mina, Nassrin and Azar think of Pamela's example?

I wasn't sure what to do about this potential misunderstanding (of Pamela's statement about Muslim women, education and 'family' involvement) in the group, as the members had continued to talk about the medical model vs. the social model of

disability without seeming to notice this reference to race (or culture), but I did think I should do something. When there was a pause in the discussion I asked the group if the 'three Muslim women' wanted to respond to what Pamela had said. It was an exceptionally clumsy intervention as I rambled on about culture, Ubuntu[54], English as a second language and difference which can create an energy between people. I was anxious and didn't really know what to say, but my asking what the Muslim women in the group thought seemed to have worked, as Azar and Nassrin began to explore the cultural assumptions that are made with, and about, clients.

Azar said that the statement was 'true' as it referred to times past when women didn't go out to work and things had 'obviously' changed. I thought she was referring to the fact that three Muslim women were in the group, all professional working women. Nassrin continued the discussion by saying that the history of the country had played a part in denying women legitimate education and work opportunities. With this, she said, it was important to remember what had happened in the past to avoid imagining all people from that 'culture' were like that.

> **Nassrin:** I think that with the history of the country lots of people assume that it is the religion that does that and to certain extent it does because there are roles for men and women in the religion, but it is also because of opportunities … I mean universities weren't open – it was a privilege to actually finish matric … if you were non-white not too long ago … so I think it is partly economic, and I think sometimes people stereotype because of religion and forget about the history and what opportunities were … I think that … it gets stereotyped … we assume it is the same for all … we … see a middle-aged Muslim woman and assume that that is okay for her … but it might not be …
>
> **Lindsey:** So you are saying … culture sensitivity … is overdone to the point where we create categories for people and we stop really looking.
>
> **Nassrin**: We start assuming that it is okay for them and that is what they would want.

This interaction in the group was important because it opened up a new area of inquiry of how assumptions are made about clients based on their race, language, gender and age. It had not escaped my attention that the age attributed to the non-disabled Muslim woman was my age, 52 years! I realised that having highlighted Pamela's assumption about the woman, she may have been feeling 'out-ed' (or marginalised) by my drawing in the opinions of the Muslim OTs. She was in a vulnerable position in the staff team as

[54] Commonly used term now in South Africa, initially used by Tutu in his description of the reconciliation process needed to heal the wounds of the past. 'Ubuntu' means that a person is only a person through other people.

her work role made her different. She did not often have the 'feelgood' factor of caring for a vulnerable and grateful patient – her job was to assess clients and sometimes try and 'catch them out' for faking their application for a grant.

I asked Pamela if I had left her feeling a bit misunderstood; she laughed and said once she had spoken she had looked at the group and thought, 'I'm on dangerous ground here…' and as she said that everyone laughed. This drawing the group's attention to the differences amongst the members did seem to provide a new avenue of discussion and thinking about how clients were viewed by the group, particularly how the 'cultural assumptions' that were made could preclude clients from being offered certain choices. As Terre Blanche and Durrheim (1999) stated, 'through group interviewing, we also gain access to understanding differences between people whom we might previously have thought of as an homogenous group, i.e. the ways in which they do not share a common base of experience' (p.388).

My highlighting of Pamela's and Nassrin's different views on culture and race in the inquiry group came from my experience of living and working in South Africa, which was that talking about the real differences in race and class were avoided as much as possible. I had several painful encounters with this denial in my work as a lecturer and in the interviews I had done earlier with Nassrin.

> 'After returning to South Africa and teaching young undergraduate students about health care I found that at any mention I made of the past (particularly apartheid) the class would often roll their eyes towards the ceiling as if I was being boring or 'old fashioned' … they said that they felt it was 'my past' and not 'their past'. They [the students] assured me that they had not experienced apartheid and they did not see why we should spend 'so much time' looking at it – after all, they said, it was in the past. I wondered if it was my own need to speak about my experience of the past, assuaging my sense of guilt and culpability, and even potentially using them for some unconscious act of redemption. I wondered if the past was behind us and if they were the new generation of the 'rainbow nation' … Was this the hope I had denied myself?' (Nicholls & Wright, 2009)

What Has Race Got To Do With It?

I have been aware of my own bias and self-interest in choosing to focus on one aspect of the study before another. This use of reflexivity to deepen the areas of discussion was, in part, prompted by the dreams I had which told me to pay closer attention to what I was observing and doing. Frank (1997) said that by using reflexivity 'the challenge is not to eliminate "bias" to be more neutral, but to use it as a focus for more intense insight…' (p.89). To think that I could have neutralised my 'bias' about race would have been similar to wishing that I could neutralise my gender in thinking about what I saw and heard.

I was born and raised in Zimbabwe, a colonial outpost of the British in Africa. My paternal grandfather had been part of the last pioneer columns from Cape Town to join Cecil John Rhodes in Salisbury. I have a certificate which states that I am a direct descendant from a Pioneer and my father, an only son, would sneak me (a girl) into the Bulawayo 'club' members (men) only section to show me the oil paintings of the Queen and King that hung in the grand entrance to this leather-couched wood-panelled sanctuary. My father would stand in front of these painting as if to attention (like on a military parade) and I would see tears roll down his cheeks. He was intensely proud of his heritage and of his father, who had been a pall-bearer when Rhodes' coffin was carried to its final resting place in the Matopos Hills near Bulawayo, Zimbabwe. My father's love for Queen and country seemed to replace the grief he felt for his father's early death (my father was 12 when he died) and his pursuit of a masculine 'British' identity was life-long; he joined the British Territorial Army (in Rhodesia) and belonged to a Scottish Masonic 'lodge', becoming a district grand master a few years before he died at 67. This colonial heritage, with its inherent view of the superiority of the white English culture, came at a price and that was in the denigration of the 'other', i.e. the black person, who lived in the country long before any well-meaning missionary had arrived to offer salvation.

Although I have explored earlier in this study (Chapter 1) that my deeply conflicted relationship with my father may have been one of the unconscious reasons why I chose to do occupational therapy, it wasn't until I returned to South Africa in 2005 that I began to see the full extent of how I had participated (as a white person) in the oppressive practices of apartheid (I had previously worked in SA for 15 years), and how

my blindness to (denial of) the painfulness of racial inequality had made many attempts of mine to work with 'underprivileged' people seem patronising. What was missing in the relationship between me and the 'other' was any sense of my 'needing' them; I could only see myself in a 'giving' role. It was no wonder that I evoked the ire of some of my black colleagues in my new work environment by offering to help them with their work soon after I arrived. I had moved from a being 'Pioneer' to someone who could only patronise others with offers of help. It was a messy and awful time and everyone felt misunderstood. The end result was that after three years I left my work and had the dream about killing two men and hiding their bodies in a trunk. I was filled with feelings of guilt, shame and remorse and wondered if I would find a way of making sense of this ugliness without trying to make excuses for myself and/or blame others for their lack of compassion.

During this time I was fortunate to become a member of a research group which was looking at curriculum reforms (in higher education institutions in South Africa) to include the subjugated knowledge of students who were not white (see Bozalek, 2004; Leibowitz et al., 2007). This project involved running a course with a diverse group of students (race, class, professional groups and gender), researching the outcome of the module and reflecting on the curriculum design. It was during the facilitator training course[55] for the revised 2008 module that I began to feel less persecuted by my guilt and realised that what I was so afraid of was my desire to touch, hold and be held by a black person. This revelation was very powerful for me and I give thanks to my colleague Dr. Ronelle Carolissen[56], who has led me through literature and discussion to think about the 'unending grief' (Straker, 2004) that is part of the legacy of South Africa.

One of my difficulties in the SA research project (as I mention in Chapter 5) was my attempt to distance myself from Joanne (a white Afrikaans therapist) whom I saw as holding racist views, which I could not acknowledge as being my own. It was in reading the transcripts that I saw how I had positioned her in my mind, and how the transcripts presented another narrative, one of a deeply committed person who wanted to work with people who were 'other' and who didn't make excuses for herself or them.

[55] This was course held for eight black and eight white academics. It was an intensive week-long 'encounter' group. See Halabi (2004) for a fuller description of the rational and methods.
[56] Dr Carolissen is a 'black' academic and I am indebted to her for her warmth and insight as I struggled to articulate these feelings.

> **Joanne:** For me I think I am a bit of a pathological optimist … maybe nobody has given them [the clients] a chance in life … I am not expecting them to turn around and say I am so glad I met you because you have changed my life … but … everyone deserves a chance … when we hear the shackles [sound of chains which prisoners wear when coming to hospital] … everyone says 'oh no another gangster' … which I am sure they are, but they also quite frightened by the fact they have now had this injury, and they also have the same pain that has been experienced by the guy who goes to church every day …

It was thinking about my relationship with Joanne that brought a new insight to the dream I had prior to the second observation I had with her (this is described in detail in Chapter 5, p.151). In the dream I had fallen down a narrow chasm, which felt as if it had no end to it, and I was using rolls of pressure garment material to try and wedge below my feet so I could lever myself out. I have wondered what the rolls of pressure garment material may have meant. The elastic material was used as a second skin (i.e. a tight-fitting undergarment) for patients who had had skin grafts after a deep burn. Were the rolls of this material a symbol of the disfigurement which occurred during and as a result of apartheid? Like a burn on the skin, often visible after many years, one's racial past carries a legacy that is still part of the visible identity (racial markers) in current times. How do black and white South Africans bear these scars? Is there an end to the suffering?

Straker (2004) and Zembylas (2009) have both written about the inconsolable mourning process that has been (is) part of the identity of every South African. Straker's paper looks at the effects of the institutionalisation of racism in South Africa and how black and white suffered a profound loss and grief without end (p.408). Black people were the victims of a system that denied them a rightful place of belonging and the white people who were actively opposed to the apartheid regime 'could provoke … the very racism we are attempting to avoid' (ibid. p.407). These sentiments are echoed in Zembylas' (2009) use of the J.M. Coetzee novel 'Disgrace[57]', which is set in post-apartheid South Africa, to draw the reader's attention to the ongoing trauma of the racial divisions and the inconsolable mourning and 'endless suffering' (p.228) that is part of the history of the country. Both authors draw on the Freudian concept of melancholia, an unresolved grief that is distinguishable from the more healthy process of mourning. 'Mourning is resolvable, whereas melancholia is a form of grief without end. It is sustained by the irresolvability of the conflict and ambivalence that loss of the object produces.' (Straker, 2004, p.408). In thinking about what it (the object) was that was lost, Straker described

[57] 1999 Booker Prize winning novel. In 2003 J M Coetzee was awarded the Nobel Prize for Literature.

the loss of an 'idealised whiteness' that neither black or nor white can attain. Whites are also betrayed by the very values which they feel whiteness upholds: 'whiteness is castrated or limited because of its failure to live up to its own democratic and humanitarian ideals' (ibid. p.409), and blacks by the betrayal of their own repressed (denied) identities. At the same time Straker says that as much as liberal SA whites were fighting for the rights of black people, they continued to enjoy the privileges of being white people, 'who feel ashamed from benefiting from the betrayal of the ideal of whiteness' (ibid. p.409). This is a truly complicated loss of a complex object; an ideal of democracy (for white and black) and the ongoing painful reality of exclusion (for blacks) from health, education and everyday social participation.

It was following the dream, where I attempted to hide the bodies of the two back men I had killed, that I realised I had to interrogate the data for my own prejudice (assumptions) and see what I had missed. Swartz (2007) writes that 'no amount of dissociation, however, prevents messages arriving from the unconscious. What is banished sometimes returns …in fearful dreams…'(p.180). Certainly the dream had 'returned' my unconscious material, but it was Straker's articulation of the 'unending grief' that was part of all relationships in South Africa that unlocked my shame at the disapproval I had found of Joanne's narrative, and helped me own the guilt I felt at never having known about Nassrin's sense of rejection during her student years, when I had been her lecturer.

In the analysis of my dreams which contributed to the reflexive accounts of the research process, I wasn't alone. I had two thoughtful and responsive supervisors. I wrote to them and described my anguish at reading the South African data and the discovery of Swartz's (2007) work on her creative use of language (and racial terms) as a SA white therapist in psychoanalytic psychotherapy with black clients.

> I have been struggling with the data from and about South Africa. It has felt exposing of my colonial racist past and so has been painful (and shameful) to contemplate and then I had one of those landmark dreams (the internal land that is) in which the emotional tone of the dream was reparative and since then it has been much easier.
>
> I think the shift in the dreams were provoked by … article(s) … by Straker … [and] a paper by Swartz who talks about the difficulty in establishing a 'resonance of alikeness' so crucial to the first encounter with a client when the history of the past in South Africa makes difference such an obvious place of disconnection and miscommunication, the size of a chasm which cannot easily be crossed (by one or other). She draws on Benjamin's notion of empathy and intersubjectivity in a delightfully creative way.

> I am less critical of (punished by) my 'failure' to be more empathetic in the interviews and it is important to think about these things because if I don't there is the temptation to bury them and hope they won't be discovered… (and that is what my powerful dream about killing the two black men in the garden and burying them in a trunk was really about).
>
> My struggle now is to report on what was and then reflect on the difficulties of naming race. (email to Paul Hoggett and Simon Clarke, 22.9.2008)

Paul Hoggett responded to this email with a particular thoughtfulness which helped me consider my ongoing (and envious) comparison of what I could have/had achieved vs. what others seemed to have done.

> 'I think that there are times when ethical action places such a cost on us (because of its risks etc.) that only a few are prepared to take it. And the motives of the few will be very mixed - some will be mad, some will be driven mad by the price they have to pay, and some will have extraordinary courage and resilience that very few people have. … [in] Monroe's study of those who rescued Jews from the holocaust … most of the rescuers were very ordinary people who acted on impulse, because they felt they had to do it. So, just how extraordinary the ordinary can be! But for the majority of well meaning but not so extraordinary people then feelings of betrayal and failure will be part of their lot, I can see that. I suppose the thing is to learn to accept it as one's fate, not try and cover it up in manic or other ways, not to disparage the inadequate and compromised things we ordinary folk are capable of doing, nor to attack the efforts of those who seem to be able to do more than us (out of our envy).' (Paul Hoggett email 25.9.08)

Decolonising Methodologies

Dalal (2002) writes that the white missionaries and settlers in Africa created an image of a country 'discovered' by them, as if all that was there (another culture and people) before their arrival was too primitive (or inferior) to require any real consideration. This new country was to be occupied, civilised and given all that was good about being English, French or Dutch. White was right (powerful and superior). One of the mechanisms of colonisation was the exclusive use of the language of the occupiers. Dalal quotes Fanon who said, 'A man who has a language consequently possesses the world expressed and implied by that language' (Fanon in Dalal, 2007, p.94), and that 'embedded in this language are definitions of what is human (the coloniser) and what is not (the colonised), what is good and what is bad…' (ibid. p.94). Language is a potential weapon which can be used to signify superiority, words encode cultural understandings; consider the use of similes such as being the 'nigger in the woodpile'.

Swartz (2007) writes of a struggle with her position of privilege in a country whose past politics she had seldom agreed with: 'insofar as I have benefited from my whiteness, I am a perpetrator' (p.180). Swartz was born and raised in Zimbabwe and has worked all

her adult life in South Africa (a personal history not dissimilar to my own). She writes of her need to hold her colonising history and identity in mind while working with a client, so as not to project her unwanted parts onto them: 'the more I settle with, am aware of, my own gendered and raced history, the less likely I am to dissociate from my own otherness, and to project it onto those with whom I work' (p.187). She wrote of how being named as white or black (by the other) was a painful part of being in South Africa, where race is a signifier of identity and thereby an assumed experience of sameness or difference.

> 'Just as bad is being identified as belonging to a group. This is my repetition – between, outside, trapped by a body in a fixed identity, this is my other. I sit with Mary, for whom Africa has always been too hot, too smelly, too uneven. She curls away from the homeless women asking for money at the traffic lights, and collects a litany of theft and rape tales, with which she often begins her sessions. She longs for the day when her children will be grown and with them she will emigrate 'home', to the England her grandparents left in 1921. 'Where would you like to settle?' she asks me, as if I am not settled, as if I too am an Englishwoman in Africa. And then Caroline, black, for whom the phrase 'you whites' writes me into a narrative of unearned privilege and thoughtlessness as she tells me about the daily strains of office work.' (Swartz, 2007, p.182)

Swartz asks how we can use language (and its power to name and thereby wound the other) in a creative dialogic space that allows for discovery and transformation. It is within this discussion that she incorporates the work of Benjamin (1990) and intersubjectivity.

> I ask a patient to share her experience with me, and slowly we learn together …and I allow myself to be curious, not ashamed of my ignorance. …We name our black and whiteness so often that it is an entry, not a barrier …she laughs at me when I have misunderstood something, sometimes she is hurt by a resonance of difference, and we think about why. There is a carnival of voices, hers, mine, her language and mine, which we translate for each other. Through this, I begin to grasp – not wish away – the deepness of her grief, the burden on her of a racist past, to accept that it is unendurable for us both, and to do my job: to face the implications for us both, without looking away. (Swartz, 2007, p.188)

Reilly (1961) wrote an 'inspirational' lecture about occupational therapy being 'one of the great ideas of 20th century medicine'. Many OT authors have this classic text as a given in their bibliography, but I have often wondered if they have noticed its use of the term 'pioneer' in her discussion of how independence (through a drive to take action) has been viewed and used in the profession.

> 'Let us first consider the tolerance in America for the occupational therapy idea. In his social history, Max Lerner identified certain dynamic forces which impelled the greatness of this country. He cited in the American mind two crucial images present **since the beginning**. One was the self-reliant craftsman, whether pioneer,

> farmer or mechanic. He was the man who could make something of the American resources, apply his strength and skill to nature's abundance, fashion new tools and machines, imagine and carry through new constructions. …The second image Lerner drew was from the American environment. It was that of a **vast continent on earth, as in space, waiting to be discovered, explored, cleared, built-up, populated and energized**. Lerner contends that our culture is dominated by an American spirit which hates to be confined. A drive toward action, he postulated, is a part of the American character….The drive towards action seems to me to make reasonable the American idea of a patient. Our cultural concept of the man of action suffers little change when an American moves into a hospital community…It has been supported by a series of principles which merged and fused into what we now call rehabilitation.' (Reilly, 1961, p.92)

The words which struck me (highlighted above) were, 'since the beginning', implying that prior to the 'pioneering American people' (I assume the white American people) there was no other, a notion that Dalal warns us of in colonial views of time, which only starts when the conquering immigrants arrive. 'The myth here is that 'the settler makes history…He is the absolute beginning: "This land was created by us" [quoting Fanon]' (Dalal, 2002, p.93). The description (of the true blooded American) continues of a land of opportunity; 'a vast continent on earth, as in space, waiting to be discovered, explored, cleared, built-up, populated and energized' (bold above). I have wondered if Reilly (or those who promote this particular article as a foundation theory in OT) have considered that the Native Americans were already occupying the land of America? In occupational therapy's most treasured language, they (Native Americans) were already doing, loving and being before the land was 'discovered'?

Reilly states (above) that this spirit of independence is carried into the hospital environment where patients wish to get better quickly and return to their lives of discovery (work). She writes, 'The need to train patients in self care became almost a crusade to insure the rights of patients to be independent' (1962, p.92). Perhaps this was the root of some of the moral imperialism in OT (a topic I covered in my initial theorising Chapters 2 and 3) and the use of activity as a defence against anxiety. Were the anxiety and the need to do, which I observed and felt as part of my study, driven by a denial of the presence of the other; in other words a denial of the subjectivity of the other?

I had discovered through my painful analysis (and in my thwarted efforts to help my analyst help me) that I was deeply afraid of being dependent on him (or anyone else as a matter of fact). It was terrifying, like the feeling of being small and alone in a large room, until I realised that he was in fact also present (in the room), available – but not

always available on demand. He had his own subjectivity (point of view), which at times I resented, as it did not always match my view of what was going on. Was this terror of depending on someone something that we, as OTs, projected into our clients, imagining that they, like us, want to wash, dress and be ready for work regardless of their limitations, illness or disability.

Wilcock (1993) said that as human beings we have an innate drive for occupation (activity). I have disagreed with this view of people and suggested (alongside the object-relations theorists) that we have an innate drive (desire) for other humans, and we express this, in part, through doing. We don't only hug and kiss and listen to the other, we make things that we can give them, work for the greater good (of all) and play with others. My mother, whose dementia and physical frailty had robbed her of the motivation she once had to do things or to walk to the bathroom (our biggest point of contention), retained her love of people until the day she died; always holding and stroking them (and me), even when words were no longer available to her.

When I began to think about what the defences that OTs use in their work (with clients) defend them against, it isn't only the feelings of rage and envy (that is so prominent in psychoanalytic organisational literature), it is also a defence against love and intimacy as described in the shared space of intersubjective recognition (Swartz, 2007; Benjamin, 1990; Hoggett, 2001).

The Edge of Desire

Before I move to the last chapter, 'What love has got to do with it', I want to use one more example of the data which could so easily have been disregarded (like in Gabeba's poem reference to a 'failed photograph'), because it didn't match what I was looking for and I didn't want to think about it or acknowledge how much it echoed some of my experience. Some of the material below is repeated from Chapter 5, but necessarily so as I look deeper at its possible meanings.

Joanne, in the second FANI, told me of the man who had walked from Burundi to South Africa and had incurred a horrific and painful injury – an avulsed right (dominant) arm. This injury left him unable to use his arm, without a shared language (South Africans don't have Burundi as one of their 11 official languages) and with no financial resources

or nearby home. The orthopaedic clinic was considering amputating his arm so that it would not cause him further injury. A lifeless limb could have been a hindrance for him, although the amputation may not have decreased the pain from his shredded nerves.

It was through this description of her client that I began to think of the identity of many whites (particularly Afrikaners) living in South Africa as having an 'avulsed' identity, torn from its roots, a hidden pain while everything may still look the same. It seemed to me that much of Joanne's desire to work with 'these' (i.e. black) clients came from her unconscious feeling of privilege and thereby commitment to working towards a more equitable South Africa. It was very similar to how I had felt about my return to South Africa and wanting to work in a 'previously disadvantaged' university.

When I asked her why she thought he had made such an impression on her she said, after saying she hadn't really thought about it, and that it wasn't as if they 'got on' or that he was 'like her':

> **Joanne:** I don't know what it was … It's just that same thing … this is going to sound really awful now, when you see a small little animal in the wild that is about to be eaten by a lion … that is already fat from all the other small little things that he has eaten … that is the kind of thing. You just want to take the little rabbit or whatever it is and take it out of that situation … and put it in rabbit heaven … [laughs] or something like that. I don't know if it is … [laughs] …

Smith (1999) warns us in her book on 'Decolonising Methodologies' that many colonial reports about the indigenous 'other' included the use of zoological terms to describe those (indigenous) people's actions or traditions and it was a 'form of dehumanisation' (p.8). Was Joanne dehumanising the man who she so clearly had a deep compassion for? I couldn't bear to read the transcription where she referred to him 'a small little animal', it seemed to do the very thing that Smith was drawing our (researchers') attention to. Then I had a 'matching' dream about picking up a small neglected black wiry haired puppy that was full of ticks and insisting to the (dog) owners that I would take the dog home to care for it, and only if they really wanted it would I give it back.

Did I too think of black people (wiry haired) as 'animals'? I felt too ashamed to let anyone know of my dream until I realised that it represented a deeply felt loss of mine and that was that I have never had children. It is something I regret and my age has foreclosed any possibility that I can have a child. In truth I long to have a child and the

closest I have been to being a mother is having a dog. I don't honestly think the dog in my dream was a way of belittling the 'indigenous' other – it may have been the only unconscious symbol available to me in my limited repertoire of infant objects. It also occurred to me that Joanne didn't have any children and she didn't find it easy to reflect on her motivations and reasons for doing her work, but in observing her I was often moved by her sensitive and sometime no-nonsense approach to her clients.

When I asked her how she managed working in an area where she saw the results of some much of the violence and trauma that was part of South Africa, she said:

> **Joanne**: It is so sad…I think this continent is just so sad… you see the violence all the time … You very rarely see the guy who did walk from Burundi and made it and is now good and well … you don't see those people … which makes you a little more cynical about the success stories out there …

Living and working in a culture (country) that carries such a brutalised social political history requires the therapist to have an awareness of that past in order to provide an appropriate 'ethical' service and establish meaningful relationships with the patients. This provision of services cannot only be in response to government guidelines on practice, but needs also to be 'felt' by the therapists in response to the clients. When this transference and countertransference is overlaid by the appalling social / political events from the recent past, as it is in South Africa, there is a temptation to avoid reflecting on or acknowledging this pain. Staker (2004) called it the 'grief without end' (ibid, p.408) from the past, and she emphasises that; 'It is only by acknowledging that racism and exclusion are within that we will be enable to successfully combat it without' (ibid, p.420). As I realised in doing the SA part of the research, the discovery of one's inner 'racism and exclusion' is not easy to acknowledge or tolerate. In trying to communicate, i.e. give a voice to, these matters I felt that what OTs needed, similar to the UK part of the study, was a language that could support their speaking and thinking about this part of their work.

Antie Krog (1999), in writing a book about the work of the South African Truth and Reconciliation Commission (TRC), speaks of the guilt she and many other white Afrikaners felt, a desire to be forgiven and a longing for a relationship with the other;

> 'Against a flood crashing with the weight of a brutalizing past on to new usurping politics, the Commission has kept alive the idea of a common humanity. Painstakingly it has chiselled a way beyond racism and made a space for all our

voices. For all its failures, it carries a flame of hope that makes me proud to be from here, of here.

But I want to put it more simply. I want this hand of mine to write it. For us all; voices, all victims:

because of you
this country no longer lies
between us but within

it breathes becalmed
after being wounded
in its wondrous throat

in the cradle of my skull
it sings, it ignites
my tongue, my inner ear, the cavity of heart
shudders towards the outline
new in soft intimate clicks and gutturals

of my soul the retina learns to expand
daily because of a thousand stories
I was scorched

a new skin

I am changed for ever. I want to say:
forgive me
forgive me
forgive me

You whom I have wronged, please
take me

with you.

(Antjie Krog, 1999, p.422/423)

Chapter 7: What Love Has Got to Do With It

> 'The main themes that stand out therefore in psycho-social research are the reflexivity of the researcher; the ability of research to give voice to the research subject rather than a dominant theoretical paradigm; the role of the unconscious in transmitting our ethnic, gendered, and class identities (to name but a few) into the research environment; and finally, again a recognition of the role of the imagination in the research encounter and the way it is used to construct identity and make meaning in people's lives.' (Clarke, 2006, p.1167)

The quote above from Clarke (2006) speaks to the heart of my understanding of this project: we live, work and love in a psycho-social world, they are two sides of the same coin. Our belief in the goodness of others (or not) may stem from our early maternal/paternal experiences but it is the customs and language of our culture, race and gender that affect all that we do and 'see'[58]. I think what Clarke is saying is that we experience ourselves in relation to each other and that understanding occurs in the conscious and unconscious parts of our psycho-social being. This understanding is what we draw upon to make sense of the world and ourselves in it. An example of this came from the project when I moved (back) to South Africa and realised how much I was part of an unconscious social world of white dominance[59], and without this move (to a new fieldwork site) I don't think I could have fully appreciated the meaning of Clarke's quote above or his work on racism (Clarke, 2003).

This, the final chapter, summarises the main findings from the research project and reflects on the use of a psycho-social methodology to gain an understanding of the unconscious aspects of the work OTs do and the relationships they establish with their clients. I have attempted to draw these findings back into my initial aim of exploring what a psychoanalytic discourse could offer OTs in their work and I have used Winnicott's (1971) thinking about playing, time and the use of objects (and words) as essential elements to supporting OTs in their work with clients. As I describe in this chapter, there were moments in the study in which I was deeply affected (touched) by what I saw and heard, I began to realise that the work of OTs was more than a professional act (or action) with the client, it was a deeply felt compassion. Sometimes what OTs did wasn't rehearsed, it was spontaneous and reciprocal and I couldn't find a word to describe it, until I overcame my embarrassment about the sentimentality of the word 'love'.

---

[58] This is explored in Chapter 3: Seeing ↔ Believing.
[59] This is explored more fully in Chapter 6: Journey without Maps.

Hoggett (2006b) 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’ (ibid. p.192). I know my current Brunel University OT students are very suspicious of the word ‘love’ as they feel it betrays a necessary boundary set between them and the client, one that they believe protects them from feeling too much for and about the client. I have offered them a favourite quote (below) from ‘The Little Prince’. It speaks about love, but calls it another name, to tame. It also provides a salutary lesson for all therapists to maintain the boundary of time as a function of ‘holding’ (see Winnicott, 1956; Ogden, 2004). The fox tells the Little Prince he must come at the same time each day, so that the fox can anticipate (and look forward to) his arrival.

> "I cannot play with you," the fox said. "I am not tamed." …
> “What does that mean – 'tame'?" [asked the Little Prince]
> "It is an act too often neglected," said the fox. “It means to establish ties … if you tame me, then we shall need each other. To me, you will be unique in all the world. To you, I shall be unique in all the world …"
>
> "One only understands the things that one tames," said the fox.
> "What must I do, to tame you?" asked the little prince.
> "You must be very patient," replied the fox. "First you will sit down at a little distance from me – like that – in the grass. I shall look at you out of the corner of my eye, and you will say nothing. Words are the source of misunderstandings. But you will sit a little closer to me, every day . . ."
> The next day the little prince came back.
> "It would have been better to come back at the same hour," said the fox.
>
> *The Little Prince*, Antoine de Saint-Expéry, 1945, p.65

The fox tells the Little Prince he must come at the same time each day, so that he (the fox) can anticipate and look forward to his arrival. He says to tame him (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 the quote by Craib (1994) at the end of Chapter 2, which states 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).

The anticipation that the fox describes (in the excerpt above) as an important part of building a relationship may be similar to the one the child feels when it believes it has created its mother in order to fulfil its needs – a phase that Winnicott (1971) described

as the stage in play in which the 'baby has a capacity to find and [the mother] being herself waiting to be found' (p.47). This early stage of play (if successful) sets the groundwork for later mature relating, where the baby and mother can engage in mutual play, one which the intersubjective theories of Benjamin (1990), Stern (1998) and Clarke et al. (2008) considered to be the basis for the experience of love based on mutual recognition. (The use of the italics below identifies the same quote by Benjamin used above.)

> 'Winnicott's thesis suggests a basic tension between denial and affirmation of the other (between omnipotence and recognition of reality) … The wish to absolutely assert the self and deny everything outside one's own mental omnipotence must sometimes crash against the implacable reality of the other. …When the destructiveness damages neither the parent nor the self, external reality comes into view as a sharp, distinct contrast to the inner fantasy world. *The outcome of this process is not simply reparation or restoration of the good object, but love, the sense of discovering the other*.' (Benjamin, 1990, p.192)

The Brunel OT students feel uncomfortable with the word love in the context of care, and I don't find it easy to use in academic settings (i.e. in writing or presenting work in seminars), but it does seem to describe something which is beyond the manic or 'interminable reparation' that Polden (2005, p.559) has identified. To rephrase Winnicott (1971): 'to play is to love, it is neither inside nor outside (the person and/or the couple), and it is a form of doing.'

Alison said in one of the inquiry groups that no one (at university) had taught her how to manage her feelings, that she did care (very much) about the clients, and she seemed to be saying (below) that what affected (hurt) her was when they left, were discharged or died, she missed them.

> **Alison:** I don't remember having any training to deal with my emotions at all and I remember them saying something about staying professional, making sure you don't get over involved with a patient. I get told I get too involved. But I feel that the day that you stop being so involved is the day you stop caring and I don't want to be like that. What they [the college] don't do is … deal with all the caring, when you say goodbye to someone and they go home, it is a relationship that has ended, you say goodbye to them.

When, in the story of the Little Prince, it was time for him (the Little Prince) to leave, the fox cries. The Little Prince says somewhat defensively that the fox had asked him to tame him knowing he would leave and was now crying.

> "Yes that is so," said the fox
> "Then it has done no good at all!"

> "It has done me good," said the fox "because of the colour of the wheat fields" [which were the same colour as the Little Prince's hair]

The fox was telling the Little Prince that he would always remember him because of the colour of the wheat fields, and that the wheat fields were special because of the Little Prince, i.e. he had a deeper appreciation of their colour, density and charm (perhaps like a Van Gogh painting of wheat). This move between the subject and the symbolic, I think, is similar to the connection between the child's playing (or as I have termed it loving) and the appreciation of the aesthetic world that Winnicott (1971) describes in the maturation of the playing process. 'There is a direct development from transitional phenomena to playing, and from playing to shared playing, and from this to cultural experiences' (ibid. p.51).

Winnicott (1971) said that adults (and therapists) play with words, 'verbal communication' (p.40). This research study has taken its title from the book, 'The Words to Say It' by Marie Cardinal (1993), a description of the author's seven-year journey through analysis. It is a painful, poignant and fractured narrative in which the mixture of fantasy and reality during her analysis began to create a coherence in the author's life, bringing a new capacity for living life, creativity and love.

> 'This unity of my being, this cohesion of night and days permitted me to move out towards other people, to meet them, to know them, often to understand them, sometimes even to love and be loved by them. I was happy, I had confidence in myself, I knew that I would go the whole way.' (Cardinal, 1993, p.249)

Although I did see some aspects of the work OTs did as a defence against the intimacy that caring for someone with an illness or disability brings, I saw much more than the defences that they used. I saw therapists who could engage with their clients in a deep reflexive reciprocal exchange that transformed clients and therapists. I wanted to find a way that I could describe, even substantiate or evidence, this emotional work. The emphasis on describing (putting into words) what was implicitly known (but not often spoken about) seemed to capture the spirit of the inquiry process, and as I have stated previously (in Chapters 1 and 2), it was not what was done by OTs that was problematic, but the absence of a range of 'emotional' words to describe it (see Chapter 2, p.38).

This next section draws together three intersecting aspects of the research: the social defences that OTs use to defend themselves against vulnerability and/or death; the

contribution of the social / political context in every therapeutic encounter; and the desire for reparation and love which underlies much of the relational work done by OTs.

Social Defences Against Dependency, Disability and Death

Manic Reparation

> In 2004 a London OT colleague of mine had told me of the untimely death of a close friend of hers who was a young occupational therapist working in Wales. Her friend had a pernicious cancer and died at the age of 32. My colleague attended her funeral, and on her return to work I asked her how the funeral had been. She said, 'It was terrible, I am sure you can imagine, there were all these OTs there and everyone was trying to do something.'

What she was describing seemed to be a form of 'manic reparation' (see Chapter 2), where the 'doing' of something may have been a way of coping with the complex feelings associated with death: feelings such as guilt, remorse, shame and unbridled grief. Being busy with mundane tasks (like vacuuming carpets or weeding garden beds) may be a way of containing anxiety or grief or be used to detract (i.e. procrastinate) from tasks which can seem overwhelming (like writing a thesis). But when the activity is used as a denial of the emotions underlying it, it can be at its most destructive. A manic defence can mirror the real reparative drive but lack an emotional acknowledgement of the relationship with the other[60]. In manic reparation a person (e.g. carer) acts as if the other is an object, to be done to or done for, and within this doing there is a denial of the carer's own needs for the relationship.

At its most extreme, the use of a manic reparation can be seen as a form of 'do good-ing', where the carer uses a mechanism of projection of their needy and vulnerable self onto the other, who is then seen as needing to be protected or assisted to health. To look after someone, to believe that it is better to give than to than receive, may be a negation of the other and their capacity to care for themselves and you. As Zarrin said in one of the inquiry groups:

> **Zarrin:** You know, Lindsey, when we where younger we were told it is always better to give than to receive and that is true but I realise how exhausting it was to give and not receive … it can get where we want to do good but we actually aren't always good … it can get into a cycle, we can go at such a pace like a hamster that we aren't even sure who the index patient is any more.

[60] See Segal (1988 p.82) and/or the discussion in Chapter 2, pp.47-48.

I wondered if Zarrin was saying that sometimes she forgot that she, like that patient, had needs. With this loss of an appreciation of the relational field in the caring relationship the carer can become exhausted through their efforts (referred to as burnout in the caring profession) or frustrated with the lack of response of the 'object'. It also linked to the discussion the OTs had about never being able to take sick leave; the only way they were able to acknowledge they were unwell was if another OT told them to go home (see Chapter 4, p.120).

Hatred of Dependency[61]

On the surface the pressure to discharge patients, particularly in the LGH study, was to free up a bed for clients who were on the waiting list, but I began to wonder if getting the patient home was driven by the staff's anxiety about the clients' frailty and dependency. Diane's dream (see Chapter 4, p.120) of trying to carry an injured kitten/baby down a steep mountain was an indication that staff felt deeply burdened by the responsibility of caring for their clients in a way that did not cause further injury. In considering the 'manic' defence and its denial of the reciprocal nature of the relationship, any deterioration in the client's health would be felt as that therapist's responsibility. As Alison said when she had daily phone calls from a mother whose son was dying at home, 'there wasn't enough of me'.

I have previously discussed my terror at finding I was 'dependent' on another person (see Chapter 1, p.23/24) which seemed to be echoed in the professional culture of the OTs. When I asked them if they thought that OTs (as a group) were afraid of being 'dependent' – after all it was the opposite word to 'independent' – they laughed (in surprised agreement) and said they hated feeling they needed help. As Alison said, it felt like a sign of failure (see Chapter 3, p.89/90). It seemed that clients could be unconsciously used to carry this projection neediness (dependence) and by giving to them (doing things for them) the OTs could feel in control of their own longings. As Alison pointed out, she could be warm and giving (sympathetic) with her clients, but not her partner who had a life-threatening illness. His neediness seemed to be too close for comfort, she found herself thinking he didn't try hard enough to get better.

[61] This title comes from Hoggett's (2000) seminal chapter, which I have used extensively in this project.

Uniform Terminology

Staff said that they would sometimes use 'medical terminology' to prevent themselves from feeling what it was like to be that person. As Caitlyn said, about the man who had a traumatic amputation, she thought about him as a 'diagnosis' so as to not feel what it might be like to have an amputation. I would use medical terminology or appear to know what a condition meant while I watched or listened to the therapists. I found myself using this 'knowing' to stop myself from seeing or feeling the distress of the clients. I realised that sometimes my attempts to empathise in the first free association narrative interviews (FANIs) or inquiry groups sounded as if I already knew what it felt like for the therapists, pre-empting any real exploration of their meaning or experience.

Part of my experience of wearing an OT uniform was what it seemed to represent for the people who saw it; they would sometimes ask me for directions or information. I began to wonder if uniforms were also a signpost to recovery for the clients who were asked to wash, dress and walk to the bathroom. OTs said that sometimes clients wouldn't recognise them (as individuals) but would recognise their uniform and I wondered if this diffusion of their (making it less personal) meant (unconsciously) that they could shield themselves from burden of caring for their clients. As Caitlyn said, the uniform 'kept her in' as if to act as a boundary (or reminder) of her professional role. Some therapists said they used the uniform to enhance their 'assertiveness' to ask clients to demonstrate self care tasks; they described themselves as being 'quite different' outside of the uniform.

OTs frequently used the expression, helping clients be the 'best they can be', but were often not aware that a measure of what was 'best' was at its best subjective (for the clients) and at its worst a form of moral imperative for clients to get up, dressed and get on with the day. It was during the study that I read J. M. Coetzee's novel 'Slow Man' (2006) where a middle-aged man, who has a traumatic amputation of his lower leg, refuses to wear a prosthetic limb, although in many ways it would make him more mobile. His resistance to the artificial limb seemed to be the only way he could take control of the ministrations he encountered from staff. I could not imagine an OT reading this novel and accepting his choice to remain legless, it seemed so clear what was 'best' for him.

Craib (1994) wrote, 'I think that what is valuable in Freud, and the psychoanalytic theorists who followed him, is the always implicit, sometimes explicit, message that we can never quite be what we want to be' (p.35). Clients do not always co-operate, can bring their unhappiness and life pain into treatment situations and resent the interference of the therapist in suggesting new ways of managing their health. In the study I attempted to understand how OTs viewed and/or managed their client's resistance in treatment, especially if it was demonstrated through verbal abuse (as I had seen with Caitlyn, Chapter 4, p.106). OTs said they would take these 'attacks' personally (as if they hadn't helped enough) or view it as the client having a 'difficult personality', which they would record in the patient notes. What they seemed to find difficult to do was to think about what the behaviour could mean at a deeper (i.e. countertransference) level. (See discussion of Book's supervision of a registrar with a difficult client in Chapter 2, p.37.)

Role Play and Ethical Acting

The OTs in LGH seemed to use their uniforms as a reminder (to clients and for themselves) of their professional role, and this was palpable at 'going home' time (5pm) from the noise coming from the room where OT staff changed out of their uniform; they would chat, laugh and plan their evening activities. This uniform also affected my view of the therapists; I remember that directly after observing Heather I saw her again at the bus stop (outside the hospital) and I didn't recognise her until she greeted me, as she looked quite different. Bev and Janet said that wearing a uniform allowed them to ask difficult questions (see Chapter 4, p.113), but it also seemed to provide a professional shield for some therapists' more personal responses or reactions to the client(s).

Zarrin described a situation where she tried to empathise with a client's mother, who had neglected her child and was now full of remorse and guilt over her actions. Zarrin struggled not to judge the woman as a mother (Zarrin herself was a new mother) and she said she had to rely on her 'professional ethics' to work with her.

> **Zarrin:** I am a mom and she neglected her child by being drunk … she comes to me and she is very depressed and has all this guilt and … do I judge her as a mom … or do my ethics say that I need to empathise with her … and so I am in conflict … and how do I then manage it … in terms of … just who I am … because if I am saying that who I am brings me to be [an] OT, when do I need to step out from who I am in order to work with the mom like that …

What seemed to be complicating the matter for Zarrin was her differentiation between her 'real self' (a caring person) and her 'judgemental self' (believing the mother was a bad person). This left her feeling unsure of which self she could draw from in working with the client's mother. As I have stated before, OT doesn't have the words in its discourse which would allow the therapist to be (i.e. think and feel) both. Like the words in Winnicott's (1949, p.6) 'Hate in the Counter-Transference', OTs need a fuller, gutsier, emotional language to express their ambivalence in these situations.

OTs spoke about relying on their professional selves (or ethical reasoning) when they felt alienated by a client's behaviour (e.g. a client shouting at them) or morally repulsed by something they had done (e.g. a murder or rape). An OT, in one of the inquiry groups where the topic arose, described that her 'care' was sometimes an 'autopilot response'.

> **Elizabeth**: You never really stop caring even if it is the most horrible mom on earth … but sometimes your whole heart is not into it, you go into autopilot of caring … you don't fake it really … but it is not really from the heart … but the other person might not notice it … I notice it …
>
> **Nassrin**: I think a lot of our caring happens on automatic pilot … our actions translate to caring, I think we only make the distinction when somebody really touches our heart, when one of these patients manage to crawl beneath that barrier.

Nassrin seemed to say that the 'automatic pilot response' was the one that was used with all patients (not only those who annoyed or dismayed therapists) but every so often there was a client who 'touched your heart'. It seemed they were discussing what Hochschild (2003) had termed 'emotional labour', a concept that was used to understand the (often) unacknowledged relational work of nurses by Pam Smith (1992). Emotional labour, a term used by Hochschild to describe the work of flight attendants, 'requires one to induce or suppress feelings in order to sustain the outward countenance that produces the proper state of mind in others – in this case, the sense of being cared for in a convivial and safe place. This kind of labour calls for a coordination of mind and feeling, and it sometimes draws on a source of self that we honor as deep and integral to our individuality' (Hochschild, 2003, p.7).

The nature of a professional behaviour, through the 'deep acting' that Hochschild described (see Smith and Lorentzon's 2005 discussion on the 'ethics' of deep acting), enhanced by wearing a uniform and the use of an encoded profession-specific language (e.g. OT words like 'independence' or 'activities of daily living') may protect those

individual OTs from the full force of the clients' unconscious feelings (terror, envy or hatred) as Menzies Lyth (1988) had suggested, but did it prevent them from enjoying a fuller relationship with clients, one in which there was potential for a reciprocal exchange? I have developed some of these ideas in the final section of this chapter, but want to return briefly to an example of the difficulty I had in incorporating the social-political reality of the clients, therapists and my life into an understanding of the conscious and unconscious dynamics in the research.

Considering Context: Social Political Realities

In CTGH the therapists never seemed to take their uniform 'off', they felt a heightened sense of social responsibility for all the people they saw on their journeys home or in their neighbourhoods. Nassrin described seeing a man with crutches walking next to the highway she used to get home. When she saw him later that same evening as she went with her husband to a social occasion she said they should have given him a lift. She said her husband thought she was 'crazy' but said she explained to him that this man with crutches was also one of 'hers'.

> **Nassrin:** … but if he comes to the clinic tomorrow and I happen to be working in the area he will probably be my patient … and I might even know him … see his face around … and I was thinking I should do more as a person not just as an OT … we know what it takes to walk on crutches and the energy level and he has been up the whole day and its now freezing and cold and dark – completely dark, he can easily be knocked over … and yet he is coming home from his work … [like she had been] … you know.

For some of the CTGH OTs this sense of heightened social responsibility occurred without a conscious acknowledgement of the social political reality of clients' lives, leaving them either frustrated with the clients' lack of progress or exhausted by the needs they saw around them (like Nassrin above). Pamela said that she had developed a shell around her, an 'analytic hardness'; so that she could cut herself off from clients who said they needed a disability grant because they couldn't pay their rent. OTs like Nassrin, who managed the wheelchair budget, didn't seem to consider that OTs were additionally burdened by a lack of substantial social support (e.g. government grants for people with disabilities, provision of wheelchairs for those who required them etc.). The OTs had become a form of grant and equipment 'control', detracting from their therapy work. They seemed unaware of this additional burden and had accepted this role of extended accountability for the lack of social resources.

When comparing their work as OTs in the UK to SA, a therapist said that she thought that in the UK clients were 'given too much' and because of that the clients had become 'very demanding'. She said that in SA whatever you did for the clients (e.g. equipment, splints, time etc.) they were very grateful, and that made her feel better about her work. I remember having a strong reaction to this statement, perhaps because it echoed my own earlier naive comparison of OT in SA and the UK. What the therapist (and I) had failed to appreciate was the importance of a society in which there was enough for all, including the rights for citizens to complain and demand things. This 'demanding' may be a sign of an equitable (and just) society, not one dominated by a previous (and/or ongoing) culture of patronage and serfdom as SA had been, and in many ways continued to be. Murray (1997), in her article based on a tour of SA with a group of USA HIP-HOP civil rights students, captures the shock of the inequities that continue in SA. A student comments:

> 'Marisa: *Maybe I was naive, but I was really surprised at the differences between rich and poor. I had read the articles and I knew that there were economic inequalities, but to see, right next to each other, huge homes surrounded by barbed wire and then serious shanty towns, I was really shocked by that. How can you have a country that is so rich, and then have the majority of the people in the country be so poor?*' (Murray, 1997, p.4)

Murray's (1997) analysis of the new ANC government, which had begun with the good intention of 'overcoming the huge economic disparity' (p.5) of the housing, schooling and health needs of poor black people, was that it had been subverted by pressure from the World Bank economists and SA business community (many of whom had been supporters of the old regime) to '[adopt] a neoliberal economic export strategy which emphasised free markets, fiscal discipline and building business and investor confidence, even if that meant 'downsizing' [the reconstruction and development program with its dedicated government funds] to be competitive in the global economy' (ibid. p.5).

> 'South Africa, SA
> What's going on with equality today
> And has apartheid really gone away
> Better yet hey ho is freedom here to stay…'
> *words from Rap Song, Murray, 1997, p.1*

Times Past in Times Present

> 'History, despite its wrenching pain,
> Cannot be unlived, and if faced with courage,
> Need not be lived again.'
>
> *Maya Angelou, 1993, Inaugural Poem, lines 73-75*

As I discussed in Chapter 6 I was unprepared, in many ways, for the extent to which my own colonial racist past would surface in relation to my observations and interviews with both black and white therapists in the CTGH. I described my growing awareness of the importance of talking about race and culture in the description one of the SA inquiry groups in Chapter 6, p.168, where I drew the group's attention to any possible misunderstanding of the term 'Muslim culture'. McKinney (2007) described how a group of South African university students avoided using any racial terms to describe their understanding of past events or experiences with each other: 'they resist such positioning when it threatens their own subjectivities, or that aspect of their identities that they attempt to construct for themselves as 'new', post-apartheid South Africans' (p.218).

A common discourse in South Africa was that there was only one colour, the 'rainbow colour'[62] and this euphemism hid many disquieting emotional realities for those who lived under and/or participated in the apartheid structures. I felt that an ongoing silence about these matters was a form of complicity in the denial of the past, but I also felt I didn't have the right, as a researcher or as a white person, to confront what the participants said, so I found I would 'wonder aloud' if what they were saying might mean something else. This was sometimes clumsy or as a result of my own prejudice (as described in my relationship with Joanne).

McKinney (2007) said, 'What we need to do is find ways of engaging productively with students' resistance [to talking about race]. Enabling them to reflect on their views is one way of doing this' (p.228). The idea of developing reflexivity in relation to one's conscious intentions may be all well and good, but racism, like all other parts of us, is in our unconscious as well as our conscious minds. The dreams I had during the project in South Africa so clearly attested to the unconscious part of me that carried the racial legacy of my past[63]. Although I made a deliberate choice to be explicit about these

[62] See Murray (1997) for a critique of the notion of a 'rainbow nation'. A rainbow, she reminds us, keeps its seven colours separate – they never meet, even at the rainbow's end.
[63] E.g. the dream 'Burying the past' described in Chapter 7.

dreams so I could use them in my analysis of the SA data, I was ashamed of them. Cavell (2003) in her article on 'Freedom and Forgiveness' considered that 'men believe themselves to be free only because they are unconscious of the causes whereby their actions are determined…' giving the argument for psychic determinism, but she goes on to say 'we become more free as we become more conscious of the causes for our action' (p.516). There was a benefit to knowing about my shame; it allowed me to think more fully about the 'other's' experience, not just feel persecuted by it.

I began to realise that the therapists, like me and the clients, were a mixture of personal experiences (with parents, siblings and/or extended family) and 'social' ones, i.e. their gender, race, class and language had an impact on their conscious and unconscious lives and choices. Some of the OTs' early family histories had left them with a desire to work in a caring profession (e.g. in Chapter 5, pp.122-123, I discussed Alison's need to care for others based on her early experience of 'helping' a tired, stressed and vulnerable mother). Polden (2005) states, 'the desire to make reparation appears to be a central preoccupation in the lives of many patients, as well as their psychotherapists' (p.559), and Roberts (1994b) said many staff in the care profession come into the work because of their early childhood experiences (see p.110). In doing the SA part of the study I realised that the OTs were also deeply affected and shaped by their gender, race, culture, language and dis/ability. Neither part of their selves (personal or social identity) had precedence over the other (like a see-saw) and all parts came into play in the relational field of engaging with an 'other'. As I said at the start of this chapter, we work, live and love in a psycho-social world.

> 'The reason for calling this research "psycho-social", rather than just analytic, is to emphasis that the social and societal parts of analysis should be inextricable from the psychoanalytic … the object relations tradition has always been capable of casting light on social relations, while concentrating on how they get introjected and projected and the transformations that occur in the internal world.' (Hollway, 2008, p.138)

I tried to conceptualise this intersection (or interpenetration) of the two fields/planes of the social and personal identity that had areas of awareness and unconsciousness. I had become aware in my interviews with the SA OTs that they didn't often think about their social/political backgrounds as having contributed to how or why they did their work. Some described this new insight (following the first FANI) as unsettling or unnerving. It was similar to the description given by the UK OTs that the interviews were like

'having therapy', as they reflected on how their early childhood had influenced their choice of work.

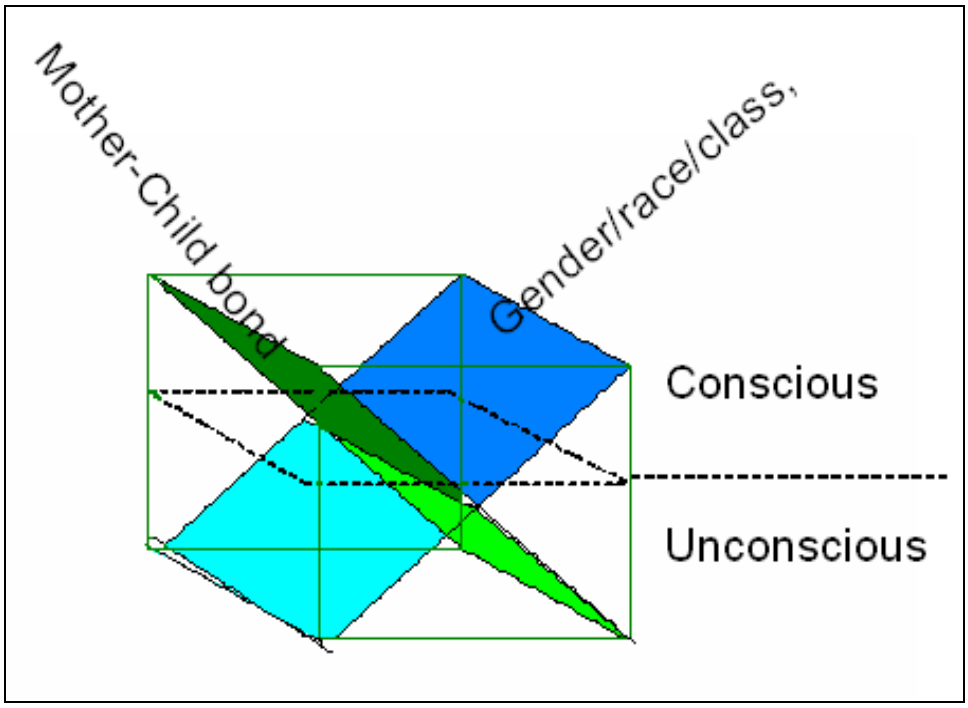


Diagram 7: Intersecting Personal and Social Planes

This diagram, although far from ideal in terms of its depiction of an evolving interrelatedness that parts of the self have with each other and the capacity a person has for an engagement with another self, does assist me in separating out the importance of a twin focus, one being on the early development of a person and the other the social political history that they lived and live in.

Nassrin, in the second FANI, gave an example of the importance of this twin focus when she spoke about two of her clients, one of whom had always puzzled and worried her. They were both young black people who had come into hospital following a traumatic double amputation to their upper arms. Both lived in the 'informal settlement' (and so were poor and may not have had access to much formal schooling) and both had lost their arms from being run over by a train. The difference was that Moses (the young man) had been pushed from a train carriage and Pumza[64] (the young woman) had jumped in front of a train (in a suicide attempt). What Nassrin had puzzled over was that both clients had a similar 'level' of injury (the site of their amputation meant they

[64] Both names are pseudonyms.

needed to use bilateral artificial limbs) but Moses had made a full recovery and Pumza hadn't.

Nassrin said Moses had returned to work as a packer and she often saw him at her local supermarket; she thought that his artificial limbs made have given him an additional income through 'tips' as he took people's groceries to their cars! She said she always liked seeing him as he was an example of what was possible. Pumza was a far sadder tale. She had been initially reluctant to use her artificial arms, they were heavy and it was hard for her to use her shoulder movements to operate the mechanism that opened and closed the hooks (her new hands). Although she did make sufficient progress to clean and dress herself independently, after she had been discharged home she didn't return for any follow-up appointments. Nassrin described doing a home visit to the client's 'shack' in an informal settlement.

> **Nassrin:** It was in the afternoon … the children were home from school, the curtains were closed, [she was] under the blankets sleeping, [her] daughter was preparing the meal … and really running the home … neighbours would help mom during the day … but this young girl … besides doing her schoolwork … would come home and look after mom, dress her, brush her hair, prepare the dinner, and look after the younger sister … you often feel that you failed in some ways … she was so severely depressed … a suicide attempt that drove her to this … but knowing that this physical disability further impacts on the lives of her children.

Nassrin said she felt she could have done more, but with the pressure of other patients had to leave the client as she was, and then by chance she heard from another patient who lived in the area (informal settlement) that the community had tried very hard to motivate Pumza to do more for herself and to be involved in local income-generating projects, but she had remained in her house, leaving all the work to her daughter. Nassrin said she felt relieved that it wasn't just her [as a therapist] that had failed.

> **Nassrin:** I think as a therapist we sometimes forget that … it is sometimes due to the patient not taking responsibility and then having a choice … that is incredibly difficult to sit with … When you see what they can do [more] and they choose not to do it … [you think] maybe I did something wrong maybe there was more that I could do to motivate her … hearing that they [the squatter community] had tried … [you realise] it is not you, it is the individual's choice and other people have made attempts with different … backgrounds and identities and yet it hasn't been enough for her.

Nassrin seemed to be saying that even the black disabled people who lived near Pumza couldn't get her to do more, yet Nassrin had worried that it might have been because she was a coloured Muslim woman (without a disability) that Pumza couldn't relate to or

identify with her. What I realised was that it was much bigger picture than one individual's effort with one person. Nassrin hadn't failed Pumza because she was a busy OT, or a coloured woman, the whole system had failed Pumza and would continue to do so. It wasn't her (Pumza's) choice to end her life; she had most likely been denied a life so that the notion of having a choice was a kind of luxury. As Roshan Galvaan said at an OT conference in Cape Town (2004), to make a choice you have to have one.

Obama (2007), discussing his early years of community work in Chicago, described his growing realisation of the related effects of racism and poverty in the marginalised black communities of Chicago. He said that many of the messages given to black people about 'improving their lot' sounded like black people were being blamed for where they were on the poverty scale.

> 'For when the nationalist spoke of a reawakening of values as the only solution to black poverty, he was expressing an implicit, if not explicit, criticism to black listeners: that we did not have to live the way we did…. [to] many blacks such talk smacked of the explanations that whites had always offered for black poverty: that we continue to suffer from, if not genetic inferiority, then cultural weakness. It was a message that ignored causality or fault, a message outside history... for a people already stripped of their history…the testimony of what we saw every day seemed to only to confirm our worst suspicions of ourselves.' (Obama, 2007, p.198)

I wondered if Nassrin had found it difficult to ask about Pumza about her experience of being a black woman in South Africa. Perhaps she, like me, had found it hard to talk about race, gender and class as part of who we were and how it made us different. I had mentioned earlier that Nassrin had told me of her feeling of being 'not needed' in her class of predominantly white students during her university training as an OT (see Chapter 5, pp.146-147). Hearing her talk about this time put me in touch with the revelation I had experienced in reading Tsitsi Dangarembga's (2006) account of attending a school in Zimbabwe at a similar time that I went to school there. Although Tsitsi wasn't at my school, she could have been. Being only one of six black students at an all-white girls' school, she described her terror of trying to find a place to stand in the queue of girls who lined up prior to assembly; her terror was that they might bump into (touch) each other.

> 'There was something they… did when that happened. This was a pulling back of their very aura from contact with you, in a way that said not even your shadows that blocked the sun should intermingle. And such a look of horror flooded their faces at this accidental contact that you often looked around to see what horrendous monster caused this expression, before you realised it was your person …We [the other black girls] spent a lot of time consumed by this kind of terror. We didn't

> speak of it amongst ourselves. It was all too humiliating, but the horror of it gnawed within us.' (Dangarembga, 2006, p.58).

What I hadn't realised, until I read her autobiography, was that this was something I had never known, it wasn't something I had 'misunderstood'. Like the distinction that Fabian (2001) made between misunderstanding and not understanding, I had never considered what the black students' experience of me – as a white person, their lecturer and a woman – was. I hadn't considered the painfulness of exclusion and that I, as a white person, was part of it. As Morgan (1998) said, 'Colour blindness, ignoring difference of this nature, is more comfortable, but I believe it to be a denial and a defence against a complex array of emotions that include anxiety, fear, guilt, shame and envy. No wonder we do our best to avoid the subject' (p.48).

I pondered over my difficulty in talking about race with the participants and I realised how it was wrapped in my sense of guilt at the past, my ignorance of the events which shaped so many people's lives and my sense of complicity in the whiteness of my skin. It wasn't easy to talk of these things, but to not talk about them was worse. I realised that if my feelings of guilt stopped me from taking any kind of action, I was even more defeated than before, and I needed to find a way where a space could be opened for talking about who we were to each other. I did ask Nassrin why she had wanted to be part of the study and she said because I had helped her to think about herself.

> **Nassrin:** If it had been a different researcher I don't know if I would have said yes to the project, but knowing you and how you think and how you work, I value that and … you have a way of putting things across that are incredibly thought provoking … you see things that I didn't know was there … me being at a space where I am quite comfortable [to be] … looked at … or being open to criticism … not in a bad way.

This unsolicited praise of my ability to engage the 'other' in a process of reflection may have had more to do with the intention of the project than my personal abilities to 'know the unknown'. I do think that OTs have found it frustrating that the full extent of their emotional work with clients has passed without comment or exploration. As I said in the initial chapters (1 and 2) there has been very little documented in the professional literature on the emotional difficulties and/or rewards of working with clients. I recently sent a abstract to an international OT conference with the title, 'What love **has** got to do with it' (based on this project) and the paper was rejected with a warning from the conference organisers that such a talk could break down the boundaries that were needed in therapeutic work with clients. If words such as hatred, envy and greed are

absent from the OT literature about working with clients, so were the words guilt, loss and love.

Reparation, Reciprocity and Creativity: Love Actually

> 'The woman I cared for was eighty-three years old and had a severe cerebral haemorrhage that left her paralysed on one side and speechless and angry. Her family did not know how to relate to this state and were frightened and depressed by her uncontrollable anger and bitterness.
>
> I, having never known her in any other way, fell in love with her. Perhaps I sensed in her anger a spirit that had not yet given up or in her inability to speak (even though her eyes spoke volumes) a voice that needed to be heard. (I was experiencing similar things in other ways.) Whatever, I had the gift of caring for her until she died, and at her coffin and at her grave the only words that came to me were 'thank you' and many tears.
>
> She helped me experience myself as tender and compassionate *and* limited. I had to learn to forgive myself for the many mistakes I made in trying to care for her in the ways that were best for her.' (Sarton, 1988, p.18)

The narrative above comes from a letter written to May Sarton (1988) and describes so eloquently the fulfilment of desire in relational (care) work. It describes the reciprocal nature of the caring relationship where the carer, in a highly reflexive statement, describes her identification with the client (she says she had also been angry and silenced) and her ability to experience herself as loving and limited in relation to the other. This seemed to echo Craib's (1994) description of how modern society hid the reality of our deeply ambivalent feelings in all our relationships.

Reparation is an act of love and it involves the subject (patient) and carer in a mutual exchange. At first glance the mutuality in the exchange is hidden from view as it appears that the professional OT (therapist) is helping the patient (subject), and the structure of this relationship is contained in recognised procedures and routines. The profession can appear mechanistic (even rehearsed) but the people who become OTs articulate a desire to work in a particular way with people that involves those people being able to achieve 'independence'.

This affective mirroring can give the therapist a sense of identification with the struggle and achievement of the patient – but if it can't be experienced in a symbolic form it stands the risk of losing its reparative potential and the therapist will equate the actual (or concrete) event with the feelings – hence the busyness at the funeral described in the section above. As if doing something can take the place of feelings, not represent them,

thus the symbolic becomes a concrete reality and the possibility of a reflexive thoughtfulness is lost. This may be similar to Segal's (1986) notion of 'symbolic equation' (p.53) where the action taken by an OT or the equipment given to the patient becomes a thing in itself for the therapist and not a transitional phenomenon which acts as part of the communication process. Menzies Lyth drew attention to this difficulty for nurses when the clients they treated became equated (in phantasy[65] and reality) with a loved one.

> 'The nurse projects infantile phantasy situations in current work situations and experiences the objective situation as a mixture of objective reality and phantasy. She then re-experiences painfully and vividly, in relation to current objective reality, many of the feelings appropriate to the phantasy. In thus projecting her phantasy situations into objective reality, the nurse is using an important and universal technique for mastering anxiety and modifying the phantasy situation … To be effective such symbolisation requires that the symbol *represents* the phantasy object, but is *not equated* with it. …[when] the symbol and the phantasy object become almost or completely equated … anxieties [are] aroused … and [the] symbol then ceases to perform its function in containing and modifying anxiety.' (Menzies Lyth, 1988, p.49)

An example of the symbolic use of containing of anxiety occurred when I observed Alison's interaction with Phillip (see Chapter 4, pp.108-110) and her assuring him that his nodding off (taking short naps) was unlikely to herald the end of his life. This exchange took place while Alison adjusted the tubes that fed oxygen into his nose and she used filling up a glass of barley water to represent his need for 'little naps' to 'fill up' his energy resources.

Alison was assessing him for a discharge 'palliative pack' for his use at home. In contacting the ward consultant's secretary to make a time for the doctor to see Phillip and his wife, something he said they had been unable to achieve, she used words (highlighted below) that echoed the sentiments of the fox to the Little Prince (the section used at the start of this chapter).

> When Alison called the consultant's secretary she said the consultant was very busy and didn't have time to speak to 'every relative'. Alison said:
> '**I am sure Dr X has many patients, but you see Mrs P has only got one Mr. P and so she really wants to speak to Dr X about him.** When do you think he will have some time to speak to her in a private place and not in front of the ward round?'

[65] The ph spelling of fantasy was used by Menzies Lyth to denote unconscious phantasy as opposed to the daydreaming fantasy of each person.

In the second FANI Alison spoke about her need to 'take care' of others and this she related to her early life history of needing to care for a vulnerable mother. It seemed that the work she did as an OT and as a team leader provided her with many opportunities to fulfil this desire, Alison's intervention with Phillip, his wife and the consultant, was thoughtful and compassionate, i.e. reparative.

Polden (2005) said that caring for others can be a form of 'reparation interminable' (p.560) which can never lead to any transformation in the object (e.g. the OT) as it was a 'compulsive activity' (p.560). In discussing the difference between true reparation and false compulsive reparation Polden said in the latter there was a lack of an awareness of the 'subjectivity' of the other, the possibility of 'mutual recognition' (Benjamin, 2004, p, 5). When reparation was manic, compulsive, the object of the therapist's attention (i.e. the patient) had to remain a vulnerable 'other' so the project of reparation could be continued.

During the FANIs Alison seemed to understand that her need to care for others had been a form of unconscious control (i.e. manic reparation), one that protected her from her own sense of being needy (see Chapter 3, p.87). She mentioned a period of career counselling in which she was changing her 'trying to take care of the world'. Some time after the project had ended at LGH I heard from Jessica that Alison had been successful in having a baby (something she had spoken about during the FANIs) and had returned to work only in a part-time role because she was enjoying her new role as a real mother.

What I think Polden (2005) was saying is that when the desire to care for others is driven by an unconscious need to 'be good for mommy', when that mother was depressed and unable to form a 'holding' relationship with her child, it creates a denial (or suppression) of the child's potency and preventing them from establishing a full relationship or enjoyment of the 'other'. But it is far more complex than the person simply acknowledging an unconsciously repressed 'self', because beneath the repressed self is the realisation of a profound loss, of a loving psychologically present (available) mother.

I have wondered whether was defending against this profound feeling of loss, a void, that might have provoked the person (Alison, Nassrin, myself) into further acts of compulsive caring to keep those feelings of void at bay. (See discussion of the 'hole' I

fell into in the dream, Chapter 6, p.176.) Straker (2004) and Zembylas (2009) have spoken about the profound losses in South Africa (for all its citizens) as having caused a melancholia, a 'grief without end' (p.408). It is this grief that Straker says provoked the manic 'do-gooding' that she had experienced alongside other white South Africans during (and after) apartheid.

This use of the object (to retain the status quo of one's manic reparative acts) was echoed in Straker's (2004) description of how some socially committed white South Africans used political projects to assuage their guilt about their white privilege. What was lost in this use (or misuse) of the 'other' (e.g. a project) was the lack of recognition of the subjectivity of the other. In Straker's paper she states that when the organisation does not appear to benefit (or enjoy) the patronage of the liberal white professional, they (i.e. the white professional) can become frustrated and enact the very racism that they avowed to hate. Hoggett (2006) writes about the difference between 'pity' and 'compassion', where he draws our attention to the use of object vs. the recognition of a subject.

> 'Pity requires an object whereas compassion requires a subject. The object of pity is innocent, a "pure" victim, without subjectivity. Compassion, in contrast, does not require innocence. The object of pity …is an impossible condition – a pure helpless innocent being [like a suffering animal]….In contrast, compassion remains steady even when the "object of pity" becomes difficult, starts to complain, becomes unmanageable, does things which seem to put him or her in a bad light, lacking in virtue. Perhaps then compassion can even be felt towards the suicide bomber.' (Hoggett, 2006, p.154)

Joanne, alongside her deeply felt commitment to working with 'these'[66] clients, seemed to really enjoy them. Her clients were not, as Hoggett (2006b) described, divided into 'good and bad', innocent and culpable (p.155). I observed Joanne working with an anxious black woman who lived in a 'squatter camp/township' and whose hand had been encased in a plastic splint for over a week without being washed or massaged (as she would have been encouraged to do). While Joanne was washing the client's hand and partially debriding[67] it she discussed the woman's home circumstances and learned that she cared for a wheelchair-bound mother and worried about her teenage son's

[66] As described in Chapter 5 Joanne had returned to SA (from the UK) to work with clients in a public hospital (CTGH). The majority of 'these' clients were poor (i.e. indigent or working-class) black and coloured adults.
[67] A process used to rid the skin of dead cells.

school work as there were many 'skollies[68]' in the area. Joanne said, after seeing this client, that her hand had probably been the last of her priorities, which was why she had neglected it. I asked Joanne how she had learned to be firm and facilitative at the same time.

> **Joanne:** Maybe it is a way of protecting yourself not to get all soft about it … she is one of my out patients that comes to see me quite regularly and she is a complete **drama queen** and I can just understand why she didn't [wash her hand] … because she would be one of those people that doesn't open the bill because if she doesn't open it - then it is not there. And [her] frustration level was so high with this hand … instead of jumping in and saying let's do as much as I can … I'd rather just ignore it. (i.e. not wash it) … She is a … [laughs] **huge** drama queen.

Joanne understood that her client avoided the things that made her life more stressful (e.g. not opening a bill when it arrived), and this created more difficulty for the client in the long run, as not washing her hand had done. But Joanne described her client as someone we all could identify with, the things she did (like avoiding difficult subjects), we all do. Joanne's appreciation of the client's subjectivity included acknowledging how the client, at times, wasn't able to help herself.

> From this position the world is no longer neatly separated into good and bad, innocent and culpability. It enables us to see that many people … who are victims of circumstance also often adopt psychic survival strategies which make things worse for themselves and for others …The point about the depressive state of mind [the Klienian depressive position] is that the self continues to love and show compassion despite the flawed nature of the other, despite this other being a complex mix of good and bad.' (Hoggett, 2006b, p.155)

There was a moment during the observations in CTGH, while I was listening to Zarrin and Mina discuss their work, that I found myself overwhelmed with feelings of pride and appreciation of them. Both had been students at the university where I had previously taught and I remembered Zarrin as a rather quiet, solidly-built person who seemed to carry great burdens for someone so young. Now, ten years later, Zarrin was livelier, she was slimmer, she seemed to smile more often and although still fairly quiet, spoke about her work with a depth of understanding that attested to a real humanity.

> While I was listening to Zarrin … I became quite tearful. I was remembering [her] as a student. She had been a large and quiet student, seemingly burdened with many responsibilities that made her large frame appear almost block-like. Zarrin is now considerably slimmer and wears less traditional clothes … she looks happy and confident compared to her previous student appearance.

[68] Young men who belonged to gangs and were responsible for much of the theft and violence in the townships (see *Tsotsi*, 2006).

> I am not sure why I became so tearful – I was feeling proud (but that word isn't quite right for the feeling I had) that these women (Nassrin, Zarrin and Mina) were working and making a contribution to the profession, two were mothers and all had compassion for those around them. They had been undergraduate students when I taught at the university.

I say, in the observation above, that I felt 'proud' but that the word 'proud' wasn't the right word to describe my feeling. I think, on refection and without trying to be too sentimental or defensive, it was love. The kind of love that Benjamin (1990) describes as a 'recognition' of the other. It is hard to acknowledge some feelings, like envious rivalry, sexual arousal or hatred, but love too is hard to say because it can feel wrong and bad, especially when talking about research participants or clients; but it is the closest word I can find for saying how I enjoyed the moment of watching and listening to these women talk about what they did in and how they thought their work.

> 'Where the feelings belong is important, but more important is discovering how to bear our feelings, and that involves a deeper understanding and not only the ability to recognise where they belong but also the ability to allow ourselves to feel.' (Craib, 2001, p.117)

In the End is My Beginning

This final section looks at what has been gained by doing this project: for OT theory and practice, as a research methodology and for me as an ethnographer and person.

Beginning Again

> There was a man called Michael Finnegan
> Who grew whiskers on his chinagin
> The wind came out and blew then inagin
> Poor old Michael Finnegan, beginagin[69]

When I began my analysis (1999) I used to think of writing my autobiography, perhaps because I believed at that time my analyst wasn't 'hearing' me (as described in earlier sections of this thesis). I considered calling it, 'Repeating Myself' because I saw so many patterns in my life that seemed to repeat themselves: a poor choice of partners, my belief that men were oppressive (and they became so…etc.). Then, as I began to trust in the process of the analysis, the title of my autobiography changed to 'Not Quite

[69] There are several web references to this children's song and each has slightly different words in the verses. This version is the one I sang as a child in Zimbabwe.

Finished', which had a particular poignancy when I left my analyst in February 2002. Many things have happened since then: I have a life partner, I/we have moved jobs and countries (twice), I undertook this research project and have recently entered into analysis again, now with a woman. I also have a new (fantasy) title for my autobiography; it's called 'Beginagin', like the children's song which rhymes 'beginagin' at the end of each line.

I wish I could begin again, there are so many things I would do differently because I understand more about myself and the world around me. If I could begin this project again I would have been far more interested in the UK OTs' past cultural histories; they were as different from each other as the OTs in SA were. For example, I would have asked Heather about her life as the eldest daughter in a home with eight siblings and mother who was a nurse. Where had they lived, what was her mother's religion, what did her father do? And how did she view me? These were the things I learned to do during the project and so the 'social' material (i.e. half of the psycho-social coin) from the UK study wasn't fully described or analysed.

I was recently listening to the BBC Radio 4 'Saturday Live' programme[70] with Fiona Glover. She was interviewing an older woman (Jenny) who had given birth (in the late 1950s) to a Downs Syndrome child. Jenny spoke about how she had initially wished the child would die and had later learnt to love the boy. Her husband had never been able to accept this baby and their marriage had finally ended because of this. Jenny had one older child (a girl) and she had consulted with Dr Winnicott, who suggested that she put her disabled boy in a care home to protect (i.e. have more time for) her older child and marriage. Jenny did put her son in a home and said he had been very happy there. She said if the child had been born now, she would probably have kept him at home, as times were different and people were far more accepting of children with disabilities.

While listening to the interview I was stuck at Jenny's accent (it was 'upper class', 'posh', having a 'stiff upper lip') and in it was her unspoken pain about the loss of this child. It seemed such a relevant example of the psycho-social world that we live in, the cultural influences on Jenny at the time when her boy was born. I told my analyst about the radio programme and how moved I had been by Jenny's story. 'Yes', she said, 'I am

[70] Saturday 4th July 2009, 9-10am.

sure, perhaps you felt your mother should have given you away when she saw you weren't the wanted child (a boy)'. It hurt terribly to think about that, and she was right. But it's both, always both – the psychological early years and the impact of the social (historical, cultural, gendered and racial) environment.

In considering the criteria for the rigour (i.e. the credibility, dependability and transferability) of this research project I have used three measures identified by Ballinger (2004) for studies which employ a 'relativist position' (p.543), which are 'reflexivity', 'transparency' and 'utility' (p.544-545). In thinking about how the bias of the researcher can affect the 'truthfulness' of the study, I want to return to Hunt's description of the ontological position taken by a researcher when doing psychoanalytically informed ethnographic research.

> 'While hermeneutic and existential sociologists accept a dynamic model of the fieldwork process, they omit consideration of the intrapsychic dimension. Psychoanalytic anthropologists accept the hermeneutic paradigm but recognise that the ethnographic encounter involves unconscious as well as cultural dimensions. Thus, unconscious as well as cultural meanings mediate the researcher's interpretations of the subjects' world. Changes in the researcher's and subject's "selves" occur at both intrapsychic and cultural levels.'(Hunt, 1989, p.29)

In other words another researcher may have experienced different emotional responses and come to separate conclusions from me because, as Hunt says above, they bring different unconscious dynamics into the process. The difficulty seems to be of separating out what the researcher knows because they 'felt it' and portraying this as evidence. This apprehension of a 'truth' as Rustin (1991, p.200) explained is 'understood not as a rational scientific correspondence with some objective interpersonal structure already established in theoretical terms, but as something more like the meaning of a shared emotional experience apprehended within a relationship.'

The key seems to be in the reflexive and transparent account that the researcher gives about the self-discovery they undertake alongside the factual verbatim reporting (i.e. thick descriptions) of the participant's narrative. For example if I hadn't explored (in analysis) my unconscious need to care for others as a form of reparation, I may not have considered that this was also present in Alison's (unconscious) desire to work in an acute care setting. If I hadn't explored my past colonial racist notions of the 'other' I may not have understood Joanna's narrative of caring about someone who she described

as being like ‘a small little animal in the wild that is about to be eaten by a lion’ (as discussed on page 167).

Fox (1991) and Huisman (2008) suggested that the soundness (credibility) of the research work is in its application, in other words did it (or will it) make a difference for OT and/or their clients? The question of its truthfulness (or plausibility) could be evidenced by the emotional resonance that readers experienced (or not!) in the accounts given by the written work. The thesis and any subsequent work (e.g. conference presentations, research papers, opinion pieces etc) may attest to its value through the response it receives. Professional recognition (through publication) of relational theory in OT therapeutic work may support the emotional work that OTs have been (and are) doing and would thus be part of the project’s ‘utility’ value.

> ‘Utility is the extent to which the research has an impact, either theoretically or practically. Within health, for example, qualitative research may result in changes in health service practices but, equally as importantly, may also change the way in which health issues are understood.’ (Ballinger, 2004, p.545)

To some extent the utility value of this research project may not be known for some time and I am cautioned by the strong criticism that Menzies Lyth’s (1988) article received on the unconscious social defences in nursing (see ‘Responses to ‘The functioning of social systems’’, Menzies Lyth, 1988, p.89-114). My research work has attracted some interest from an international audience in OT (e.g. a poster presentation at the 2010 World Federation Conference of OT in Santiago, titled ‘What love **has** got to do with it’) and we (i.e. Julie Cunningham-Piergrossi, Carolina Gibertoni, Margaret Daniel and I) have held two successful day long ‘Master Classes’ at Brunel University on ‘Re-Awakening Psychoanalytic Thinking in OT’ (January 2009 and 2010). I have considered some further application of this work in the section below.

Occupational Therapy: Holding and Containing

Winnicott (1971), perhaps more than any of the other object relations theorist, has given OTs a theory to use in their work with clients. He describes how the objects that the child uses in play, including the use of the mother as an object, develops into an appreciation of art and culture through the continued use of transitional objects to represent what is neither inside nor outside. To repeat a quote used earlier: ‘To control

what is outside one has to *do* things, not simply to think or to wish, and *doing things takes time*, Playing is doing' (ibid. p.41).

Occupational therapy is a detailed description of what people do, from making a cup of tea to using a long-handled stick to pick up objects (no longer within one's reach) or writing poems about a period of ill health. Many of these things are done in the presence of a therapist (an OT) and, as discussed in Chapter 1, the potential for play within the triangular space created by client, therapist and the 'doing' contains the place where transformation can take place. Cunningham and Gibertoni (2005) described a way of working with their clients that allowed for the creative expression of the client's internal world through the use of the play materials and the attention (verbal interpretations made and actions taken) by the OT in response to what is being made. Ogden (2004) has distinguished between Winnicott's notion of 'holding' (i.e. to be present and provide continuity over time) and Bion's use of the term 'containment', which refers to the process in which new thoughts can emerge (i.e. change takes place). It has seemed to me that OTs need to be more appreciative of the value of presence (e.g. Winnicott's holding) and use the activity as a place for transformation (containment).

'Doing' something may be a form of creativity, a reparative act which stems from the depressive position (described more fully in Chapter 2). Edwards (2005) considered that the reparative process sometimes preceded the depressive mourning process. She discussed Britton's description of Rilke's writing: '… the writing was a means to move from paranoid to depressive state…He called his writing "a kind of self-treatment" (ibid. p.323).' Perhaps, like Philip Pullman who said he didn't want so much to be a writer but that he always wanted to write, Rilke and Pullman may have felt compelled to write. The need to do and what is chosen to be done is a complex field of inquiry but what I think OTs may have lost sight of is their role as therapists in this process; therapy requires of the therapist a capacity to think about, feel with and engage in a dialogue over what is done.

This space for thinking about the client and their activity can provide an appreciation of the aesthetic and profane, potentially restoring the therapist through a process of discovery and connection with the experience of others, namely their clients. If the potential for reciprocity in the relationship with the patient is experienced only as a validation of the therapist's role and talent, the therapist cannot fully enjoy – or, I would

suggest, benefit from – the exchange with the patient. Within a reciprocal relationship which carries identification, projective identification, conflict and concern there is the potential for a creative process which benefits the pair. If therapists neglect an exploration of this emotional field they stand the risk of using (or controlling) the other as a concrete object – closing down a space for intersubjective experience, reparation and creativity: love actually.

Winnicott (1971) reminds us that play involves the use of an object which can represent something, perhaps the 'lost' mother, perhaps a frustration with 'present' mother, and it is both real (can be seen and/or heard) and symbolic (what is unconscious and cannot be known). He also says this takes place in a transitional space, and here he refers to 'time' as being the measure of the transition. I have considered that this time is an important third dimension to the intersection (or interpenetration) between the personal and social planes of the self. 'Time' can denote the social-political-cultural context of the 'doing' event alongside the actual moment-by-moment time of the playing. In other words doing 'housework' or playing 'golf' has a particular social / political / gendered history which can be located in a current or past time for that culture. Where this is relevant is in considering the choice and use of objects in 'playing', because people may use what is available to them (e.g. sea shells to represent money/coins) and what is culturally popular or relevant at that time (e.g. computer games). Thinking about Winnicott's notion of time as a social-cultural concept is also important in considering the meaning of symbols that carry of social unconscious (see Lawrence's 1998 description of the cultural unconscious).

Winnicott (1971) said that adults play in the same way that children do, but they more often use words as their objects. 'Whatever I say about children playing really applies to adults as well, only the latter is more difficult to describe when the patient material appears mainly in terms of verbal communication. …It manifests itself, for instance, in the choice of words, in the inflection of the voice, and indeed in the sense of humour' (p.40). In recent years, when I expressed my frustration at my mother's constant complaints about her itchy skin, her sore legs and her lack of companionship (i.e. my not being more available), I said that she must have got a degree in 'Irritation' from the 'University of Complaining'. She looked at me, smiled and said; "*Well, they were the only university that would take me.*"

Occupational therapists may lack the range and depth of words that psychoanalytic theory can give them, and it may be the widening of this emotional repertoire of words for them to use that could bring about some of the changes in how OT is undertaken and understood. This knowledge of the emotional complexity in their work (or 'emotional labour' as Smith, 1992 and Theodosius, 2008 described) needs to be explicitly taught in university courses and reinforced by professional literature that supports this understanding and way of working.

> '…understanding that emotional labour not only is integrally linked to, but flows from personal identity, is important in how the profession teaches and monitors it. Emotional labour….requires complex emotional reflexivity where the nurse's real emotions need to be acknowledged rather than denied – even though in the act of emotional labour they may suppress them.' (Theodosius, 2008, p.218)

Craib (2001) located feelings (i.e. emotions) at the interface between our unconscious wishes and the reality of external constraints. Emotions are both consciously felt (or defended against through denial, rationalisation etc) and unconsciously driven. He said it was the conflict between our inner (unconscious) desires and 'the threats presented by the outside world that push us into the activities of what we like to call culture – rational thought, the many forms of artistic production and so on' (p.116). He goes on to state that 'where feelings belong is important, but more important is discovering how to bear our feelings, and that involves a deeper understanding and not only the ability to recognise where they belong, but also the ability to allow ourselves to feel' (p.117).

Encouraging student OTs and clinical therapists to allow themselves to feel what it is like when working with a client requires a supportive (containing) environment and a capacity to use their emotional imagination (or countertransference responses). This could be undertaken in supervision where an emphasis is given to the feeling (emotional) content of the work with clients. This reflexive effort needs to include how therapists racial, gendered and class histories affect the relationships they establish with clients. Richly textured accounts by OTs, such as Finlay (1998a) and Kinsella (2006), can support this deeper exploration of unconscious desires, as can watching poignant and ethically complex films (e.g. 'The Sea Inside'[71]) in undergraduate teaching programs.

[71]This Spanish film, made in 2004 and directed by Alejandro Fernando Amenábar Cantos, is based on the life story of Ramón Sampedro who, following a spinal cord injury as a young man, fought a 29 year legal battle to end his own life.

When the culture of OT places an emphasis on tasks performed and assessments given, this emotional reflexivity can be lost or denied. I was reminded of this recently at an informal curriculum meeting I had with a non-health colleague, a lively attractive woman, whose background was in art. She had asked about my work in OT and volunteered that she had cared for her mother who had MS (multiple sclerosis) until her death. She said an OT had come to see them and brought different forms of adaptive equipment, she added shyly, that they had not used them because they were *'ugly and smelt funny'*. I immediately knew what she meant, the equipment does 'smell funny' and I wondered if the OT, who had done the assessment and given out the devises, had seen the look of shock and horror on the carer's face when she suggested they could be used to care for her beloved and aesthetically attuned mother.

Perhaps even more crucial than finding the words to say it, OTs may need to learn how to be 'present' in the space of potential play; for the client to make use of them and the equipment offered. Clients may use objects to express (and/or work through) their feelings, e.g. in writing or reading poetry, in the vigorous work of gardening or in the construction of a woodwork project. Clients can use the therapist like an object (see Winncott, 1969, 'The use of an Object and Relating through Identifications') and clients can use activities (occupations) to avoid painful realities. The potential in occupational therapy is that it can be the place of healing, the play of love.

Researching the Unconscious

As I stated earlier, if I were to do this project again, I would want to know more about the 'social' circumstances of each person and each work place (e.g. the history of the organisation) to understand the context in which the work took place. What has been a guide for me in the reflexive analysis of the data has been the dreams I have kept, poetry I have found, and biographical accounts of people's lives that have extended my understanding of the participants' lives (e.g. Dangarembga's 2006 account of her childhood). What I have struggled with is the ability to be surprised by what I saw and felt; my conscious mind so often had already decided what lessons should be learnt, what processes I would see. In some ways theory can offer the same kind of surety, and I fear that when I read some accounts of case studies in psychoanalytic journals, I often wonder if the espoused theory led the clinician to see the client in that light, or vice versa. If I were to embark on another ethnographic study, it would be with a poetry

book in one hand (with poems written by poets from that culture) and a (blank) dream diary in the other. And if I could learn how to, I would surrender to the experience.

> 'To surrender, to be moved by the other … is not mere passivity. It does not mean that one is absolutely constructed by the other, by language or culture. In the moment of surrendering to language, for example, one also constructs or generates experience by using the signifying functions of language. The poet, Heidegger (1971) argued, generates meaning in his or her use of language in constructing verse, and at the same time, the poet surrenders to the word, experience, and the other. The disruption of this paradoxical tension between surrendering to and generating experience is revealed in the "habit of always hearing only what we already understand" (Heidegger, 1971, p.58). In those moments, we use language to construct experience, while refusing to be open to being moved or surprised by the other's meaning, needs, and desires. To surrender, then, is to be moved, while also constructing or generating experience through signifying functions.'
> (LaMothe, 2005, p.211)

To return to the quote from Clarke (2006) that begins this chapter, I would surrender more to the experience so that I may use my 'imagination in the research encounter' (p.1167) to articulate some of what I had begun to understand about the 'other'.

> Home is where one starts from. As we grow older
> the world becomes stranger, the pattern more complicated
> Of dead and living. Not the intense moment
> Isolated, with no before and after,
> But a lifetime burning in every moment
> And not the lifetime of one man only
> But of old stones that cannot be deciphered.
>
> *TS Eliot 'East Coker' (1959) p.31*

Bushman Rock Painting *Taken by L. Nicholls at Rockhaven, Western Cape 2006*

References

Adamson, B. J. Kenny, D. T. & Wilson-Barnett, J., 1995. The impact of perceived medical dominance on the workplace satisfaction of Australian and British nurses. *Journal of Advanced Nursing,* 21, pp.172-183.

Anderson, H. C., 1993. The Emperor's New Clothes. In: H. Anderson. *Anderson's Fairy Tales.* 1993. Ware: Wordsworth Editions, pp.220-225.

Angelou, M., 1993. *Inaugural Poem.* [Online]
Available at http://www.poetry.eserver.org/angelou.html
[Accessed 20 November 2008].

Armstrong, D., 2004. The analytic object in organisational work. *Free Associations*, 11(57), pp.79-88.

Athill, D., 2008. *Somewhere towards the end*. London: Granta Books.

Atwal, A. & Jones, M., 2009. *Preparation for professional practice*. London: Blackwell.

Baderoon, G., 2005. *The dream in the next body*. Cape Town: Kwela Books.

Ballinger, C., 2004. Writing Up Rigour: Representing and Evaluating Good Scholarship in Qualitative Research. *British Journal of Occupational Therapy*, 67(12), pp.540-546.

Banks, E.J. & Blair, S.E.E., 1997. The contribution of occupational therapy within the context of the psychodynamic approach for older clients who have mental health problems. *Health Care in Later Life*, 2(2), pp.85-92.

Bannigan, K., 2002. A positive attitude is a professional imperative. *British Journal of Occupational Therapy,* 6(9), p.397.

Bateman, A. & Holmes, J., 1995. *Introduction to psychoanalysis: contemporary theory and practice*. Hove: Routledge.

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

Benjamin, J., 2004. Beyond doer and done to: an intersubjective view of thirdness. *Psychoanalytic Quarterly*, 73(1), pp.5-46.

Bick, E., 1964. Notes on infant observation in psychoanalytic training. In A. Briggs, ed. 2002. *Surviving Space.* London: Karnac Books, pp.37-54.

Bion, W.R., 1962a. *Learning from Experience*. London: Karnac Books.

Bion, W.R., 1962b. A theory of thinking. In: W.R Bion. *Second Thoughts.* 1984. London: Karnac, pp.110-119.

Bion, W.R., 1984a. *Second thoughts*. London: Karnac Books.

Bion, W.R., 1984b. *Learning from experience.* London: Karnac Books

Bion, W. R., 1991. *The Long Weekend*. London: Karnac Books.

Birch, M. & Miller, T., 2000. Inviting intimacy: the interview as therapeutic opportunity. *International Journal of Social Research Methodology*, 3(3), pp.189-202.

Blenkiron, P., 2005. Stories and analogies in cognitive behavioural therapy: a clinical review. *Behaviour and Cognitive Psychotherapy*, 33(1), pp.45-59.

Bollas, C., 1987. *The shadow of the object*. London: Free Association Books.

Bolton, W. & Roberts, V. Z., 1994. Asking for help: staff support and sensitivity groups. Reviewed in: A. Obholzer and V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.156-165.

Bonington, C., 2001. *The Everest years*. London: Weidenfeld and Nicolson.

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

Bozalek, V.G., 2004. *Recognition, resources, responsibilities: using students' stories of family to renew the South African social work curriculum.* Unpublished PhD thesis. [Online]
Available at: http://igitur-archive.library.uu.nl/dissertations/2004-1203-094505/full.pdf [Accessed 11 October 2008].

Breines, E. B., 1995. Understanding 'occupation' as the founders did. *British Journal of Occupational Therapy,* 58(1), pp.458–60.

Briggs, A., 2002. *Surviving Space*. London: Karnac Books.

Britton, R. & Steiner, J., 1994. Interpretation: selected fact or overvalued idea? *International Journal of Psycho-Analysis*, 75(5/6), pp.1069-1078.

Britton, R., 2004. Subjectivity, objectivity, and triangular space. *Psychoanalytic Quarterly*, 73(1), pp.47-61.

Brown, D. & Peddar, J., 1991. *Introduction to psychotherapy.* 2nd ed. London: Routledge.

Brown, D., 2001. A Contribution to the Understanding of the Social Unconscious. *Group Analysis*, 34 (1), pp.29-38.

Burawoy, M., Burton, A., Ferguson, A.A., Fox, K. J., Gamson, J., Gartrell, N., Hurts, L., Kurzman, C., Salzinger, L., Schiffman, J., Ui, S., 1991. *Ethnography Unbound. Power and Resistance in the Modern Metropolis*. Los Angeles: University of California Press.

Burr, V., 2003. *Social constructionism.* 2nd ed. Hove: Routledge.

Canadian Association of Occupational Therapists, 2002. *Enabling occupation: an occupational therapy perspective.* Ottawa: CAOT Publications ACE.

Cafavy, C., 1911. *Ithaka*. Translated from Greek by E. Keeley & P. Sherrard. [Online] Available at: http://danielholz.com/danielholz/poem-ithaka.html [Accessed 23 May 2009].

Capote, 2006. [Film] Directed by B.Miller. USA: Sony Pictures.

Cardinal, M., 1993. *The words to say it*. Translated from French by P. Goodheart. London: Women's Press.

Carroll, L. 2006. *Alice's adventures in wonderland*. Stroud: Nonsuch Publishing.

Casement, P., 1985. *On learning from the patient.* London: Routledge.

Casement, P., 2006. *Learning from life*. London: Routledge.

Cavell, M., 2003. Freedom and forgivenss. *International Journal of Psycho-Analysis*, 84, pp.515-531.

Christiansen, C. & Baum, C., 1997. *Occupational therapy: enabling function and well-being.* 2nd ed. Thorofare (NJ): Slack.

Christiansen, C. H., 1999. Defining lives: occupation as identity: an essay on competence, coherence, and the creation of meaning. *American Journal of Occupational Therapy*, 53(6), pp.547-558.

Clarke, S., 2002. Learning from experience; psycho-social research methods in the social sciences. *Qualitative Research,* 2(2), pp.173-194.

Clarke, S., 2003. *Social Theory, Psychoanalysis and Racism*. Basingstoke: Palgrave Macmillan.

Clarke, S., 2006. Theory and practice: psychoanalytic sociology as psycho-social studies. *Sociology,* 40(6), pp.1153-1169.

Clarke, S., Hahn, H. & Hoggett, P., 2008. *Object Relations and Social Relations*. London: Karnac Books.

Coetzee, J. M., 2006. *Slow Man*. London: Vintage Books.

Cole, M., 1998. *Group dynamics in occupational therapy*. Thorofare (NJ): Slack.

College of Occupational Therapy, 2010. *Working for Health*. London: College of Occupational Therapy

College of Occupational Therapy, 2011-12. *Occupational Therapy Career Handbook*. Available from London: College of Occupational Therapy - downloaded from www.cot.org.uk on 7/8/10.

Collins, M., 2001. Who is occupied? Consciousness, self awareness and the process of human adaptation. *Journal of Occupational Science*, 8(1), pp.25-32.

Collins, M., 2004. Dreaming and occupation. *British Journal of Occupational Therapy*, 67(2), pp.96-98.

Craib, I., 1994. *The importance of disappointment*. London: Routledge.

Craib, I., 2001. *Psychoanalysis: a critical introduction*. Cambridge: Polity Press.

Creek, J., 1997a. The truth is no longer out there. *British Journal of Occupational Therapy*, 60(2), pp.50-53.

Creek, J., 1997b. *Occupational therapy in mental health.* 2nd ed. London: Churchill Livingston.

Creek, J., 2002. *Occupational therapy and mental health 3rd edition*. London: Churchill Livingston

Creek, J., 2003. *Occupational therapy defined as a complex intervention*. London: College of Occupational Therapists.

Creek. J., 2008. The knowledge base of occupational therapy. In: J. Creek & L. Lougher, eds. 2008. *Occupational therapy and mental health.* 4th ed. Philadelphia: Churchill Livingstone Elsevier, pp.31-56.

Cummings, A-M., 2002. The road to hell is paved with good intentions: quality assurance as a social defence against anxiety. *Organisational and Social Dynamics*, 2(1), pp.99-119.

Cunningham-Piergrossi, J. & Gibertoni, C., 2005. The interactive process and mental function in occupational therapy. *World Federation Occupational Therapy Bulletin*, 52, pp.25-28.

Dalal, F., 2001. The Social Unconscious: A Post-Foulkesian Perspective. *Group Analysis*, 34(4), pp.539-555.

Dalal, F., 2002. *Race, colour and the process of racialization*. London: Brunner-Routledge.

Dangarembga, T., 1988. *Nervous conditions*. Banbury: Ayebia Clarke Publishing.

Dangarembga, T., 2006. *The book of not*. Banbury: Ayebia Clarke Publishing.

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

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

Dartington, A., 1994. Where angels fear to tread: idealism, despondency and inhibition of thought in hospital nursing. In: A. Obholzer & V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.101-109.

Denzin, N. & Lincoln, Y., 1994. *Handbook of qualitative research*. London: Sage.

Denzin, N. K., 2001. The reflexive interview and a performative social science. *Qualitative Research,* 1(1), pp.23-46.

Department of Health (DoH)., 1990, *Community Care in the Next Decade and Beyond: Policy Guidance*. London: HMSO.

De Saint-Exupéry, A., 1974. *The little prince*. Translated from French by K.Woods. London: Pan Books.

Dickinson, E., 1990. From Madness to Mental health: A Brief History of Psychiatric Treatments in the UK from 1800 to the Present. *British Journal of Occupational Therapy*, 53(10), pp.419-424.

Dryden, W., 1996. *Handbook of individual therapy*. London: Sage.

Duncan, M. & Watson, R., 2004. Transformation through occupation: towards a prototype. In: R. Watson and L. Swartz, eds. 2004. *Transformation through occupation.* London: Whurr Publishers, pp.301-318.

Edwards, J., 2005. Before the threshold: destruction, reparation and creativity in relation to the depressive position. *Journal of Child Psychotherapy*, 31(3), pp.317-334.

Eklund, M., 2000. Applying object relations theory to psychosocial occupational therapy: empirical and theoretical considerations. *Occupational Therapy in Mental Health*, 15(1), pp.1-26.

Eliot, T. S., 1959. *Four quartets*. London: Faber.

Etzioni, A., Lortie, D., Katz, F., Scott, W.R., Toren, N., Simpson, R. L., Simpson, I. H., Goode, W. J., 1969. *The Semi-Professions and Their Organisation*. New York: The Free Press.

Fabian, J., 2001. *Anthropology with an attitude*. California: Stanford University Press.

Fabricius, J., 1991. Running on the spot or can nursing really change? *Psychoanalytic Psychotherapy,* 5(2), pp.97-108.

Fabricius, J., 1995.Psychoanalytic Understanding and Nursing: A Supervisory workshop with Nurse Tutors. *Psychoanalytic Psychotherapy*, 9(1), pp.17-29.

Fabricius, J., 1999. The crisis in nursing, reflections on the crisis. *Psychoanalytic Psychotherapy*, 13(3), pp.203-206.

Farnworth, L. & Whiteford, G., 2002. Debate and dialogue: professional necessity and responsibility. *Australian Journal of Occupational Therapy,* 49(3), pp.113-114.

Fearing, V. & Clark, J., 2000. *Individuals in context.* Thorofare (NJ): Slack.

Fidler, G. & Fidler, J., 1963. *Occupational therapy as a communication process in psychiatry*. New York: Macmillian.

Fidler, G. & Fidler, J., 1978. Doing and becoming: purposeful action and self-actualization. *American Journal of Occupational Therapy*, 32(5), pp.305-310.

Finlay, L., 1997. Good patients and bad patients: how occupational therapists view their patients/clients. *British Journal of Occupational Therapy*, 60(10), pp.440-446.

Finlay, L., 1998a. Reflexivity: an essential component for all research? *British Journal of Occupational Therapy*, 61(10), pp.453-456.

Finlay, L., 1998b. *The life world of the occupational therapist: meaning and motive in an uncertain world.* Unpublished PhD Thesis. Milton Keynes: The Open University.

Finlay, L., 2002. Outing the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research,* 12(4), pp.531-545.

Finlay, L. & Gough, B., 2003. *Reflexivity*. Oxford: Blackwell Publishing.

Fisher, A., 2003. Why is it so hard to practice as an occupational therapist? *Australian Occupational Therapy Journal*, 50(4), pp.193-194.

Fortune, T., 2000. Occupational therapists: is our therapy truly occupational or are we just filling gaps? *British Journal Occupational Therapy*, 63(5), pp.225-230.

Foster, A. & Roberts, V., 1998. *Chaos and containment; managing mental health in the community*. London: Routledge.

Fox, K.J., 1991. The Politics of Prevention: Ethnographers Combat AIDS Among Drug Users. In, M. Burawoy, A. Burton, A. A. Ferguson, K. J. Fox, J. Gamson, N. Gartrell, L. Hurts, C. Kurzman, L. Salzinger, J. Schiffman, S. Ui, eds, 1991. *Ethnography Unbound. Power and Resistance in the Modern Metropolis*. Los Angeles: University of California Press, pp.227-249.

Frank, G., 1997. Is there life after categories? Reflexivity in qualitative research. *The Occupational Therapy Journal of Research,* 17(2), pp.84-98.

Frost, L., 2007. Why Teach Social Work Students Psychosocial Studies? *Social Work Education*, 27(3), pp.243-261.

Gilbert, N., 2001. *Researching social life.* 2nd ed. London: Sage.

Gordon, P., 1993. Souls in armour: thoughts on psychoanalysis and racism. *British Journal of Psychotherapy*, 10(1), pp.62-76.

Gosling, R., 1999. Another source of conservatism in groups. In: W. G. Lawrence, ed. 1999. *Exploring individual and organisational boundaries*. London: Karnac Books, pp.77-86.

Green, S., 1991. Shaking our foundations, part 1: occupational therapy – its path to professionalisation. *British Journal of Occupational Therapy*, 53(5), pp.11-12.

Greener, I., 2009. Towards a history of choice in UK health policy. *Sociology of Health and Illness,* 31(3), pp.309-324.

Griffin, S. 2001. Occupational therapists and the concept of power: A review of the literature. *Australian Occupational Therapy Journal*, 48(1), pp.24-34.

Haddon, M., 2003. *The curious incident of the dog in the night time.* London: Jonathan Cape.

Hagedorn, R., 1992. *Occupational therapy: foundations for practice*. Edinburgh: Churchill Livingstone.

Halabi, R., 2004. *Israeli and Palestinian identities in dialogue*. New Jersey: Rutgers University Press

Hall, P. & Weaver, L., 2001. Interdisciplinary education and teamwork: a long and winding road. *Medical Education,* 35, pp.865-875.

Hammell, K.W., 2009. Sacred texts: a sceptical exploration of the assumptions underpinning theories of occupation. *Canadian Journal of Occupational Therapy*, 76(1), pp.6-13.

Hammersley, M., 1992. *What is wrong with ethnography?* London: Routledge.

Hammersley, M. & Atkinson, P., 1995. *Ethnography.* 2nd ed. London: Routledge.

Hasselkus, B.R., 1997. Meaning and occupation. In: C. Christiansen and C. Baum, eds. 2nd ed. 1997. *Occupational therapy: enabling function and well-being.* Thorofare (N.J): Slack, pp.362-377.

Hasselkus, B.R., 2002. *The meaning of everyday occupation*. Thorofare (NJ): Slack.

Hinshelwood, R.D. & Skogstad, W., 2000. *Observing organisations – anxiety, defence and culture in health care*. London: Routledge.

Hinshelwood, R.D., 2002. Applying the observational method: observing organisations. In: A. Briggs, ed. 2002. *Surviving space.* London: Karnac, pp.157-171.

Hochschild, A., 2003. *The managed heart.* 2nd ed. Los Angeles (CA): University of California Press.

Hoggett, P., 2000. Hatred of dependency. In: P. Hoggett, ed. 2002. *Emotional life and the politics of welfare.* Basingstoke: Macmillan, pp.159-180.

Hoggett, P., 2001. The love that thinks. *Free Associations*, 9(1), pp.1-23.

Hoggett, P., 2006a. Pity, compassion, solidarity. In: S. Clarke, P. Hoggett and S. Thompson, eds. 2006. *Emotion, Politics and Society*. Basingstoke: Palgrave Macmillan, pp.145-161.

Hoggett, P., 2006b. *Seminars Post Graduate Psycho-Social Study Group,* University West England, Bristol, UK. [Seminar] (Nov 2006).

Hoggett, P., Beedell, P., Jimenez, L., Mayo, M., Miller, C. 2010 [in press] Working psycho-socially and dialogically in research. *Psychoanalysis, Culture and Society*, 15(2), pp.173-188.

Holland, J., 2007. Emotions and research. *International Journal of Social Research Methodology,* 10(3), pp.195-209.

Hollway, W. & Jefferson, T., 2000. *Doing qualitative research differently*. London: Sage Publication.

Hollway, W., 2008. The importance of relational thinking in the practice of psycho-social research: ontology, epistemology, methodology and ethics. In: S. Clarke, H. Hahn & P. Hoggett, eds. 2008. *Object relations and social relations.* London: Karnac, pp.137-162.

Hooper, B. & Wood, W., 2002. Pragmatism and structuralism in occupational therapy: the long conversation. *American Journal of Occupational Therapy*, 56(1), pp.40-50.

Hopper, E., 2001. The Social Unconscious: Theoretical Considerations. *Group Analysis*, 34(1), pp.9-27.

Huisman, K., 2008. "Does This Mean You're Not Going to Come Visit Me Anymore?": An Inquiry into an Ethics of Reciprocity and Positionality in Feminist Ethnographic Research. *Sociological Inquiry*, 78(3), pp.372-396.

Hunt, J., 1989. *Psychoanalytic aspects of fieldwork*. Sage University Paper Series on Qualitative Research Methods Series 18. Newbury Park, CA: Sage.

Hunter, B. & Smith, P., 2007. Emotional labour: just another buzz word? *International Journal of Nursing Studies*, 44, pp.859-861.

Jones, A., 1997. Death, poetry, psychotherapy and clinical supervision (the contribution of psychodynamic psychotherapy to palliative care nursing). *Journal of Advanced Nursing*, 25, pp.238-244.

Jong, E., 1973. *Fear of flying*. London: Grafton Books.

Joseph, B., 1983. On understanding and not understanding: some technical issues. *International Journal of Psycho-Analysis*, 64, pp.291-298.

Joseph, B., 1989. *Psychic equilibrium and psychic change*. London: Routledge.

Karpf, A., 1999. Marion Milner, journey to the centre of the mind. In: M. Milner. 1999. *A life of one's own.* London: Virago, pp viii-xii.

Katz, F., 1969. Nurses. In: A. Etzioni, D. Lortie, F. Katz, W.R. Scott, N. Toren, R. L. Simpson, I. H. Simpson, W.J. Goode, 1969. *The Semi-Professions and Their Organisation*. New York: The Free Press, pp54-81.

Keenan, B., 1992. *An evil cradling.* London: Vintage.

Keilhofner, G. & Burke, J., 1977. Occupational therapy after 60 years. *American Journal of Occupational Therapy,* 31(10), pp.675-689.

Kelly, K. 1999. Hermeneutics in action: empathy and interpretation in qualitative research. In M. Terre Blanche & K. Durrheim, ed. *Research in Practice*. Cape Town: University of Cape Town Press, pp.398-420.

Kinsella, A., 2006. Poetic Resistance: Juxtaposing Personal and Professional Discursive Constructions in a Practice Context. *Journal of the Canadian Association for Curriculum Studies*, 4(1), pp.35-49.

Klein, M., 1988. *Love, guilt and reparation*. London: Vintage.

Kleinman, A., 1988. *The illness narratives.* New York: Basic Books.

Krakauer, J., 1997. *Into thin air.* London: Macmillan.

Krog, A., 1999. *Country of my Skull*. London: Vintage

Krog, A., 2006. *Body bereft*. Cape Town: Umuzi.

Krog, A., 2009. My Heart Is on My Tongue – The Untranslated Self in a Translated World. In: Pramila Bennett, ed. *Cape Town 2007, Journeys, Encounters: Clinical, Communal, Cultural, Proceeding of the 17th International IAAP Congress for Analytical Psychology.* Einsiedeln: Daimon, pp.133-147.

Kronenberg, F., Simo Algado, S., Pollard, N., 2005. *Occupational Therapy without Boarders*. London: Elsevier Churchill Livingstone

Kundera, M., 1985. *The unbearable lightness of being*. London: Faber & Faber.

Kvale, S., 1999. The psychoanalytic interview as qualitative research. *Qualitative Inquiry*, 5(1), pp.87-113.

LaMothe, R., 2005. Creating space, the fourfold dynamics of potential space. *Psychoanalytic Psychology*, 22(2), pp.207-223.

Law, M. et al., 1996. The person-environment-occupation model: a transactive approach to occupational performance. *Canadian Journal of Occupational Therapy*, 63(5), pp.9-23.

Lawrence, W.G., 1998. *Social dreaming @ work*. London: Karnac.

Lawrence, W.G., 2003a. Social dreaming as sustained thinking. *Human Relations*, 55(5), pp.609-624.

Lawrence, W.G., 2003b. *Experiences in social dreaming*. London: Karnac.

Layton, L., 2008. Relational thinking: from culture to couch and couch to culture. In: S. Clarke, H. Hahn & P. Hoggett, eds. 2008. *Object relations and social relations.* London: Karnac*,* pp.1-24.

Leibowitz, B. et al., 2007. It doesn't matter who or what we are, we are still just people: strategies used by university students to negotiate difference. *South African Journal of Psychology*, 37(4), pp.702-719.

Macionis, J. & Plummer, K., 2002. *Sociology: a global introduction.* 2nd ed. Essex: Pearson Education Limited.

Mackenzie, A. & Beecraft, S., 2004. The use of psychodynamic observation as a tool for learning and reflective practice when working with older adults. *British Journal of Occupational Therapy,* 67(12), pp.533-539.

Mackey, H., 2007. Do not ask me to remain the same: Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal*, 54(2), pp.95-102.

Main, T., 1957. The Ailment. *British Journal of Medical Psychology*, 30, pp.129-145.

Martel, Y., 2003. *Life of Pi*. Edinburgh: Canongate Books.

Mattingly C., 1998. *Healing dramas and clinical plots: the narrative structure of experience*. Cambridge: Cambridge University Press.

Mattingly, C. & Fleming, M.H., 1994. *Clinical reasoning; form of inquiry in a therapeutic practice*. Philadelphia: F.A. Davis Company.

Mayers, C.A., 2000. The Casson memorial lecture 2000: reflect on the past to shape the future. *British Journal of Occupational Therapy,* 63(8), pp.358-366.

McAllister, M.M., 2001. In harm's way: a post-modern narrative inquiry. *Journal of Psychiatric and Mental Health Nursing*, 8(5), pp.391-397.

McKinney, C., 2007. Caught between the 'old' and 'new'? Talking about 'race' in a post-apartheid university classroom. *Race Ethnicity and Education*, 10(2), pp.215-231.

Mead, M., 1949. *Male and Female: A Study of the Sexes in a Changing world*. New York: Morrow Quill Paperbacks.

Menzies Lyth, I., 1979. Staff support systems: task and anti-task in adolescent institutions. In: I. Menzies Lyth. 1988. *Containing anxiety in institutions.* London: Free Association Books, pp.222-236.

Menzies Lyth, I., 1988. *Containing anxiety in institutions*. London: Free Association Books.

Menzies Lyth, I., 1989. *The dynamics of the social*, London: Free Association Books.

Menzies Lyth, I., 1990. Social systems as a defense against anxiety. In: E. Trist & H. Murry, eds. *The social engagement of social science volume 1*. London: Free Association Books, pp.439-462.

Meyer, A., 1977. The philosophy of occupational therapy. Reprinted from the Archives of Occupational Therapy 1922. *American Journal of Occupational Therapy*, 31(10), pp.639-642.

Miller, E., 1993. *From dependency to autonomy*. London: Free Association Books.

Milner, M., 1950. *On not being able to paint.* London: Heinemann.

Milner, M., 1996. *The suppressed madness of sane men*. London: Routledge.

Milner, M., 1999. *A life of one's own*. London: Virago.

Moreau, J., 2008. The elusiveness of spiritual wisdom in the art and science of nursing practice. *Spirituality and Health International*, 9, pp.123-134.

Morgan, D. L., 1997. *Focus Groups as Qualitative Research*. Sage Qualitative Research Methods Series Vol. 16. 2nd ed. London: Sage Publications.

Morgan, H., 1998. Between fear and blindness: the white therapist and the black patient. *Journal of the British Association of Psychotherapists*, 35(3), pp.48-61.

Morrison, T., 1992. *Playing in the dark*. London: Picador.

Mosey, A.C., 1985. Eleanor Clarke Slagle lecture 1985: a monistic or pluralistic approach to professional identity? *American Journal of Occupational Therapy*, 39(8), pp.504-509.

Murray, N., 1997. Somewhere over the rainbow: a journey to the new South Africa. *Race and Class*, 38(1), pp.1-24.

Nafisi, A., 2004. *Reading Lolita in Tehran*. London: Fourth Estate.

Nattrass, N., 2006. *Disability and welfare in South Africa's era of unemployment and AIDS.* Centre for Social Science Research (CSSR) Working Paper 147. Cape Town: University of Cape Town. [Online]
Available at: http://www.cssr.uct.ac.za/index.html
[Accessed 2 May 2009]

Nicholls, L., 1992. Looking behind to get ahead, occupational therapy in perspective. In: *Van den Ende memorial lectures*. University of Cape Town. [Unpublished].

Nicholls, L.E., 2000. *Working with staff groups: containment as a prelude to change*. Unpublished MA thesis. London: Tavistock and Portman Clinic Library.

Nicholls, L.E., 2003a. *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, UK.

Nicholls, L.E., 2003b. Occupational therapy on the couch. *Therapy Weekly*, 30(2), p.5.

Nicholls, L.E., 2008. Touching the void. Mountains as transitional objects: climbing as a defence against anxiety. *Psychodynamic Practice*, 14(3), pp.249-262.

Nicholls, L.E. & Wright, S., 2009. Surprise and recognition: experiences of being a stranger in familiar places, of being at home in a strange place. In: Pramila Bennett, ed. *Cape Town 2007, Journeys, Encounters: Clinical, Communal, Cultural, Proceeding of the 17th International IAAP Congress for Analytical Psychology.* Einsiedeln: Daimon, pp.810-825.

Obama, B., 2007. *Dreams from my father*. Edinburgh: Canogate Books.

Obholzer, A. & Roberts, V., 1994. *The unconscious @ work*. London: Routledge.

Obholzer, A., 1994a. Fragmentation and integration in a school for physically handicapped children. In: A. Obholzer and V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.84-93.

Obholzer, A., 1994b. Managing social anxieties in public sector organisations. In: A. Obholzer and V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.169-186.

Ogden, T., 1979. On projective identification. *International Journal of Psychoanalysis*, 60, pp.357-373.

Ogden, T., 1994. The analytic third: working with intersubjective clinical facts. *International Journal Psycho-Analysis*, 75, pp.3-19.

Ogden, T., 1997. Reverie and metaphor; some thoughts on how I work as a psychoanalyst. *International Journal of Psycho-Analysis*, 78, pp.719-732.

Ogden, T., 2001. Reading Winnicott. *Psychoanalytic Quarterly,* 70, pp.299-323.

Ogden, T., 2003. On not being able to dream. *International Journal of Psycho-Analysis*, 84, pp.17-30.

Ogden, T., 2004. On holding and containing, being and dreaming. *International Journal of Psycho-Analysis*, 85, pp.1349-1364.

O'Kelly, G., 1998. Countertransference in the nurse-patient relationship: a review of the literature. *Journal of Advanced Nursing*, 28(2), pp.391-397.

Orbach, S., 2008. Democratizing psychoanalysis. In: S. Clarke, H. Hahn & P. Hoggett, eds. 2008. *Object relations and social relations.* London: Karnac, pp.25-44.

Ormont, L., 1988. The leader's role in resolving resistances to intimacy in the group settings. *International Journal of Group Psychotherapy*, 38(1), pp.29-45.

Palmer, B., 1999. Learning and the group experience. In: W.G. Lawrence, ed. 1999. *Exploring individual and organisational boundaries*. London: Karnac, pp.169-192.

Paterson, C. F., 1998. Occupational Therapy and the National Health Service, 1948-1998. *British Journal of Occupational Therapy*, 61(7), pp.311-315.

Pillow, W., 2003. Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education*, 16(2), pp.175-196.

Polden, J., 2005. Reparation terminable and interminable. *British Journal of Psychotherapy*, 21(4), pp.559-575.

Popper, K., 1966. *The open society and its enemies, volume 2*. Princeton, NJ: Princeton University Press.

Posel, D., 2001. What's in a name? Racial categorisations under apartheid and their afterlife. *Transformations: critical perspectives on Southern Africa*, 47, pp.50-74.

Price, M., 1986. Health care as an instrument of apartheid policy in South Africa. *Health Policy and Planning*, 1(2), pp.158-170.

Pullman, P., 1998. *Northern lights*. London: Scholastic Children's Books.

Reason. P., 1988. *Human inquiry in action*. London: Sage.

Reberio, K., 2000. Client perspectives on occupational therapy practice: are we truly client centered? *Canadian Journal of Occupational Therapy,* 67(1), pp.7-14.

Reed, K.L. & Sanderson, S.R., 1983. *Concepts of occupational therapy.* 2nd ed. Baltimore: Williams and Wilkins.

Reilly, M.,1962. Occupational therapy can be one of the great ideas of 20th century medicine. In: AOTA, eds. 1985. *A professional legacy: the Eleanor Slagle lectures (1955-1984.)* Rockville, MD: American Association of Occupational Therapy, pp.87-105.

Roberts, V., 1994a. Till death us do part: caring and uncaring work with the elderly. In: A. Obholzer and V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.75-83.

Roberts, V., 1994b. The self-assigned impossible task. In: A. Obholzer and V. Roberts, eds. 1994. *The unconscious @ work.* London: Routledge, pp.110-118.

Robson, C., 2002. *Real world research.* 2nd ed. Oxford: Blackwell Publishers.

Rogers, J.C., 1982. The spirit of independence: the evolution of a philosophy. *American Journal of Occupational Therapy,* 361(11), pp.709-715.

Rose, D. & Douglas E., 2000. *Regions of the Heart.* London: Penguin Books.

Rustin, M., 1991. *The Good Society and The Inner World*. London: Verso

Sachs, A., 1990. *The jail diary of Albie Sachs.* Cape Town: David Phillips.

Sarton, M., 1988. *After the stroke*. London: The Woman's Press.

Segal, H., 1986. *The work of Hanna Segal: delusion and artistic creativity and other psychoanalytic essays*. London: Free Association Books & Maresfield Library.

Segal, H., 1988. *Introduction to the work of Melanie Klein*. London: Karnac.

Serett, K.D., 1985. *Philosophical and historical roots of occupational therapy*. Binghamton: The Hawthorn Press.

Simpson, J., 1997a. *Touching the void*. London: Vintage.

Simpson, J., 1997b. *Dark shadows falling*. London: Vintage.

Sinding, C. & Aronson, J., 2003. Exposing failures, unsettling accommodations: tension in interview practice. *Qualitative Research*, 3(1), pp.95-117.

Skogstad, W., 2004. Psychoanalytic observation – the mind as a research instrument. *Journal of Organisational and Social Dynamics*, 4(1), pp.67-87.

Smith, L.T., 1999. *Decolonizing methodologies: research and indigenous peoples*. London: Zed Books.

Smith, P., 1992. *The emotional labour of nursing*. London: Macmillan Press.

Smith, P. & Lorentzon M., 2005. Is emotional labour ethical? *Nurse Ethics*, 12(6), pp.638-642.

Steiner, J., 1985. Turning a blind eye: the cover-up for Oedipus. *International Review of Psycho-Analysis*, 12, pp.161-172.

Steiner, J., 1993. *Psychic retreats*. London: Routledge.

Stern, D., 1998. *The Interpersonal World of the Infant*. London: Karnac Books.

Stokoe, P., 2000. Holding the boundaries. In: S. Brookes and P. Hodson, eds. 2000. *The invisible matrix; an exploration of professional relationships in the service of psychotherapy.* London: Rebus Press, pp.23-40.

Straker, G., 2004. Race for cover. *Psychoanalytic Dialogues*, 14(4), pp.405-422.

Stratton, P., 1998. Culture in systemic practice. *Human Systems*, 9(3-4), pp.155-158.

Sumsion, T,. 2006. *Client centred practice in occupational therapy.* 2nd ed. London: Churchill-Livingston Elsevier.

Sumsion, T. & Smyth, G., 2000. Barriers to client-centeredness and their resolution. *Canadian Journal of Occupational Therapy*, 67(1), pp.15-21.

Swartz, S., 2007. The power to name: South African intersubjective psychoanalytic psychotherapy and the negotiation of racialised boundaries. *European Journal of Psychotherapy and Counselling*, 9(2), pp.177-190.

Symington, J. & Symington, N., 1996. *The clinical thinking of Wilfred Bion*. Hove: Routledge.

Terre Blanch, M. & Durrheim, K., 1999. *Research in practice*. Cape Town: University of Cape Town Press.

The Sea Inside, 2004. [Film]. Directed by Alejandro Fernando Amenábar Cantos. MMIV New Line Entertainment, Fine Line Features, USA.

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.* London: SAGE, pp.121-146.

Touching the Void , 2003. [Film]. Directed by Kevin Macdonald. UK: Filmfour Ltd & Film Council MMII, UK.

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

Townsend, E., 1999. Enabling occupation in the 21st century: making good intentions a reality. *Australian Occupational Therapy Journal,* 46(4), pp.47-159.

Townsend, E., 2003. Reflections on power and justice in enabling occupation. *Canadian Journal of Occupational Therapy*, 70(2), pp.74-87.

Townsend, E. & Wilcock, A., 2004. Occupational justice. In: C. Christensen & E. Townsend, eds. 2004. *Introduction to occupation.* New Jersey: Prentice Hall, pp.243-273.

Townsend, E. & Polatajiko, H., 2007. *Enabling occupation II:aAdvancing an occupational therapyvVision for health, well-being, & justice through occupation*. Ottawa: CAOT Publications ACE.

Trapido, B., 2004. *Frankie and Stankie*. London: Bloomsbury.

Trist, E. & Murray, H., 1990. *The social engagement of social science, volume 1.* London: Free Association Books.

Tsotsi, 2006. [Film] Directed by Gavin Hood. South Africa: Sterkinekor Home Entertainment.

Turner, A. Foster, M. Johnson, S., 2002. *Occupational Therapy and Physical Dysfunction 5th edition*. London: Churchill Livingston.

Wadee, H. et al., 2003. Heath care inequity in South Africa and the public/private mix. *United Nations Research Institute for Social Development (UNRISD.)* [Online]. Available at: http://www.unrisd.org
[Accessed 17 April 2009].

West, W., 1984. A reaffirmed philosophy and practice of occupational therapy for the 1980s. *American Journal of Occupational Therapy,* 38(1), pp.15-23.

Whiteford, G., 1997. Occupational deprivation and incarceration. *Journal of Occupational Science: Australia,* 4(3), pp.126-130.

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

Whiteford, G., 2004. When people cannot participate: occupational deprivation. In: C. Christensen and E. Townsend, eds. 2004. *Introduction to occupation.* New Jersey: Prentice Hall, pp.221-241.

Watson, R. & Swartz, L., 2004. *Transformation through Occupation.* London: Whurr.

White, J., 1997. Internal Space and the Market. In: E. Smith, ed. 1997. *Integrity and Change*. London: Routledge, pp.156-175.

Whiteford, G., 2005. Understanding the occupational deprivation of refugees: a case study from Kosovo. *Canadian Journal of Occupational Therapy*, 72(2), pp.78-88.

Wilcock, A.A., 1993. A theory of the human need for occupation. *Journal of Occupational Science: Australia*, 1(1), pp.17-24.

Wilcock, A.A., 1998a. *An occupational perspective of health.* Thorofare (NJ): Slack.

Wilcock, A.A., 1998b. Reflections on doing, being and becoming. *Canadian Journal of Occupational Therapy*, 65(5), pp.248-256.

Wilcock, A.A., 1998c. Occupation for health. *British Journal of Occupational Therapy* 61(8), pp.340-345.

Wilcock, A.A., 1999. Reflections on doing, being and becoming. Reprint in:. *Australian Occupational Therapy Journal*, 46, pp.1-11.

Wilcock, A.A., 2001a. *Occupation for health, voume.1. A journey from self-health to prescription.* London: British Association and College of Occupational Therapy.

Wilcock, A.A., 2001b. Occupational science: the key to broadening horizons. *British Journal of Occupational Therapy*, 64(8), pp.413-417.

Wilcock, A.A., 2002. A theory of the human need for occupation. *Journal of Occupational Science*, 9 (special edition), pp 3-9.

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

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

Winnicott, D., 1945. Primitive emotional development. In: *Through paediatrics to psychoanalysis.* D. Winnicott. 1985. London: Karnac Books, pp.145-156.

Winnicott, D., 1949. Hate in the counter-transference. *International Journal of Psycho-Analysis*, 30, pp.69-74.

Winnicott, D., 1956. Primary maternal preoccupation. In: *Through paediatrics to psychoanalysis.* D. Winnicott. 1985. London: Karnac, pp.300-305.

Winnicott, D., 1958. The capacity to be alone. *International Journal of Psycho-Analysis*, 39, pp.416-420.

Winnicott, D. 1969. The use of an Object and Relating through Identifications. In: *Playing and Reality*. D. Winnicott 1971. Hove: Brunner Routledge, pp.86-94.

Winnicott, D., 1971. *Playing and reality*. Hove: Brunner Routledge.

Winnicott, D., 1985. *Through paediatrics to psychoanalysis*. London: Karnac.

Winship, G. Harniman, B. Burling, S. & Courtney, J., 1995. Understanding countertransference and object relations in the process of nursing drug-dependent patients. *Psychoanalytic Psychotherapy,* 9, pp.195-207.

Winship, G. & Hardy, S., 1999. Disentangling dynamics: group sensitivity and supervision. *Journal of Psychiatric and Mental Health Nursing,* 6(4), pp.307-312.

Yerxa, E.J., 1998. Health and the human spirit for occupation. *American Journal of Occupational Therapy*, 52(6), pp.412-418.

Zadok, R., 2005. *Gem squash tokoloshe*. London: Pan Books.

Zembylas, M., 2009. Bearing witness to the ethics and politics of suffering: J. M. Coetzee's Disgrace, inconsolable mourning, and the task of educators. *Studies in Philosophy and Education*, 28(3), pp.223-237.

Zemke, R. & Clark, F., 1996. *Occupational science, the evolving discipline*. Philadelphia: F.A. Davis Company.