EXPERIENCING THE RELATIONSHIP: THE CLIENT AND THE COMMUNITY OCCUPATIONAL THERAPIST

A Phenomenological Study

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Abstract

While the therapeutic relationship between clients and therapists has been explored from the therapist perspective, few studies show the client view. This qualitative study reveals the experience of 'being in the relationship' from the viewpoint of both people with physical disabilities and community occupational therapists.

The philosophy underpinning the research and analysis is that of Heideggerian hermeneutic phenomenology. This approach is used in order to reveal the significance of taken-for-granted aspects of the relationship that lie hidden, covered over by everyday assumptions. Study participants include five clients, and six therapists, who have a depth of experience of the relationship being examined. In-depth narrative audio-taped interviews are used. The stories tell of participants' experience of interacting with each other in relationships that work well for them and in ones that do not.

The findings of this thesis show that clients recognise previously hidden aspects of the relationship, frequently unacknowledged by therapists, such as the importance of the therapist's persona and the significance of therapists' actions to clients' perception of their own value. What happens when the therapist is not with the client matters within their relationship. The differing modes of care therapists use influence clients' wellbeing. Therapists need to acknowledge the effect of their prejudices and 'personal selves' in their interaction with clients, and the breadth and depth of their 'professional role' within therapeutic relationships. They need to be open to recognising when the relationship is unsatisfactory for the client. For it is therapists who hold the key to accessing future possibilities including resources. When the relationship fails, it will be the client who loses out.

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Chapter One

Introduction

and Context to the Study

> Wherever it arises, the problem of the
> beginning is, in fact, the problem of the
> end. For it is with respect to an end that
> the beginning is defined as a beginning
> of an end. (Gadamer, 1982, p. 472)

The beginnings of this study lie in my work as an occupational therapist. My work roles have led me to my choice of research question, and into this phenomenological study. In this study I ask the question – what is the meaning of the experience of the relationship between community occupational therapists and people who have a physical disability and live in the community? Assumptions may be made by the people participating in this relationship that what occurs between them is already understood and 'known,' yet there is little New Zealand research to support such perceptions. Are clients and therapists aware that their relationship affects outcomes for them? Is there a gap between how each group perceives their relating? Using Heideggerian hermeneutic phenomenology as my methodology I will explore the experience of being in the relationship for both clients and therapists, showing the meaning that lies within it, and the outcomes extending from it.

The study's focus is on the experience and the meanings within the relationship. Yet what cannot be ignored is the background of ongoing change that impinges on the interaction for both people who have a physical disability and community occupational therapists. There has been a movement in Western world countries away from hospital-based healthcare to the provision of community-based practice (Stewart, 1994). Much of the change impacting on relationships has occurred during a period when consumers

pushed for services and outcomes that meet their needs. It seems that increasingly people with ongoing physical disabilities do not have a view of themselves as 'patients' and as 'sick' and this influences their expectation of relationships with health professionals. Shifts have also occurred in the philosophical underpinnings of occupational therapy. While occupational therapy practice shapes the relating it is also shaped by the context the relationship occurs in. As a consequence new ways of being together in a therapeutic relationship are evolving.

A major aspect of the background to this study is an examination of this shifting context of the relationship. Both my impetus to begin the study and the questioning I bring to it will be explored. An overview of the study will then describe the content of the thesis. Within this study I ask many questions, for the philosophy that guides it is a questioning one. Some questions will be answered. Others remain unanswered. Much is up to the reader who will have their own path to follow in seeking to understand.

What is disability?

In order to bring understanding to my research question it is necessary to discuss what I mean by disability. People with ongoing disabilities can be quite fit and healthy whilst for others there will be loss of function as their physical condition alters (French & Sim, 1993). Organisations of disabled people define disability as the "limitations imposed on the individual by the interaction between the impairment and the physical and social environment" and therefore disability is considered by them to be an aspect of physical and social environments demonstrated by such things as inaccessible buildings (French & Sim, 1993, p. 31). Alongside this the World Health Organisation (WHO) definition of disability is seen by Fischer (1995) as defining disability as the reduction or inability to carry out a desired role. Although in the past illness, sickness and disease have been words used instead of disability French and Sim tell us that there is now a tendency to follow the names used by organisations of disabled people. This demonstrates a shift in power away from the dominance of the traditional medical model to a social model that enables the consumer of the service to identify themselves in the way that they choose (Stewart, 1994).

What is community-based practice?

What of community occupational therapists' practice with this client group? The services they work within aim to both enable people to live in the community and return them to live in it. Therapist encounter people within this client group in the following ways: after the initial diagnosis when the GP or specialist refers them to the service, referrals come from a hospital source, such as the occupational therapy department, following diagnosis or treatment, and community agencies catering to the needs of a particular client group contact therapists on their clients' behalf. In my experience it is frequently through the client's own awareness of the service, and of their particular need to access it, that people with disabilities come to 'self-refer' to community occupational therapy. Once a relationship is established the client tends to initiate contact as and when required. Clients are seen by therapists primarily at home, situated within their life-world, and this is where the client/therapist interaction and the forming of a relationship occurs.

What is 'relationship'?

While human relationships come in many forms and are complex, multifaceted ways of people interacting with one another, this study sets out to examine a very specific relationship – that between people with ongoing physical disability and community occupational therapists in the New Zealand setting. In terms of this study I will be exploring the aspects of the client/therapist relationship that the participants taking part in this study point to as being significant. For this is where the phenomenon of relating will lie, within those stories waiting to be uncovered, ready to be brought into the light.

This brings us to the things that make up the background to doing this study; the questioning and impetus that caused the study to be undertaken, and an exploration of the research question and the underlying philosophy.

Why this study?

Several years ago a disability co-ordinator working at a New Zealand University commented to me that a health professional such as a community occupational therapist was unlikely to be considered suitable for employment as a disability co-ordinator. It seemed that they would be viewed as 'contaminated' by their immersion in the world of health care and therefore unable to see people with disabilities as 'normal' and not sick.

I was being told that, as health professionals, others saw us in this way because of our immersion and saturation in the healthcare culture. I had never previously had this perspective so clearly spelt out to me, and was both surprised and disturbed. As a health professional endeavouring to work with a client-centred focus I found the remark challenging. Completing papers in the Masters of Health Science programme at Auckland University of Technology kept the conversation alive in my mind, evoking a questioning that came at a perfect time for me. I could look back and reflect on many aspects of my own practice and the way it had impacted on clients' lives. Concern regarding the limited New Zealand research guiding our understanding of the relating that occurs between people with physical disabilities and occupational therapists has stayed with me, raising challenging questions.

The following story is one that makes visible for me some of the ways of being with a client that I have also encountered in practice. 'Seeing' from the client's perspective shows aspects of relating in a way that highlights for me both the client's vulnerability and the power of being the health professional. This story of a woman's experience, with all her hidden thoughts and fears revealed, describes her relating with a therapist who seems to 'know best.' It comes from a book of stories written by women with disabilities living in Britain (O'Sullivan, 1994). While having parallels to therapeutic relationships in this study there will also be differences within the detail and context of people's experience in New Zealand:

> *How funny I think to be sitting here in my home with this woman…Funny name that – Occupational Therapy…"I will start by asking you some routine questions, Mrs… and your answers must be truthful. I will ask you to sign a form at the end of the interview confirming as much. Do you understand?" I nod eagerly at the woman, anxious to show willing, feeling childish in front of this officialdom, in my own house, in front of my own child.*
>
> *I'm sure she thinks that I should be able to manage. I'm sure she thinks that. She probably sees people much worse off than me. She probably thinks that I'm a fraud, a malingerer, someone trying to get something for*

nothing. I don't look like someone who needs help. People are always saying how amazed they are at how I manage. I'm amazed at their amazement. Why shouldn't I manage - I'm not that bad.

"Okay," says the woman, "what we need to do is decide which home aids will best help you cope with your disability. We'll proceed room by room, that way we should avoid leaving anything out... and the bathroom?" I feel hot, the room is too hot. I must tell her about the bath. If only Charlotte weren't here. If only she'd go down stairs...because I have to tell her about the business of the bath...My child is here and I don't want her to know how helpless I am ... I finish and I see the woman before me soft with sympathy. "Don't worry," she says kindly, "we'll get the chair installed as quickly as possible." I do not look at Charlotte. I want to ask her forgiveness, I want to tell her how ashamed I am, that she needn't worry, that I'm okay... I rise to show the woman out. I do so awkwardly and full of pain (p. 13 – 17).

So much of this woman's story lies hidden from the therapist. The therapist is busily doing the work that could be construed as the point of the visit. How much has the therapist understood about what is really going on between the client and herself? This story reveals hidden, undisclosed, aspects of the relationship. The ability to reveal what lies out of sight in this story and others has been my impetus for this study. Revealing and showing a phenomenon, removing the covered-over aspects that hide it, links with and confirms the chosen methodology for this study. During my process of questioning what lies within such relationships it has been stories such as this one that have convinced me that there is much more to know, more to learn from.

The study – from question to methodology to method

Questions

I have chosen to make the focus of this study the relationship between clients and therapists. The question being asked is: What is the meaning of the experience of the relationship between people who have a physical disability and live in the community and community occupational therapists? Alongside this primary question is another: Does the relationship have the same meaning for the client as it does for the community

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occupational therapist or is there a gap between these perceptions? This study revolves around three integral components: people who have ongoing physical disabilities, referred to as 'clients' in this study; community occupational therapists, referred to as 'therapists'; and the focus of interest, the experience of the relating that occurs between them. I chose to ask questions that would not limit and place boundaries around what is being examined other than the broad focus of relating between these groups of people. In this way the meaning of the experience is able to emerge.

Methodology

The philosophy that underpins this research study is Heideggerian hermeneutic phenomenology. Heidegger (1962) a German philosopher from the existential school of philosophy, reminds us that phenomenon are frequently partially hidden, remaining invisible to us, yet we assume we understand what is going on. Complementing the use of phenomenology, interpretive hermeneutics allows for the close examination and exploration of texts and analysis of them, for "it is in our interpretation that we will understand" (Smythe, 1996, p. 9). This methodology presents an ideal way to explore something already thought to be understood but where the understanding has been distorted by assumptions. Relationships between clients and therapists appear to have parameters, boundaries that are frequently unspoken and assumed. In looking at the relating that occurs between these two groups of people I was conscious of those hidden expectations and taken for granted ways of being with each other, of the rules that are seldom written down in texts and appear only briefly in the therapist's codes of ethics and the codes relating to privacy and consumer rights.

This methodology gives no measurable outcomes, findings cannot be generalised and yet it seems to show 'truths' rather than telling or proving 'facts.' I came to see that through the power of story, through the use of evocative language to show people's 'truths' that ways of relating and practising may be changed and attitudes altered. Van Manen (1990) tells us that "lived experience is the starting point and the end point of phenomenological research" and lived experience is "the breathing of meaning" (p. 36). Heideggerian hermeneutic phenomenology, in taking a phenomenon and expanding the way that it is viewed, while paradoxically attempting to reduce it to its essence, also attempts to show in a new way what is already there (Van Manen, 1990).

The method

To a large degree my research method has been influenced by Van Manen's (1990) description of 'how to do' Heideggerian hermeneutic phenomenology. The steps he outlines show the way that such a mode of enquiry could be informed by the methodology chosen. When using phenomenology the method, the 'way,' is one of openness, of discovery, of being attentive to the appearance of things. This close involvement with the research material assists in finding the path forward, with a sense of 'knowing' what matters, of seeing what is significant in the interviews, in participants' stories and in the analysis of them.

Why use phenomenology?

During a pre-entry module to the Masters of Health Science programme I attended a presentation on hermeneutic phenomenology. The lecturer strongly believed in the methodology that she was using in her own PhD study 'Being safe in childbirth' (Smythe, 1998). Hearing a story read from that study demonstrated how the participant's world had been captured, showing to us the listeners, her life-world, her experience of knowing about herself and her own body in a way that the health professionals hadn't understood. And so I came to be 'captured' by this sense of new understanding coming to me through a story that was 'second hand,' and had been altered to fit and flow better. A methodology that uses other's experience to add to the researcher's own understanding presented to me a new way of investigating the meaning of events in people's lives as they had lived them. It opened up the opportunity to look behind taken-for-granted everyday activities to what lies within the life-worlds of research participants. I saw this methodology as giving openness to seeing whatever came out of participants' narratives thus showing a good fit with my questions that look to meaning rather than presupposed issues within the relationship.

It seems that the world people with disabilities inhabit is ever-changing, and as a consequence so have their relationships with health professionals. The social, political, professional and personal context of this study will now be shown so that the reader is able to situate this research in its world.

Context of the Study

During the past thirty years health professionals' relationships with the clients they work with have come under considerable scrutiny and have been criticised from both within healthcare by health professionals and without by healthcare clients, by people with disabilities, and by society (Craddock, 1996). No longer do we inhabit a world where the power of the medical person and health professionals closely associated with them, such as occupational therapists, go unquestioned (Stewart, 1994). Many differing influences can be seen to have impacted on the interaction between clients and therapists. They have come primarily from within society, from group movements and from individual actions, rather than being initiated by health professionals. It has been a combination of these demands from consumers, along with changes to the social and political context and consequent legislative changes that health professionals have responded to, to ensure that their practice 'works' positively for the clients that they are interacting with. Those 'movements' in society that have had a major influence in shaping changes which impact on the relationship between people with disabilities and community occupational therapists will now be outlined.

Consumer-driven society

Throughout the Western world during the past three decades, people with disabilities have increasingly wanted to participate in society and help themselves through setting up their own support organisations (Townsend, & Brintnell, 1997). 'Movements' toward social change, many of them originating in the USA, have come out of feelings of oppression with groups claiming rights that they believe they haven't previously had (de Lacy, 1984). In describing the consumer society De Lacy tells us that consumerism arose through a process of advocacy and the patients' rights movement arose more from individual concerns. She describes individuals being dissatisfied with a particular doctor/patient interaction, or with treatment in or outside of the hospital setting, but suggests "perhaps the patients rights movement mainly indicates a dissatisfaction with the traditional role of the patient as a passive recipient of health care, and with a desire to become a more active partner in the healing and recovery process" (de Lacy, 1984, p. 44). Tennant (1996) confirms the idea of active involvement, describing the emergence of consumer advocate groups during this time as being dominated by disabled people and their families rather than professionals and the 'charity inclined' people of the past

(p. 21). It seems that a common complaint coming from many of these people was that they did not count. Individuals frequently felt powerless faced with the size and complexity and specialisation occurring in bureaucracies. As a consequence, during the 1970s and 1980s anger was frequently directed at the healthcare system that was not meeting their needs and provoked change within it (de Lacy).

Independent Living Centres, called 'Disability Resource Centres' in New Zealand, and community agencies to support people with specific disabilities came into being as a part of the patient rights movement. Craddock (1996) tells us that we now see organisations of people with disabilities replacing organisations for people with disabilities. The first Disability Resource Centre was established in Lower Hutt in 1978 and was followed by other centres (Horrocks, 1983/1990). Horrocks says "this is people helping themselves and their kind but more importantly… it should provide a down-to-earth service that caters directly to the disabled persons needs" (p. 72).

Community agencies have been established for some time in New Zealand, the Multiple Sclerosis Society since 1964. A client participant in the study tells how she came to form a support group within a broader association:

> *When I joined the association one of the first things I said was, "I want to meet people of similar age, similar condition, preferably female, so that we can get together," and there were two people who were interested in the same thing and we contacted each other and made arrangements from there. Both of them are still really good friends of mine and we've had a lot of times talking about things and it's been great.*

Such groups, with a sharing of information and support between members, are likely to create less dependency on the base of 'scientific knowledge' that has given health professionals in the past much of their power.

De-institutionalisation

Alongside the movement towards greater rights for patients, by the 1970s, institutions such as psychiatric hospitals and others catering for people with physical disabilities treated more people as day patients or outpatients and hospital bed occupancy rates fell

(Tennant, 1996). Factors influencing these changes were the availability of new drug therapies and public awareness of what occurred in some institutions (Tennant). Minkoff (1987) also describes "radical changes in our values and beliefs about how care should be provided to the chronically mentally ill" (p. 945). 'De-institutionalisation' has meant that increasingly people with disabilities are likely to live in the community (de Lacy, 1984). Their ability to remain a part of the community, where they frequently formed working relationships with occupational therapists, was enhanced by legislation passed during the successive years.

Legislation and codes impacting on the client / therapist relationship

As a consequence of the consumer movement and groups within it, such as the patient rights group, we now see codes of rights protecting many people in society. These changes have opened up the way for people with disabilities, as consumers, to claim access to services and protection from health professionals and services that discriminate against them or provide an unsuitable service. They also provide guidelines for expectations of health professionals when interacting with clients.

The Disabled Persons Community Welfare (DPCW) Act 1975
The DPCW Act was passed in order for people with ongoing disability to get practical assistance to enable them to live at home and attend school and work. "For once, parts of the environment were to change to suit disabled persons: the longstanding assumption of earlier policy had been that disabled persons should fit in to their surroundings or decently hide themselves away" (Tennant, 1996, p. 24). Community occupational therapists frequently worked with sections of this act that had the capacity to open up opportunities for people with disabilities. Occupational therapists' role within the act has been to assess people's requirements for housing alterations, equipment and vehicles, advising on their essential nature. This drew therapists into a more significant and decisive role with people with disabilities and placed them in an increasingly powerful position. In 1996 the act was repealed following disability-funding moving from the Department of Social Welfare to Health Funding Authorities. However occupational therapists' role with regard to people's access to this type of funding remains equally important within their relationship with people with disabilities.

The Health and Disability Commissioner Act (1994)

As a part of the trend to empowerment of health consumers the New Zealand Government brought into law the Health and Disability Act (1994). The 'Code of Health and Disability Services Consumer Rights' (1996) is a regulation under this act. There are obligations under this code that impact on both the clients' expectations of their relationship with therapists and therapists' interaction with people with disabilities. Some of the more significant aspects relevant to this study, because they relate to the relationship, are that consumers must be treated with respect and dignity, and they have the right to services provided with care that are consistent with their needs. Consumers also have the right to have support people with them and to complain about the service provider, with the individual providing that service obliged to respond speedily. What the Code of Rights does is to make transparent for clients and therapists the obligations and responsibilities the health professionals are accountable for when interacting with clients.

Codes of Ethics for Occupational Therapists

New Zealand occupational therapists have followed Great Britain and America in establishing Codes of Ethics that make clear therapists' ethical responsibilities as professionals. The New Zealand Code of Ethics for Occupational Therapists (Occupational Therapy Board, 1998) clearly outlines expectations of therapist/clients relationships. In Section A of the Code (1998) the relationship with persons receiving occupational therapy services is outlined as "occupational therapists will respect the autonomy of people receiving their service, acknowledging the client's role, and the power sharing and decision making" (p. 5). Alongside this, therapists are expected to ensure that people feel safe and accepted and not threatened by therapists' actions. Continued relationships with clients that have the potential to exploit or harm the client are seen as breaching the moral code. There is an expectation written into the Code of Ethics (1998) that therapists receive appropriate supervision as well as protecting the confidential nature of client information (pp. 6-7). All practising New Zealand occupational therapists have received a copy of this Code and the expectation of the Occupational Therapy Board who are monitors of the Code and from employers and professional advisors is that therapists will comply with the Code. The New Zealand Occupational Therapy Board has the power to take legal action against therapists who are found in breach of the Code of Ethics.

In discussions with community occupational therapists that took place following the New Zealand Code of Ethics being adopted there were indications that some of those therapists prefer to have clear boundaries around their relationships with clients, enabling them to remain objective:

> I think it helps to maintain an emotional distance. If you get too close to people, if you allow yourself to be drawn into the 'space' in which they are functioning, then you can no longer act as a therapist does. The overview that you bring to the situation makes it worthwhile you being there. The bringing of some impartiality, and the seeing of both sides, that's the therapist's role, to be immersed, involved but objective (Paddy, 1997, p. 23).

It is the boundaries around the client/therapist relationship and such things as the place of objectivity within the interaction that appear significant, impacted on by clients and therapists' perception of their relationship.

Professional context

An evolving profession

While much has changed for clients, therapists also find themselves situated in a context of 'professional' change. An early New Zealand occupational therapist defines the profession in this way: "Occupational therapy is treatment given to aid in the recovery of those unfortunate people who suffer from some mental or physical disorder" (Inman, 1940/1990, p. 12). These words convey through the language used attitudes and assumptions that will have impacted on their relationships. These attitudes will have been a part of their time, within the context of both society and health professions including occupational therapy in New Zealand in the 1940s. In the late 1950s and 1960s a widely used occupational therapy text in New Zealand was 'Occupational Therapy in Rehabilitation' (MacDonald, 1960). This text refers to therapeutic relationships and describes the success of treatment depending on the therapist herself, on her professional manner and objectiveness. The importance of the therapist needing to develop a rapport with patients using empathy rather than sympathy is commented on. "She should in no way over-impose her will or intention. Some firmness may be necessary and some persuasion called for, but these should be tempered with good judgement, a genuine interest in life in general, and a happy disposition" (MacDonald, 1960, p. 14). This text goes on to say of the domiciliary occupational therapist "she

must act as a spur and stimulus, take an authoritarian or supportive role, and occasionally play the maiden aunt! She must *not* however take upon herself the functions for which the health visitor, the almoner and other members of the health service team have been trained and appointed for" (Rostance, 1960, p. 245).

The 'patient' and their role in the therapeutic relationship are not described in this text other than in terms of their condition. However several clues to the 'correct' attitude to patients came through. Therapists are warned that 'concentrated attention' on patients could encourage them to become demanding and self-centred (MacDonald, 1960). These references are from a British text yet seems to me to be not dissimilar from the work practice, attitudes and relationships I encountered at times during my training and early years of work as a therapist in New Zealand. This raises questions about the evolving practice and therapeutic relationship and attitudes to clients within occupational therapy.

The beginning of community occupational therapy
It seems that community occupational therapy in New Zealand first came about as a result of therapists from hospital departments visiting people living at home. Initially, in 1952, public transport was used by the first domiciliary occupational therapist at Auckland Hospital (Riordan, 1958/1990). While there is little in this article to indicate aspects of the client/therapist relationship, craftwork was described as remedial and the motto for homebound patients was "how to live with your disability" (p. 22). There is an interesting contrast in this writing. On the one hand the craft work is deemed remedial, indicating a reductionist view of the patient's body, seeing it as numerous body parts, with a focus on restoring the 'disabled part' of that person through the use of activity. Yet on the other hand the motto would seem to show a focus on the whole person situated within their life-world, a notion described as having always been aligned with the occupational therapy profession (Hopkins & Smith, 1993).

When a past charge occupational therapist of Extramural Hospital, Rochelle Currie (1978/1990), wrote about the creation of this community-based service in Auckland in 1961, she described the concepts around its development as:

(i) To prevent hospital admission by assisting the general practitioner to maintain his patient at home. (ii) To provide an alternative to admission for those patients seen at hospital out-patient departments. (iii) To enable patients already in hospital to be discharged earlier to their own homes. (iv) To enable long term or terminal cases to be maintained in their own homes for the duration of their lives, in most cases without re-admission to hospital. (p. 51).

The article moves on to describe district occupational therapy from 1967 to 1987 with Currie telling us that "over the past ten years our role has changed from dealing entirely with activities of daily living and aids to one of a 'facilitator' assisting the person at home to develop his own full potential and satisfying life style" (p. 52). There is an indication that during this period there was a move away from the traditional medical model of 'the health professional knows best' to a greater openness where the health professional places the client at the centre of their practice.

Client-centred relationships – reality or rhetoric?

The notion of client-centred practice originated with an American psychoanalyst, Carl Rogers in 1939. He believed that the therapist must listen to the client, be self-disclosing and have no professional façade. Alongside this Rogers (1951) used 'unconditional positive regard' in the belief that, given appropriate support, clients could determine their own direction and healing. Since that time, other health professions have taken this concept that implies client participation and a sharing of power between the client and health professional and adapted it to their own practice areas. A claim is made that aspects of client-centred practice are evident throughout the history of occupational therapy (Law, Baptiste & Mills, 1995) and the Canadian Association of Occupational Therapy in writing guidelines for practice incorporated and adapted the concept. Client-centred practice in occupational therapy is described by Townsend and Brintnell (1997) as embracing a philosophy of respect for, and partnership with, people who are engaging in occupational therapy services. They remind us that professional dominance has occurred in health care with expertise seen as more important than individuals' knowledge of themselves. If therapists wish to be client-centred in their practice then a greater awareness of what is happening in their relationship with clients would seem to be necessary.

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These influences impacting on the client/therapist relationship are an interweaving of individual, group and societal movements and repositioning. Many of these have come from clients, as consumers, wanting change that gives them greater control of their lives. It seems that health professionals have frequently been the followers.

My personal context as an occupational therapist

My own immersion in this world goes back to 1960 when I moved from Nelson to begin my occupational therapy training at the School of Occupational Therapy in Auckland. As I look at the nature of the relationship between clients and therapists I recognise that just as it has evolved so has my practice as an occupational therapist. The world has changed and along with it so too has my horizon to understanding (Gadamer, 1982). I see the place that I left, my early years of practice, was full of assumptions and absolutes and the world of practice and study that I later entered also have their own understandings and paradigms of practice. To begin at the beginning for me involves going back to my understandings as a student.

As an occupational therapy student

This is a story from my experience of being an occupational therapy student in 1961 that both connects to and contrasts with my later years of practice:

> *I'm working in a hospital in Auckland as a student in a clinical placement. It is my first year of training. I am wearing my yellow uniform with brown shoulder epaulets, my student badge and my brown lace-up shoes. This is the uniform of occupational therapy students in the 1960s. It's an exciting day. I'm going to leave the department behind and go out with the domiciliary occupational therapist on her round of visits throughout the whole of Auckland. I assist her to pack the car with the items she expect to need and then we drive off. I don't recall looking at patient files or anything like that. While we are driving the therapist tells me about the people we are going to visit. It seems that they are unable to easily leave their homes. We enter the first house with arms full of materials, moccasins cut out and ready to stitch, cane for making baskets, fabric for toys, needles, threads and tools and a purse and receipt book for payment. Much of what the therapist requires is carried in her basket. The first*

person we visit has rheumatoid arthritis. She is happy to see us, very appreciative and respectful. We know we have come 'to do good.' I don't remember that we asked how she managed her daily life and I followed the therapist through her day unquestioningly. The focus was on craft work and 'keeping the patient occupied.' It's possible that we went into bathrooms that day for the sole purpose of soaking the cane in the bath.

So often in the years of my training as an occupational therapist it seemed that what I was taught in the training school did not correlate with what I encountered at times in clinical areas. In contrast to the above story and only two years later, while still a student, I accompanied a 'patient' on a visit to her home, leaving the hospital with her to assess how she would manage on her return to live with her family. At the end of a lengthy stay in hospital, and prior to her discharge, a quite in-depth assessment of daily living activities was carried out with her at her home. She was very excited to be in her own house at last and while doing some kitchen activities, chose to make her favourite cake. Although I was expected to complete an assessment somehow it all seemed to fit within the whole of her life. In comparing these two stories of disparate home visits two years apart, it is possible that the different nature of the interaction was a consequence of the individual therapists and the occupational therapy department's perception of occupational therapy 'treatment' rather than the two-year time difference being a major factor.

Being a community occupational therapist from 1980 into the 1990s
The work world I entered and became a part of as a community occupational therapist in 1980 was vastly different from that day out as a student with a domiciliary therapist. We wore no uniform, we had no equipment for craftwork, and while we had considerable autonomy to plan our own work we were also more answerable in terms of accountability. The interdisciplinary team within the community setting seemed to provide greater support for therapists as well as clients living at home than my perception of the insular way work was carried out by health professionals in 1961. Students working with me as a part of their clinical placements were frequently both questioning and informative. Therapists' relationships with clients ranged between the extremes of being enabling to disempowering with quite a strong pervasive element

showing through in 1980 that although we came as guests into their homes we were the 'experts' and knew best.

My changing perception

At times during my years of practice in the community there have been 'revealing moments' that caused me to stop and reconsider, to evaluate my ideas and beliefs about my role and about relationships with clients. One day when I had called to see a woman at home she said "isn't it nice that you can be a real person when you visit me." This was puzzling, for what were occupational therapists when they visited people with disabilities at home if not 'real people'? Perhaps 'professionals' keeping their distance, possibly being the 'expert' and not listening or hearing what was important to the client? On another occasion a man became very angry with me and the anger disrupted our relationship. It seemed that he did not accept my role as someone able to assess the essential nature of the housing alteration he hoped for. I had cause to reflect on what my attitude had been prior to and during this visit. My preconception had been that he did not meet the criteria laid down by Government agencies that therapists must take into account. Visible to him but invisible to me were the ways that this attitude had prejudiced my ability to be open with this client.

This was one of a number of occasions when in hindsight I recognised the power of the health professional, as the person who could assist with accessing resources or knowingly or unknowingly block that access. Prior knowledge and understandings seemed so important, even at times critical, yet I struggled to not let that impact on my attitude when present with clients. Although I came to have strong beliefs around the importance of being open with clients, of seeing them as having expert knowledge about themselves and their wishes, of involving them in choices and decision making, it was primarily when the relationship was negative that I came to reflect and recognise what had been going on. It was easy to take events at a surface level and believe that my practice was acceptable when people did not object. Understanding what was happening in the relationship and keeping the client at the centre of my practice and maintaining that focus was harder in reality than in theory. My research question therefore looks to uncover what currently occurs in this relationship in New Zealand, exploring the experience and the meaning within that experience.

Overview of the Thesis

Throughout this study the focus is on the experience of the relationship for people with ongoing physical disability and community occupational therapists. Heideggerian hermeneutic phenomenology as a methodology allows the research question to be opened up. Exploring the relationship, and uncovering aspects of that relationship that have been unclear and covered over, can bring new ways of seeing what is already there. This then gives the opportunity for increasing understanding and changing perceptions of the relationship.

Being involved in the type of research that I have undertaken involves looking for deeper meaning in words and in phrases in the participants' stories. Words make poetry and I turned to poetry in order to 'capture' the meaning that came out to meet me from participants' stories. These poems represent my feelings about the meaning and the emotions showing in stories. I make no claim to represent the participant's feelings but rather to show the emotional responses that were evoked within my own understanding. Sometimes poems came not from participants' stories but from my own reactions and experience of doing research, of writing a thesis. It was hard to know where the poems would fit but as they were such an integral part of this study I have chosen to place them at the end of each chapter, hoping that this is where they best show aspects of stories or the process of doing phenomenological research.

Within chapter two lies the literature I reviewed that connects aspects of ways of relating, establishing what already exists and showing and highlighting what is missing from that literature. The literature review shows the historical context to client/therapist relationships. Both New Zealand and international research that is significant and relevant to this study is examined and discussed. The links and parallels to other health professional literature that show relationships with clients are also described.

The philosophical approach I have used is discussed in chapter three, the methodology chapter, and shows in the study design. Issues such as the number of participants, their age range, gender and ethnicity are outlined in this chapter. As all participants are women I sometimes refer to the participants as she. When the analysis moves to more universal themes I have tried to be gender inclusive. The type of interview used in a

phenomenological study such as this is outlined along with the data analysis process. The methodology chapter concludes with an examination of the study's trustworthiness.

Chapters four, five and six are made up of the stories and themes that arose within the study. Their interconnectedness and the hidden aspects of relating will be revealed through the analysis. These chapters named 'Fore-having,' 'Being There' and 'After-having' present the core of the study. The writings and notions of Heidegger (1962) and Gadamer (1982) and Van Manen's (1990) four existential life worlds are used to inform the analysis. I have explained each new notion as it has arisen within the analysis. I believe that these hermeneutic and phenomenological notions fit the analysis, being particularly suited to the concerns of occupational therapy.

The discussion within chapter seven draws all the significant threads from previous chapters together. Their links and importance in the relationship can be seen more clearly as a consequence and the differences between the client's perception of relating and the therapist's will fully show. Implications for both people with physical disability and occupational therapists are discussed and areas for further research will be outlined. Recommendations from the study will clarify the essence of what has emerged from the study pointing to that which is new. Chapter seven ends with a conclusion – the end of the beginning.

> The white rabbit put on his spectacles. "Where shall I begin, please your majesty?" he asked.
> "Begin at the beginning," the King said gravely, "and go on till you come to the end: then stop" (Carroll, 1962, p. 154).

A Poem ~

that shows the endless beginnings

Where am I?
I'm at the beginning
But I've been here before
I'm at the beginning again
And it seems
Again
And again

When I first started
I was at the beginning
For such a long time
It seemed
Then thank heavens
…I moved on

In the middle
I found
I was back there
…oh no
At the beginning
Not again

Now I'm on the home straight
It's all clear ahead
But no…
How can it be?
This sense
Of being
Back there again
Always starting anew
At the beginning
I'm back there again

and the ending that lies in beginning

Chapter Two

Literature Review

> …It is instructive how rapidly and how completely one generation's orthodoxies become superseded, denounced as unenlightened or even reprehensible by its successors. An awareness of the past underlines the fragility of today's certainties: there can be no assurances that analyses and solutions proposed in our own times (however well intentioned and seemingly progressive) will not be similarly rejected in the future. (Tennant, 1996, p. 3)

Introduction

To bring understanding to the present relationship between people with disability and community occupational therapists it is necessary to go back in time, looking behind what is currently showing to where the relationship between clients and therapists is situated in the writings of past occupational therapy theorists. Therefore an historical perspective will form the beginning of this literature review. The literature around the notion of the relationship between clients and health professionals is both broad and deep. In a study of this nature it is not possible to show all the relevant writing that forms the background to this study's focus. Instead, I hope to present some glimpses of what I believe are the most significant notions and themes concerning the client/therapist relationship arising in a variety of literature, both national and international, both occupational therapy based and that related to other health professions. At times the themes will be strongly showing in a range of literature. On other occasions themes on relationships will be significant primarily by their absence.

In a phenomenological study a review of the literature seeks to highlight the phenomenon, the client/therapist relationship, thereby showing and reflecting it to the reader in new ways so that the understanding of 'relating' is enhanced (Van Manen, 1990). The actions and thinking that surround the phenomenon, at times hidden and not fully seen, may show us more fully that which is being explored. Therefore in examining the literature I am not seeking to categorise or define the relationship, but to show meaning and to place my questioning and the study in a context of what already exists.

From a Historical Context

Many occupational therapy theorists have written about their perception of the relationship between client and therapist. While Peloquin (cited in Rosa & Hasselkus, 1996) considers the relationship the heart of occupational therapy practice some models and theories pay little attention to therapeutic relationships. The following section will briefly examine what it is that a number of occupational therapists and theorists significant to the profession have said or what their theories indicate about occupational therapists' relationships with clients.

Amongst the early philosophical writings on occupational therapy is that of Dr Adolph Meyer, a psychiatrist who promoted occupational therapy in 1922. Christiansen (cited in Christiansen & Baum, 1991) says that Meyer "viewed the individual and health in a holistic rather than a structural sense" with the individual's health seen as a part of the context of their daily life (p. 7). Expanding on this Yerxa (1992) tells us that Meyer believed that people should be studied in their everyday environment and that the person's subjective experience must be included in any assessment of that person. Eleanor Clarke Slagle, an early leader in occupational therapy, who began a training programme for occupational therapists, was influenced by Meyer and "developed an appreciation for the importance of occupation to health and well-being" (Christiansen & Baum, 1991, p. 9). In the United Kingdom, at the same time as Meyer was working in the USA, Mary Dendy is described by Finlayson and Edwards (1997) as having a perspective of occupation that included a broad focus. It is therefore interesting that they say that "regardless of the breadth of vision described, occupational therapy between the 1920s and 1960s focused on curative approaches" (p. 475).

Gail Fidler saw herself as being at the very beginning of the development of occupational therapy (in Miller, Sieg, Ludwig, Shortridge & Van Deusen, 1988). Outlining her theories in her second book (Fidler & Fidler, 1963) she discusses the therapeutic relationship. She called being able to anticipate and respond in a helpful way to patients the 'therapeutic use of self.' Kielhofner and Burke (1977) say that she was at the forefront of the psychoanalytical model in the 1950s and 1960s where "the therapist-patient relationship was seen as the core of treatment" and the therapist worked in a reductionist way, for example, with activity that would sublimate feelings (p. 683).

The models and frames of reference developed by Anne Cronin Mosey in the 1970s and 1980s of occupational therapy as a profession are still prevalent in occupational therapy knowledge and practice today. She outlines one of the tools making up her model of practice saying "conscious use of self, simply stated is the use of oneself in such a way that one becomes an effective tool in the evaluation and intervention process" (Mosey, 1986, p. 199). This is seen as differing from the spontaneous response that people have in everyday interaction with each other, requiring instead forethought on the part of the therapist.

Lela Llorens contributed a developmental theory for the practice of occupational therapy that was put together during the late 1960s and during the 1970s (Miller et al., 1988). The theoretical constructs she developed placed the developing child in the context of its family and environment recognising the importance of context to treatment. Over a similar period in time Jean Ayre's work centred on the development of children and neurologically disabled adults and the construction of a theory that she named 'sensory integration,' developing into a model between 1958 and 1976. Her theory is based on testing and scientific measurements involving five syndromes (Miller et al., 1988). While there is considerable emphasis in her work on the child as situated within its environment and the child/parent relationship is discussed, the place of the therapeutic relationship between therapist and child appears to be absent in much of the writing about sensory integration. The focus seems to have been very much on the 'science' of practice.

The paradigm that Mary Reilly first published in 1963 involved four concepts some of which see people as embedded within their life-world and able to adapt to their

environment (Miller et al., 1988). Yet there is little mention in her work of the importance of relationships between that person and the therapist. Kielhofner's (1995) 'Model of Human Occupation' was first published in 1980 following the early work he shared with Reilly. His 1995 updated theory shows the living system of the individual interacting with their environment. Chevalier (1997) says that one of the strengths of this model is that it places 'the volition subsystem' which includes personal causation, values and interests, as primary to occupational therapy. This model does not however specifically address the client/therapist relationship other than to formulate a number of interview techniques. Rather than this signifying a gap in their theories I would suggest that the focus with both Reilly and Kielhofner's work remains elsewhere on understanding phenomena other than therapeutic relationships.

It can be seen that there are many differing models and conceptual frameworks that have been carried from the not too distant past into the present. Within these models there is a diversity of focus. Some show a holistic view of the client, with an integration of body and mind. At times this is connected to a perception of the significance of the client/therapist relationship. Kielhofner and Burke (1977) say that the 'reductionist model' came about by the end of the 1950s through the influence of the medical model on occupational therapy. A shift in focus to the internal mechanisms is described, where occupational therapists "had to give up the breadth of practice in favour of the depth" (p. 682). Alongside this focus on an aspect of the body or mind of the patient, the previously described work of theorists during this period shows that in some models the relationship between client and therapist was also put aside, with the theorists' model intent on explaining a different phenomenon or the relationship between phenomena.

It is interesting to note the contrast between developments that were occurring for people with disabilities and occupational therapists. At the time in the 1960s and 1970s when people with disabilities were pushing for the right to be seen as individuals and feeling powerless faced with specialisation (de Lacy 1984), occupational therapists had moved into a period of increasing specialisation and treating parts of the body and mind. Kielhofner and Burke (1977) outline the 'scientific era' in occupational therapy from the late 1950s saying that the reductionist paradigm had three dominant models: the kinesiological model, the psychoanalytical model and the neurological model. They say confusion about roles occurred for therapists through the focus on technology and

treatment and the undermining of occupational therapy's philosophical base. Supporting the inadequacy of the reductionist view of 'Man' within healthcare, Safilios and Rothschild (cited in Kielhofner & Burke) are quoted as saying that "the medical model view has failed to address the problems of the chronically disabled" (p. 685).

Theories and views promoted by occupational therapy theorists involving the nature of practice and of the relationship between therapists and clients will have influenced and impacted on present-day occupational therapy notions of therapeutic relationships. What does the present-day literature tell us? It is to this writing we now turn to explore the themes and notions that at times show themselves and in other writing remain less clearly seen.

Themes within the Literature

There are a number of views that arise in current writing that show or describe aspects of the relationship being studied. Occupational therapy codes of ethics aim to state the profession's moral values and expectations of client/therapist relationships. The literature showing these values and the professional expectations that therapists work with will be discussed along with a description of therapeutic relationships. Disability agencies too show some references to possibilities within the client/health professional relationship. Alongside this, professions within health care have theories and expectations around relationships with clients, with an assumption that there is a 'right way' that can perhaps simply be followed. When therapists begin the interaction it is likely that their minds will be full of prejudgements. Alongside the writing that shows these fore-conceptions are theories and literature that focus primarily on skills and tasks, that don't discuss the significance of the client/therapist relationship indicating a possible tension between occupational therapy tasks and occupational therapy relationships.

Within the literature there are messages from clients about what they want and expect from such relationships. This challenge to health professionals to take notice and take action will be explored along with responses to it. Partnership comes through as a much-explored notion in current health professionals' literature. This literature review will compare what is being said in a variety of writings about partnership. The final

theme in this exploration of the writing around the relationship between people with disabilities and community occupational therapists is the meaning of friendship within health professionals' relationships with their clients.

The authority of the profession

The profession's perspective

Much of the authority that guides the practice of the occupational therapy profession, along with that of other health professions, comes from their Codes of Ethics. Alongside this stands the writings of theorists and leaders within the profession who point to the profession's values. I have discussed in the introductory chapter the expectations the New Zealand Code of Ethics for Occupational Therapists (Occupational Therapy Board, 1998) outlines for therapists' relationships with clients. These revolve around respect and power sharing between therapists and clients with an expectation that therapists will not continue with relationships that have the capacity to exploit or harm clients.

The British Code of Ethics (1997) also states the profession's expectations of therapists' relationships with clients. There are aspects of client-centred practice in this code when it outlines the need for therapists to recognise and respect the autonomy of clients, acknowledging the need for client choice and the therapist working within a partnership with the client. It sees the need for the therapist to advocate for the client "upholding the autonomy of the individual" (p. 33). In describing relationships with clients the Code resembles the later NZ Occupational Therapists Code of Ethics (1998) saying that, "the college considers it unethical to indulge in relationships which may impair the professional judgement and objectivity of the therapist, and/or may give rise to advantageous/disadvantageous treatment of the client" (p. 35). This is based on a fundamental moral principle of 'do no harm.' New Zealand's Code of Ethics has similarities to the American Association of Occupational Therapists Code (1994) which in part states that "occupational therapists shall avoid those relationships or activities that interfere with professional judgements and objectivity" (p. 1037).

Reacting against what he considers to be the language of 'Cartesian dualism' with what he describes as an "appeal to the scientific objectivity" Van Amburg (1997) argues that in stating so strongly the case against subjectivity the code is promoting a distancing, depersonalising within the client/therapist relationship (p. 186). He goes on to describe

this 'disengaged perspective' as resulting in "depersonalisation of human experience" (p. 186). He believes that it is frequently in the engaging in relationships with clients that therapists find meaning in the work they do. While Van Amburg describes a revolution in the way that therapists interact with clients, moving away from the distancing of the past, Lyons (1997) calls these changes a re-conceptualisation of the client/therapist relationship. He describes occupational therapists as "encouraged to reflect particularly on the issues of control and collaboration in their practice with persons who use their service" (p. 691).

The stated need for objectivity on a therapist's part when engaged in relationships with clients stands out as an integral aspect in this range of occupational therapy professional codes of ethics. While acknowledging the importance of the requirement for therapists to not become involved with clients in such a way that is detrimental to their wellbeing, there is a case that can be made against the use of language that distances and objectifies. Objectivity can be seen as one-sided with Van Amburg (1997) saying that it is the therapist who is to be objective, implying a depersonalised and distancing relationship with clients that may not always be compatible with a relationship of partnership and reciprocity. He describes a link between disengagement and the client being seen in a 'reductionist' way. A call for a more holistic, engaged approach that focuses on the meaning within relationships with clients comes from Van Amburg, who quotes Helfrich and Kielhofner's perspective, "an alternative way of viewing how meaning is experienced in therapy is to consider therapy as an advent coming into the life of the patient" (p. 187). Van Amburg sees this as a shift to having the therapist's practice revolving around the client rather than the therapist.

While there is a new interest in the wholeness of human beings this stands alongside the way that people have been seen as divided into parts through the specialist approach to their bodies and minds (Yerxa, 1994a). Another tension within therapists' relationship with clients is described by Chevalier (1997) as the "ambivalence and discomfort of therapists working within a paternalistic and hierarchical framework which determines priorities on behalf of patients" (p. 539). It seems that occupational therapists, while having been strongly influenced by the medical system, have also been closely aligned with a view of the client embedded in their own world (Yerxa, 1992). She describes occupational therapy as being one of the few health professions where students have

been educated to see the body and mind as connected, to see them as whole individuals situated within their own environments. Yet the question needs to be asked – is this view, supposedly held by occupational therapists of their clients, fully reflected in their codes of ethics? The New Zealand Code of Ethics (Occupational Therapy Board, 1998) uses the language of partnership and client-centred practice and does not refer to a requirement for objectivity in therapist/client relationships.

Assumptions of relationships

The client perspective

Alongside the professional codes of ethics are indications from the New Zealand Code of Health and Disability Consumer Rights (1996) and organisations for people with disabilities about the expectations clients should have of their relationships with health professionals. People with disabilities also have organisations working for them and with them giving them the information and awareness needed to support them. I found on reading the information from two such disability organisations (Muscular Dystrophy Assoc. of NZ, 1999, and Multiple Sclerosis Society of NZ, 1999) that there is a wide range of useful and significant information available to clients. This covered many aspects of their condition, questions they might want answered and service availability both from within the organisations and without. The Muscular Dystrophy Association gave information regarding their client service advisor programme that provides an advocacy service supporting clients and a similar service is available from Multiple Sclerosis Field Officers. The MS Society advises people with multiple sclerosis that they need to openly communicate with their doctor who should be an ally in their management of multiple sclerosis. While clients' relationships with therapists are not covered in brochures, details of the service they provide and their availability and accessibility are. The relative scarcity of information regarding the relationship between clients and health professionals generally, and occupational therapists in particular, may indicate a lack of awareness of the potential in this relating for both positive and negative outcome for clients. There has been little focus paid to the phenomenon of the client/health professional relationship in research in this area which has been strongly positivist and 'scientific' and aimed at understanding the disease.

The New Zealand Code of Disability and Consumer Rights (1996) outlines for both people with disabilities and occupational therapists the ways in which consumers can

expect to be treated. In outlining the right to be respected and to be free from exploitation and the right to make informed choices, aspects of this code are consistent with the New Zealand Occupational Therapy Code of Ethics (1998). Are people with disabilities aware of their rights within the Code of Disability and Consumer Rights that relate to their relationships with therapists? None of the studies that I have read explored this within the New Zealand setting.

The therapist perspective

Within the occupational therapy literature there are a number of theories and assumptions of practice and relationships that impact on the occupational therapist's view of their interaction with clients. Peloquin (1989) says that the American Occupational Therapy Association was using the term 'art and science' in 1972 when defining aspects of occupational therapy practice. This 1972 notion was supported by an occupational therapy theorist, Mosey (1986), who believed that the art and science of practice involved qualities in the therapist such as being able to develop a rapport with clients as well as assisting them to their full potential. While science can be regarded as something that can be learnt during a therapist's education, the art of practice is more difficult to teach and to learn (Robnett, 1997). Peloquin says that "the art of practice is intrinsically centred on relationships, on the qualities that make relationships meaningful, and on the meaning of occupation in life" and she goes on to describe "the art of practice as the soul of practice" (1989, p. 219). One aspect of the 'art of practice' that I have encountered present day therapists incorporating in their practice and that came from several theorists such as Fidler and Mosey is the notion of 'therapeutic/conscious use of self' (Miller et al, 1988).

There is a range of writing from occupational therapists that discusses the meaning of the therapeutic relationship (Devereaux, 1984; Peloquin, 1990 & 1993; Rosa & Hasselkus, 1996). Devereaux most clearly outlines this relationship in a paper about the caring relationship. She put forward the following elements as a basis for establishing a therapeutic relationship with caring described as the base on which all other elements build. First, occupational therapists must be competent, secondly that they have a belief in the dignity and worth of the individual, thirdly a belief that each individual has the potential for change and growth, fourthly that true communication takes place, and fifth that the therapist's values are present within the relationship. Her sixth element is a

belief that touch is important and the seventh element is a sense of humour. Robnett (1977) writing about the work of occupational therapist Linda Leonard's practice in a community mental health setting also discusses the art of practice. There are similarities and differences within this description to Devereaux's (1984) concept of the caring relationship. When using the art of occupational therapy Leonard says therapists must always view the person with positive hopefulness, understand who the person is within his or her current situation and envisage possibilities (cited in Robnett, 1997).

While there is a decade between these elements being outlined few differences show apart from Devereaux adding elements of touch and humour. A further, more substantial difference comes through in a deeper reading of the meaning of values. Devereaux states that therapists' values, showing as beliefs, are integral to the relationship, telling therapists, for instance, when something is good. However Leonard says that we must "learn to suspend our values…as we must encourage and respect choices that are not our own" (cited in Robnett, 1997, p. 35). In other words there is an expectation that therapists will present a value-neutral persona in their relationship with clients.

Client-centred practice, a framework developed by a syndicate of Canadian occupational therapists, has many aspects of therapeutic practice embedded in it. Described within this framework is a philosophy of respect for and partnership with clients that goes hand in hand with recognition of the client's strengths, their need to have choice and the benefit of a collaborative approach with therapists (Law, Baptiste & Mills, 1995). Townsend (1993) further adds that the concept of client-centred practice takes a holistic view of clients, seeing them as integrated with their body rather than divided into parts or classified as cases.

Describing the nature of therapeutic relationships Rosa and Hasselkus (1996) define helping and working together as intertwined and essential in the ideal therapeutic relationship. Reciprocity, when the patient they are interacting with inspires the therapist, is seen as an ideal in relationships that work well for both clients and therapists. Other aspects of this study are themes of connecting and caring. Strong emotional responses from therapists are associated with connecting or not connecting. They are described as "rejoicing in patients' successes" with their caring involving helping (p. 255). Rosa and Hasselkus describe emotional responses as being aspects of

both the "personal and professional identities" of therapists' (p. 256). It is in the combining of these two identities in order to think and feel when involved in interactions with clients that can lead to greater understanding and positive relationships (Rosa and Hasselkus, 1996; Peloquin, 1993). At times there are indications that personal closeness to clients can lead to therapists becoming exhausted and feeling rejected. This occurs when their personal identity seems threatened by 'uncooperative' patients or where they feel unable to 'make a difference' to a client's progress (Rosa & Hasselkus, 1996; Hasselkus & Dickie, 1994).

Another view of the therapeutic relationship shows in other studies. There has been a strong movement in the USA in the 1980s and 1990s that looks to a framework for practice called clinical reasoning (Finlay, 1999). Within 'clinical reasoning' Fleming (1991) outlines three different types of reasoning telling us that it is within face to face encounters between client and therapist that interactive reasoning takes place. This type of reasoning is used for a variety of purposes, for instance when therapists wish to know their client better as a person, to understand disability from the client perspective, and build a relationship of trust and acceptance (Fleming). Indications from Fleming's study were that the therapist wants to see their client as a whole person, as an individual.

Seeing the client as an individual has been described already as a positive aspect of a therapeutic relationship. One way of ensuring that the client is seen as more than their disability is through eliciting stories from clients about their life and experience of their disability (Kirsh, 1996; Mattingly, 1991; Van Amburg, 1997). Occupational therapists have a history of using their client's personal stories to better understand that person and their needs (Peloguin, 1995; Mattingly, 1991a). Kirsh (1996) says that through eliciting the client's story the aspects of the client's life-world that they choose to voice can be taken into account. This gives an opportunity for therapists to respond by making the client central to the process rather than their condition being central. In her article on clinical reasoning Mattingly (1991a) reinforces the notion of narrative being central to client/therapists interaction, describing the need for both the therapist and client to see themselves in the same story as they move through the therapeutic process.

The therapist's understanding

Tensions causing conflict

The expectations of health service managers, who themselves are situated amongst a context of changes in the arena of healthcare, will impact on therapists' interaction with clients (Devereaux, 1984). There will be challenges by decision-makers within healthcare services in terms of expediency and cost effectiveness says Barnitt (cited in Creek & Ormston, 1996). The drive to measure the work that therapists put through so that they provide 'value for money' is one possible outcome (Creek & Ormston, 1996; Devereaux, 1984). As a consequence it may be difficult for therapists to find the time and focus required for developing and maintaining therapeutic relationships with clients.

Evidence-based practice, that is "delivering care based on the most credible scientific evidence," provokes another tension for some occupational therapists and is described in a grounded theory study as necessary in order to survive professionally when funding decisions within healthcare are linked to keeping costs down (Dubouloz, Egan, Vallerand, & von Zweck, 1999, p. 445). Although the researchers describe the need for evidence-based decision-making that is relevant to day-to-day occupational therapy practice, a participant in the study discusses a contrasting way of making decisions that is more instinctive than based on evidence… "I'll say 'okay' my instinct was that they would function well at home…Your clinical reasoning becomes more innate, so that in a sense that turns into an instinctual process" (p. 44). There seems to be a pull in two different directions, in one direction the 'scientific' approach that measures the delivery of healthcare. In the other direction there is discussion of ways of being with clients that is personal, involving trust, and the therapist's depth of knowing about their practice area that comes about through being open to what they see and sense. Yet Peloquin (1989) tells us that "there is no escaping the reality: Practitioners must engage in the science of practice in order to function in the healthcare system" (p. 221).

Occupational therapy texts at times focus on practice skills and tasks, on descriptions of occupation and the person as an occupational being. When this occurs, relationships between clients and therapists involved in the task may be pushed to the background, becoming less visible. A tension between the biomedical tasks of care and the everyday

requirements of the patient is described by Yerxa (cited in Crepeau, 1991). In some theories of practice, such as that of Ayres (1983), little attention is paid to the relationship between client and therapist, the focus remaining on the intricate skills of assessment and intervention techniques. Yet Crepeau and Peloquin (1993) remind us of the importance of balancing the power inherent in being 'a professional' with recognition of the clients as they are, people situated within their life-world. Peloquin (1990) describes one type of relationship that therapists have had with their clients as being a technician saying that "technician occupational therapists are chiefly concerned with technique and technical issues" and that "competence in techniques pre-empts relationships; the therapist refines technical skills above all else" (p. 17). Devereaux (1984), in a paper on the caring relationship, postulates that caring can counterbalance the depersonalising aspects of technology.

Messages from clients

There are a number of qualitative research studies carried out by occupational therapists that show aspects of the client's perception of their relationship with therapists. As much of this data is included in other parts of this chapter I have chosen to focus primarily here on the information that has come through from people with disabilities, in magazines, journal articles, and presentations. They describe their experience of being in such relationships telling us what they want from their interaction with therapists.

Just as therapists in a number of studies have pointed to the ease at which their thinking as health professionals can become focused on their clients' disability or condition, people with disabilities also draw attention to this issue. Bonny Sherr Klein, (1996) a Canadian film maker, broadcaster and writer, has written about her relationship with occupational therapists, her experience of disability, and her reactions during treatment following a series of strokes that left her with ongoing disability. She has become a strong voice for people with disabilities with writing published in the British Journal of Occupational Therapy (1996a) and a journal called OT Practice (1996b) as well as having presented at the Canadian occupational therapy conference in 1995.

Klein (1996b) describes a sense of being divided up by different health care professionals who competed over who would treat differing parts of her and did not feel

confident that the so-called multidisciplinary 'team' attended to what mattered to her. While recovering from a stroke she describes an expectation by the occupational therapist that she would focus primarily on her rehabilitation activities and she experienced a sense of disapproval when she didn't. She preferred to continue with her 'real work' of filmmaking. Unlike the therapist, Klein understood that this work "reconnected me to the wide world outside the problems of my body… I regained a sense of myself through that occupation" (1996b, p.35). She describes how "the conventional therapies worked from the outside in, focusing on the outcome, like my gait or the activity, rather than the inside out. I began to see from my body's experience that I was one integrated organism" (1996a, p. 23). Klein (1996b) says the approach of the therapist needed to change as her condition changed. She expected but did not receive the support she required from her therapist, who was not an ally in her struggle to readapt to society. Rather the therapist took a 'technical approach' to their work, focusing on an aspect of her rehabilitation. She writes about the need for therapists to work with their clients, being partners with them and advocating for what they need from society.

Writing in a journal, Hockenberry (1997) refers to his relationship with therapists and his views on his disability. He spent sometime in rehabilitation following a motor vehicle accident and talks about the problem of therapists focusing on injury and disability when he, as the client, struggled with his dependency on 'strangers,' the therapists working with him. What he described as needing from them was a spirit of improvisation and an openness of mind. He says that "the best therapists have a way of custom fitting whatever academic information they may have acquired to the individual at hand, learning how to be flexible because disabilities are very unique" (1997, p. 2). Hockenberry dislikes the labels that dehumanise, saying that "the things that bother me are 'confined to a wheelchair' which is obviously incorrect because…it's just how I get around" (p. 3).

Sue Robertson (1990) wrote in a positive way, in a magazine, about her daughter's disability and the health professionals she interacted with. She outlined the features she most valued in her daughter's occupational therapist. She described her as sensitive and having an intelligent approach: "she feeds us with information, she encourages us to take an active part in the therapy, and she is a patient and astute listener – a professional

who takes time to care outside of appointment hours. It has mattered"… (p. 21). In taking the time to listen to what was important the therapist showed her support for them.

There are a number of significant issues in the above literature about these consumers, experience of their relationship with therapists. Both Klein and Hockenberry tell therapists that they want to be seen as individuals rather than have the therapist fit them into some preconceived notion of what will be best for them. They object to their bodies being viewed as parts 'requiring servicing' rather than the uniqueness of the whole of their person being attended to. They need therapists' knowledge and expertise while at the same time want their therapist to connect with them in a human way rather than as 'strangers.' The need for acknowledgement of their own understanding of their disability also comes through in these writings. Labels such as that of 'wheelchair bound' have the potential to ignore the person, describing only the disability. Hockenberry (1997) criticises labelling that disempowers. In contrast to what clients say they need from therapists, Clarke (1993), writing the story of her client's experience of her disability, tells us:

> She remembers being inserted into a line of wheelchairs to re-experience awaiting her turn to be wheeled back to her room. She felt passive, disempowered, and not quite human, as therapists rushed around, caught up in their routine with no time to connect with the survivor as a person (p. 1071).

Support from therapists was seen differently by Klein, Hockenberry and Robertson. For Robertson (1990) it came from the giving of time in order to really hear her concerns. Combined with this was the therapist showing understanding while at the same time giving the assurance and information needed to continue moving forward. Klein asks for a closer connection between clients and therapists that allows the therapist, through their knowledge and understanding of that person, to be an ally and advocate. Support means for Hockenberry that the therapist will adapt their approach to suit him as an individual so that he get the best from them, a combination of knowledge and expertise, with recognition of him as a person. In all of these stories people are asking therapists to be a partner with them in a relationship of openness and shared understanding.

Responses from health professionals

The push from clients wanting to change their relationships with occupational therapists and other health professionals shows through in the literature. A range of qualitative studies look at the significance of the client/therapist relationship or aspects within it. Frequently the focus is on the therapist/health professional perspective. These and other studies show evidence that health professionals are indeed receiving the messages coming from clients that their interaction is not always satisfactory. There is a questioning of the ways that therapists relate to the clients they interact with and the meaning in that interaction. The consequence is that frequently changes are proposed to ways of interacting and behaving.

Occupational therapists have responded to a perception clients have of them as being indifferent to them as human beings, as standing back from them (Corring & Cook, 1999; Peloquin, 1993; Lyons, 1997). While objectivity in evaluation using specific assessments can be necessary, Van Amburg (1997) describes this as acceptable only when the therapist is aware that they are involved in a "disengaging therapeutic practice" and that this disengagement will effectively distance them from closeness with the client (p. 188). For therapists there remains the dilemma of how to carry out interventions that require a degree of objectivity yet at the same time retain their 'connectedness' with the person they are interacting with.

A sense of not being connected arose in a research study by Rosa and Hasselkus (1996) that encompassed negative aspects of relating where the therapist felt they weren't getting anywhere. This occurred for instance when the therapist found herself working with a group that was too large for her to develop a therapeutic relationship with each client. Therapists sometimes lacked understanding of the client's life-world and used phrases such as "I never linked up" (p. 253). Sometimes not being connected involved the therapist taking a stance of "doing battle" when the client was seen as uncooperative. Peloquin (1993) describes clients' expectations that health professionals will maintain awareness of them and communicate with them. When health professionals do not respond, or absent themselves without an explanation to the client, she says that this reminds clients of how little they are valued. Client participants in studies complain about therapists being too busy to deal with their concerns (Corring &

Cook, 1999). Gage (1997) reinforces this notion regarding concern saying that being cared about as a person by therapists remains a critical issue for many clients.

Understanding that clients have 'expert' knowledge about themselves can enhance the client/therapist relationship by bringing both respect and acknowledgement to the client (Corring & Cook, 1999; Lyons, 1997). In contrast Lyons (1997) says that the confidence that health professionals have in their expertise can bring with it assumptions that they know best what the client needs. Yet Chevalier (1997) describes this as 'unempowering' for the person receiving the service. The challenge to at times lay aside their own role of 'expert,' a persona that therapists may use to shield them from closer involvement, comes from the need to be real with clients and to move their stance from that of expert to one of partnership (Chevalier, 1997; Lyons, 1994; Stewart, 1994). Being 'real' may involve such things as putting aside some of the prejudgements that the therapist holds and being open to listening and 'seeing' the client, situated as they are, within the context of their life.

It would seem that trust between client and therapist comes from their openness in the relationship with each other. In writing about the philosophy of client centred-practice Law, Baptiste and Mills (1995) included trust as a one of the integral aspects that occupational therapists see as part of this concept. They describe the shifting of some of the power base within the client/therapist relationship as occurring with clients wanting greater control leading to openness in a more trusting relationship. Aspects of client-centred practice that develop trust are partnership and reciprocity within the relationship between client and therapist.

Lyons (1997) amongst others suggests that power is at the centre of difficult professional relationships (Crepeau, 1991; Peloquin, 1993). While professional expertise can be seen as an important aspect in an empowering relationship, this will depend on the way in which it is offered (Lyon, 1996; Crepeau, 1991; Stewart, 1994). Crepeau says that occupational therapists, like physicians, are not immune to the problem of failing to listen and respond to patients. Pieranunzi (1997), in exploring power as a key element in nurse/patient relationships, questions psychiatric nurses' responsiveness to the unempowered patients that they work with.

The tensions from therapists coming through in this literature raise a number of questions. How close should the therapist get to the client? Does that closeness distort competence and if it does so, in what way? The other issue raised in the literature that has considerable impact within our current health system with its focus on cost effectiveness is, how to establish and maintain a therapeutic relationship with a client in an era when time equals money.

The question of partnership

Equal partnership?

There are a number of journal articles, written by New Zealand occupational therapists that are not research based, that articulate perspectives on partnership within practice. Gordon (1994) writes about her vision that practice partnerships require a relationship that is more than a business partnership, one based on healthcare ethics with the therapist needing to gain awareness of such influences as power and self-interest. The need for therapists to be aware of the potential power inherent in their position has been acknowledged in several papers (Henare, 1993; Paddy 1997). Both Gordon's and Henare's discussions extend to the necessity to work in a relationship of trust, co-operation and to be inclusive of biculturalism[1] within health culture relationships. While these papers have the potential to contribute significantly to the awareness and understanding around occupational therapy practice and the relationships inherent in that practice there is a need to explore further through research the ways that partnership exists in New Zealand occupational therapists' interaction with clients.

Whiteford's (1998) phenomenological doctoral thesis is one New Zealand study that explores therapeutic relationships in the context of questioning the dimensions of intercultural competency in occupational therapy students' narratives. She examines a range of relationships in the process. Amongst the findings in this study she indicates that "being client-centred meant being culture centred" and involves putting aside the role of 'expert professional' (p. 229). Being client-centred also signifies working in partnership with clients.

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[1] Biculturalism is a term used in New Zealand to describe the partnership of two cultures inherent in the Treaty of Waitangi signed in 1840 by Maori, and the British Crown. Biculturalism reflects the sharing between two cultures of the land with an exchange and an acceptance of cultural values and practices.

In her interpretive qualitative study, Wright-St. Clair (1996) chose to research the lived experience of women with multiple sclerosis. An aspect of her study was the exploration of the relationships that the participants had within families, with friends and the health professionals they interact with. Through using a constructivist view, she examined power, gender and understanding the subjectivity of the illness experience. One conclusion coming from her study highlighted the educational need for health professionals to explore and increase their understanding of using a client-centred approach to the way they interact with clients with ongoing disabling conditions. She also commented on the value for the person in telling their story to a health professional, with the narration of their story as a vehicle for them to reconstruct meaning of their illness and work. In contrast to these elements of partnership within relationships, Wright-St. Clair was also critical of occupational therapists for their focus on practical solutions rather than seeking to understand as partners in the relationship.

Smythe's (1998) doctoral thesis also examines relationships between practitioners and women. She writes about the "power within relationships, the power of knowing and understanding, the power of telling in a certain way, the power of being a practitioner" (Smythe, 1998, p. 174). This study also draws attention to the knowledge held by the client. Much depends on the openness between client and practitioner, in the sharing of understanding and knowledge. Within this study there is the contrast of medical practitioners who think that it is better to stand 'outside' the experience and be objective. Both Pairman (1998) and Smythe (1998) agree that it is the notion of reciprocity and power-sharing in the partnership as well as 'intuitive knowing' that is an inherent aspect in positive relationships between practitioner and client. In a challenge to evidence-based practice, Smythe (1996) outlines a case for a different kind of knowing, one that explores the midwife as being a part of practice, of interpreting and of understanding the client, a way of practising that offers an expanding vision.

Coming through strongly in both New Zealand nursing and midwifery writing are definitions and discussions on practice relationships with clients (Pairman, 1998; Guilliland & Pairman, 1994; Christensen, 1990). This writing reflects the movement within the Western world towards the concepts of practice partnerships and client-centred practice with a variety of meanings and themes within these concepts. Midwifery promotes the concept of a partnership that involves several principles: the

ability of the client to negotiate over rights and self-knowledge, equality and sharing of responsibility within the partnership and continuity in the care given (Guilliland and Pairman, 1994; Pairman, 1998).

Exploring professional friendship

When discussing an aspect of the client/therapist relationship, others have also outlined something resembling a friendship. Crepeau (1991) says that occupational therapy is a small and relatively new profession and that the everydayness of occupational therapy practice brings therapists into a close relationship to their clients, that therapists are likely to have a similar social status to their patients. She says that this is a strength enabling therapists to enter the patient's life-world more easily. From there it is possible to gain a depth of understanding of the client with clients in some literature "talking about therapists as friends" (p. 1019). A sense of reciprocity is described as existing in some therapeutic relationships and Peloquin (1990) says that this and personal respect are aspects of friendship. Peloquin (1990) cites Mays as using the word 'covenanter' to describe the occupational therapist as a friend, a term that implies "a sense of reciprocity characterising the giving and receiving" (p. 18).

Other health professionals' writing also discusses the notion of friendship between clients. Within midwifery in New Zealand a notion of 'professional friendship' is put forward. One finding from Pairman's (1998) study is that the ongoing and frequently very personal interaction between midwives and women can be described as a special type of friendship that she defines as 'professional friendship.' She says that on the one hand the woman is likely to describe the midwifery relationship as friendship while on the other the midwife calls it a partnership. Pairman describes the relationship being much the same for both though the context differs for each person. The name 'professional friendship' allows for the professional role while still incorporating the notion of friendship within the relationship. Yet, because the relationship has been entered into because of the client's need, Pairman (1998) refutes the idea that health professionals can have a true friendship with clients and cites Bignold, Cribb and Ball as agreeing. They prefer to use the word 'befriending,' which implies elements of friendship yet also recognises the concerned involvement of the practitioner. The description of 'professional friendship' put forward by Pairman, while putting boundaries around midwives' involvement as professionals, also allows for the trust,

reciprocity, and a knowing closeness that may develop as an aspect of friendship. For many clients, a relationship with a health professional that could be described as a 'professional friendship' is likely to have positive outcomes in terms of feelings of trust and being understood.

What is missing in the literature?

During the process of exploring themes of client/therapist relationships I made a number of discoveries. While there are many international qualitative studies showing aspects of this relationship there are a negligible number of quantitative studies. The nature of exploring the meaning and significance of relationships from the client and therapist perspective lends itself to a variety of qualitative methodologies within research. Morse and Field (1995) confirm this, telling us that in qualitative research there is a view from the "emic perspective, that is from the 'native point of view', and in clinical research that may be from the perspective of the patient, caregiver or relatives" (p. 10). They describe quantitative research "seeking causes or facts from the etic, or 'world–view' perspective" (p. 11). It is therefore hardly surprising that in this area there are few studies using quantitative methodologies. What is surprising is that so much of the literature in this area focuses on the relationship from the therapist's perspective. A perception of the client view emerges in studies through their interaction with the therapist participants. Alongside this while the relationship between health professional and clients shows as an integral aspect of a number of New Zealand-based studies related to other health professional groups there is a negligible range of research in this area that originates from occupational therapists in this country. The need becomes apparent for research that explores such relationships from both the client and therapist perspective.

Not a lot of information comes through in disability magazines, journals and books written by and for clients about what matters to them in relationships with health professionals. The focus tends to be outward looking to general or national issues affecting the people the magazine is written for rather than focused on individual experience of relationships with therapists. There is very little in the literature that I have read that is given to people with disabilities that alerts them to choices that they have in their interaction with health professionals and occupational therapists in particular. Although many people with disabilities have written books about their lives

it seems that only occasionally does the issue of interaction with health professionals arise and this is more frequently about the medical practitioners' attitude, particularly at the time of diagnosis.

Summary

Showing through in this literature review is the way that views held in the past of the patient/client and the therapeutic relationship have influenced occupational therapists' thinking and practice today. A number of current theories and perceptions of practice impact on the client/therapist relationship. Clients can be seen to be giving important messages to occupational therapists and health professionals at times critical about their way of interacting with them. Occupational therapists' writing shows that they are taking notice and responding to this information from clients describing what matters to them and owning that their relationships with clients are not always satisfactory. There remains insufficient research into the client's perspective to identify what they expect from therapists.

A poem ~

about all the words

Whose voice
Do I hear?
Some within
Some out there

I hear
This feels the best way
No
This is the right way

Was it
Simpler
To know
In the past?

Fewer choices
Simply follow
Fewer voices
Telling how

How to see
What they say
What are they telling
What matters?

that come from everywhere

Chapter Three

Methodology

> Heidegger talked about phenomenological reflection as following certain paths, "woodpaths" towards a "clearing" where something could be shown, revealed or clarified in its essential nature. However the paths (methods) can not be determined by fixed signposts. They need to be discovered or invented as a response to the question at hand. (Van Manen, 1990, p. 29)

Introduction

The journey that I have followed in doing a phenomenological study, and the path that I took leading to the research becoming a thesis, is captured in this chapter. Beside the pathway there are signs indicating the philosophical underpinnings of this research study and my position within it. The way that Heideggerian hermeneutic phenomenology supported and linked with my research question is described. Notions from Heidegger, Gadamer and Van Manen, used as a means of interpretation in the study, will be outlined showing the interconnectedness between them and the philosophical approach. Their links to the relationship between clients and therapists and their relevance to occupational therapy will be shown. My own embeddedness in the study was addressed in chapter one and this chapter will focus in more depth on the prejudgements I brought to interviewing and interpreting stories from participants' narratives. Voices other than my own are described as having influenced the interpretation. Aspects of the study design will be outlined along with a discussion on trustworthiness.

Philosophical underpinnings

Guiding this research study is the philosophy of Heideggerian hermeneutic phenomenology. In the first chapter, in outlining the background to my starting this research I have shown how I was drawn into using this methodology. My research question "what is the meaning of the experience of the relationship that people with a disability who live in the community have with community occupational therapists?" lent itself to the use of a methodology that centred on understanding and interpretation. With the focus of my study being the experience of relating between client and therapist there was a call for a methodology that gave the opportunity to look at everyday lived events, through the experiences of clients and therapists, crafting stories from these, interpreting their narratives and writing in such a way as to show their deeper meaning. The showing of these hidden ways then offers health professionals, such as occupational therapists, and the consumers of health and disability services, the opportunity of a new way of seeing and engaging in future therapeutic relationships.

Heidegger (1962) tells us that "phenomenological description, as a method lies in interpretation" (p. 61). Phenomenology as a philosophical methodology provides the opportunity to see a person in the context of their life-world. Yet Heidegger also warns that we may be taken in by the appearance of a thing, an entity, that it may be only a semblance of the thing in itself and we may not be seeing what's really there. Smythe (1996) says that in phenomenological inquiry what we seek to understand is the 'being' of a phenomenon, and in this way I looked to understand the 'being' of the phenomenon of relating. Peeling back the layers, searching for what was already there, frequently hidden or only partially showing, became a quest in this study. Alongside this, using hermeneutics provided me with a way to express the interpretation, to 'show' participants' experience and their context through language. Gadamer (cited in Allen, 1995) tells us that "language speaks us" (p. 176). In combining hermeneutics and Heideggerian phenomenology it seems that I have come to use interpretive phenomenology as my methodology.

Having started out with the belief that I was using Heideggerian phenomenology to guide my study I have found throughout the process of examining and interpreting the participants' stories that there was much that was hermeneutic. Frequently the

participants moved away from immersion in their stories to tell me what they thought about their experience and thus began their own interpretation of the story. Alongside this, my involvement with the text has been one of close engagement, of writing and rewriting and bringing my own concerns and views to the data in order to reach a place of understanding that previously lay hidden from me. At times this 'writing to understand' involved my capturing in verse the thing that was speaking out to me in the story. Heidegger (1971) tells us that "language speaks," that "we must seek the speaking of the language in what is spoken," that "what is spoken purely is the poem" and so we come to listen to what is spoken through that bond (p. 193 -194).

Van Manen's (1990) ideas revealed how to take a story and move it to a different place where new things could become known. His writing showed me a way to analyse others' stories, moving from immersion in the subjectivity in the narrative, to linking the story to other worlds, and to metaphors and the 'truths' that permeate our world. He tells us that "to write is to measure the depth of things, as well as our own depth" thus showing me that in writing I also produce something of myself, adding this into the study (Van Manen, 1990, p. 127). Coming to understand Van Manen's work gave me increased access into ways of looking at the, at times, inaccessible and linguistically complex notions of Heidegger. As I came to understand some of these notions I found that they brought a new sense of life into the analysis, showing more clearly the participant's world of interrelating and bringing this world out into the open in a way that I had not previously seen.

Heideggerian notions used in this study

Central to Heidegger's (1962) philosophy is the notion of 'Being' or 'Being there' and from this all others flow. In this study the notion of 'Being' shows participants to be different people each situated within their world. This life-world is not static but rather is full of the action of living in the world, a world that is already there. Grenz (1996) says that this embeddedness in the world, this 'Being-in-the-world,' is one of the most important aspects of Heidegger's thinking (p. 105). Throughout the three findings chapters I have used further notions from Heidegger and these are outlined as each new notion arises in the analysis of the participants' narratives.

Van Manen's life-world existentials

Threaded throughout and guiding the analysis and discussion are notions that Van Manen (1990) described as grounding human existence, the life-world existentials. These provided an additional guide to seeing and describing what was occurring in the participants' stories. The 'lived body' refers to the idea that we are bodily in the world, experiencing it through our bodily presence, and shows in this study in the way that a client reacts with signs of physical anxiety in the presence of their therapist. 'Lived space,' shows in the way we 'feel' space and in stories of the meaning of home as a safe place for clients. 'Lived time' is a notion that shows how subjective the meaning of time is and in this study time is both given and taken away. 'Lived other,' the way that we maintain a relation with other people, comes through in sub-themes such as the stance that both clients and therapists take with each other. These 'life-worlds existentials' come from Heideggerian notions of 'being-in-the-world.'

Gadamer's notions used in this study

At times it was Gadamer's (1982) notions that fitted best with participants' stories with his description of the 'self' needing to be open to the 'other' in order to reach a new place of understanding. Gadamer's philosophy is closely linked and built on Heidegger's concept of 'being-in-the-world.' He tells us that because we each stand within a world there is no escape from our historical context, and because of that we develope different perspectives (Grenz, 1996). To reach a new point of understanding involves the 'self' being open to the newness of the 'other' whether it is text or people. In this way a 'fusion of horizons' can be reached. These "metaphors for understanding" made Gadamer's concepts seem particularly relevant when participants' stories involved the different life-worlds of clients and therapists (Koch, 1996, p. 176).

Dilthey and the hermeneutic circle

In describing what Dilthey called the hermeneutic circle, Grenz (1996) tells us that understanding text is complicated … "that the complex wholes and their parts are always inseparably intertwined. We can comprehend a whole only by appeal to its parts but the parts acquire their meaning only within the whole" (p. 101). This was just as I found the process of analysis and the search for emerging themes in this study. Frequently it was the parts that guided me to a new understanding of the whole, and yet

it was the whole of relating that showed me the meaning of each major theme that made up the whole.

Why use this methodology?

During the course of my studies I have come to understand the usefulness inherent in a range of qualitative and quantitative methodologies. However the qualitative methodology I chose to use seemed to offer an opening up of possibilities and a keeping open of those possibilities within the research question (Van Manen, 1990). The questioning that I brought with me to the study was one of looking to unearth and uncover the essential meaning of a lived experience rather taking a pre-determined position on the meaning of the experience of relating between client and therapist. Van Manen also tells us that, unlike phenomenology, much other social and human science research has a clear-cut and frequently precise question that enables much of the research to be shared out within a team. Phenomenology, on the other hand, with its looser questioning, depends on the researcher's commitment and ability to 'live' with the research question as it evolves. It is then up to the researcher to draw the reader into this world of experience showing through in the study. As an integral aspect of hermeneutic phenomenology is the search for meaning within lived experience, this linked well to my research question. For people with disabilities, relating to community occupational therapists the context of their life-world matters and will guide and shape the interaction. This methodology lets this context, the client and their personal and social world, as well as the environment that they live in, come through as integral aspects of the study. In this way phenomenology allows for both a focus on what is unique, the personal, yet recognises the broad context of the whole (Van Manen, 1990).

The possibility of showing this human to human interrelating in a study of this nature seemed to provide opportunity for insight and understanding of the client/therapist relationship. The focus would remain on the participants shown as embedded in their life world, for it is through listening to participants' stories that we can gain awareness of what really matters to them. This leaves the opportunity for other ways of 'seeing' and understanding what is going on and unearthing the many ways these people interact with each other.

How does phenomenology fit with occupational therapy?

As part of a growing interest in qualitative research, occupational therapists, along with other health professionals, have contributed to the increasing output of qualitative studies being published in professional journals (Krefting, 1991). While there have been many studies coming from other health professional groups that have the philosophy of phenomenology underpinning them, this has occurred to a lesser degree in occupational therapy research. In examining much of the occupational therapy literature it becomes clear that while these studies have a 'phenomenological flavour' phenomenological methods have not necessarily been used (Finlay, 1999). Mattingly and Fleming (1994) carried out an extensive Clinical Reasoning Study in the USA which emphasised occupational therapists' "phenomenological way of thinking" (p. 299). Finlay says that, in occupational therapy in the USA, much of the interest in phenomenology has been prompted by this study. There has been an increase in occupational therapy phenomenological literature, and at times research, that focus more frequently on practice and less so on relationships.

Peloquin (1993) has published a paper that looks at the depersonalisation of patients using a phenomenological perspective to explore themes while Lyons (1994) published an account of professional behaviours of students working with clients in a mental health setting. Hasselkus and Dickie (1994) have examined dimensions of satisfaction and dissatisfaction within occupational therapy and there is a study by Rosa and Hasselkus (1996) that looks at the personal experience of professional helping. Finlay's (1997) paper outlining a theme from a larger study on therapists' perception of patients describes her use of a phenomenological approach. While these studies are described as phenomenological, there is a varied interpretation by the researcher of what this means within their study. The majority of these studies do not describe underpinning the research with Husserl or Heidegger, who are described by Morse and Field (1995) as having laid the foundations for phenomenology.

When working as the Occupational Therapy Head of School in Auckland, Whiteford (1998) completed her doctoral thesis. This hermeneutic phenomenological study explores the meaning of being culturally competent from the occupational therapy student's perspective and in doing so examines both relationships between therapists

and clients of differing cultures and those between students and therapists. I have been unable to find any further occupational therapists in New Zealand who have published studies using a phenomenological methodology. Yet occupational therapists have long claimed that the work that they do goes beyond 'treating' an aspect of the person, encompassing the person's life, their environment and other factors that are affected by ongoing disability. Mattingly (1991a) tells us that "occupational therapists have known for a long time: To effectively treat persons with long-term disabilities, one must treat the whole patient, which involves looking beyond the disease to how that disease is experienced by that particular patient" (p. 1000). The methodological approach of this study that sees both the client and therapist as embedded in their life links strongly to this perception of occupational therapy. Kielhofner (1982) describes why it is that occupational therapists are drawn to use qualitative methodologies:

> There is a special harmony between the concerns of occupational therapy and the paradigms and methods of qualitative research. Both focus on the reality of everyday life. Both appreciate the deep richness of mundane affairs. And both attempt to gear their techniques to the realities of the people involved (p. 162).

Explicating my assumptions and pre-understandings

Heidegger (1962) tells us that our interpretation will be influenced by our fore-having, fore-sight and fore-conceptions, that we bring this historical context to all our encounters. Van Manen (1990) also reminds us that the problem with doing hermeneutic phenomenological research is not that we know too little but through our pre-understandings we know too much. Our everyday assumptions as well as the knowledge gained in relation to our field of work gets in the way of 'seeing' clearly the phenomenon that is in front of us.

Within phenomenology there are differing expectations of how this fore-knowledge will be managed. While Husserl's method of phenomenology would expect that these pre-conceptions and beliefs would be 'bracketed,' holding them aside so that they would not impinge on interviews, this is not an expectation when using Heideggerian phenomenology as a methodology (Koch, 1996). Van Manen (1990) tells us that if the researcher tries to suspend beliefs they will simply 'creep' back into the research. However there is an expectation that a researcher using Heideggerian phenomenology

will reflect on their fore-having, their own context, acknowledging this as an aspect of themselves maintaining awareness of their influence during the interview and interpretation process and throughout all aspects of the study. Koch and Harrington (1998) remind us that it is unavoidable that our interests will be incorporated into the study. How to signal and show when this occurred challenged me as the researcher.

Professional context

As an occupational therapist with experience of working in the community with clients similar to those participating in this study I had a degree of credibility with both the agencies supporting the client group, community occupational therapists and their professional advisors. During the almost sixteen years that I worked with people with physical disabilities I saw a small number of people throughout much or all of that time. These clients were the people it was difficult to not to think about when I returned to my life outside work. They were significant relationships in my life. Sometimes there were problems arising from being unable to spend sufficient time with clients. Issues, such as funding, could be a major barrier to having an open relationship with people who both needed my support and the access to resources that I could provide. My work world included at times being a friend, a partner, an ally and an advocate to clients. On other occasions I was a person to direct anger or dissatisfaction at. Always there were professional standards to comply with, and management decisions and funding criteria to fit in with. For the last six years I also supervised therapists showing them how to do the things that I sometimes struggled to do well myself. Overall I gained a picture, possibly a fixed view, that became part of my prejudgement about how a community occupational therapist should relate to and practise with clients, and about the boundaries around those relationships.

Eighteen months ago a paper that I wrote in partial fulfilment of the Masters of Health Science degree was published in the New Zealand Journal of Occupational Therapy (1997). This paper, titled, 'Unearthing the core relationship: The client and the community occupational therapist,' led onto my present research study. Those years of experience, followed by study focused on therapeutic relationships, while giving a depth of immersion in the area of my research also provided what Koch (1996) described as "frames of meaning" to my understanding about therapeutic relationships and occupational therapy practice (p. 176).

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How my pre-understandings affected my research interviews and analysis

At times my pre-understandings influenced the way I felt during the process of the study. When a client participant told me about difficulties she had experienced I wanted to step out of my research interviewer role and ask about the absence of a social worker involved in her life at that time. My years working as part of an inter-disciplinary team gave me strong beliefs about the challenges that had faced her. I wanted to 'leap in' and become actively involved. As this situation was in the past, and not a current crisis, I instead elected to listen and saved the discussion for my thesis supervisors. I held my previous role as a therapist in my mind, acknowledging its influence but also aware that this was not the purpose of the interview.

Sometimes client participants told me stories that made me wonder at the amazing work of a therapist. Supervising the work of other community occupational therapists, I had experience of acknowledging to them the occasions when their practice was exceptional. As I listened to stories from participants that described, for instance, a therapist thinking laterally to come up with a wide range of possible solutions I wanted to applaud the ability of that therapist. But I was not there to make judgements about occupational therapists' practice or the quality of their relationships. I needed to refocus on the client's story without being caught up in the therapist's ability. Also, because the occupational therapy profession is small, many of the therapists who clients talked about were former colleagues or friends of mine. Sometimes they named them; often they did not. I was always curious about who these therapists were yet, because of the confidential nature of research, I didn't ask.

When the therapist participants told me their stories of extremely difficult times they'd had when relating with clients I felt empathy with them for the stress they'd experienced. When I came to analyse these stories I found it difficult to take myself out of the therapist's role, to look at the story from all angles, to see it using 'other's eyes.' Believing that I had come to achieve this also gave me an uneasy feeling of 'disowning my own,' of betraying the therapist's position in such a stressful situation when it seemed they had so few options. It has been a struggle, a struggle to honour the stories that participants so openly and generously gave me, to uncover what wasn't clearly showing within the relating in order to find the many meanings in those stories and to feel that I had done participants' stories justice.

Considering potential participants

I decided to involve as participants in the study people who came from both groups interacting in the relationship that I was exploring. Hearing the stories from both clients and therapists gave openness to 'seeing' whatever might come out of the participants' narratives. At the same time there were dilemmas for me in choices of participants. I have visited many people with ongoing physical disabilities in the city the potential participants lived in. During the years that I practised as a community occupational therapist I was part of a wide network of community occupational therapists. This familiarity worked both for me and against me. On the one hand I had a high level of awareness of who to contact and how to make those contacts. On the other, there was considerable risk, within both the client group and the therapist group, of people feeling coerced to participate. This issue was resolved by electing to only interview clients who I had not seen when I worked as a community occupational therapist and to only access therapist participants who I had not had a close working relationship with.

Study Design

Ethical approval

The Auckland Institute of Technology Ethics Committee granted ethical approval in February 1999 following the study being approved by the North Health Funding Authority Ethics Committee whose consent was also granted in February 1999 (Appendix A, p. 176). I remained conscious of my obligation to protect participants throughout the research study and thesis writing process.

Accessing participants

Phenomenological research requires from participants that they are able to share their stories in a way that is evocative of their experience therefore a factor was that participants needed to be able to articulate their stories clearly in English. Ensuring that client participants had not been visited by me in my past working capacity was no easy task. It involved a delicate negotiating with the co-ordinators to ensure that we did not breach the client's right to privacy.

Clients

I initially wrote to various New Zealand disability organisations describing my study. I enclosed participant information sheets (Appendix B, p. 177) and asked for co-ordinators' help in finding participants that met the inclusion criteria. Later when I rang them they had frequently been in touch with potential participants. I ensured they met the inclusion criteria. Clients needed to have an ongoing physical disability, as this was the group of people whose experiences I was researching. They needed to have experienced a relationship of some depth with a community occupational therapist. I was concerned to ensure that I would not find a person that I was interviewing had only had a single visit of little consequence from a therapist. The age range chosen was twenty-five to fifty-five years as I considered that people over twenty-five years were more likely to have left the family home and be making their own life choices.

Therapists

Community occupational therapists working for Community Health Services in New Zealand were asked to participate in the study and were given an information sheet (Appendix C, p. 179) by their Advisory occupational therapists who I had written to outlining the inclusion factors for therapists in the study. These factors closely resembled those for the client group although no age factor was specified. Several therapists declined to participate in the study because of factors such as workload and annual leave being taken.

Once co-ordinators of disability organisations and advisory occupational therapists had sought and received agreement from people to participate in the study the participants were asked to ring me or told that I would contact them. All participants had information telling them that there would be one interview lasting between three-quarters of an hour and one and a half-hours and would involve signing a consent to participate form (Appendix D, p. 181). They understood that a second short interview might be necessary and that I would send the stories from their interview narrative to them. This gave the opportunity for them to comment on whether they believed this represented what they had said to me and to allow for any deletions or changes.

The study participants

I am conscious that in order to protect participants I must give only general information rather than individual descriptions that might identify participants. Five people with physical disabilities and five community occupational therapists agreed to participate. I chose to interview all five people from each group, recognising that a large number of participants are not required for a phenomenological study that has an aim of "illuminating the richness of each individual's experience," with each person's stories giving value to the findings (Baker, Wuest & Stern, p. 1357). Generalising findings is not compatible with the method. A decision was made early on to interview the clients first and the therapists second. This gave the opportunity for the therapist interviews to be guided by the things that stood out in clients' stories and early analysis of the client narratives.

Clients

All the client participants in the study were women. As participants were identified by agency co-ordinators using my inclusion factors I'm unsure of why this occurred and can only speculate that availability and willingness to participate may have been factors. At one point a man who I had contacted withdrew before being interviewed, having decided that his experience of relating with a community occupational therapist was insufficient to meet the study requirements.

These five people were aged between twenty-nine and forty-two years. The length of time that they had had their condition/disability was from twelve to forty-two years although some conditions had only been correctly diagnosed as recently as five years earlier. The participants' conditions/diagnoses encompassed neuromuscular conditions, neurological conditions and a genetic disorder. While all participants had ongoing physical disabilities some were independently mobile while others used a wheelchair for the majority of their mobility. Four of the five client participants had tertiary education/training and this may have influenced their decision to participate. All had worked or were currently working in the paid workforce outside the home. Two participants were engaged in some voluntary work. At the time of interviewing, two were also actively involved within the family as caregivers of their children. It seems possible that the selection of so many client participants with tertiary training/education

was influenced by an inclusion factor asking for participants who were able to clearly articulate their stories. It is also possible that the agency co-ordinators were more likely to choose people like themselves with tertiary education and training.

All client participants were of European descent. No Maori, Pacific Island or Asian people or people from any other minority ethnic groups were participants in the study. This was not influenced by any exclusion factor. However an inclusion factor requiring participants who could clearly articulate their stories in English may have influenced co-ordinators to approach certain prospective participants. The five client participants had been visited by from one to three different community occupational therapists over a number of years. While some involvement was frequent and regular, much was intermittent. All had experienced at least one significant therapeutic relationship with a community occupational therapist.

Therapists

The five therapist participants were women. The likelihood of having a male therapist participant would have been affected by the low ratio of men to women in this profession. Quite late in the study, I chose to engage in a discussion with a therapist around an aspect of my analysis. Through doing this she became another participant. The therapists' ages spanned from twenty-eight to fifty-seven years. Participants had one and a half years, to twelve years, experience of working in the community with a client group that included people with ongoing physical disability. The time that they had worked as occupational therapists was five years to twenty-two years. This depth of experience gave me an expectation that they would all have had significant therapeutic relationships with clients with ongoing physical disability.

There were no Maori or any other minority ethnic groups represented in the therapist group. All were of European origin. There was always a strong possibility of this being the case as there are limited numbers of people from Maori, Pacific Island, Asian and other ethnic groups working as occupational therapists in New Zealand.

Protection of participants

All participants were contacted through a third person. This ensured that there was no coercion from me, as the researcher, to participate in something that they preferred not

to take part in. I chose to not interview therapists who were visiting client participants that I did interview so that there were no matched pairs in my study. Participants' names were coded with a pseudonym of their choice. The audiotapes used in the interviews were offered to the participants if they wished. They chose not to have them returned. Two different typists transcribed four of the eleven interviews and signed a confidentiality document (Appendix E, p. 182). I transcribed the other seven. The tapes and transcripts from interviews are securely held in a locked cabinet.

Strategies to ensure confidentiality and anonymity

From the beginning of the study I was aware that anonymity and confidentiality were important issues that could be inadvertently compromised. Both client and therapist participants came from quite small populations of people within New Zealand. Being mindful of keeping participants' identity confidential involved a variety of strategies. I eliminated precise diagnoses from all participants' stories. Details from both clients and therapists' narratives that may have identified the therapist or client they were discussing were also altered. I chose to remove or alter details of participants' stories that revealed locations, unusual circumstances, or identifying details of their life and work. Alongside this, I offered on my information sheet to meet participants at the place of their choice. This was suggested as a way of eliminating the possibility of family members or work colleagues being aware of their participation in the study. However, all participants chose to be interviewed in their homes or place of work.

Incidents occurring during interviewing

During one interview a participant began to refer to a sensitive aspect of her social history that she had mentioned prior to my turning the tape on to record the interview. I stopped the tape and asked her if she wished what she was saying to be included in the study. She said she preferred that it wasn't and that brief aspect of the tape was wiped. During another interview a participant became very tearful when talking about someone she'd interacted with who had died. Preferring to sit quietly, and not intrude into the situation while she recovered, I left the tape running. She did not request that section of the tape be removed. Once, ten minutes into an interview, I discovered that the tape recorder was not recording. We stopped, talked about the issue of starting again, and then continued. Some of the earlier interview material was particularly valuable and I

prompted the participant to recount some of those earlier stories, and she appeared relaxed about doing this.

Phenomenological interviewing

Interviewing for a hermeneutic phenomenological study involves the researcher getting as close to the individual participant's experience of the phenomena as possible (Van Manen, 1990). It was important therefore to focus on the research question and to keep that constantly in my mind during the 'conversational interview' with the participant as described by Van Manen. My approach to participants and their stories was one of valuing and accepting that the encounters they were discussing were an honest telling of that experience. The phenomenological approach to participants is that "the 'truth' is what the participants are saying" (Finlay, 1999, p. 302).

We frequently started with coffee at the participant's suggestion. As a guest coming into their home and as a gesture of appreciation of their involvement I took food with me which we sometimes ate as we drank the coffee. This frequently set the tone for relaxed, informal interview sessions together. The interview format was of an unstructured nature and therefore varied from participant to participant. I recognised that the phenomenological interview resembles a conversation where the researcher has the participant tell a story about a specific event at a specific time in order to remain focused on and as close to the actual experience as possible. There were a number of occasions where I felt that the participant appeared pleased, gratified or relieved to have told a researcher that particular story. At other times I sensed, and it was largely unspoken, that a participant felt that they were putting the past to rights by having their story heard through my research study.

There was a tendency for some participants to move away from the description of being in the experience to more general and, at times, objective discussion of the relationship. In keeping with the boundaries that exist around conversation I sometimes chose to let this happen, recognising that it was too intrusive to interrupt. Sometimes by asking 'how' questions I could draw them back to 'being in the story'. On other occasions I waited until they had finished before leading the participant into telling me about their experience by being very concrete. I would ask, *Can you tell me how it happened? How was the choice made about which room to sit in on that first visit? How did you feel*

about that? Therapist participants tended to stand outside their stories to a greater degree and this altered the 'flavour' of many narratives, giving a more hermeneutic description where they moved away from describing a pre-reflected encounter to explaining the meaning of what had occurred. The interviews overall had a strong combination of both hermeneutics and phenomenology showing through in the experiential narratives (Van Manen, 1990).

The client participant interviews

During my initial interviews I found that in order to feel confident I needed to go in to them with some questions on paper along with several prompts. I then tended to hold the questions in the back of my mind so that when the person being interviewed 'ran dry' I had something to move the interview along with. My opening question for each interview with clients was of this nature: *Can you tell me about the last time the community occupational therapist came to visit you and what happened – starting at the beginning tell me how you felt about the visit and the things that 'stood out' about it?* The stories that followed were an interweaving of several visits from a therapist, in no apparent order and sometimes stories of visits from different therapists.

Occasionally the interviews took place with children or a caregiver present. Again this presented no problems. Interviews were between three-quarters of an hour and one-and-a-half hours. The length depended on the client and when they felt they had finished and said all that they had wanted to say. I waited at the end of stories and the interview for those last words that were sometimes added, frequently something significant that had been held back. Then each interview was finished with the question: *Is there anything else you'd like to tell me about your interaction with the community occupational therapist that might be helpful to others?* This elicited some interesting responses of a hermeneutic 'standing back', looking at the relationship variety. The five interviews with clients, while varying considerably in length, depth and content, provided such a wealth of narrative that I did not need to return for a second interview with any client to clarify narratives or gain additional stories.

The therapist participant interviews

All of the community occupational therapists chose to be interviewed in an office at a community health base. Interviewing therapists in the workplace, while appropriate, possibly added a more formal aspect to some interviews. At times difficulty was experienced with noise and keeping the fact that interview sessions were taking place confidential. Prior to starting the interview, we discussed the client group that I wanted therapists to have in their mind when telling the stories of their relating. I also assured them that their practice was not in any way being evaluated but that rather I was looking to use the stories of their experiences to seek out the depth of meaning in relating between them and a particular client group.

I brought two opening statements to each interview based on the stories and early analysis that was emerging from the earlier client interviews. The first was an invitation of this nature: *Tell me a story about a visit with a person from the client group we've discussed where you felt that it went particularly well, where the relationship worked.* And following that response: *Tell me a story of a visit to a person from the client group where the relationship didn't go so well, where the relationship didn't work.* These opening discussion points elicited many stories though there were occasions when a therapist spent some time considering a relationship from their experience that met the request and was with someone from the client group. Examples of prompts that were used are *Can you tell me more?* And *How did you feel about that?* The therapist participants generally expressed interest in the focus of the study.

For most therapists five minutes into the interview with the tape rolling and stories underway their early tension eased. Much of the initial hesitation and apparent search for the 'right story' moved into the background and the way they began to express themselves became more fluid. At times, therapists appeared to be enjoying the opportunity to tell about their relating with a particular client. On other occasions, therapists struggled to find the right expression or words to describe their experience, feeling the need to be 'correct' or perhaps clear in what they were saying. This was not so apparent in the client interviews. Therapists also had a greater tendency to stand back from their stories and talk about what happened in a less 'involved in the experience' manner. Perhaps this is in the nature of being a health professional and the perceived need to be objective. At times it seemed, when reflecting on difficulties in the

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relationship, that therapists wished to 'be fair' to the clients, explaining and giving the 'bigger picture' to me of why for instance the client may have been challenging to work with. It is possible that for some therapist participants the relationship they at times 'stood back from' when discussing were of a less personal nature than for client participants who were describing the experience of the therapist entering their family home and environment, their life-world.

Difference showing between client and therapist interviews

When the interviews with each participant were complete it became apparent that there was a difference showing through in client and therapist stories of effective relationships. All the client participants had offered a variety of stories about relationships with therapists that were particularly rewarding or where there was a sense of attunement between them. Therapists' stories differed. Their stories told of their own struggle to overcome barriers when working with clients where they believed they had developed positive relationships with them. Frequently the clients in those stories had long-term deteriorating conditions with loss of function over time.

Because of this difference I decided to interview one therapist participant immediately after she'd visited a client where the relationship between them was positive. This was an attempt to catch the relationship working on an everyday basis rather than the challenging experience that lingered in their memory. This second interview was approximately half an hour long. While there was apparent ease in the relating between the therapist and client, it seemed that the therapist worked hard in reaching a place of being satisfied with where she had got to with the client. It was the same pattern coming through of the therapist's perception of the relating working well when she had struggled to overcome obstacles to get there.

Working with the data

In total I transcribed seven of the eleven taped interviews myself. Although this was time-consuming, a major advantage was the familiarity that I developed with each participant's narrative. I found that I was able to remember significant aspects of these stories. This assisted in showing me the connections between stories and recognising aspects of stories that showed 'another side' of what I had already seen. A whole variety of themes 'jumped out' of the narratives over the five months that I was interviewing,

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transcribing, listening, reading transcripts and pulling the threads of stories together from the narratives.

From each participant's narrative I pieced together between four and eleven stories pulling the threads of stories from different sections of the interview. This was the material that I sent back to participants. It was important to me that that in changing the order or sequence of the story to improve 'the flow' and in altering the grammar, that the stories still represented the narrative they had given to me (Van Manen, 1995). Minor alterations were made as participants requested them. At times I struggled with how the stories would fit together into themes at the same time believing that they showed important aspects of the client/therapist relating. Many of these early 'themes' from the material became sub-themes within the umbrella chapters of the research findings.

Analysis

Van Manen (1990) describes six stages to conducting hermeneutic phenomenological research giving a method that guided my study. He tells us that these activities overlap and impinge on each other rather than happen in an orderly sequence and this is how I found it to be. These steps involved the following activities: firstly turning to the nature of lived experience – in my study this was my focus on an area that I was deeply interested in, the client/therapist relationship. Secondly, investigating experience as we live it revolved around the participants' story of what happened, their experience of relating with each other. The third research activity of reflecting on the essential themes that characterise the phenomenon was an ongoing process that I found developed throughout both the interviewing and analysis stages occurring concurrently. Van Manen's fourth activity of describing the phenomena by writing and rewriting involved me in constantly reworking the analysis and findings chapters. In his fifth activity of maintaining a strong and oriented relation to the phenomena I am reminded of the way in which the phenomena of the client/therapist relationship came to dominate my thinking during the months of the study and thesis. Balancing the research context by considering the parts and the whole is the sixth activity Van Manen described. It was easy to become engrossed in one aspect of the study. Yet standing back to examine the total of the relationship became necessary in order to understand better the parts of it. This then leads on to a new sense of the whole.

Each story from the narratives was looked at using three questions. These questions were, w*hat is the meaning of this story (what does it say about the relationship), what matters about the relationship in this story, and what is showing itself in the relationship?* Through approaching each story with these questions I came to learn to move my interpretation from what was happening for those particular people in the relating in that story, to a slightly removed stance of pulling out the significant issues that linked client/therapist relating, to seeing some universality that might also be 'true' for others in what was occurring. An example of the last level of interpretation would be the meaning of time in several stories. This period of writing and rewriting around the interpretation of stories occurred continuously over more than six months of the study. Early on in the process of working with participants' stories I began to write verses that seem to come from the way those stories spoke to me, showing something significant in the relationship. This method was another way of coming to interpret participants' stories. Frequently these verses seemed closer to bringing understanding to the text than my early analysis had and so I turned to them to assist and guide my interpretation.

From the beginning of the study I was aware of the need to search out the literature that would explain to me more about what I was seeing. Texts added to the reflective process I was going through often assisting in crystallising ideas that I had been playing with. I used research material, occupational therapy studies, texts on phenomenology, and other literature such as biographies and autobiographies, poetry and fiction. I 'squirreled' information away, storing ideas for their potential usefulness. Frequently I worked with words and phrases from the stories, playing with them, searching out possible and deeper levels of understanding. This was a very hermeneutic way of interpreting. Metaphors could show the meaning in another way and at last I would reach that new place of seeing something that had always been there, a covered over-aspect of the phenomenon.

The research narratives came from the participants. I added my knowledge and experience, analysing them, to move beyond the taken-for-granted, assumed meaning to show what was hidden from sight in the depths of the relationship. My analysis involved looking at the experience in concrete terms as well as searching for the essential nature of that experience (Van Manen, 1990). My own prejudices lay in my background, primarily showing in the area of identification with the community

occupational therapist role. This meant that when I came to analyse stories from therapists where they had experienced challenging situations with clients I found it initially difficult to see other sides to the story. When clients' stories told of being treated neglectfully by their therapists it was difficult for me as a therapist to move beyond concerns around those practices of fellow occupational therapists to seek out additional meanings. This area became clearer to me through reflection and discussion with my thesis supervisors.

Further involvement with participants

I had undertaken to send each participant in the study the stories that I had drawn together from their interview narratives. My letter thanking them for their participation in the study and indicating the progress that I had made accompanied the stories. I received back a range of responses by email and telephone. More than half wanted no change to the stories, several asked for a clarifying word or two to be altered or inserted. Two participants asked for a larger number of words or sentences to be changed. Many of the changes requested gave a greater degree of detail or explanation within the stories that I had pieced together from their narrative. All the changes asked for were made other than those that might lead to identification of an individual. One client participant who had indicated to me that she wasn't interested in having the stories sent back to her did not respond. Following discussion with my thesis supervisors I elected not to re-contact that participant though her stories remained included in the study.

Themes coming into being

Van Manen (1990) describes phenomenological themes as structures of experience, and as a means of getting to the notion, reducing it, of giving shape to the shapeless. He offers a variety of ways of structuring the research themes. I chose to combine an analytical approach to structuring themes with highlighting phrases that seemed significant to the relationship. The following shows how this occurred. I reached a point eight months into the study where it seemed I had many parts showing a whole but only a small sense of how they fitted within the whole of relating. As I came to begin to write the findings chapters of the thesis as opposed to writing analysis of individual stories I found myself at a crossroads. This was the point at which decisions needed to be made about structuring into themes the sub-themes that had already arisen. Through a process of grouping sub-themes and ideas together for 'fit' I found that they fell into one of

three areas with links between all three. There were the 'things that came before' the face-to-face relating, the many 'things that made up the being together' in the relating and the 'things that came later.' All interconnected and made the whole of relating. This was a 'feeling my way forward' process, while trusting the plan that had come out of my reflection and work and the guidance of others.

During the process of writing the thesis, the placement of stories into chapters where they best fitted expanded the analysis and reflection. This showed their interconnectedness, and highlighting the contrasts, seemed to bring a deeper level of Heideggerian notions to the analysis. As in the hermeneutic circle the whole became greater than its parts. At the same time the value of the parts of relating were revealed in new ways.

Trustworthiness

Rigour and the issue of trustworthiness are much-debated issues in research of the nature that I have undertaken. While trustworthiness is an important aspect of all research, the dilemma remains of how to show what has been done and what framework to use. While quantitative studies have clear guidelines, and some methodologies within the qualitative paradigm such as grounded theory point to their own set of rules, Emden and Sandelowski (1998) tell us that there is a strong trend away from a reliance on quantitative criteria within qualitative studies. They believe that there is no absolute answer about what represents 'goodness' in qualitative studies. Koch and Harrington (1998) also describe little agreement within hermeneutic phenomenological research. They argue for an expanded conceptualisation of rigour involving reflexivity and a location of the researcher within the study. I have chosen Koch and Harrington's conceptualisation of rigour to show the strategies that were in place to guide my study to ensure its trustworthiness. These will highlight for the reader whether the interpretations and findings that I come to are warranted, whether they ring true, giving a sense of authenticity.

Reflexivity

While the interpretation and work involved in writing the thesis belongs to me, there are other voices speaking out from within it. The participants, former colleagues, fellow students, my thesis supervisors and many authors of journal articles and books can be seen incorporated into aspects of the study, supporting and at times verifying my work. The journal that I kept early in the study for reflection gave way later to writing and rewriting interpretations of participants' stories. During thesis supervision I kept a record of the discussion and the questioning. This questioning, both from within supervision and from my thesis supervisors' reading of my work in progress, became an important guide in expanding my understanding of what I was looking at yet not always seeing. Much of my progress came about through the reflection that moved my thinking along to a new place.

The issue of context has been given significance in this study. My personal and professional background within the context of this study has been examined and described in the introductory chapter and within this methodology chapter. I have shown that I have not been a neutral bystander but rather a part of the research process, involved and embedded within it. I have endeavoured to examine and maintain awareness of how my own horizon to understanding has affected the process of doing this study. Throughout the research study I have shown the social context in which it is situated. The introductory chapter and literature review show the historical and political backdrop, giving a context to the world that people with disabilities and health professionals came from thirty years ago and moved to in the current consumer-driven society. Therapeutic relationships have been shaped by the context of the social and political changes occurring within the Western world. Participants' stories also show them situated in their life-world, the context they are positioned in.

The work engages the reader

My intention has been for the stories from participants to stand out in the thesis capturing interest and provoking emotional response as well as speaking to the reader of the participants' world of lived experience. Some stories were left out. Some did not fit within the emerging themes showing isolated examples of relating. Other stories did not evoke a picture of the participants' pre-reflective experience as is desirable in a phenomenological study. It is hoped that the findings chapters of the thesis linking

participants' stories and the themes will engage the reader in such a manner that will encourage them to follow the analysis, to read the summary, moving on to the recommendations and conclusions that grew from them. The work as a whole should revolve around the lived experience and humanity visible in participants' stories and the interpretation of them, for these are the features that will give the study its plausibility.

Internal logic

I have endeavoured to show the way in which the research question links to the background to the study, the methodology and the method. A distinction has been made between different phenomenological approaches and those that have been used in the study. Heideggerian hermeneutics, notions from Van Manen's existential life worlds and Gadamer can be seen to link with and build on each other as part of a coherent whole. Heideggerian notions have been integrated to expose and highlight my interpretation of the relationship. These notions can be seen to connect with occupational therapy practice uncovering the significance of overlooked aspects of relating. Alongside this and showing through in much of the narrative material and analysis in the thesis is the path that was followed in reaching for a new place of understanding. Moving the interpretation from the participants' stories to the possibility of universal meaning and themes showing in the process of client and therapist relating indicated logic to this sequence. Many of the sub-themes in the findings chapters consist of common themes that came through from a number of participants' stories rather than being isolated individual incidences. I have endeavoured to show each interpretive turn in detail within its place in the research.

Credibility

Interviews with participants were carried out in an open and conversational manner that fits within a phenomenological approach as described by Van Manen (1990). Despite the interviews varying in length, it seemed that that enough time was allowed for sufficient depth to be achieved during those interviews. I had a sense that each participant had finished saying all that they wanted to say, had told their stories of relating, by the interview completion. Through returning stories to participants and giving the opportunity for them to ask for changes to their stories I gained an understanding that they were 'real' from each participant's perspective. The changes they requested and that I subsequently made were in terms of words rather than for

deletion of paragraphs, giving credibility to my belief that the stories did represent the participants' narrative. It is important in a study such as this to have involvement and input from people within the study who are consumers of the service that community occupational therapists provide to them. Near the completion of the thesis I contacted a client participant who was willing to read a chapter from the findings section of the thesis. This gave an additional opportunity for feedback and the information that came back from this participant was that she found the clients' stories believable and that she believed they had been treated with respect (Appendix F, p. 183).

Throughout this study the writing was commented on by my two thesis supervisors, prompting my reflection and rewriting. My understanding is that they are in agreement that my interpretation and the themes arising fit with the narratives. During workshops I have had the opportunity to present participants' stories along with my interpretation to fellow students and they indicated that they supported what I saw in those stories. At a presentation of my thesis to date to the academic staff and fellow Masters of Health Science students at the Auckland University of Technology it seemed that those who offered comment saw my work as credible. When presenting to a group of midwives at a seminar on 'doing phenomenological research' they described some of the participants' stories as 'feeling familiar' to them. Some stories and analysis caused them to stop, sit quietly and reflect. There appeared to be identification, on their part, with the universality within those stories.

I have also discussed my analysis of stories with an occupational therapy colleague who is a fellow Masters student. This too has supported my interpretation of the narratives. As a consequence of engaging in these 'conversations' with a number of people involved in hermeneutic phenomenological inquiry and with fellow occupational therapists I have confidence that the enacting of the methodology and method meets expectations of trustworthiness.

Plausibility
I have taken care to construct the research project thoughtfully incorporating reflective accounts in such a way that it shows the reader the possibilities of richness lying within. Notions showing the theory underpinning the study can be seen throughout the analysis. Alongside this much of the descriptive narrative from participants is included within the

stories in the three findings chapters. The interpretation within the study has been visited and revisited in the hope of bringing a greater depth of understanding to that narrative. It is through description that plausible insight of human experience occurs, bringing understanding in a phenomenological study (Findlay, 1999). Does understanding of the experience of the phenomenon of relating between client and therapist emerge, as it should in this study? As the reader, your role will be to judge the study's insightfulness and whether the interpretations show meaning, whether they reflect the essence of the phenomenon. You will decide on its believability and plausibility and whether it is worthy of attention. From this the usefulness of the research will be judged.

Summary

This chapter has described and shown the connections between my research question, the philosophy underlying the thesis and the method used. The 'fit' between the methodology and occupational therapy has been explored. My subjective involvement in aspects of the study has also been shown and the design of the study detailed. Koch and Harrington's (1998) conceptualisation of rigour has been used to demonstrate issues of trustworthiness.

While writing this chapter, describing the methodology and the design of the study, I have been aware of the need to show the process of the method and philosophy that underpins the research. Yet throughout the study I have also been drawn to the creativity within it, to the story that shows the whole of the interweaving of the parts. Smythe (1998) confirms this position of the phenomenological researcher, describing a tension between the need to be scholarly and the desire to write in a spontaneous, free-flowing way. At the centre and heart of a thesis lies the exploration within the research findings. These three following chapters, shaped and guided by the research process, seem to show an increasing fluidity as the movement into the themes and analysis came to capture what the research was all about, the meaning within participants narratives.

A poem ~

that signposts

Thesis supervisors
They say
It's good
It's very good
You need to dig deeper
There's another level

They say
It's good
It's very good
That bit doesn't work
Maybe all those bits need to go

They say
It's good
It's very good
Let it settle
Give it a rest
It'll be better next time around

They say
It's good
It's very good
Keep going
You're getting there
Thank heavens
It may even be true

the pathway

Chapter Four

Fore-having

The things that come before

> We try to come to terms with our
> assumptions not to forget them again, but
> rather to hold them deliberately at bay and
> even to turn this knowledge against itself
> revealing its concealing nature. (Van Manen,
> 1990, p. 47)

Introduction

We bring to our relationships the background presuppositions that people carry with them as part of their Being-in-the-world (Heidegger, 1962). For those coming into a therapeutic relationship there is a bringing to the interaction of that which has come before. Both the client and the community occupational therapist will bring ideas, thoughts, knowledge, understandings and misunderstandings about themselves, each other and the other's roles, so that prior to, and coming into the encounter there is already a sense of 'knowing' each other without truly knowing. Alongside these presuppositions and already firmly in place will be the persona that makes these people who they are. In this chapter I will show through stories told by both the client and therapist participants the many embedded factors that these people bring to their shared relationship that may prevent them seeing each other clearly. These influences are frequently silent, unseen, unacknowledged and taken-for-granted ways of their Being-in-the-world, a part of their 'knowing' that impacts on their interaction. The voice of study participants is interwoven, linked and shaped by my own voice.

Who we are and what we understand in advance constitutes the central theme of this chapter 'Forehaving'. Heidegger (1962) describes 'fore-having' as what we have before us, as part of the understanding of our being-in-the-world. The three sub-themes in this chapter that have arisen from the participant's stories are named: The Unavoidable Persona, Seeing the Mindset, and Taking a Stance. The analyses of them will assist in unravelling the complexity of the meaning at the beginning of relating, in the human-to-human, health practitioner/client relationship.

The unavoidable persona

We all have differing ways of being in the world. This comes about through aspects of our genetic makeup, through our nurturing, through the context in which we live our lives, through our being with others and from the impact of the world around us. Persona is the term that is being used in this theme to describe the inherent tendency that assists in making people who and what they are. To all interactions we bring aspects of our persona effected also by the mood that we are always in. Heidegger (1962) describes understanding as always having a mood, and inherent in understanding is the way that our changing mood colours it. For some participants, most frequently clients, the persona that the therapist has is perceived as a significant 'fore-having,' something already embedded in the therapist prior to the interaction. This 'fore-having' has the capacity to impact both positively and negatively on their interaction. Katie, a client participant, describes her community occupational therapists and the consequent effects of their 'persona:'

When my first community OT came I felt fine because she was a bright, cheerful person with a good attitude. It was somewhat disheartening when the second one came on the scene. Even initially I did not feel good about her because of her general attitude. It was the way she spoke. There was no "I'm sorry I got the wrong address because your records were incorrect," nothing like that. She was outspoken and gave the impression that she didn't want to be in the job but for some reason she was. It made me reluctant to talk with her.

My current OT is quite a contrast to the last OT I had, not pushy and fairly quietly spoken and doesn't push opinions onto you. She's a positive sort of

person and friendly and that leaves me feeling comfortable with her. What I
think is that the OT's attitude makes a tremendous difference. When it's
positive and helpful it's completely different to one that's unhelpful and gives
the impression of the OT not wanting to be there.

Katie names certain aspects of each therapist's persona 'their attitude'. For the most part individual therapists are perceived as having some consistency in their 'attitude' indicating the likelihood that ongoing dimensions of their spirit and temperament are showing through in the interaction. Katie finds that her experience of some of these differences alter her confidence and ability to respond openly. Heidegger (1962) describes understanding as always carrying a mood. Although the second therapist's mood of the moment, of seeming indifference, is likely to have impacted on the relating, it seems from Katie's story that this goes beyond that of mood and is of a more ongoing nature with larger consequences for her. She describes a therapist seeming to not want to be there and not wanting to be in their role as a community occupational therapist working with clients.

While Katie refers to her therapists' attitudes, another client uses other terms when naming the personal qualities of her therapists. Anne, who has seen a number of different therapists, finds that the substantial differences in what she called the therapist's nature and personality affects her ability to relate to them:

Both my more recent OTs have been really, really good. The past one was an
absolute honey and she sticks in my mind. Not once did I feel uncomfortable or
threatened because she had such a neat nature and way of talking to me.

When a therapist sticks in the mind they remain and become a standard against which others are measured. It seems the client's character and the therapist's are well attuned to each other. It will be difficult for others to 'measure up' against the high regard this therapist is held in. Anne indicates why therapists need to earn her respect and trust when she tells the following story showing another therapist failing to 'measure up.' She compares the personality of an occupational therapist, who comes from a different

state-funded service rather than a community home health service, and the tension the visits produce for her:

I've had dealings with another occupational therapist from another service. I have a great aversion to this person who I didn't like at all. She was very intrusive and quite rude. She asked all these questions as though she didn't believe me, and it felt like she was trying to catch me out all the time. I think personality had a lot to do with it and she needed a personality transplant. There was nothing nice about her. She was brusque, she was abrupt, and she was sharp. There was no relaxing with her.

In describing her therapist as needing a 'personality transplant' Anne is clearly indicating that she views the therapist's attitude and behaviour as not just the consequence of this therapist having had a 'bad day.' Anne's dismay at being confronted with the therapist's way of interacting is one of recognising that there will never be a meeting ground for them in a relationship where they can be open to each other. There is not going to be a 'good day'. It is more than a mood that the therapist is in, for this encounter shows her everyday mode of relating to the people she visits in her work role.

When the therapist brings dominating aspects of her persona, negative responses will ensue. Heidegger (1962) outlines differing modes of care, describing both leaping in and leaping ahead as being two extremes of positive concern and both at times having a place in relating with others. When the therapist comes into an encounter with a client, with her mode of care being to leap in, dominate and take control when there is no indication that this is needed, a lack of attunement with the client is showing. What were the motives for the therapist's behaviour? Alongside the therapist's intrusive way of being with the client, and not well hidden, are facets of judgements already made with regard to 'being deserving' and a guarding of resources. It seems the determined persona displayed greatly affects the client's ability to interact with this therapist. Alongside this intrusiveness lies the safety of home. For many people home has a special meaning as the place where they feel secure, the place they can truly be themselves. Is it possible for clients to feel that way when verbally attacked in their space, the hoped-for-safety of their home?

Both the client's and therapist's persona will affect the interaction that occurs between them. It seems that this facet of fore-having is an unavoidable ingredient in their relationship. While client participants show a high awareness of the impact therapists' persona has on their ability to have a positive relationship with therapists this was not commented on with such clarity by therapists.

Seeing the mindset

One aspect of fore-having is the frequently invisible 'stumbling block' of a mindset that both clients and therapists may bring to their interaction with each other. A locking of prejudgements into a mindset, that closes the mind to other possibilities, that says 'I know what is happening here' without knowing can be a barrier to understanding. When does this mindset become visible? Frequently it will be seen as a barrier that is instrumental in closing off other options. At times it will be the client who sees this obstacle while on other occasions the client's mindset will become tangible to the therapist. Recognising and seeing one's own mindset and its impact on the interaction that follows are likely to present as a difficulty for both clients and therapists. It seems that one of the problems for the client and community occupational therapist coming to their relationship, as outlined by Van Manen (1990), may be not that they don't know enough about what they are coming to, but that they know too much. He goes on to describe our common sense pre-understandings, our suppositions, and assumptions as predisposing us to interpret the nature of what is before us before we know what it is. Experience and knowledge have the capacity to shape and mould our view of the world, developing into a firm − even an implacable − prejudgement. So how are clients and therapists to be truly present with each other when much is already assumed and prejudged prior to the interaction?

Teresa, a therapist participant in the study, talks about the frustration and difficulty she experiences when coming to an interaction with a client who she believes has made a prior judgement about her condition:

This person I was visiting was very much in denial, very much wanting everything but also not accepting, wanting a magic wand basically. She was denying that things were as bad as they were. It was the same problem; the

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carers were hurting their backs because the transfers were so heavy. They were telling me one thing and she was saying, 'I don't want it, I don't need it. Every month you knew there was going to be a phone call. It's been like banging my head against a brick wall. You see the need but they won't accept it.

A mindset of this sort is likely to affect the client's responses and interpretation of situations with a consequent impact on the relationship with the therapist. The therapist too may also come to prejudge situations that involve a particular client where a label of 'difficult' or 'in denial' has come to be associated with the client. A sense of evasion between the therapist and client permeates this story, a not wanting to know. Perceiving a magic wand being needed to grant wishes, the therapist sees the client she visits as dwelling with a response to her condition of hoping for a magical solution, rather than working with her towards possible concrete answers. It seems that the client's fixed mental attitude precludes the possibility that her condition is progressively disabling, and with this she refuses to see and understand what her own body is telling and showing her. Reality can be described as relative with people's view of it depending on where they stand and their horizon (Gadamer, 1982).

Anne, a client participant, finds her prejudgements rising to the surface, as her past experience came forward to meet her when a therapist from a different service is sent again to visit her…*Another time they said they'd send an OT and she came out again. The minute she turned up and it was the same person, I thought, oh no, please no. All my barriers went up. I thought, here we go again.* Prior encounters with the therapist mean that this relating was already known and foreseen for what it will be in the future. The therapist's persona and the client's response of prejudging the relating in the coming encounter, while difficult to avoid, will provide additional barriers impacting on their being together with little chance of the development of a new understanding.

Therapist participants are at times aware of carrying preconceptions with them. Teresa offers this story:

There are people I've seen in the past who haven't been eligible for things and they want you back every six months for another reassessment. I've

gone with this mindset of thinking, they're trying it on again. It's a bit defensive and I know it's a barrier. So when I get out of the car I try to leave it behind in the car. I may have been fuming about it but I think, okay another assessment like the first occupational therapy visit. When I get there I just leave it behind.

When the therapist leaves the car and closes the door on the mindset is it waiting in the car for her return or does it dissipate? How realistic is it to expect to leave preconceptions and prejudgements behind and for there to be no glimmer of them showing through in the interaction that follows? To expect to be able to 'bracket' one's fore-having is to believe that prejudgements can simply be put aside (Van Manen, 1990). Yet how easily is that done?

It is likely that therapists will have prior ideas, possible preconceptions and judgements from receiving extensive data around the client: the referral information and its source, the case-notes, telephone calls, and interdisciplinary discussion. Therapists may find that sometimes information is erroneous and misleading and yet it becomes difficult to set aside and clear from their mind. It then has the potential to become an obstacle between them and the client.

For some therapists fore-conceptions are held in the back of their mind, and cleared from their recall when they meet the client 'face to face,' as though they are starting back at the beginning again as the fuller picture comes into focus. A therapist describes how this happens and how this shift in thinking has the capacity to surprise those with less knowledge and experience:

Sometimes I find that the situation has changed so dramatically that, oh okay, I have to readjust on the spot, which can sometimes freak out occupational therapy students because they don't understand it. It can happen very quickly. You totally readjust your thinking and turn it around but you can justify it because you have mentally gone tick tick tick, cross cross cross.

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The therapist is able to change previously held ideas to fit around the client's changing situation. This occurs with a smooth 'knowing' of how to rightly interact, and make a judgement in the new circumstances that the therapist is now looking at. These are skills that it will be hard to teach others because it involves a trust in one's own judgement, 'thinking while doing' and an ability to change that comes about through a depth of understanding and experience. Some reasoning and actions will require an expertise that can be compared to wisdom (Mattingly, 1991b).

There are occasions when previous knowledge is useful and although it may contribute to a 'mindset' the knowing may also reduce the chance of being manipulated by someone 'trying it on.' Teresa describes wishing that she had known and understood more before visiting a client:

> *When I first went in there I didn't realise the conflicts that were going on. When I learnt and savvied up a bit I was more cautious in what I said and did because it could be turned around so easily. Looking back I wouldn't let the conflict escalate. I should have been more assertive in the beginning and said 'this is what I'm here to do to both sides, but I'm a bit of a wimp when it comes to confrontational matters. It would have been easier if I'd done it at the beginning.*

Through being open to the client this therapist is now caught in a difficult situation. While it is not in her nature to be confrontational the therapist's lack of 'fore-knowing' has brought her to this place. At times the knowing that comes in advance that is held in the back of the mind can be accessed to prevent complex and not easily resolved situations developing further. Yet whatever the impression given at the beginning of the relating may be difficult to undo and change. The inter-linking of past actions and communication with the present has the capacity to impact on 'fixing in place' all future relating. In this quote Alice finds this so when she demonstrates determined and hasty decision-making that then becomes impossible to change:

> "The cause of the lightning, "Alice said decidedly, for she felt quite certain about this, "is the thunder – no, no!" she hastily corrected herself. "I mean the other way." "It's too late to correct," said the Red Queen: "When you've once said a thing, that fixes it, and you must take the consequences" (Carroll, 1962, p. 325).

For both the client and the therapist, changing the effects of whatever has negatively impacted on their relationship with each other, redeeming themselves in the other's eyes, will be a difficult process.

Perceiving difference

An aspect of the mindset we carry is a perception of ourselves that distinguishes between that self and other people. When describing how we are with others in the world Gadamer (1982) uses the notions of 'self' and 'other.' He outlines the way that people come to understand, saying that through being open to the newness of the other we bring back to ourselves all those thoughts and ideas adding them to what we already know, for "understanding is always the self understanding the other" (Smythe, 1996, p. 9). Yet the life-world that each person is immersed in gives a range of vision, what Gadamer (1982) calls a 'historical horizon,' that may limit or expand what we are able to see. There are times in participants' stories when it seems that the horizon of the client or therapist affects their ability to be open. As part of an unseen, frequently unacknowledged mindset, this perception of difference between the self and other has the capacity to affect relating at times, highlighting that difference.

When responding to a request to do a second 'consult' visit, a therapist participant, Louise, tells about the tension around having prior knowledge that both prepared her and warned her:

> *I was asked to do a consult visit where the relationship between the occupational therapist and family had broken down, completely exploded, destroyed. Something needed to happen, I had to go in. I was walking into a situation, set up in a way. In preparation I had got a lot of information from the old notes and my gut instinct was that this gentleman did not have a major disability and that the alteration that they wanted did not need to be done. I felt okay about going in to see him.*

> *The family was quite well versed in policy and insisted on being there while I assessed him. I had a gut feeling and was a little worried about the client's state of mind. I knew he would not submit to further assessment. The client,*

a Maori gentleman, was walking around quite well and I asked him to show me situations and we got talking and then he played the card I hate, that I like least and that was, "they don't want to do anything for me because I'm Maori." It's a hell of a thing. I never know how to respond to that. What do you do?

Lisa holds a picture of the client that prepares her prior to her interaction with him. This picture will have the capacity to shape what follows both in a positive and negative way. Does the shaping of ideas then go on to produce the consequences the therapist is led to expect? To be open to possibilities is to understand what it is that you are taking with you, to comprehend the potential of prior information to distort or enhance the good will that may exist in being together. The client has a differing mindset of wanting resources, not expecting to get them and believing that he understands why he will not. Past experience, along with their understanding of it, will be an influencing factor for both the client and therapist. Gadamer (1982) describes the experience we are in as being connected to all other facets of our experience, and that we only understand this experience by understanding how it fits with all the others. He tells us that "every experience is taken out of the continuity of life and at the same time related to the whole of one's life" (p. 62).

Reading case notes and having additional information also affects Lisa's thinking, producing feelings of anxiety, and reveals itself prior to visiting a client:

I had read the previous notes and they did give me a mindset... prepared my mind in some ways. I knew that this person was living in a block of flats in relative squalor, was difficult to communicate with as a result of an earlier head injury and had poor social support. So I had this mindset of, oh God, great! I understood that this was not going to be an easy intervention, an easy situation.

I had tried to contact his family but got no response with some family members having moved. The needs assessor confirmed that there were some whanau and that they were hard to get hold of. What I got from her was that they were popping in and out and not consistently involved. Usually I feel

quite confident but there was an element of discomfort. It was a strange place with a lot of people living in this block of flats and dogs and bottles and cans. Maybe I should have visited the first time with someone with me. Going in quite tense was certainly an aspect that could have affected how I came across to him.

The flats were familiar to me and you know they look a bit rundown with rubbish here and there. So my feelings walking into that place weren't terribly good. I'm very conscious of the fact that I don't like smells. You know there was quite a stench in that flat, so that probably caused my mind to have ideas. I felt that the place and safety were less important during later visits. I'd been there the first time and I'd felt safe and my anxiety levels were less on the later visits. Yes I think I was a bit less intimidated on those later visits. I was more relaxed with him and able to tune into a way of understanding, getting to understand him.

Being aware before you visit of what you think about the visit does help. Talking about it now I've realised that I was intimidated and taking someone with me would be the action to take. I could have taken the Maori needs assessor who would have stood alongside him. That would have made a difference.

Here we see two differing life-worlds, where everyday life is in contrast. In one there appears to be little support, a reduced ability to communicate, and there is litter and poverty. In the other, a work world, there is support from colleagues to discuss incidents with and a clean place to work in. There is a paradox in knowing so much about the client and yet at the same time knowing so little. Will it be possible to build a bridge between these differing worlds so that there can be a new sense of knowing? At times this may be achieved by bringing another person to the initial interaction, a person who understands the cultural differences – someone with the potential to assist in 'bridging the worlds' of different cultures, someone who can stand alongside the client. On other occasions, the client and therapist may find that they can set aside their prejudgements

of the situation, and of each other, in order to be open to hearing and seeing the other in a new way.

Information and communication can give a picture of the client in their life-world prior to interaction taking place. When that picture causes prejudgements to be made before the full story or fuller picture of the client has been arrived at, then a mindset regarding the client or outcome of the intervention reveals itself. Differences between the self and other will be a primary barrier influencing both the client and the therapist when a range of dissimilarities exists between them. Van Manen (1990) outlines the possibility that even forgotten experiences will leave their trace. For the therapist there will be the challenge of keeping the client at the centre of the relating while recognising and holding bodily felt reactions of anxiety and nausea, related to past, present and future experiences, in a place where they will not impact negatively in relating with the client.

Being a guest in their home

Carried within the notion of 'being a guest in their home' is a clear picture, a mindset, or prejudgement that will show itself in the therapist's demeanour, attitude and communication. By 'wearing' this visible mindset the therapist acknowledges that they are entering the client's world. This differing fore-conception is held and comes through in a number of therapists' narratives with regard to themselves entering clients' homes. The therapist as a guest in the client's home has no uniform to hide behind and at times a transparency and openness shows in the relationship with no hospital building providing a barrier to both the client's and therapist's perception of equality. Louise tells how she locates herself within a client's environment.

> *One of my things is that I am a guest in the client's home. I wear that very firmly. I remember doing a home visit once with a medical student and the medical student started looking through the client's cupboards and I was astonished. I was a new graduate and I didn't know what to say, you know how you are funny about doctors anyway. So I was thinking, do I say anything or not? The medical student looked completely through cupboards and other stuff and I remember sitting there and thinking − whoa that's no good.*

As a community occupational therapist I think we make it very clear that we are very much guests in the client's home. You know the client has the power, we can't hide behind uniforms or the context of hospitals. We are like a cold-call brush salesman. We front up at the door and all of a sudden have to show and sell our wares and who we are. And who we are differs depending on the client that we meet. With a lot of my clients being older than me I pitch it at my grandmother's level which sounds 'schemey' as though I'm manipulating the situation, as indeed I do. But sometimes clients are younger and then it's different.

Responding to a client as one would to a grandmother is to have a sense of knowing and understanding how to be with them, to bring forward into the mind a picture of them in their life-world, along with the likely concerns and issues that the therapist will possibly encounter during the relating. The therapist's belief in the concept of being a guest causes shock when others demonstrate by their actions that they don't necessarily hold to the same set of professional or social rules. What does it mean for the therapist to come to the client's home as a guest? On the one hand therapists could expect to be greeted and welcomed in a cordial manner, on the other they would expect to behave amiably, interestedly, respecting clients, their wishes and their property.

There are likely to be some tensions around the notion of therapists being guests in clients' homes. At times the therapist may find herself withholding access to resources that the client wants, may find themselves not being treated like a guest but instead with hostility or coldness. The client's home may not be a welcoming place but a place of smells and snapping dogs. How then to behave like a guest? Conversely the client may find the therapist not behaving as a guest in their house, pushing their way in, uninvited, and arriving with a determination to proceed in a pre-established direction, not inquiring, not consulting and seemingly without concern for them. Both the therapist and client are likely to have a mindset about the 'rules' that apply within the client's home. When either of the two people coming into the relationship do not act in a way that fits with this mindset, inadvertently or purposely breaching the unwritten rules, a breakdown in relating would seem inevitable. Behind the perceived equality the

therapist, even as a guest in the client's home, has the power to alter the future for the client in terms of possibilities and resources.

While Louise outlines a clear picture of what being a guest in the client home entails for her, another participant, Teresa, described the ambivalence involved in being a visitor in the client's home. …*You go into their house, you're in their domain, so you're a visitor but you also have to poke your nose into all sorts of different aspects of their lives.* Being a guest would seem to involve a surface and superficial 'polite' relationship, whereas Teresa describes a different relating, of peeling back the surface layers to reveal the important issues that a visitor would not be privy to, a difficult merging of roles. At what point in the relating does the therapist go from being a guest to being a trusted health professional, a person whom the client can 'open up to' about the real and sometimes devastating issues in their life that will need the therapist's attention?

Sometimes therapists do not behave like guests. Katie, a client participant, describes what it was like to have a community occupational therapist visit who appears to not have a concept of coming to the client's home as a guest:

> *The first time she came to see me we were in a flat waiting to move into our new house. She burst in the door and proceeded to grizzle about having gone to my previous address. And I thought, excuse me! I was dumbfounded and after that I had definite reservations. It was not a good experience. She just sat down where I happened to be working at the table when she came in. I didn't know when she'd turn up. She tended to take potluck on whether I'd be home or not and that seemed senseless.*

Taking potluck shows a lack of preparedness and a haphazard approach to involvement with the client. It is the therapist, whose future is unlikely to depend on her seeing this client, who can afford to take this random approach rather than the client whose future possibilities may well depend on her seeing this therapist. Heidegger (1962) determined that one way of 'Being-with-others in the world' is being with concern. The mode of concern of the therapist described in this story would seem to be a deficient one of neglect, of leaving undone with the impact on the client likely to be a feeling of helplessness and of being overlooked.

Following a visit by an occupational therapist who was not part of a community health service, feelings of distress and anger are described by a client, Anne, when she outlines behaviours of the therapist that do not fit the concept of being a guest in her house:

She would come to the front door and would seem really sullen and then she'd barge her way in and sit down. It was a different manner, one I'm not used to and I didn't like it.

Anne is thrown into a relationship with this particular therapist through circumstance. There may be possibilities of altering her involvement with this therapist but these are not easily seen. A sense of 'knowing' as part of a mindset can be a factor brought to their interaction by both the client and therapist. Knowing may bring with it an assumption that all issues and factors are already understood, thereby closing off the possibility of finding out. Munhall (1993, p. 125) talks about the need to "stand in one's socially constructed world and unearth the other's world by admitting, I don't know you, I do not know your subjective world." She describes this unknowing as "equalling openness" but admits that it is no easy task, requiring as it does both a childlike stance and an acknowledgement of the two differing perspectives in the relating.

Being a 'guest in the client's home' is perceived differently by a therapist treated as an unwanted guest when the client's mindset is one of maintaining distance. For the therapist, Lisa, the context that she moves into when visiting a client in their home is one of family distress at the recent diagnosis of a seriously debilitating condition. Along with distancing herself from the condition, the client also holds the therapist at a distance. The client's two differing encounters, first with the condition, closely followed by the therapist's visit, creates the link in her mind:

It was a case where there was rapid deterioration and I went in quite quickly to see her and was faced with someone who had only been diagnosed eight weeks before I went in. She was really grieving and not accepting. In the beginning when I first got involved she more or less had to accept me as part of her needs. But I was a part of this condition that she

preferred to have go away. I was packaged in with that, part of a package
that she didn't want. I turned up when the condition turned up.

The therapist becomes the recipient of the client's fear and distress around the client's recently diagnosed condition and describes being 'packaged' with it. When different items are wrapped together in a package they become inextricably linked and tied together. A diagnosis that discloses the inevitability of a progressive disabling terminal condition is uninvited and may also be unexpected. An uninvited package is not the choice of the receiver, and unlike a gift accepted with pleasure may be one that there is resistance to accepting. The linking of the therapist to the condition, and the resulting distancing of the therapist from the client has the capacity to reduce what the therapist can offer to the client. Unbundling of this package may occur over time as the client comes, with increased understanding and a sense of trust in the therapist, to separate out her linking of the two.

A therapist describes trying to put prejudgements aside: *There may be a history of* *problems but you have to go in with an open mind, you can't prejudge them. It's that* *professional thing. You have to treat each episode separately.* When examining issues around the possibility of therapists' mindsets I discussed the concept with Elizabeth, a community occupational therapist, who tells how she deals with fore-having that has the capacity to influence her interaction with clients she is about to visit:

> *I find the most difficult occasions are when the client has already made up*
> *their mind what they want. Generally other ideas I have from reading the*
> *notes and other referral information disappear the minute I see them and*
> *become open to who they are. Listening then becomes important, and being*
> *compassionate. I find I can be swayed, can change my mind, and can resist*
> *holding a fixed position or posture. The challenge is to be open to going in*
> *intending to win people over. While I am prepared to disagree I try not to*
> *boss people around and try to listen and let them have their say. I will*
> *myself to towards thinking – 'I'm just going to offer what I can offer' and*
> *being low key with them. While acknowledging the worst, I try not to react*

negatively. At the same time I still see it as important to have information beforehand to prepare myself.

Going in to a client with ideas, acknowledging that the pre-conceptions do exist and yet being ready to put them aside gives the opportunity to recognise that person and their world. By trying to come to terms with our assumptions, rather than hold them to one side we may be able to see more clearly what has been concealed through our vision being clouded (Van Manen, 1990). For clients there will at times be mindsets around expected behaviours and outcomes, at times involving funding issues. Showing in the therapists' stories is the influence of differing life-worlds, including social or economic factors and ethnicity, that can create images and ideas in therapists' minds about clients prior to the visit.

For both clients and therapists, recognising or acknowledging the role that prejudgements and fore-conceptions have in influencing them as part of their mindset, and seeing these for what they are through questioning, leads on to the opportunity for new understanding of the person they are relating with. Conversely, not seeing the mindset, staying bounded by restricted thinking and 'absolute truths' has the capacity to close down the avenues to creating better relationships, locking people into positions and postures.

Taking a stance

When the therapist remains unaware of the mindset they have regarding a client or behaviour this may lead them to unthinkingly 'taking a stance.' On other occasions this positioning will occur in a quite deliberate way. At times it will be the client who adopts a stance. Adopting a position involving views and judgements points to taking a stance or attitude on that point of view. Fore-conceptions leading to a mindset can then cause both clients and therapists to make a stand over what they expect to happen in the subsequent interaction. It would seem in some of the following stories that a posture had been adopted in advance that then influences and impacts on the relationship.

Kerry, a therapist, feels that a position has been taken by a client prior to this visit that she finds intimidating:

When I first went in to visit I would be greeted at the door and asked to take my shoes off. That was fine but there was a very cold feeling, very tense. There was a feeling coming from the family that they were going to ask for everything, but they had the feeling that they weren't going to get it… It happened more than once and I didn't understand the anger. He would stand over me and almost shake his finger at me and say "Look, in this house we are very positive and I don't want to hear anymore of that negative talk." Which was me trying to be realistic about the fact that there was a waiting time after all our trying to help him. He'd say, "I don't want to hear that things can't be done, I want to hear that you will do your best."

The client's response indicates that he regards the therapist as a gatekeeper to the system, the system through which resources he wants can be accessed and which he sees her as possibly blocking. A perception of oneself as being outside the system has the potential to shape the client's relating with the therapist, into being one of opponents, as opposed to being together and alongside each other. An adversarial stance diminishes the possibility of reaching a new place of understanding. Habitual ways of looking at the world and at people in their world may get in the way of the relating. Gadamer (1982) describes the need to be open to what is the other, to the self understanding the other, saying that we can only achieve understanding for ourselves through being open to the newness we encounter.

In a contrasting story, Teresa, a therapist, feels driven to deliberately take a firm stance in response to a client that she visits:

I could see myself getting like it…I would get more like a schoolteacher and be very firm. I am very laid back in a lot of my dealings with people but when the situation arises I can be very firm and I had to be very firm with her. I had to be very firm about what I would and would not do.

The therapist finds herself being transformed, from her accustomed way of being in the world into being a different person, inhabiting the guise of a schoolteacher. This is a role that the therapist prefers not to choose but rather is one that she feels compelled to 'put on.' In what way does this new persona show itself? It is likely to be in the stance,

a little apart and authoritative. It will show in the voice, the tone declaring to the client that the therapist will no longer be flexible and negotiate. Alongside this will be the words that are used to show that the therapist has 'superior' knowledge and the ability to make choices, to say *I will* or *I won't*.

Allison and Strong (1994) outline in a study of verbal strategies used by occupational therapists, a variety of voices used in differing situations. The voice utilised by the therapist in being like a schoolteacher will be that of 'the therapy voice' used when the client is seen as 'difficult' and the therapist wants to come across as a professional. In conjunction with 'the therapy voice' is 'the directive voice' that comes across even more strongly and is used when the therapist looks for interpersonal control with a client who is seen as uncooperative. There will be times when the therapist needs to take such a stance when situations appear to be getting out of control. Yet the consequences are likely to be difficult to move beyond to reach a more positive place in the client/ therapist relationship.

When a therapist, Kerry, visits a client she feels that a barrier to communicating has been installed, and a position taken prior to her visit that then shapes the interaction:

> *She avoided dealing with me. I recognised that I had to see more of her and communicate with her. At some point early on I thought, she's the client and I should be getting information directly from her; what she likes, what she wants, what she'd like to be able to eat.*

> *I had made a specific appointment to see her. That day I felt particularly set up. It was very weird. She had sunglasses on and I couldn't see her eyes. I had never seen her in sunglasses before. It's almost impossible to talk to someone when there's no eye contact. If I'd been braver I could have asked her to remove the sunglasses or challenged what was happening. I would have been better to have said, "I feel really uncomfortable not being able to make eye contact with you." But I felt that there were a lot of cultural issues that I wasn't clear about and so I didn't want to upset things more than they already were. She could have put them on herself. Now that I know her better I know that she could have been more communicative.*

The stance taken by the client in readiness for the therapist's visit is one of holding at bay that which she doesn't want close. Sunglasses both shield the wearer of them and alter appearance, masking expression and feeling. The real person hides, able to see but not be seen. A mask worn on the face is a barrier to transparency. Using a mask conceals, keeping true identity safe. In this human-to-human relating it seems that the client did not want to be present with the therapist. Why avoid the therapist? To keep at a distance that which one does not want to have close, shielding oneself from the possibility of prying eyes and questions? To keep at a distance those representing the system, the 'other' from institutions, not allowing them to be drawn closer to the 'self'?

Teresa, a therapist, describes her belief that she had to go into a client with a firm stance because of pre-existing positioning on the client's part:

I think I was cast as the 'bad person' but I had to be, I couldn't be that nice person. But I was fine with that because I had to do it from a professional point of view. I'd tried negotiating with her but it hadn't worked and I'd been authoritarian. Because I always think that the person should be involved in the process I don't like doing that but there comes a time when it's up to them.

The 'bad person' comes in as an outsider or possibly as the enemy would. At times it seems in these stories that therapists forearm themselves for a battle, ready for the struggle, in any possible skirmish that might lie ahead. A sense of armouring and steeling oneself, and drawing the battle line surfaces when potentially hostile or angry situations show themselves. Inherent in armouring is self-protection and the creation of a barrier. While one therapist reveals the weapon of openness and unchallenging behaviour that she uses to win people over, calculating that it will make a difference in potentially 'hazardous' relating, others seem to stand their ground, marking out their territory, awaiting potentially damaging and explosive situations. Alongside this stance is a feeling of anxiety and fear coming through from both client and therapists around involvement with people who they differ from. This is a contributing aspect to erecting barriers that in all likelihood will reduce the possibility of reaching a state of understanding or attunement with each other.

Client participants sometimes perceive therapists as pushy. They describe being particularly 'put off' by therapists who behave that way. Being pushy encompasses aspects of 'persona', 'having a mindset' and 'taking a stance.' It seems that they are impossible to separate with all three appearing to be integrated within the concept of 'pushiness.' This mode of care that the therapist sometimes brings to their interaction is one of dominating, of leaping in and taking over control from the other (Heidegger, 1962). Conversely, being with the client in a mode of care that leaps ahead, anticipating what is likely to happen and offers control back to them will take away the assumption that the therapist 'knows best.' Although there are times when safety is at issue and leaping in will assist in resolving crises, when it is the therapist's dominant everyday way of relating it becomes understandable why clients express dislike of this way of therapists showing care.

Stories from client participants show that they frequently know when they are being pushed in a way that does not 'fit' with what they want from their interaction with therapists. At times the therapist will 'guide' the course of events in being with the client. One aspect of the therapist understanding the client that they are interacting with is to know when to push and when to step back. It is when the 'push' clearly reveals itself and is felt by the client that they become conscious of it. This knowing, felt subjectively by the client, abides in their encounter with the therapist and will come to them through the therapist's gestures, through a bodily felt sense of things in this encounter with the therapist (Gadamer, 1982). On the therapist's part, knowing how to interact will involve a depth of awareness of the client and a 'knowing' of themselves. Some predetermined ways of relating, dominating or influencing both the therapist's stance and behaviour will affect these possibilities.

Within the theme of 'Fore-having' and the notions of persona, mindset and taking a stance, I have been attentive to the ongoing series of thrownness that many of the client and therapist participants' stories disclose. Inwood (1997) tells us, that being already in the world is associated with thrownness, that we are already in situations determining the possibilities available to us.

For one client it is the geographic area that is a factor determining that the therapist who comes to her house seems, in her eyes, to require a personality transplant. A therapist

describes being thrown into the impossibility of working with someone who seems to want their condition to magically disappear. One therapist is thrown into the role of 'schoolteacher' when the relationship with a client appears out of control. Both clients and therapists carry responses with them already laid down prior to the point of meeting. Participants' stories in this study show the thrownness of two strangers coming together into a relationship in a situation of uncertainty and untold possibilities.

Summary

The three integral aspects outlined in this chapter as part of 'Fore-having,' the things that are there before the therapist meets with the client, can be seen to build upon each other. They begin with the things in people that seem least flexible and least able to be changed – persona and character traits. They then move through to those most likely to be affected and altered by reflection and the need to construct positive relationships, the acquired mindset and subsequent stance that is taken at times by clients and therapists. Persona is the foundation, and most solidly grounded, that other aspects of 'the things that come before' develop from. The aspects that follow, of 'mindset' and 'taking a stance,' are constructions built upon this foundation and have the capacity to take off in new directions, showing their greater flexibility.

The stories in fore-having speak to us, showing us how these embedded factors, of persona, mindset and taking a stance impact on the relating in ways that have the ability to both heighten and undermine relationships between clients and therapists. The therapists come complete with their characteristics and persona, already with a mindset, which at times leads on to taking a combative stance. Clients find themselves living with disability and ongoing or progressive conditions. Both client and therapist participants repeatedly find themselves in situations with each other into which they fell or were thrown.

Alongside this are the ways that 'the things that come before' impinge on both the clients' and therapists' life-world. At times bodily felt impressions, such as anxiety or fear, give indications to both the client and therapist that the relating will not be easy. These will be hard signals to ignore. Past experiences and impressions stay on in both

clients' and therapists' minds. Aspects of a mindset are brought forward into the present, showing the future and giving a horizon of understanding. At times, therapists bring with them a neglectful or hostile stance that invades clients' space – their home – where they should feel most safe.

Embedded in other stories are mindsets around the difference of the other, the experience of coming to relate with someone who is not like us. Clients can be seen taking a stance that may involve fear around their future and vulnerability. At other times therapists find themselves being pre-prepared prior to visiting the client, fore-arming themselves with information and 'facts.' The preparedness has the capacity to provide them with additional and useful insights. On the other hand, it also has the potential to restrict the interaction with the consequence of little possibility of a greater knowing developing between client and therapist.

Some things appear immovable. The persona, or character, of each of us may be largely laid down as part of our makeup, and seem beyond our ability to change or control. Do we have a choice in what or who we become? Does this depend on whether we wish to see ourselves more clearly, making transparent that which has been hidden from our understanding? Recognition of the different worlds that the client and therapist are situated in may assist in alleviating the rigidity of the stance taken with the partner in the relationship. Munhall (1993, p. 125) says that, "it is essential that we understand our self and our patient as two distinctive beings, one of whom we do not know." Many participants' stories indicate that 'the self' was also hidden, not fully known or understood. The following chapter 'Being There' will disclose more of the disguised nature of the relating between people with physical disabilities and the community occupational therapists who work with them, uncovering the possibilities within the thrownness.

Poems ~

showing the thrownness

Thrown
Falling into
Ways of Being
Unavoidable
Always there

that brings

Different worlds
Me
Anxious
Fear
Smells
Mindset

He
Squalor
Dogs
Smells
Different

the persona, the mindset and a stance

Push push push
Like a boulder
A barrier
Just a slab in the way

Searching eyes
Judge me
No caring or listening

Not an obstacle
Not a number
I'm a person
See me

Chapter Five

Being There

Being with the other

> When in our everyday Being-with-one-another, we
> encounter the sort of thing which is accessible to
> everyone, and about which anyone can say anything, it
> soon becomes impossible to decide what is disclosed in
> genuine understanding, and what is not... Everything
> looks as if it were genuinely understood, genuinely
> taken hold of, genuinely spoken, though at the bottom it
> is not: or else it does not look so, and yet at bottom it is
> (Heidegger, 1962, p. 217).

Introduction

Central to the relationship between client and therapist is 'Being with the other,' their
involvement with each other during an encounter, their sense of the relationship. While
the interaction would appear to be narrowly focused on the client and the community
occupational therapist it will be shown to also have meaning and significance that goes
beyond what can be seen on the surface, unearthing human-to-human relating in many
of its various modes. Beneath the everyday veneer, the overt manner of being there with
each other lies a multitude of things that 'already are,' a part of their existence.
Responses to situations in the present will have both ideas and events from the past and
expectations of the future interwoven within them. Husserl (cited in Van Manen, 1990)
outlines the life-world of lived immediate experience, as a world pre-given and in its
original primordial state. This chapter takes apart that world and those encounters and
reveals through participants' stories and the analyses brought to those stories some of
the assumptions and hidden ways of knowing within them. Their stories show the fabric

of their being with one another, and the analysis offers another way of seeing it. Three sub-themes drawn from participants' narratives of being in the client/therapist relationship are discussed within this chapter and have been named as Being Seen, Being Close to Others, and Being Apart with Others.

Being seen

Coming through clearly and constituting a theme in this study are stories that show the importance to participants that the therapist or client recognises them as a person. It seems that recognition and attention given by therapists in aspects of their relating has the capacity to confirm clients' belief in themselves as individuals. Being seen signifies to that person that others not only show understanding of them but also respect what is important to them. The notion of being seen as a person, of being made visible, encompasses many ways of being with others. Possibilities within 'Being seen' lie in the enhancement and expansion of what already exists inside that person. In contrast is the certainty for others that have not been seen, that they have remained invisible, in a way that diminishes their self-belief. Ways of being with others may not be clearly visible in everyday interaction but lie at a deeper level in clients' changed perception of themselves as reflected to them by therapists. There are times in these stories when it becomes clear that the therapist did not see or understand the client but believed they had. Or believed they hadn't but, on the contrary, had. Through the light we shine on others their visibility may increase with their taking on what is reflected to them.

Making visible: being a person - not a number

The client participants spoke about their need to be seen as individual beings in the context of the life-world that they belonged in. Clients showed concern around being both distinguished from and treated as distinct from others that the community occupational therapist visited. Having an identity and not just being a client, a person with a disability, gives a sense of singularity, individuality. A client participant, Anne, describes how the therapist's way of relating to her mattered and made a difference to her feelings of well being:

> *My last occupational therapist always sticks in my mind. She'd ring me up*
> *on the odd occasion just to see how I was going. I was on her caseload and*
> *I might not need anything but she'd say, "is everything okay?" She'd think*

about me. It was really good because it felt like she was being considerate and concerned about my well being. One time she went down every avenue looking for a particular thing for me. I knew I could rely on her and it was really good. She had the courtesy to ring when she was leaving to let me know and so I knew that I wasn't just a number to her, I was a person.

In showing concern for her, Anne's therapist demonstrates Anne's importance as an individual. The client's need to be understood in terms of their world seems to matter almost more than anything else. Self-perception is likely to be affected by others' perceptions of us and will be influenced by differing ways of relating.

Brigit, a client participant, describes her therapist's concern for her and her life world when Brigit was planning for her baby's arrival:

She has said that the priority is to get what's best for me. The other day she was saying to me that there is so little assistance for a mother with a disability. Probably she's outraged on my behalf that there is so little. I think she's sort of passionate about things like that.

It seems that Brigit feels that she is affirmed as a worthy person by her therapist's recognition and consideration of her special needs. Being clearly seen as situated in their world came through as a thread in many stories across the study.

Possibilities for affirming

Being seen as a person allows for possibilities to arise within the client and therapist relationship. Valuing each other can produce aspects of equality. Showing we have concern for someone and attending to them has the capacity to lift their spirit and belief in themselves. In the client/therapist relating, the way that the client relates to the therapist can affirm for them that their work is worthwhile. Clients will sometimes make assumptions about their own worth based on the manner in which therapists carry out their work.

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Another client participant found some belief around her future from the therapist's way of responding genuinely and with concern. Rosemary tells this story about the therapist's way of doing her work:

My current therapist is very official, you know very, very professional, writing down all the things that she's going to do. She always lets me know what that is. She'll say, "okay, next week you will get a letter about this and then we'll make an interview time" that sort of thing. That's the sort of official I mean, not in a harsh way. She gave me a list of things that needed altering. It wasn't just hand written, she'd actually officially typed it all up! I felt that I was treated with such respect on an adult-to-adult level and taken seriously by someone who was prepared to treat me as intellectually okay and help. Even professionals sometimes don't do that. People often belittle me. She was able to see me as different from the label, to see over and above my appearance and disability. It was exciting for me, believing in myself, thinking you can do it, you can do it! She gave me that belief in myself because she believed in me.

It seemed that for this client her experience of the therapist giving valuable time and attention to detail, and being organised, equated with a belief that she was also being valued. The therapist's focus on 'getting it right for her' and showing her opportunities in the way ahead was felt by Rosemary as being acknowledged as a person. Being in an efficient, accomplishing mode of being-in-the-world can be seen in the therapist's engagement in the relationship with the client and the subsequent work.

While primarily in the study it is stories from client participants that stress their need to 'be seen', therapists too discuss the need to recognise each person they see as an individual situated in the context of their life. At times this helps to make sense of the client's experience. Clients are frequently seen by therapists in their homes, often with family members or caregivers present. Alongside this there is an expectation that they will give time to understanding what matters to the client as they manage in their life world. Teresa tells about her view of seeing beyond the disability to see the client as a person:

Because we work in the health profession we can deal with people who have severe disabilities. We can still treat them as a person, whereas a lot of his friends couldn't see beyond the disability and felt pity for him. I felt sadness for what had happened but I would still tell him to pick up his act and get on with it. I don't know whether it's hard-heartedness, but because we see beyond the disability to the person I think well, you've got this much strength, you can carry on. The professional side of us sees the disability but we deal with that and we can see the person on the human side and we can talk to that person. We don't just see the wheelchair and all the things around them.

It is through being there and having an intuitive understanding of her client that Teresa is able to judge how to best help him towards other possibilities. To be able to judge how to show that concern requires a depth of knowing the person, an understanding of them in the context of what is happening in their world and a recognition of their mood. Heidegger (1962) describes ways of being with others as having concern. At times this concern will show itself as in taking time, in considering. At other times we are in a deficit mode of concern with others that renounces or leaves undone (Heidegger, 1962). We may take on this mode when we are tired or stressed. Because we are always with others in the world, they are part of our lives or in our memories, how we show concern will impact on their lives.

There were negative aspects for a client, Katie, when her therapist did not attend to her as someone with individual needs. These needs were of concern to her yet appeared to matter little to the therapist. While it is possible that Katie's therapist believed that she knew and understood what was important in her client's life, Katie's story shows us otherwise:

About fourteen months ago I was having trouble and couldn't butter my toast. I thought, the occupational therapist's the obvious person to ring but her attitude was, 'well you're managing to eat, you're not about to die, so it's not urgent.' She came with a box full of bits and pieces that she hadn't actually looked through before she came, to see if there was anything relevant for me. I'd told her specifically what was needed. Then she sort of

rubbished through these boxes, telling me what things were for, even though they weren't what I needed. When she pulled out all these bits and pieces I sat there thinking, what is she doing? They had nothing to do with what I asked for and I couldn't think why she was doing it, or why she was doing OT. I found that very frustrating. I expressed my frustration to a friend who got me something from the supermarket that worked. The therapist actually took four months to come up with anything and even then it was so heavy it wasn't useful.

Missing in Katie's description of her encounter with her therapist is any genuine concern for her though the therapist may not see the situation in this way. This narrative shows a therapist in a deficient mode of being with a client, of neglecting and forgetting. There is little likelihood of the equipment being useable when it seems that the therapist has come to relate with the client in a mode of not bothering, and of disregard, of treating the client as worthless. Rubbish is worthless matter of little use to people and is frequently cast aside.

When clients find themselves not being affirmed as a person by therapists and feel 'invisible' they are likely to interpret this as a lack of recognition of them as the person they are, embedded in their life-world. While the previous study participant, Katie, was left feeling frustrated and invalidated by her therapist's inattention, therapists in this study described the complexity of understanding a person's individual requirements and the struggle to make things work for their client. Munhall (1993, p. 125) describes the dilemmas of this issue: "It's possible that decisions made and actions taken by therapists may be inadequate when based on what we assume we know rather than what we have allowed the client to teach us about their experience and need." Louise talks about this challenge:

I visited a young man who had come from an institution to live in the community. Everything had changed for him and nothing was dependable anymore. When his transit commode chair needed replacing he wanted one exactly the same. The trouble was the company didn't make them anymore. We'd try a new one and it wouldn't be right. Then we'd spent all the money and it still wasn't right. I felt I was being a bit thick, that I just wasn't

getting it right. The guy must know what he wants and I'm just not asking the right question to get it out of him. I don't think I'd engaged him in enough conversation around the topic. I'd taken quite a physical approach rather than talking around how he used it. It's about having time to listen to the client's story and find out what's important in the narrative. And asking the right question.

Not seeing someone as they are, embedded in the context of their life-world, the world as they live and experience it, has the capacity to produce unworkable solutions. For the therapist this may result in inability to provide what the client needs. A lack of clearly seeing the client has the capacity to affect and alter future possibilities, while genuinely 'knowing' will frequently involve both letting go of assumptions and the giving of time. When people in a relationship come from vastly different life worlds, then recognising and acknowledging this and affirming others as different beings becomes important and especially significant for the therapist.

For many client participants their disability may be an embedded aspect of who they are, yet being seen as a person beyond their limitations mattered to them. Rosemary, a client, clearly outlined in an earlier story how meaningful that was for her: "She was able to see me as different from the label, to see over and above my appearance and disability… She gave me that belief in myself because she believed in me." For client participants 'being seen' was an important aspect of their interaction with therapists. Following on from this, for clients and therapists 'every day heedfulness,' or attunement, presented as a critical element in creating a successful relationship. It comes though the text, indicating how their relating is working and whether their 'being together' will enhance and open up the future or close down future possibilities.

Being close to others: attunement

We are never alone in the world. Heidegger (1962) says that 'the other' are people that we know, that are almost a part of us. We come to being with the other, to interacting with them in ways of care and concern. Along with our mode of care we also bring our mood to interacting with others. At all times we carry a mood with us that will affect our understanding (Heidegger, 1962). Both therapists and clients' ways of being with others, their modes of care and concern, their mood, will impact on their ability to be

attuned with each other. For the therapist attunement in their relating with clients will show in a certain harmony, a knowing of how and when to adjust and accommodate their behaviour for the best outcome for the client. There will be times that the concepts described can clearly be seen embedded in the client/therapist relating while at other times they lie hidden in participants' stories.

Locating the calm place

Stories from both client and therapist participants tell of creating a sense of calm in their relating. Calm had the potential to be that tranquil place that the therapist can provide for the client at moments of great stress, a place where the whirl of distressing emotions can be put aside. Finding a place of inner calm is also a way to pace, slow down and open up the possibility of changing the determined push towards a hurried decision being made. At other times calm involves the therapist in being the silent partner, remaining calm through anger and upset.

When Rosemary, a client participant in the study, seemed caught in an emotional storm she felt her therapist listening to her, hearing her pain and offering a way of managing:

> *The disability people referred me to my current community occupational therapist. When I rang her up I was very emotional because I was going through a severe trauma. She came and visited me here and I had no furniture, nothing really. Then she sat down with me and I said, "I'm sorry for the tears but it's been that bad that I've basically had to run away from my home." She listened to me speaking from the heart and I saw that she was really sympathetic to the injustice of it all and just said, "I know, Rosemary." She was really supportive and said, "If you ever need to ring me do so, if you need any support or anything like that." Sometimes you are so traumatised that you can't think straight, when you can't see a direction for your future you become fuzzled and fogged up. She was calm and I guess it was that calmness and not trying to own my anger that helped so much. She was able to listen 'calmfully.' Because she was there, that person at that crisis point in my life and referred me to an agency for counselling I now feel that I've got a future.*

During a storm of emotions, anger, distress and other powerful feelings fog up the mind. While being whirled around feeling befuddled and fogged up it is almost impossible to reach that place where time will slow down and the future will show itself more clearly. In the storm is a calm place, somewhere beyond the chaos. Calmness slows and paces emotions allowing the time needed for thinking and recovery. The occupational therapist provides a lifeline leading Rosemary to that calm place, showing the way when she is unable to reach it for herself. This assists her to move out of the fog and to face the future renewed.

Just as Rosemary describes the therapist offering a way to manage her emotional turmoil, so does a therapist, Teresa, when telling of her experience of providing a sense of quiet. She reflects on the value of simply listening:

> *Probably the only complaint was the length of time that the equipment was taking, like ordering a bed or something like that. It was a complaint more about the system but I was at the base of that. I was the human face. He had to live with it for twenty-four hours a day, he had to cope with it until the funding came through. He had to get those frustrations out. In the end he felt comfortable enough with me that he could rant and rave about somebody, or about a service that wasn't meeting his need. I didn't involve myself in that conversation but I could sit there and listen because he needed a sounding board and he knew that I was a safe person to do that with. I could also offer reasons why a person wasn't doing what he wanted and give him information that he may not have had. I could take it that he was yelling at the system and I was just the human face of it, which was fine.*

While the system may be seen to represent those people 'out there,' the uncaring face of bureaucracy, therapists may find that through their presence they are linked to the system's seeming lack of concern. Aspects of this story indicate that in part Teresa was not 'being seen' clearly as who she was. Alongside this she is 'being seen' by her client as safe to vent feelings of frustration to. Teresa finds herself being that immediate face, someone to both defuse the anger, bringing calm to the storm, yet, also being able to provide the quiet voice, conveying meaning to that which seems meaningless.

In a differing situation of conflict and anger Louise, an occupational therapist, finds herself looking inward for the place of calm in order to reason and to be clear about decisions:

> *About halfway through I stood back. When you are in those situations there is immense pressure to come up with an answer and soon. It was just 'yes or no' to the money as far as he was concerned, a bit like going into social welfare and asking for the emergency benefit. So I tried to pace myself, to pace the situation in order to get my thoughts together. I stood back and got my clinical reasoning going in my head; the client did have a deteriorating condition and if he didn't need the alteration now he would in a few years, the family felt incredibly passionate about it as he did. So I agreed to it and walked out feeling that it had gone incredibly well and that I hadn't given in because the decision was the right one.*

In a situation where emotions are heightened and possibilities seem very limited with the therapist finding it difficult to see options, then pacing, steadying and slowing down what is happening both from pressure without and the turmoil within allows space and time to feel that the best possible decision has been reached. At the same time it is likely that the degree of push to come up with the 'right' decision has the potential to affect the outcome. It seems from the narratives that it was generally therapists who were in a position to stand back and bring calmness either to the encounter or within themselves. It will be the role and responsibility of the therapist to use the knowledge and skills that they bring to the relating to effect the changes needed for the client. Yet Pieranunzi (1997) has put forward the notion that relationships aren't one sided, that they should be mutually enriching for both the client and practitioner.

Possibilities of equality

Many stories had the notion of 'needing to be seen as an equal' embedded in the narrative. This was seldom discussed in terms of partnership or as the therapist as an ally, but rather in terms of sharing and control. Pairman (1998) describes models of partnership as involving trust, and a sharing of control and responsibility, with the client having more authority than in the past with a greater degree of reciprocal interaction.

For a therapist, Teresa, there are dimensions of negotiated decision-making in the manner in which resource decisions are made with the client she is visiting:

With him I was a resource person. We would work things out very much together. He would ring me up and say, "This is my problem, this is what I'm having difficulty with." I'd say, "Okay I'll come out and see you." We did have long conversations on the phone but it was easier if I was there because he could show me something. I'd say, "These are the options that might help. This one is better, this one is not so good, what do you think?" Ultimately he had to live with everything twenty-four hours of the day and he was cognitively with it. He was still his own person and he needed to have a decision in it. After I'd known him for about a year he'd send faxes to me quite regularly of things that he'd seen and that was his way of giving something.

Acknowledging that the client is an 'expert' with regard to their bodily understood needs and requirements allows them a voice in decision-making. Who best to be that expert than the person experiencing disablement in his own life world? This person lives with it, he feels it, and he knows what it means for him. Balancing the notion of the client as 'the expert on himself' is the therapist as 'the expert on available options.'

Coming through in other stories are feelings of anxiety, anger and negativity pointing to a past relationship that may have been of a more hierarchical nature. Louise, a therapist participant, outlines in this story how she finds herself relating with a client who in the past had rejected her therapist's way of working with her. For Louise there is a challenge to relate with the client and her husband in a manner that informs and involves them so that they are able to share in choices and be empowered with regard to decision-making:

With one of my clients we hit it off immediately. She had had a bad experience with a therapist that she just didn't click with. That bad experience was with someone who'd been extremely bossy and she and her family had just been repelled by the experience. She had not wanted to be involved with a therapist for a long time and had reached crisis point before

I visited. I found because she was not an older person it threw up all sorts of interesting things for me. Because she and her family were intelligent and articulate, I found I had to relate to them very much equal to equal. And they wanted to share in the clinical reasoning and talk about how we define 'occupation'. I was able to answer their questions and I think they saw me as someone who was honest, saying if I couldn't answer their questions not fluffing or foxing. She's probably a client in the truer sense of the word than most people that I see are.

To hit it off and 'click' with someone is to feel attunement and connectedness. Through her recognition of the lack of equality in a past relationship with a therapist, it seems that the client determined to be more demanding and assertive in her relating with the next therapist. The need to relate as equals came from the client's expectations of the relating. As a consequence the relationship developed as one of reciprocity with the therapist listening and working at giving what was asked of her, allowing recognition of the need for openness and honesty. A relationship where one partner, the therapist, is able to 'fox' and 'fluff' is seen as unworthy and in conflict with mutual decision-making and shared control. With this person being seen as a 'real client' there is an understanding on the therapist's part that the client will seek advice about choices and be involved in them. At times people that the therapist visits may not have the ability or knowledge to make choices. Finding ways to involve those people in making suitable selections will be challenging for the therapist. Questions arise from this story about community occupational therapists' 'normal' mode of relating with clients.

Paradoxically at times it was the therapist who found they felt unequal in their relationship with the client. While the therapist has their own field of 'expertise' the client will also be 'an expert,' an expert with regard to themselves, having a depth of understanding of their body, their disability and life-world. Being new to the field of work and going in to see a client with a complex condition affected this therapist's feelings of knowing what she was doing and resulted in disparity in their initial relating. Teresa describes how she was affected both leading up to and during an encounter with a client:

The main thing was that he did scare me when I first went in to see him. I felt like a little girl and I think that he looked at me as a little girl ... "What do you know?" I could have been put off right from the beginning because I was given the option of whether to take him over or not. I had met him on a joint visit and thought...whoa, look at these problems, this is just so big. But I went in and had a cold sweat whenever I went there and thought, oh my God am I going to say the right thing.

He could be very critical. What he wanted done he wanted done now and he wanted it done properly. It was almost like I proved myself to him. I proved that I actually could do the job and he respected that.

To be a little girl is to be small in the eyes of the world. Accompanying this feeling of diminutiveness for Teresa were feelings of vulnerability and uncertainty about which direction to take, what course to follow and of not understanding the big picture, the overview that adults in the world appear to have. There is a reversal and shift in frequently held expectations of who will lead in this situation. Both the client and the therapist's understanding of her inexperience in this area shifted the possibility of where power and control resides. Yet are the client's expectations of having 'the right things' done for them so difficult to deal with? Through her lack of confidence in knowing this therapist has reached a state that could be described as 'unknowing.' She has situated herself in the client's world, acknowledging to herself her state of 'unknowing' about him (Munhall, 1993). Therapists benefit from placing themselves in this situation to better understand the client's world.

The value of time
Within the theme of attunement the notion of time is another possibility. Time, and the giving and taking of time, especially time which allows for their voice to be attended to, recurs as a feature in clients' narratives. Therapists also find that the taking of time impacts on whether the clients they visit feel heard and acknowledged and is a factor in feeling 'in tune,' of being aware of their clients' needs and feelings.

There are times when Rosemary, a client participant, experiences difficulty with planning her day. She talks about her troublesome time with the therapist's answer-phone:

> *The only thing that I find hard is leaving a message on her answer-phone. I can't just ring and say, "Hi, it's Rosemary here." I have to talk on the answer-phone and then wait around for her to ring back. I mean it just sucks my day because I desperately want to hear back from her. I don't know when she's going to ring so I've got to spend all day at home. Sometimes I'm honest with her and say, "Oh gosh you're so difficult to get. I've been trying all week and I had to get up the courage to put a message on your machine and I've finally done it." She'll say, "Well done I know it's not easy." At first it was the most frustrating thing, waiting at home, not knowing when she'd ring. Then it would disrupt what I wanted to do in the day. I do understand that she has other commitments but now I get around it by ringing her just before she finishes work and leaving a message on her voice mail. That way I can get her to ring me at 8.30 am when I know I will be home and that really resolves it.*

Time has an intrinsic value and can be given generously as a gift. Conversely it can be withheld and then has the capacity to suspend life, draining the day of anticipated activity. Whose time can be seen to have the greatest value in this story? It's the therapist who is able to hold onto her time rather than the client who uses hers up waiting. Time withheld has the capacity to undermine the client's feelings of worthiness. Creating a sense for the client that they are being given time, when the therapist's time is limited may lie in such things as the swiftness of the therapist's response to messages.

Kerry, a therapist, outlines how the giving of time connects her to a greater understanding of her client:

> *I remember one day that I really enjoyed even though I'd only had some little thing to drop into her. I spent quite a bit of time with her. She told me a lot more about herself and her history, in a way that topped off the*

connection. I felt better that I'd had time to listen to her story. I think that it
was also quite important for her, that she had someone coming in not just
for personal care, her body, or a piece of equipment but just to listen to how
she had got to that time in her life. It was interesting.

An aspect of hearing and acknowledging a client in their world may involve the therapist bringing the past to what is happening now. Of the moment and at any one point, for all of us our past, present and future are present. To listen to a client's story and to be available to them is to acknowledge them as a whole person, rather than endorsing as valid only their physical needs and requirements. Alongside the recognition of themselves experienced by clients, many therapists find this 'knowing' of their clients will also be felt by them as very powerful (Pieranunzi, 1997).

Client participants indicate that a feeling of attunement with their therapists has significance for them. Brigit tells how she feels about her therapist's availability to her:

Our relationship has been very friendly and I never feel that she doesn't
want to phone back or that she's not interested when I get hold of her. She's
so enthusiastic, really helpful and has never been negative about anything.

Brigit words show the ease with which she approaches and encounters her therapist knowing that the therapist will 'make time' available for her. The time given gives her confidence that she will be both listened to and responded to. One consequence of always knowing there will be a response is an experience of acknowledgement leading to confirmation of worthiness and the perception of equality. The ways in which clients see themselves will be shaped and changed by the time given by therapists alongside their own perspective of their past, present and future. 'Lived time' is not linear but rather is subject to how we experience it. Describing 'lived time' Van Manen (1990) says, "the temporal dimensions of past, present and future constitute the horizons of a person's temporal landscape" (p. 104).

Being personal and professional
Reaching beyond their own sense of being to the other person that is the client can involve the therapist in moving beyond what may usually be regarded as 'the therapist's

role.' Yet a recurring theme in therapists' interview material revolved around the balancing of their professional role with the 'pull' towards a real and often deeply felt personal relationship, that had emotional and lasting consequences for them. When describing the relationships that are most powerful for nurses Pieranunzi (1997) said that they were those that connected to the humanness in other people, seeing them as they were and with an opening of themselves to each other's meaning. This is likely to be similarly true for community occupational therapists. There is tension for therapists within the balancing of time given to clients in a professional and personal capacity. Heidegger (1962) describes this pressure to conform as coming about through the judgement of 'the theys' – the invisible way that all interaction and relating will be measured. Within healthcare practice 'they' will be professional bodies, 'the interdisciplinary team' and the health system, making judgements, measuring ways of behaving and setting a standard or norm that therapists will be influenced by.

While clients were more concerned with the need for a relationship with therapists that was professional yet friendly, that acknowledged them as a person, therapists seemed to struggle with the dilemma of closeness in their relating with clients. The therapists interviewed discussed how being professional and personal, viewed by them as the two sides of their relationship, were either integrated or held separate. Teresa, an occupational therapist, describes how she found the paradox of being separate but close:

> *The balancing act with our relationship was balancing the professional and human side. For instance when he went into hospital we arranged to loan the bed to the hospital while he was there. I went in my own time after work and met the company rep there who helped me set up the bed. The family was there. This was a very personal and intense time and we were there helping in a professional manner but also there with the family at a private time.*

While being attentive to the role she can provide in her professional capacity of helping to ensure the client's comfort, Teresa also speaks of being there in a personal way for both the client and his family. To be present, not avoiding the pain and distress around the client's condition is personal yet also has the paradox of being 'truly professional'

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bound up within what outwardly appears to be dual roles. How far into the personal relationship professionals travel with the client and their family in times of distress will depend on the depth of trust developed and the meaning of the relationship for these people as they take this journey. Understanding when and how to finish their journey together will be the challenge for the client, their family and the therapist.

Sometimes it was clients describing a tension around personal ideas about relating to the therapist as a professional person. When a client participant, Anne, had her new therapist visit she experienced some concern about her ability to provide what she needed:

> *The new one seemed so very young. When she walked in the door I thought, "My God you're younger than I am!" She was a lot younger than my last therapist was and a little new to it all. When she came she had most of my notes and she'd actually read them and had got a lot from that. She had some specific questions about my condition and just wanted to clarify those aspects for herself. It was really good. I'm so impressed when people are well informed.*

While Anne found that it was initially difficult to align her beliefs around age equating with competence in her perception of the therapist as a professional, she found that the therapist was able to show her by her manner and actions that she could be that person. At times therapist participants described situations where their youth or newness to their work in the community was perceived negatively when relating with clients. This perception impacted on their initial ability to gain clients' confidence in them as a professional. Showing that they were reliable, were concerned with the clients' world and had the necessary knowledge and skills to assist the client became the way to build up trust demonstrating their worth.

Therapists also found that there were times in relating with clients when their ability to use their occupational therapy skills, thereby fulfilling an aspect of their 'professional role,' was at variance with the client's feelings at that time. Lisa describes in her story the struggle between wanting to use her professional knowledge yet not pressure the

client into unwanted decisions, while being caught up in the relationship between the client and her husband:

> *For a few weeks I was the main support for him. He rang, we talked, and I visited. My client's husband had previously had some mental health problems and making decisions was not his strength. So when he was there she felt she had to be strong for him. At times it felt like going in circles, like a struggle actually between three people. You know there were those two and me, him trying to get things underway, her not wanting to and me trying to give them the facts.*

Lisa is seeing her role in this relating as needing to bring 'the facts' to the interaction. While showing the client the need to move forward in decision-making could be seen as one aspect of a therapist's role, the bringing of 'facts' requires a knowing about their meaning in connection to the client's world. Being attentive to the client and her husband's ability to cope with decision-making while the client was trying to come to terms with her condition has the capacity to pull the therapist into their world.

A client participant, Jane, describes the ingredients needed for her to disclose aspects of herself when relating with the therapist about the issues that were important to her:

> *With different therapists it depends on my feelings of confidence in them, whether I can open up, saying things like "This is the thing I'd really like to be doing, and of course I can't do it." Being able to do that depends on them being a friend – being fairly friendly and open with you so that you feel able to talk about your needs. When they are here as health professionals you don't spend much time with them. They are sort of in and out, friendly but not a friend.*

Feelings of trust and safety come about when the client has come to see the therapist not as a stranger entering her home but as someone she can both rely on and feel open to talking with. Jane has used the notion of friendship to explain the sort of relationship that is conducive to talking openly. Giving time and demonstrating concern will be

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aspects of the relating that will make a difference to unearthing the things that really matter in the client's 'life-world.' Is it possible that the therapists visiting Jane leave the interaction believing that they have fully understood her concerns when from the description there is a lack of attunement to her and her needs?

Teresa compares her involvement in her client's life-world as a professional with skills to give alongside giving recognition to his very human need for her time and attention:

> *I was that professional person but he was divulging personal stuff so I would meet him half way. We got to the stage where we would do the work and then we would have conversations about other things, which was neat, a normal conversation after the professional stuff. Then before I left I'd round up and say, "Okay this is what I'm going to do, this is what we are going to do." Sometimes it was a quick visit and then I'd zoom in. If I knew that he needed to talk I would book up the time so that I would not have to be looking at my watch, so that I could be there. So it was a balance between the personal side and the professional side because he needed both. Hoping that he felt comfortable enough with me knowing that I was open and aware about the other things that were going on in his life.*

'Being there' with the client will involve the therapist as 'a professional' in a variety of roles. It may also involve therapists putting aside roles in order to be open to what is needed through the 'knowing' in the mutual attunement and connectedness between clients and therapists. At different points while interacting with the client the therapist may be seen as friend, ally, advocate, confidant and partner, all requiring the giving of time. Knowing when these divergent roles or ways of being together are required will reveal the depth of understanding of that client. An intuitive grasping on the therapist's part around the client's needs may at times be necessary. When positive modes of being-with-concern (Heidegger, 1962) such as attending to something, discussing and considering are present, then the likelihood of the therapist 'getting it right' with the client will be revealed in the quality of their relating and the understanding and actions that follow.

Possibilities of friendship

In discussing friendship within therapeutic relationships Pairman (1998) talks about the notion of 'professional friend' with the word professional added to that of friend, acknowledging that the relationship of friendship between midwives and women has constraints within it. Participants in this study also distinguished the friendships arising between them as being different from other social friendships that they experienced. One ingredient of friendship is an involvement in an ongoing social relationship that is unlikely to occur in many situations with clients and therapists. Frequently their friendship will be limited although aspects such as trust, camaraderie and knowing each other will be present in the client/therapist relating.

In response to conversations that were generally not directly about friendship, client and therapist participants sometimes described the place of friendship in their being together. To questions such as: how would you describe the relationship between yourself and the community occupational therapist? And Can you tell me a story about visiting a client when the relating seemed to go very well? Or conversely when the relating didn't go well? there were diverse responses. A client participant, Jane, describes the special quality in her relationship with her therapist that came about because of a combination of their pre-existing close friendship and Jane's positive perception of the qualities of her friend as a therapist:

> *I would really describe my therapist as a close personal friend, so my relationship with her was quite different. We had a lot of fun joking with each other and had a similar sense of humour. That was before she went back to OT of course. She was such a good friend. And she seemed to know that people like me need a great big hug frequently even though I'm sitting in a wheelchair. People often find it difficult to get physically close to someone in a wheelchair.*

> *The only way it would complicate things is that I would feel awkward asking her about things when she was here as a friend, not working. She would always say how much she loved doing OT things anyway so she was only to happy to be asked when she came as a friend. We both like to treat problems as more of a challenge and she'd always say, "There's a way we can get*

around that." Regarding health professionals, I'm always stressing that the best that they can do is to encourage the best sort of quality in care. I believe that for people like me quality care is the icing on the cake. I guess for me, having a therapist who was also a close personal friend was the icing on the cake.

There is a sense in this story of Jane's therapist being able to be fully present with her on a scale not limited by what some could described as 'the narrow gaze of professionalism' or the way we sometimes think professionals should behave. For many health professionals there will be a standing back and focus on objectivity that links back to past paradigms and perceptions of 'correct' behaviour for people in such roles (Lyons, 1994). It seems that the therapist has a perspective on her client, having concern for her special needs and yet is also able to see in her the person that she is through their past shared laughter and hopes and dreams for the future. Jane's description of the therapist providing 'the icing on the cake' discloses how fortunate she felt in having this exceptional relationship. A question arises around the possibility of creating a relationship with the ingredients present in Jane's story. Is this possible without the ingredient of a pre-existing friendship to build such a relationship or was the quality of the relating produced by the ability of the therapist and the client?

While Jane found the boundaries around roles of friendship and professionalism difficult to negotiate at times, a therapist clearly disclosed how she combined them. For Teresa, friendship with a client who had a deteriorating condition and who she was seeing over an extended period of time appeared to be both a strategy and something that came about as an integral aspect of their being present together. Acting as a substitute for friends was the way she described this special aspect of their relating:

Sometimes they sort of look at you as a substitute for their friends because they haven't got their friends to talk about their problems with. Sometimes they can't put the burden on their friends and tell them about the problems they're having. He was like a prisoner in his own home to some degree. He still had friends but he had pushed some away. He said that he couldn't talk to people. He did not want to put that on his friends but he could talk to me because I was that professional and I'd let him know that I was there to talk.

When you see these people day in day out you do get personally involved with them. It's not a friendship per se as in a normal friendship but it's a friendship within the bounds of that situation.

I would disclose things about myself, just in a general conversation such as, "How was your weekend and what did you do?" I think that's your 'conscious use of self.' It's a trade-off for all the personal information that they have had to give you during your time with them. He loved cats and I had cats so brought some photos to show him of my cats and he liked that. When the team knew that he was down we would make an effort. On his birthday we couldn't take a cake around because he couldn't swallow, but all of us rang him to wish him a happy birthday.

To have an ongoing deteriorating physical condition is to live in a life-world partially created by both living with the condition and the management of it. Health professionals entering the client's world may find themselves participating in unexpected ways, at times partially filling the void left by former friends, colleagues and at times family members who have moved away or been held at a distance. In comparison, therapists may appear to hold the world in the palm of their hand, with seeming good health, a working life, colleagues, friends and future possibilities. Drawn into the space left by others, the therapist may choose to open their hand, offering as a gift an aspect of themselves, sharing some of their world with the client thereby expanding a narrowing world. Pieranunzi (1997) tells us that reciprocity is an important aspect of interaction with clients while Pairman (1998) describes this concept of friendship between clients and midwives in terms of 'professional friendship.' Being a 'professional friend' to a client is likely to involve the therapist in an intuitive knowing of the client that is personal and negotiates carefully within the boundaries of the client/therapist relationship.

When a therapist participant, Paula, came to visit a client she finds her own way of balancing the role of being a health professional with a past friendship:

When I visited his wife opened the door and said, "Oh, it's you!" I greeted her from way back, from long ago when I had known her. I had no idea until

I visited that his wife was an ex neighbour from my childhood. She hadn't known it was me coming to see them either. That made it quite different from anything else. It put me on the spot. I felt it was important to get things right. I had to be really professional even though underlying it there was this, 'I know you and I know where you've come from and what you've done and everything else.' There was that edge of friendship added as well. We had to quickly re-establish a whole new set of guidelines. I concentrated on her first. My way was to focus first of all on the past and then bring it to the 'here and now' and talk about the house that had been especially designed for her disabled husband. Then it went like, "Show me your house and let's see where this piece of equipment would work well." It was the house and then her husband and the house. I think it worked that way and worked really well.

Lived time stood out as an integral aspect in the story of this therapist's interaction with her client and his wife, showing a horizon to the landscape of their lives and opening opportunities for a new way of relating to each other. Through the thrownness in the circumstance where she found herself in this particular situation, her past confronted her at the entrance to the client's house. The inappropriateness of focusing solely on her present professional role was brought into her consciousness. By bringing their shared past to the present through discussion with the client's wife, focusing then on the client's home, the now, and then looking at the work that he would need to have completed on the house in the future, she was able integrate aspects of each of their lives within the framework of being present, there with them in their home.

Elements of friendship pervaded stories from both clients and therapists. Within the thrownness of their being together lies the possibility of differing ways of being friends. At times pre-existing friendships confronted the present with the past. On other occasions, the client and therapist found ways of being a friend of a nature that was special to those circumstances and times. Being with each other sometimes in close proximity and sharing experiences that have a depth of emotional significance for the client has the capacity to draw these partners together into a shared and mutual understanding.

The key to the future

Community occupational therapists have the capacity to assist the clients they work with to create what they need to change the way they manage their lives. Conversely they can close down those possibilities. One aspect that became apparent through clients' narratives was the range of possibilities that existed for them was dependent on this frequently hidden power that therapists had the key to.

The holder of a key can unlock and open doors, removing barriers in the way. They can also leave the door locked, reducing access to opportunity and resources. The key has the capacity to give the holder power and control that may prevent others from moving in new directions. The therapist, knowingly or unknowingly, has the key to resources and it seems that the client has an intuitive and at times deeply felt knowledge of this. One aspect of this knowing can be the way it will influence the client's mindset prior to and during the therapist's visit. While holding the key gives power, when the therapist brings the client into the decision-making, the power and control can be shared between them with the focus being the client's needs and wishes.

At times clients see that community occupational therapists have the potential to open up access to resources that they could not otherwise gain entrance to. On the other hand there is a sense of disruption to their life-world in clients' stories with so little happening for them, and the potential for access to resources, a covered-over aspect of their relating with therapists. Brigit is one of several clients who sees the occupational therapist as the person providing information and opportunity for her:

> *I guess she's really my key person in terms of how I deal with things. She found out about all sorts of things for me and made phone calls on my behalf to funding bodies to find out about what they will and won't do. She'll ask, "Do you want me to do this?" Mostly I do it, but she is dealing with these people all the time. More recently we've done a bit of information swapping. She says, "Have you seen that" and I say "Yes, but have you seen this?" It's really good.*

Brigit is assigning her occupational therapist the key to opening up possibilities for her. The openness in the relating makes many things feasible, giving the entry for Brigit, who can then decide which door to walk through, which path to follow. There is a mood of willingness and optimism showing in this story and that mood will impact on the degree of co-operation and attunement between the client and therapist. A client participant, Jane, describes how her past therapist unlocked and pushed aside many of the doors that presented as barriers to her:

> *She always said, "Nothing is insurmountable, there is always a way to improve things" and she'd nut the problem out. I'm sure her approach was catching even. Part of it came from me and was because I knew that they were things that she loved doing. It was wonderful the things that the OT knew about. She knew that I found it tremendously empowering to do the things that I used to do. I guess it made me feel positive and not depressed about being unable to do things. It's horrible to drop everything, drop your career, your ability to earn a living.*

In this story the client has described the opening up of previous future possibilities thought lost to her. It is through the therapist's skill and mode of care, her concerned mindfulness that barriers are removed. By attending to the things that greatly concerned the client she has revealed things that had been seen as impossibilities. Does the occupational therapist in Jane's story understand the degree that she was able to open up possibilities for Jane or does the full meaning of her work remain partially hidden by the notion that she was just 'doing her job?' Conversely, Jane tells the story of how restricted her options are, when not having sufficient time with a therapist affects and closes off possibilities for her:

> *The situation is not one where a therapist comes and looks at the overall situation at all. Someone comes for a problem when there is one. If there is anything that I was really suffering without I'd ring but I know that the therapist is not there every day. Though I can leave a message I'm a little reluctant to and just leave it and hope that things will happen in time. I've never heard back about the bathroom and I'm not sure whether they did contact a builder or whether my husband is expected to try to do the work.*

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I've just got to be patient. If I had more time to spend with an occupational therapist I'd probably be asking for a few more things like ramps.

When a therapist's response to the client they visit is one of focusing primarily on the presenting problem, then opening the door to opportunities to attend to the client at a deeper level will be neglected. The client waits. She waits to ring until it is essential, for the therapist to clarify their arrangement and for the entrance to her home to be improved. Through the therapist's absence and lack of recognition of the key she holds to this client's choices there is a valuable loss to the client of ideas and of the resources that have the potential to change her life. The key to future possibilities that could be offered is unknowingly withheld. It seems that the therapist's concern has not been attuned to the client's need, A deficient mode of concern (Heidegger, 1962); of leaving undone, impacts negatively on the client's life-world and has the potential to diminish feelings of control and self-worth for the client.

Having the tenacity to stay with the challenge of finding workable solutions for her client is a concept present in a story Louise told:

We worked together on designing the bathroom and she was particular about every little detail. She was a very precise person and it could have driven you completely out of your mind. It took three times as many visits to get it right for her but we did. She was very quick to say to me, "I don't understand or what you are suggesting isn't a real solution for me." By rolling with it you actually got there. I feel really good about the tenacity that was required to do that because basically someone else might have said, "too hard, too much detail." Now because of the relationship that we have built up doing that she is discussing issues with me about how to make her environment at home better for her. It's taken quite a lot of patience and tenacity to draw it out but together we've been able to work on some issues that have been real for her, rather than things that I thought would be a good idea.

Being attentive to the need to share decision-making will pull the therapist towards working in a client-centred way. This concept sees therapists as listening to clients, in a

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relationship of partnership, while giving support to the client's need to determine their own direction (Townsend & Brintnell, 1997). The therapist as part of her role could be described as the holder of the key to resources. However sharing that power in a relationship of reciprocity will be important for both client and therapist. The give and take in the relating with belief on both the client's and therapist's part that they are contributing will result in the opening up of possibilities (Gage, 1997).

For the therapist, to be truly professional could be in knowing when to lower the so-called 'mantle of professionalism.' Removing that layer in such a way that it is beneficial for the client and their family may mean closing the space between themselves and their client, becoming attuned and more deeply connected to what the client needs from them.

Synchronising: moving with the client

While I have used the notion of synchronising as an aspect of attunement to describe the interplay that sometimes occurs between client and therapist Polatajko (1996) uses the notion of synergy when she outlines the 'flow' that exists in a positive therapeutic relationship. The pull the therapist at times feels towards greater involvement with the client and their family and caregivers will come from their own response to the humanness in situations they are involved in. Being in a mode of concern that recognises that being with the client involves attending to them will bring the therapist into a relationship where it is not possible to pass by and be indifferent. For the therapist to accompany and follow a client on their journey into what may be an uncertain future is to step into their world, lowering barriers that held at a distance pain and suffering and personally felt involvement. To become almost a part of the family is to step across a barrier that can exist as a protection for both the therapist and client. It is also to be truly present for the client and their families at times when they most need the support that closeness and being there can give.

A therapist, Teresa, describes how it was for her when the family she was working with included her in their distress when a family member was in failing health:

> *It was like being part of the family. They sort of brought you in to them*
> *being worried, through their conversation. It was nice and it was nerve*

racking as well. So it sort of drew you in emotionally and I felt sick when I left there and was just waiting for the phone call.

Being included in that private place at the heart of the family has the contradiction of being both something special and yet something difficult that can produce feelings of unmanageable involvement and vulnerability. The relationship between client and their family and the therapist, while being intensified and heightening good feelings about the relationship, may also become stressful, leading on to an inability to set the relationship aside when outside of work roles.

In contrast, with the client that Lisa talks about in this story, she finds that their relationship became easier, more open and close during the advancing of the client's condition as the obstacles between them came down:

> *In the early stages it was her husband describing her problems while she was still in the mode of "I can do all this, thank you very much." No way did she want to talk about what was going to happen next. In the past the contact was often through other people, with her not wanting to talk. At that later stage when I visited her in the hospice for self-feeding, positioning and pressure care, that's where I felt I really had built up a rapport with her. We had gone through quite a lot of things. It was in some ways like she was pleased with what I did. It showed in her body language and talking more openly about the difficulties that she had. She'd say, "This is better than that one" and just talk about her loss of function. In some ways things felt resolved. It was like her and me, we were having quite a history together, and she was letting me get close. The barriers were not there anymore.*

A differing response to the therapist was revealed when the client perception of her condition and future changed over time. Trust is a quality that has the capacity to alter ways of being together. When the therapist became a trusted person she entered the life-world of her client who lowered the barriers to openness and closeness that previously blocked their interacting.

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Synchronising movement with what is happening about you results in an ease and flow in sensing the steps in the dance, of how to interact with people. Embedded in several therapists' stories were listening, intuiting and acting in response to the client. Inherent in the involvement was a rhythm that frequently followed clients' lead rather than therapists superimposing their own. Awareness of mood gave clues as to what action to follow. At the same time the thrownness of each situation introduced a variety of factors showing the therapist which steps to take, which possibilities to open up. Taylor (cited in Hiley, Bohman, & Shusterman, 1991) when discussing the flow of co-ordinated experience tells us that "integration into a common rhythm can be one form this shared understanding can take" (p. 311). He describes this feature of human action as showing as a 'rhythming' of cadence, of having a flow. At times this response to the other person showing in a common rhythm will cause confusion when actions become disrupted.

There is a sense in Brigit's story of the therapist being in rhythm with Brigit when this client participant tells about how it was having the therapist coming to visit on the same day that she heard exciting news about her unborn baby:

> *It was a good day. That was the same day that I'd had the scan and found out about the baby's sex. I'd had the whole day off work, and they'd found from the scan that the baby was all okay. I hadn't told the therapist initially and then I thought I must phone her. In terms of who's going to be providing the assistance there's only going to be her. We discussed all sorts of things but the main thing was the baby situation and how that's going to work for me.*

The client describes drawing her therapist into her life-world with the expected arrival of her baby and sharing the joyful news around the baby's health status. It seems that she wanted to include her therapist in this experience through a feeling of trust in her willingness to be involved. As she moves into the unknowns of the future she has a belief that the therapist will be alongside her, moving ahead with her, involved in the experience.

Participants' stories uncover the possibility that clients perceive the ways that therapists fulfil their work role as being equated with worth. When in the relating, insufficient

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attention is given by the therapist to the client's requirements the result can be either the therapist or equipment being unavailable or unsuitable equipment. Then the resources being unready to hand at a time when it is most needed will have the capacity to reveal to the client the significance of its absence. Heidegger (1962) described objects and equipment that are ready to hand, as doing what we want them to, and being more conspicuous in absence or unsuitability when unready-to-hand. In the clients' life world, the world of lived experience, the 'unreadiness-to-hand' of equipment can be seen as confirming that they are undeserving and unworthy. Connecting of the concrete aspects of the client/therapist interaction such as accuracy and the supply of equipment to the quality of the relating may not always be clearly seen by therapists.

There was a paradox in descriptions of relating that worked well. Clients tended to use words that demonstrated ease in the interaction, *It was really good because it felt like she was being considerate and concerned about my well being.* Whereas it seemed that even within relationships with clients that went well for therapists, that had a successful outcome, there were signs of struggle on the therapist's part to overcome challenges to reach that point, *At times it felt like going in circles, like a struggle actually.*

Being apart with the other: separateness

At times participants' stories revolve around a feeling of attunement, trust and confidence in the relationship they have with therapists or clients. On the other hand, there are other stories that disclose relating of a differing nature, stories that tell of the things that keep the client or therapist embedded in their own life-world. While being apart could be construed as another way of being with, elements of difference have pulled these stories towards a separate theme. The most significant difference that arose in stories is the awareness, the knowing, particularly on the therapist's part, of what they are doing, of how they are responding in their 'being with the other.' Sometimes in the relating there was a distancing, coldness or deliberate taking on of a differing role that involves stepping away from close involvement in each other's world in order to provide an objective view, the fuller picture, or the health provider's intent. Other occasions differ. Clients and therapist separate because they believe nothing can be changed and that there is an element of impossibility in their situation. Veiled in some stories is the therapists' need to preserve themselves from stress and possible harm. There are other stories that show that the client and therapist are simply out of step with

each other in ways that relate to their differing life-worlds and their belief in the purpose of their encounter.

Standing back

When therapists believe that they have to be the person anchoring the client to the possible they step back in order to 'see' more clearly what they feel is needed in doing so breaking the flow of connectedness with the client. In this situation Teresa, a therapist, talks about believing that she needed to provide the rational voice:

> *Quite often he would get all excited and get me out there because he'd seen a new piece of equipment. And then I had to go out and say, "It's very nice but it's not yet in this the country." You know I had to be the voice of reason because he was on the internet and he'd come up with all these fantastic ideas and I had to come in and go, "Very nice but…it's not going to happen. This is the reality, this is what funding is available, this is what you can get, this is what you can't get."*

The therapist had a view of 'the larger picture,' an understanding and a knowing of what was possible and what was not. Assisting the client to move towards a different view is to show them a larger horizon. At times this will be accepted and at other times will be rejected by the client, whose focus may differ.

Similarly when Lisa visited her client she found herself in the role of trying to show them a glimpse of their future needs, needs that they were not yet willing to face:

> *They were not wanting to look at the bigger picture, only at the detail and wanting to put things down very firmly as though nothing else would be needed or changed as in "nothing else will be changed because that will be all we need." I was trying to get them to understand the situation of being at home and where they were in that.*

It seems that providing 'the voice of reason' is a role that therapists may find themselves in, in attempting to lead the client into the future and assisting them to construct ways of managing their lives. The balancing of the client's own expert

knowledge of themselves with the therapist's ability to look ahead with a knowing of future possibilities and impossibilities will require the taking of time, talking, waiting and intuiting the right moment to move forward. There will be times that the client is not yet ready to see the present or the future. The sense of being apart, of separateness will frequently lie in the differing view that the client and therapist have of future possibilities.

Anne describes how it was for her when her therapist came up with a sensible, reasoned solution for her that she was not ready to face:

> *She wanted to double check and asked questions so that I could say, "Yes I'm managing with that" or "No I'm not." She saw the potential for an injury with the way I was getting out of bed and now I have this bar that pokes out of the side of the bed. It was quite a major for me. I was upset when she left. She probably didn't realise, as I didn't say anything. I wasn't pressured and she said "If it doesn't work for you we'll find something else." They are here for their knowledge though I know what I need and don't need.*

Do therapists always recognise whether they have understood clients in ways that are genuine? While the therapist saw potential for injury, the client saw injury to her picture of herself. How much was verbally communicated in this relating and how much was left unsaid, showing itself in other ways of being together, through emotions, through silence, in ways that may not have been sensed or realised? Heidegger (1962) draws our attention to the ease of believing we know and understand what clearly shows and the difficulty of seeing and comprehending what is less transparent.

Alongside the challenge of a 'knowing' that is genuine in nature there were challenges for both clients and therapists when there seemed to be nowhere to go, a sense of impossibility that was beyond their control and at times came from outside their relationship.

Impossibility: caught in the middle

When Rosemary requires a visit from her therapist, both she and the therapist find little room for manoeuvring in a situation where future possibilities seem blocked:

> *I was in a boarding situation when the occupational therapist visited and encouraged me to have equipment that would make it easier for me. She was going to put in bath rails also to make me independent with bathing but the family wouldn't have it. The house was not to be touched in any way. Oh my therapist was a bit shocked at that sort of attitude but we both realised it was not really my home. That's what they said, "This is not your home, it's our home." So we just left it that I accepted the equipment and I would get in touch with her if I needed to but I never did. The woman of the household had fobbed her off and made her feel that she wasn't welcome back.*

Just as this client finds it is others who have the power to close down the possibility of change occurring, the therapist also encounters a similar obstacle. Control of future plans has been taken over and it is outside either of their abilities to change the immediate circumstances. Not being able to support a client in what they want produces a similar sense of impossibility in a story that a therapist Lisa describes, where she finds herself caught between the client's wishes, her professional judgement and her obligation to a funding body:

> *He wanted something from me, he wanted items I couldn't deliver. With some people you can problem solve but with him there was no way that he was receptive to it. I said to him, "I can hear that you really want this wheelchair, we've tried it and it would have been a good option but you are not safe with it so I can't give you a letter to the Lotteries Grant Board I'm sorry." Basically it was "Can I have it?" "No." "Get out." He saw me as having taken his chance away with all this bureaucratic stuff. Maybe it couldn't have gone any differently but I didn't feel terribly good walking out of there being told to get the hell out.*

Caught between them, holding them apart, and playing a role in terminating their relationship is a judgement the therapist made. There is a tension showing for the

therapist between being focused on the client's needs and wishes and on the decision made both as a professional and as someone with an obligation to a funding body. Not being able to 'deliver' when delivering is a major aspect of your work had a negative impact on the relationship that was evident not only for the client but also for the therapist. Teresa tells about having tension arising from being in the middle between the client and the care agency:

> *I had been to see her a few times. It seemed that the client and her husband did trust me. But I ended up in between the care-giving organisation and them. There would be a slagging off about the home care to me and home care would be on the phone saying, "Look, this is a crisis situation." I said, "I'm in the middle and I can't put in the equipment unless they agree to it, they are not agreeing to it and she will not use it." I was being set up by both sides wanting me to take their sides. The caregivers were telling her one thing because they didn't want to upset her but they were telling their boss "It's too difficult." There was talk of meetings and mediation. They were putting me in another role, that of mediator and I actually let it escalate to that level. It was out of control until I said that I did not feel comfortable with it. I was getting all these stories and I finally said "Stop, I'm not doing it anymore, I'm pulling out."*

'In the middle' is a central position when differences and dispute erupt, at times an uncomfortable place to be. It will require a difficult balancing and negotiating around the client's and caregiver's needs and yet needing to maintain the focus on the client. While the therapist understands that the client has the right to make choices affecting their own management little progress can be made by the therapist while the client avoids options facing them. The therapist is drawn into the problems of the caregivers and their organisation. Is the role of negotiator/mediator one that the therapists should allow themselves to be placed in when it may involve advocating actions and making decisions that the client does not agree with?

Summary

The basis of being together in any relationship will be that the people within that relationship, in their being with one another, are able to see the other as a person in the context of their life-world. To be only able to see others as they are labelled with the name of 'client' or 'therapist' masking who they are as a person is to not know them. The client's disability or diagnosis may blanket and cover over who they really are. Therapists also may not be seen clearly because of their identity as a health professional and the possibility of being hidden behind that identity. I have used the notion of *making visible* to build upon the sub-theme of Being Seen, using it along with the notions identified in the chapter Fore-having as the foundation for constructing a notion around the client and therapist being there with each other in the relationship. The dwelling I have put together houses many ways of the client and therapist being close and attuned to one each other. Also situated within the dwelling are the divergent ways in which they are held apart by their differing roles, beliefs, wishes or needs.

The parts of the theme Being There make a whole. Within that whole composed of aspects of the client and therapist being together there are varied ways of relating. There are the obvious and the hidden ways. These can be seen in the openness of shared decision-making showing itself clearly and the not so easily revealed withholding of the key to resources. There are the focused ways in which the occupational therapist brings skills specific to their profession to the relating and alongside it the broad way that is primarily around human-to-human relating that show in stories where the client had a rapidly deteriorating condition. There are stories that show the separateness of the client and therapist who sometimes want two different outcomes and others that show the closeness of being at the heart of the family. Some stories indicate a disparity in the relationship between the client and the therapist.

Showing through in many stories are the possibilities that occur within the 'thrownness' of the client and therapist finding themselves in the relationship. There are stories from both clients and therapists that indicate that they did not feel that they or their situation were genuinely recognised and we are reminded that Heidegger tells us that what is easily accessible is not necessarily genuinely understood. Therapists are shown in

modes of care that leap ahead and assist the client to find their own way forward and therapists can be seen to leap in and manage the situation.

Many stories show both clients and therapists as being with each other with concern and in a mood of understanding resulting in attunement in their relating. Alongside this are descriptions of the therapist not being in a mood of understanding and being in a negative mode of concern of forgetting and neglecting. When this occurs one outcome is that equipment and other resources are not ready to hand when needed by the client. Frequently it is through the ways of relating and actions taken or not taken that both client and therapist know and understand the significance of the interaction.

Aspects of both client and therapist life-worlds are constantly present in the relating in the stories. Being bodily with each other is felt in such ways as bringing and providing a place of calm in the whirl of emotion and distress with a slowing and pacing altering the future possibilities. Time, with both the giving and taking of time, affects clients' views of themselves, frequently altering their perception of their worth. The past is repeatedly brought back into the present in stories of friendship where the future is already being addressed. Past present and future are experienced in a sequence yet at the same time show the whole of the client and therapist's situatedness in their worlds. When therapists interact with clients it is usually within the client's own space, their home. This has the capacity to draw the therapist into the client's world at times of emotion and distress.

Coming through the narratives is a flow in much of the relating of being attuned to the other, a shared understanding. At times it is the therapist who chooses to follow the client's lead whereas on other occasions it is the client following. Making a decision to stand back is deliberate on the part of therapists in order to be apart from the client when they feel that an open approach is not working. Sometimes factors from outside the relationship result in their situation seeming impossible. Deciding when and how to use this flow between them will challenge both partners in the relating.

Within this chapter there is a sense of the complexity of the client and therapist 'being there together' in their relationship with the many possibilities that lie before them. The direction these possibilities will take them in frequently lie in an intuitive knowing, the

every-day and nonreflective response that is an aspect that the partners in this relationship bring to their being together. Within our humanness is the capacity to change that knowledge. We see that the relating alters as one of these partners reflects on what has occurred and makes a conscious decision or move to change the interaction. Linking to 'being there together' are the things that come later. In the following chapter 'After having' hidden connections will be brought into the light.

Poems ~

possibilities

within the thrownness

Lost in the fog of being
Whirled round
Caught in the slipstream of living
Round and around and around
Sucked down, can't get out
Caught in a fog that's befuddling
With no future in sight

Speaking from my heart
I saw that she listened
Calmly, oh so calmfully
She cleared the mist away
Guiding me to firm ground

Waiting, it sucks my day
Like the proverbial gooseberry
I'm always available, she is not
I have time to wait she does not
I need her time but does she need mine?

Like the carriage pulling the engine
I must be pulled along by her direction
She does not, she has her own direction
Of which I have so little she has so much

of being together-in-the-world

Shared worlds
Drawn in
Seeing
Being
Open
To his pain

Giving
A life
A world
Receiving
The knowing
That resides within

No concern
Rubbish
Just litter
Bits and pieces
No longer worthy
Not whole
Thrown about by the waves
But unable to make my own

Chapter Six

After Having

The things that come later

> Its own past … is not something which follows along after Dasein [Being] but something which always goes ahead of it.
> (Heidegger, 1962, p. 41)

Introduction

Later, the relating continues. It continues in hidden ways, in the mind, in thoughts and ideas, and in ways of remembering. It continues in actions that reflect the depth of the relationship and the understandings that come from within it, indicating to both clients and therapists the value and the 'knowing' in their relationship. For understanding comes with them from the past and links to their future revealing itself in the thoughts, opinions and actions that ensue. This chapter follows the client and therapist participants' stories into the future of their relating showing those links and their significance. Of all aspects of the interconnectedness between client and therapist those things that come later outwardly appear to be the least connected to the relationship and yet have the potential to have ongoing and profound consequences for both the client and therapist. The ways in which both clients and therapists hold each other in their minds, how they reconnect, the actions they take and the ways they remember and neglect to remember will unfold in this chapter. Three sub-themes make up the chapter 'After-having,' Meaning in Action, Mindfulness and Moving On.

Meaning in Action

Actions, visible in the following-through of assurances, show a commitment to an agreement made. Conversely the lack of such action may show itself in its absence, by equipment for instance not being ready-to-hand, by applications not being completed and sent, and in being interpreted by clients particularly, and therapists at times, in a variety of ways not always recognised by the other. These actions have the capacity to demonstrate to the partners in the relationship the significance of what has already taken place through their involvement with each other. Actions show as a continuity of the relationship, taking on a mindfulness or at times a forgetting. There is meaning in the action taken particularly for clients who may understand it as a reflection of the relating and a signifying of their own worth.

Being superwoman

Superwoman can perform extraordinary feats. But are the accomplishments brought about through speed of response and attention to detail really that out of the ordinary or are they what clients should reasonably be able to expect from health professionals? At times client participants talked about the therapist's ability to 'get things done.' This was commented on with wonder, just as Brigit, a client participant, does in this story:

> *Sometimes it doesn't feel quite right; it just seems so easy. You say, "I feel I need this" and someone gets it for you. I feel a bit guilty actually. The other day when we were looking at the bathroom and discussing a $2000 piece of equipment, I suddenly thought, she's probably thinking, well why don't you buy one then? That's so weird isn't it? She probably wasn't thinking that at all, it was just me feeling guilty. That's always how I feel, that there are so many more deserving people out there. I've probably always had a hang-up about that. I prefer to have things on loan. Then I feel better that one day I'm going to give them back and someone else will get the use out of them. I was really surprised the other day when the equipment was there. Someone says they're going to do something for you and you think, 'yeah, a month from now' but it was only two days. It happened so quickly.*

Brigit questions her worthiness as the recipient of equipment that her therapist can access for her. That the therapist follows through on commitments seems to be a source of both wonderment and reassurance for Brigit. For the client to express such disbelief that actions happen so promptly conveys the idea that in the past this wasn't always the case with other services or health professionals. The therapist has a mode of concern that is one of attending to and remembering and being in a ready-to-hand mode of existence accessing equipment for Brigit in an engaged and practical way (Heidegger, 1962). Alongside this, time and the speediness with which this therapist is able to achieve the desired outcome for the client stand out in this story as having significance for the client, who may be accustomed to using her own time waiting. There is a sense that both the assurance and action of the therapist confirm Brigit's worth and cause a feeling of wonder at the therapist's ability to magically produce what is needed. Brigit has come to understand the significance of her relationship with the therapist in terms of the therapist's later action. Heidegger (1962, p. 401) tells us that "understanding is grounded primarily in the future (whether in anticipation or in waiting)."

Equally surprised is another client participant, Katie, when she receives equipment that her therapist has agreed to deliver to her. She comments: *When she ordered the equipment she was quick at getting it out to me, she doesn't muck around!* In contrast Katie tells the story of waiting for equipment that turns out to be unusable when another therapist brought it to her, *The therapist actually took four months to come up with anything and even then it was so heavy it wasn't useful.* The unuseability of this equipment shows how the thing in itself, the breadboard, is deficient and does not fit with the context it was anticipated for. Katie is unable to use it because of her inability to lift heavy objects. There is a breakdown in the way things have been expected to happen, the taken-for-granted way, with the equipment remaining unready-to-hand (Heidegger, 1962) made visible initially in its absence and then later through its unsuitability.

Rosemary, a client participant, also outlines the impact on her life when her therapist attends to her described need and responds rapidly following their being together:

At the first meeting I said to her that I'm not very good at remembering things by word of mouth. Sometimes I'm better with things written down to prompt me and she agreed to that. Her response to me was very quick. When I started living on my own here I found that I'd come across another obstacle and I'd think when I ring her up, she's going to be sick of this. But she'd say, "Write me a list and we'll look at it." So that's what I've done. She tells me how things are going through, saying "Right, we can get a grant for that and when it's approved I'll let you know." She writes me a letter to let me know that the funding authority has approved it and then the next letter tells me when they are going to do their work. Now I can ring her without thinking, what a pain. I want some control very much because I think people have had too much control over me.

Implicit in the therapist's response to her client's needs is a sharing of control that allows the client to manage her life more easily. Rosemary's therapist is seen to be in a mode of care that 'leaps ahead' showing the way for the client who is then empowered by the knowledge she has gained. In leaping ahead (Heidegger, 1962) the therapist can anticipate what is going to happen, leading on to the client being liberated to take charge of their life. The understanding that the therapist has about working with 'the system' is given over to the client and not held by the therapist as a manifestation of control. Heidegger tells us that just as the present is, the past is always with us showing in our everyday actions. A speedy response shows an engagement and involvement even in bodily absence.

Missing the action
Client and therapist participants told of times when expected or hoped-for actions did not eventuate, becoming the 'missing' action. This tended to highlight for them the meaning behind the information or equipment's unavailability and the lack of the telephone call of acknowledgement.

In a story that contrasts with the former picture of the therapist having superhuman powers to 'get things done' Katie, a client, describes the lack of connecting that occurs with her therapist. It seems that the therapist is being in a deficient mode of concern, of

forgetting and taking a rest that has negative consequence for Katie in getting the assistance she needs:

I was reluctant to talk to her because I wasn't confident with the attitude that came through that she'd do a good job that would work for me. I found out that there were things at the Disabilities Resource Centre that she could have accessed. I was disheartened when she came on the scene and basically relieved when she left.

There is nothing magical about the response this client participant receives from her therapist. No magic wand is waved, no equipment miraculously appears, and there is no immediate action. Rather, Katie is reduced to feeling that there has been a disregard of her needs, with what seems to be a deficient mode of concern on her therapist's part, of leaving undone and neglecting and not considering. The consequences for the client in this instance are felt both emotionally with the lack of care and support shown to her, and in concrete terms with a reduction in the assistance she requires.

When Teresa, a therapist, works hard to produce what she believes the client wants she finds that frequently the result is unacknowledged. She describes how this 'neglecting to comment' occurs:

If it's right you don't hear from them. Even though I'm joking it probably is true. When there is something wrong the client will tell you. But when it's right you don't usually get told, "Oh, that's fantastic." You ring up to find out about the bathroom to check that it's working okay and it's "Yes, yes, it's fine." If it's not fine there'll be that hesitation and you'll have to probe a little deeper then.

With the alteration to this person's place when I drive past his house I can see the ramp. You know we had a few contentious issues about that but there it is and it works. And you can see it and you can see him coming and going, see it working well when you visit. You know that it's all sorted. It's hard to explain how you know, it's a feeling. I just love it…driving past and seeing it done, seeing the ease of things.

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The alterations to the bathroom and the addition of a ramp have in part come to be successfully in place through the concerned and engaged doing of the therapist. For the client there is an acceptance that this is the therapist's work. As long as the therapist's actions result in the changes needed to the client's situation and environment the client sees this as the therapist responding and acting within the context of their work role. There is an expected everydayness about these activities for the client. For the therapist, the ready-to-handness (Heidegger, 1962) of the completed alterations despite the challenges experienced, the knowing and the understanding around the difference this will be making in the context of this client's life-world remain as part of her attunement with this client. It will be 'the seeing in the doing' that frequently give therapists satisfaction when their work role has the focus of occupation and activity within the context of each client's life.

Mindfulness

Threaded throughout many of the narratives from both client and therapist participants are strands of stories involving the client seeming to be present to the therapist even when physically absent. This 'mindfulness' manifests itself in a variety of ways; at times relating to an awareness of the client through looking for a specific item needed, while on other occasions thinking of them and recognising aspects about them when involved in everyday activities. Sometimes it goes beyond these perhaps not unexpected ways of connecting with the client's needs or feelings in their absence, to what seems like an ongoing bond that, once established, remains. Some clients become 'special people' to therapists. For therapists, 'keeping clients in the back of their mind' appears to relate to the degree of care and concern that has become a part of their ongoing relationship with a client sometimes lasting over a number of years. It may also link to the vulnerability of that client. The vulnerable people will be those who have come, through increasing disability, to require considerable support and need a 'fully engaged' and attuned relationship with the therapist.

Being held in the mind

A sense of acknowledgement and support from the therapist is evident in some stories coming from client participants. The perception that she is with her therapist despite the physical absence and distance is an uplifting experience for a client participant Brigit:

I feel like she sort of has me in her mind when she's doing things. I may not have talked to her for quite a few months, and there's no problem with that because I feel that even when there's a long gap I can just ring her up when I need to. I feel that's quite appropriate, that I phone her when I need to and I don't phone when I don't need her. Then when I do talk to her she really has things in mind and asks, "Did you see this, have you thought about that?" It seems that when she comes across something that is suitable, she thinks of me and I think that's really brilliant. I think she's genuinely interested in assisting me. I'm not sure what an occupational therapist's job description is, but I would have thought that noting ideas that could be of use to me, thinking of me and then passing that information on is an extra. I feel that I'm always with her.

Some of the concerns Brigit lives with on a day-to-day basis seem lifted from her and dissipated through her sense of attunement with her therapist that continues despite the therapists not being present. Along with the reciprocity evident in the relationship the therapist being in the mode of concern and 'taking care of' has assisted in producing this outcome. When you 'do extra' it goes beyond the everydayness of ordinary experience and expectations. The unexpected extra has that uncommonly good feeling around 'going the extra mile.' It is the bit that is unexpected and when it arrives has a rich quality bringing a confirmation of one's worth.

Holding a client in the mind presents in a variety of ways in stories from different therapist participants. In this story that Louise, a therapist tells, there is mindfulness showing around the client's needs:

I think because I've been seeing this client a long time she stays in the back of my mind. When I'm out and about and seeing other people in wheelchairs I'm always thinking, "Oh gosh would that work. Is that a good idea?" I think I do that with most clients, I'm always on the look out. With someone you see in an ongoing way it's always in your head.

Always being on the look out demonstrates a consciousness of the client, with the therapist gazing out beyond their own inner world and immediate needs and interests, in

an attempt to find what it is that would be of benefit to the client. It seems that this frequently goes beyond the boundaries of work expectations to an ongoing concern for the client, to find something that is not just 'ready-to-hand' but to search for ideas and items that may exist but that have not yet been found.

At other times the awareness of the client seems inextricably linked to the therapist's work role and possible vulnerability. Lisa describes seeing a client whose condition is of concern and she describes how it is for both herself and other health professionals at her work place during this time:

> *This particular client was in my thoughts even when I did not see her for a week. We had at least two case-conferences that we needed because I guess it was just such a challenging situation with these people having so little time to adjust to a rapidly progressing neurological disorder. This is quite a big building and some staff operate quite separately but they made an effort to be there, the whole team did. ...I think it was something that we all found with a relatively young woman, you know with so little time, we all felt touched and affected by her emotional state, by his emotional state. It's really in some ways that you are dealing with your own mortality and sickness and debility. That was certainly something that made me think of her.*

Both the client's relatively young age and the rapidity of her loss of physical function have drawn the therapist and other health professionals into the client's life-world. Being with her has lasting and ongoing effects. She's with them when not with them, on their minds and in their planning and discussions. Gage (1997) in describing synergistic relationships between clients and therapists suggests that it is with younger clients, frequently closer to the same stage of life to the therapist, that therapists appear to have special empathy and feel most drawn to assisting. At such a time one's own mortality is likely to be brought into the picture, sharpening the focus on one's own future and the uncertainty and thrownness in all our lives. Alongside the therapist's possible feelings of vulnerability is attentiveness to the client's emotional needs. Walters (1995) uses two terms, 'allowingness' and 'in-tuneness', in discussing the frequently unspoken willingness to share emotional feelings with others, to make things easier for them and

also being attentive to our own feelings and emotional responses to clients when in situations with them that require such a response.

Conversely this phenomena of being carried in the therapist's mind also shows itself through its absence when it is clear to Jane, a client participant, that she is not being thought of and her needs appear to have been forgotten, leaving her in a state of suspended waiting. *I just leave it, and hope that things will happen in time. I've never heard back about the bathroom...I've just got to be patient*. We are reminded by Heidegger (1962) that understanding lies primarily in the future, in anticipation or in waiting. This client's understanding of the actual relating that has taken place is likely to be perceived differently as a consequence of her anticipation that now leads nowhere. Possibilities lie dormant while waiting for the therapist to respond, giving a sense of being stuck with 'nowhere to go' for the client. Yet how does the client move forward without the needed input from and connection to the therapist?

> "Would you tell me please which way I ought to go from here?" "That depends a good deal on where you want to get to," said the Cat. "I don't much care where" – said Alice. "Then it doesn't matter which way you go," said the cat. "– so long as I get *somewhere*," Alice added as an explanation (Carroll, 1962, p. 87).

Alongside therapists who tell stories of being mindful of their clients, Paula, a therapist participant, describes why she feels it is not possible to remain cognisant of clients and their needs when her work with them feels complete. *I guess there comes a time when you say, 'That's it for me now, I don't think I'm needed here anymore." I decide that's the finish. I don't carry them with me. I have too many, eighty-three clients.* It is understandable that therapists with heavy caseloads find that they need to move their thinking and concern along in order for them to manage with the clients' needs that they are currently working with. That so many of the therapist participants told a variety of stories around carrying the client with them when they weren't physically present is both interesting and surprising. For some therapists it will be the depth of their connectedness with a particular client that shows the relationship standing out distinct from others.

Teresa's story, of her involvement with clients with ongoing and at times increasing disability, has a strong, evocative quality that shows the depth of this therapist's feelings around her relationship with some clients and this one in particular:

Those sorts of clients are a priority. They are always there and you know that it can be a quick visit, you can fit them in, and you know that if he needed something then he did need it. He wasn't one of those people who 'cry wolf' and when you get there they need nothing. He was always there in the back of my mind, when I saw equipment, saw something that might be useful, when I talked with other therapists and they had instances that click into similar instances I'd had with him. You always have half a dozen of your long-term people in the back of your mind. They are the ones. You get them, you may discharge them from one episode to another, but they are always going to come back, it's like a revolving door. Sometimes it's not worthwhile discharging them. You keep them there.

When a therapist knows that a call for help from a client is genuine and urgent the knowing has an element of trust in it. The trust will have been built up over time and will depend on the quality of the relating between the client and therapist, for it is the openness and honesty that is likely to produce the 'knowing.' An intuitive grasping of the meaning of the request and its urgency will accompany this knowing. But do we always understand and 'know,' and do we recognise when we are most needed?

The therapist maintains an ongoing awareness of certain clients. Who are the clients likely to have this sort of priority, constantly moving in and out of focus, in her minds - eye? It is likely to be the people where a merging of the boundaries between the client and therapist has occurred. Pieranunzi (1997) argues that the nurse/client relationship is not just a role that can be taken off, removed, but rather the relationship shows as being a part of the context of the nurse's life. It seems that for some therapists in this study this was not so and yet there are strong indications that for others that remaining true to who they are is about showing themselves honestly in their relationships.

The client's awareness of therapists holding a picture of them, as a person with their own particular needs, is evident in these stories showing in various ways. However, at

other times following the interaction between the client and their therapist, a different mindfulness shows through in stories from therapists that expose quite contrary thoughts and emotions to the former.

Recharging

Despair, weariness and anger are responses that therapists at times need to work through and to let go of in order to move forward and not take these feelings and reactions with them into future interactions. Distressing experiences have the capacity to undermine the therapist's confidence in re-entering the client's home. A therapist describes a situation she found threatening: He would stand over me and almost shake his finger at me and say, *Look, in this house we are very positive and everything has to be a problem for you. I don't want to hear any more of that negative talk.* When therapists visit clients in the community setting they will not have the 'security' of the institutional base that a hospital can provide. As a consequence therapists are more likely to be exposed to encounters that undermine their ability to continue with some relationships. In this story Kerry describes her feelings following a visit with a client that has been particularly stressful for her:

> *Often I came back in tears, once or twice anyway. I was just shocked really, especially the time that I was really stressed out anyway. I realised that I needed to give myself a bit more time, more space when I needed it and some times I need it more than others do. At times I had to use my senior therapist and other staff to unload to because of difficulties in the relating.*

When there has been hostility or anger between the client and the therapist there are likely to be feelings of vulnerability on the therapist's part through being in a place where this can occur. There will be challenges around re-entering this space, the client's home, with fear of being with the client in the future unless these reactions have been examined and worked through. Van Manen (1990) tells us that we will be affected by the space that we find ourselves in. The therapist is likely to experience bodily felt anxiety and fear. Alongside this it is possible that these aspects of living with fear will come back to therapists when they find themselves in differing situations where fear does not 'fit' the circumstances, the anxiety being triggered by past experience. Being able to reflect on aspects of client interaction with a supervising therapist who has a

depth of experience and whose thinking has not been clouded by emotionally fraught events can bring a new sense of vision and understanding to what has occurred.

For another therapist feelings of vulnerability and the inability to move forward produce the same need to talk the relating through with a senior therapist in order to disperse anger and place the situation into its context. Visiting a client, who she describes as 'being in denial,' Teresa finds herself experiencing emotional consequences arising from the interaction and discusses the effect that has for her:

> *I would need to come in and have supervision because it was so frustrating. I had to off load. I'd just come in and bang things; it was so frustrating... there was just that constant denial.*

Being out of step with the client's expectation and wishes may show as a lack of attunement and flow between the therapist and client. Jacobs (1994) describes 'flow' as the positive effect produced by the therapist using skills to meet work challenges with the possibility of enhancing the experience of relating with clients. Conversely Jacobs sees anxiety stress or apathy as possible consequences of 'flow' being absent in relationships.

Lisa, a therapist, talks about having to unwind emotionally when she has been unable to convince a client and their family of the need to move on with decision making. *Sometimes after seeing them I would need to just go back and have supervision with my senior therapist because it was so emotional and frustrating.* These three therapists describe having a senior therapist available to them to discuss challenging situations with. When it has not been possible to reach a place of understanding with a client there are other possibilities for the therapist. Reaching a new place of 'knowing' moving beyond their own range of vision will involve the therapist being open to what is new and looking behind what is said (Gadamer, 1982).

What happens to therapists who are the only community occupational therapist at the base they work at? Are these issues of understanding able to be addressed safely within the interdisciplinary team? Do all teams of health professional have members senior enough to be mentors and provide the 'knowing' that may be required to assist

therapists understanding to move forward? Without this reflection and reaching for new understanding it is possible that therapist's beliefs and judgements will be confirmed in ways that estrange the therapist even further from the client.

Moving on

The relating appears to be over. However there tends to be a cyclical quality to the client's involvement with a community occupational therapist. Following a period where the client therapist relationship is in abeyance there will frequently be further need on the client's part to re-establish the past relationship or establish a new one. Heidegger (1962) tells us that the past already goes ahead of us and this shows itself in the way that client and therapist reconnect. Alongside this those things that can be seen making up the aspects of 'after having' such as remembering will be carried in the mind becoming the 'fore-having' in the next series of visits. How this occurs, and whether clients are able to make those connections as easily as therapists do, is disclosed in aspects of the following stories from participants. While some relationships appear to be emotionally difficult for the therapist there is often a need to continue the relating or to re-establish it in the future as clients' needs alter or their physical condition changes. Coming through the client narratives are also a number of stories that tell of their feelings of impossibility, of being stuck and unable to move on, when their relating with a therapist has been negative.

Connecting and reconnecting
'Getting back in touch' may require the client to be 'proactive' and initiate contact with an occupational therapist. At times a former relationship with the therapist will be resumed. On other occasions it will be the start of a new series of relating. Client participants frequently describe resuming contact with a therapist as they find they have a new requirement to see them. Sometimes this involves the client in going to considerable lengths to get the information they require and yet clients describe feeling enabled to do this.

As a part of her plan to move to a new home in Auckland, Rosemary, a client participant, goes to considerable trouble to locate and then be referred to a community occupational therapist:

I was a bit naughty but I was fighting to get my independence so much. I was at the hospital and I saw this disability information on the notice board. It was the only one and I had no pen or paper and I thought, blow it and I pinched it off the notice board. Then I thought "Right, I'm going to use this, and when I get home I'm going to call upon them." So I rang up the disability people and that's how I got my new OT.

The importance of reconnecting with an occupational therapist shows through in Rosemary's story when she feels compelled to take what she needs because of its value and importance to her. She does this despite a feeling of guilt around her actions. Rosemary and other client participants demonstrate a certain assurance when making moves towards gaining new input from a community occupational therapist.

When Anne, another client participant, needed to see a therapist following her last therapist leaving her job she felt confident enough to ring and request a visit…*Recently I saw my new OT. I'd rung and made an appointment because I was having a few problems mainly in the kitchen area.* Once again the client does not hesitate to initiate the contact when recognising that the occupational therapist is a useful person to review her situation. Most stories in this study show clients confidently resuming contact with therapists.

Supporting many of the stories of client participants initiating contact are those from therapist participants who describe situations where they haven't seen a long-term client for sometime but are available to become re-involved. Teresa tells about the re-engaging initiated by a client who she visits intermittently as his condition changes…*his file was always in the filing cabinet, always there. He had our number and would fax and ring me if something came up, which was good because he had the awareness that if he had a problem I was always there, and I would always come out that day or the next day.*

Holding the client's file in the cabinet, close and never closed, keeps Teresa connected to her client. The client remains in her space. He's there though he's not there, held not in the filing cabinet but in her mind and her awareness of him. The connectedness between client and therapist will be experienced by the client as that of continuity and

ongoing availability in their relationship with the therapist. For the therapist the connectedness is experienced as another way of remembering.

Therapist participants describe setting boundaries around the level and length of engagement with clients, with expectations of the client's self-management. Showing through in this narrative is the way a therapist participant Paula manages this:

> *I guess more and more the OT process is to back off and say "I've done my bit" and work to discharge the client. If they come in again they have a specific reason and then I can come in where I left off really and say, "What happened about such and such?" Or if there was turmoil in the family "How was that resolved?" …You have a gap and then it's picked up again, a new chapter.*

Returning to past situations is a method that is used by this therapist to connect the current interaction with what had gone before. Through seeing each episode of care as a chapter in the story of their client's involvement with them the therapist can simplify engagement with a client. These two contrasting stories from therapists, Paula and Teresa, seem to show a difference primarily in their approach to their work rather than a difference in availability. How this impacts on a client's sense of connection is likely to depend on the response of the therapist to the reconnection than to where the file is held.

Stories from client participants tell of their confidence and assurance in going to great lengths to establish a connection with an occupational therapist. In contrast there is tension showing in stories around their inability to change relationships that are not working for them either at that point or in the past.

Calm seas or troubled water?

Out of the thrownness that we are in at all times clients are sometimes visited by therapists who do not develop a satisfying and reciprocal relationship with them. Afterwards some clients have little respect for therapists whose skills and sense of the relationship do not seem satisfactory and who do not seem to take into account their client's life-world. Following such interaction, a belief that they have to 'put up' with the therapist who happens to visit them, comes through in several clients' stories.

Clients later feel a sense of impossibility about taking on 'the system' and asserting their individual requirements. Katie, a client participant's story, shows this difficulty:

When you are feeling in need of help and you have an OT like that it works negatively, because you can't ask for the help you need and you have no-where else to turn. I didn't go through the complaints procedure because I'm not the sort of person who likes making waves.

Feeling 'stuck' with nowhere else to turn can reduce the sense of possibilities. Not only does Katie's decision to not complain limit these possibilities, but the input from the service she requires is also reduced. Afterwards there is an undermining of confidence both in the system's ability to provide for her and in her own worth is likely. Alongside this Katie may feel diminished by her experience of disregard from her therapist. The same sense of being cast adrift, helpless in 'the system,' also shows in a story from Anne, a client participant, in the study. An occupational therapist she is unable to relate with well, and who puts her under a great deal of pressure, keeps being sent out to her from a different state-funded organisation. She outlines her inability to complain after these visits:

The minute she turned up all my barriers went up. I thought, here we go again. I'm not one to make a fuss and I don't like to rock the boat ...so I haven't complained. But I used to dread her coming, I really did.

Even her feeling of dread isn't enough to empower this client to complain. The likely loss to her from upsetting the therapist and alienating herself from 'the system' must appear too great. Alongside this, fear has the ability to immobilise and freeze action.

It is hardly surprising then that although clients expressed little difficulty reconnecting with therapists, they are frequently unable to disconnect from them. In the former situation clients stand to gain considerably in ways that will assist them to manage their lives more easily. In the later they stand to lose so much. Clients will have much to lose from fighting the prevailing conditions. At risk is access to resources and the fear of the consequences of being labelled 'difficult.' Stormy weather and waves set boats rocking on the water. The possibilities of disruption and catastrophe are ever-increasing while

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these turbulent conditions persist. To want to maintain calm seas, to not make waves that will rock the boat is to fear the disruption that may occur.

Inherent in decisions to not rock the boat or make waves is the quiet and hidden influence of the 'theys' of the health world. Heidegger (1962) tells us that the people we know who are closest to us are 'other' and are almost part of us, whereas the 'they' are those who are at a distance setting a standard or norm from which we are judged. This then has the capacity to condition what we do. While therapists come from this health world they are still at times cognisant of the way that 'management,' 'funding agencies' or 'the system' impact on their decision-making and work with clients. The 'they' of the health world surround them and are familiar to them.

The client sees it differently. The 'they' of the health system have power to affect their lives in ways that can reduce possibilities, opportunities. When there is a lack of attunement and synergy in the relationship with the therapist it is as though the therapist becomes removed, distant, and one of them - 'the theys.' They can influence and change the client's access to health services by labelling such as 'difficult' or a 'demanding client' and alienating them from what it is that they need. To complain about a therapist, to 'rock the boat,' is to risk so much and possibly gain so little.

Ways of remembering

Remembering is one way of linking past experience and the experiences to come in the future. It will influence both client and therapist expectations and perceptions of future relating with the other in the partnership. Remembering has both negative and positive qualities. Embedded in some stories from client participants Katie and Anne is a sense of recalling their relating with a particular therapist as a destructive and anxious time. For them it was a time when they felt unable to change future possibilities. Yet on other occasions both clients and therapists tell stories where the remembering is linked to strong positive experiences in the relationship.

At times the attunement between client and therapist is such that although aspects of the relationship are in the past, in terms of being physically in each other's presence, an ongoing awareness and attunement persists. Anne, a client participant, experiences an exceptional attunement with her therapist and describes what is a real loss for her…*The*

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past therapist was an absolute honey and she sticks in my mind… When she rang and said she was leaving, I thought, "They'll be hard shoes to fill." Can others step into these shoes in replacing this person? It is likely that any future therapist will be measured against this therapist and evaluated critically.

On other occasions, therapists describe distressing situations that link to 'unfinished business' with a client where their interaction concludes in a way they did not choose. Teresa, a therapist, finds this particularly difficult and grieves over what happens with a client whom she has built a relationship of openness and trust with:

> *They are still there, they don't go away. They are there until they die. You just keep them in your mind. Because you know them so well, you've had so much to do with them, you become a part of their life and they a part of yours….I was going away on holiday and he wanted me to bring back photos. I didn't actually get to do that because he died. That was very hard. I had other people who died that year so it wasn't a good time to be away.*

Being pulled into becoming a part of each other's lives depends on a deep knowing of each other. It depends on concern, on openness and a revealing of the inner core of each person's humanity, with a relating to each other that is truly human to human. An important aspect of this relating is the quality of the listening. While knowing each other as people will frequently involve some sharing of relevant information, on the therapist's part even more critical to an open and synergistic relationship will be listening that truly takes from the client's views and context (Gage, 1997).

Therapists frequently enter the client's domain with their own set of assessments and pre-programmed responses. How then to engage in a mutually trusting relationship where the client feels heard? Mattingly (1991a) tells us that it is through the client's narrative that we uncover what matters, come to enter the story of the client's life and come to understand them. This will frequently involve looking to the past to find out who this person is in order to move forward with them into the future. Making time to hear a person's story as well as valuing and acknowledging it as worthwhile will challenge therapists intent on their own pattern of relating.

Afterwards, I carried him around with me in a secret place inside me (the heart which is the same place I keep my mother). Just because you cannot see someone doesn't mean that they're not there (Atkinson, 1998, p. 373).

Summary

It seems that later is also before, just as before is also later. At the end of relating lies the beginning. For the end often has the ingredients of the relationship to come already embedded within it. Elliot (1974, p. 221) tells us the same thing in his words… *What we call the beginning is often the end and to make an end is to make a beginning. The end is where we start from.* A therapist likens reopening relationships with clients to different chapters in the same book. There is a cyclical quality showing through in much of the relating, moving it forward and back again in time. Sometimes this will be in the mind in the way that the therapist holds a memory of the client. Clients also hold a picture of the idealised therapist to measure the new one against. Reconnecting, next time, with a therapist lies in the way the past relationship worked for them and ended. Yet reconnecting is the easy way for clients compared to the hard way of finishing relationships with therapists that do not meet their needs. Therein lie the dilemmas of the relationship.

Outlined in this chapter 'After having' are the things that come later, following the face-to-face relating between client and therapist. What is the significance of the things that come later? In what way do they reflect and show the relationship between clients and therapists? So much of what comes later seems disconnected from the relating, removed and apart. These are the hidden ways frequently named by therapists and their managers with misleading labels such as 'administration' and 'paperwork' that do not show them as part of the client/therapist relationship. Yet so much of what happens later reveals the relationship for what it is. The client 'knows' their worth in terms of the therapist's later actions and remembering. The therapist is unable to forget a client who has become special to them.

The things that come later also dwell in the house that is constructed upon the foundations of 'the persona' and 'making the client visible'. They remain covered over by the constructions of the dwelling with little acknowledgement of their meaning and significance. This chapter has brought into awareness the significance, and connectedness, of the 'things that come later' with the other aspects of the relationship.

At times the less visible aspects inhabit the memory in being mindful of the client or therapist and in ways of remembering. They also present themselves in concrete form through the actions that follow face to face encounters. Many of these stories from clients and therapists show ways of remembering. The remembering is demonstrated by an attunement to the client's needs on the therapist's part. This shows itself by the client's sense of being held and supported, carried in the therapist's mind, and sometimes comes through as an ongoing feeling of closeness when their being together moves into the past. At times a sense of attunement continues for the client when the therapist who they have had a close rapport with moves out of their job. At times it is death that intervenes in the relationship, but for one of the partners the feeling of connectedness survives. From other clients come stories of their therapist being 'out of tune' with their needs, of being inattentive to their requests and of forgetting and neglecting with consequences for their future.

Being attuned to each other following the intervention will depend on what has come before. It will not happen in isolation. The therapist is unlikely to forget or neglect the needs of a client where rapport has developed between them. Actions signal and speak to the client showing whether the therapist remembers their need. At times there is an almost magical quality in the therapist's responsiveness to the client and of needed items being 'ready-to-hand.' However forgetting is also visible in the things that come later, in the actions that follow the visit, in equipment being 'unready-to-hand.' The linking back with the client may not occur because they are not thought of with the therapist's mode of concern being one of neglecting and passing by. At times therapists will remember clients, labelling them as 'hostile' or 'non-compliant,' showing a need to reflect on, and reconsider, their relationship with that client. Is there a possibility of them developing a positive and constructive way of working with that client in any future interaction or does it need another therapist with a 'fresh' and possibly different approach to work towards a different outcome?

Words that we commonly use may be a barrier to seeing the interaction more clearly. Recognising this and seeing through the words to what the action is about may make visible for the therapist the meaning in the action. Stories from both clients and therapists point to the ease with which the reconnecting of their relationship occurs. In contrast clients stories tell of them experiencing a reluctance to in any way challenge therapists or ask for a different therapist to see them. It is the 'theys' of the health world whose subtle influence affects clients in this reluctance to 'make waves' causing possible disruption.

It seems that the relating does not have arbitrary, dictated boundaries around time, presence and location but rather continues in the imagination, thoughts and actions of these two differing groups of people in the relationship, manifesting itself in both a personal and professional manner.

Poems ~

that show the action

The Magician
The amazing OT
She makes it all seem so easy
It happens so quickly
She's like a magician
The way she produces equipment for me

I just say I need this
And with a flick of her wrist
She fills out the forms
And sends them away
And in no time at all
The equipment turns up in my hall

Sometimes I feel guilty
And long to say NO MORE
Whatever can she be thinking?
There are hundreds of others
Who are much more deserving
She makes it just seem so easy

and the meaning

She holds me in her mind
Though I don't see her often
I matter, my needs are known
I'm with her when I'm not with her
Carried in her mind's eye

Lacking presence
Though present in her thoughts
Made substantial
By her awareness and intention
I'm held and supported

Chapter Seven

The End is also the Beginning

> We shall not cease from exploration
> And the end of all our exploring
> Will be to arrive where we started
> And to know the place for the first time.
> (Elliot, 1974, p. 222)

Introduction

The relationship between people with physical disabilities and community occupational therapists is a complex, multifaceted whole. The previous three chapters took apart that whole, teasing out the themes and sub-themes in the process of searching for the meaning lying within. This chapter pulls those parts back into a composite picture of relating, making it visible, illuminating it, so that a more complete view of the phenomenon of the relationship is revealed along with its implications for practice.

In many stories and themes it is the humanness that stands out of the people in the relationship. Whiteford (1995) supports this, saying that "at the end of the day, it is like the waiata.[2] It's about people, the hearts and minds of people" (p. 4). Through a series of thrownness people find themselves together in a therapeutic relationship. Yet Merleau-Ponty (1962) tells us that "we choose our world and the world chooses us". While we are thrown into existence and relationships with certain people, there are also possibilities for change and commitment within that world" (p. 454). Further to this he

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[2] Waiata are songs and a treasured part of Maori culture that capture a peoples traditions and culture, reminding the generations of tragedies, conquests love and war. They express the dreams and passions of Maori ancestors to pass on to the next generation.

says that by being in the present we transform our past. Aspects of relationships have the past, the present and the future all inseparably entwined. While the life-worlds of the client and the therapist are two different places these worlds meet and overlap at times briefly and sometimes substantially in the context of the whole of clients' and therapists' lives. Baker and Diekelmann (1994) suggest that through the "storied nature of our existence," we come to "dwell within the lived experience of each other" and thus become caught up in the lived world of another (p. 67). This study has shown that the life-worlds of the community occupational therapist and the person with an ongoing physical disability can become deeply interwoven.

Merging the themes

Within the hermeneutic circle lie the parts of the whole. These parts link in a dynamic intertwining with each other leading to a new sense of the complexity of the whole (Grenz, 1996). In this way the parts of the relationship show in the findings chapters as themes that cannot be separated from each other making visible aspects of the relationship that are already there, embedded in the whole. There is interplay between them, revealing that what has come before and what has come afterwards always influence the moment of 'now'. The therapeutic relationship involves these dimensions of time and place and people in relation to one another. Within the experiences in the stories making up the study's themes, therapists and clients can be seen in a 'mode of being', of being in the 'there' with each other (Heidegger, 1962).

Having care and concern for others is a fundamental aspect of being human, and yet that care will show itself in a variety of ways. At one extreme is 'being with concern' for others a mode of care that 'leaps in', dominates and takes control away from the other person (Heidegger, 1962). At times this will be necessary when a decision must be made or when safety issues are involved. But a therapist who is accustomed to being with 'the other' in this mode of care will take the client's control of their choices and decision-making away from them. In this story a therapist acts by leaping in…*You know I had to be the voice of reason…I had to come in and go, "very nice but…it's not going to happen. This is the reality, this is what funding is available, this is what you can get, this is what you can't get*". When a therapist recognises the need to place some boundaries around the client's expectations of what can be accessed there is a loss of control for the client.

In contrast, being with care that 'leaps ahead' sees the therapist anticipating the clients need and assisting them to move in that direction. The therapist of whom the client says: *I phone her when I need to and I don't phone her when I don't need her. Then when I do talk to her she really has things in mind…* has brought this leaping ahead mode of care to interacting with the client, thereby offering the client control.

At the other extreme of being with others is the deficient mode (Heidegger, 1962). This mode shows people, at times therapists in this study, neglecting, forgetting, leaving undone and taking a rest. Therapists may interact in this mode when they are under pressure, when they no longer enjoy the work that they are involved in and when they are working with a client for whom they have little regard. A client says of her therapist: *I didn't know when she'd turn up. She tended to take potluck on whether I'd be home or not and that seemed senseless.* The therapist's being with others in a deficient mode of care, impacts on how the client measures the relationship. At other times being too open and accepting, of leaving undone rather than leaping ahead, will also impact negatively on the client when decisions that need to be made are not.

While therapist participants' stories demonstrate similar notions to those of these clients, consequences for them differ. Therapists are likely to have a larger range of options, a greater freedom to make choices and a differing degree of control within the relationship than clients. Yet at times they too experience difficulties and get caught up in situations offering few possibilities, or that cause an overpowering sense of frustration. Therapists sometimes find the client leaping in, taking control or 'being with a mood' that colours their interaction. One therapist participant said: *I had to off load. I'd come in and bang things; it was so frustrating… there was just that constant denial.* When the client's way of being with them lacks openness, therapists too experienced repercussions in the relationship.

For the people interacting within the relationship, the clients and therapists, time is experienced differently. Lived time (Van Manen, 1990) stood out in participants' narratives. Frequently it was clients, waiting, waiting, and hoping for the therapist's attention for what seemed like a long time. A client describes waiting to hear from her therapist: *I have to talk on the answer phone and then wait around all day for her to*

ring back. I mean it just sucks my day because I desperately want to hear back from her. I don't know when she's going to ring so I've got to spend all day at home. The client lives with the growing tension of silence. In contrast therapists seem, busy, busy, busy with time hurrying by. A therapist describes finding time for a client: *Sometime it was a quick visit and then I'd zoom in. If I knew he needed to talk I would book up the time so that I would not have to be looking at my watch.* Even when the therapist is not with the client, and appears to not be taking action, they may be, at times, connected to the client by the 'invisible work' that they are involved in on their clients' behalf. Stories from therapists also show that they are connected to clients by their thoughts carried with them into the future: A therapist says: *They are always with you. They don't go away.*

Central to a relationship that works in a positive way for the client is an occupational therapist who has a number of qualities that show in many themes within the study. A relationship is 'good' when the therapist is open to the client, when the therapist is receptive to hearing the client's needs, and when the therapist is ready to respond to those needs. This involves a willingness to recognise the uniqueness of each person's situation, to let in the concerns of 'the other' and to care for the wellbeing of that client. The therapist's openness to the other, who is the client, allows them to know how to interact with the client, how to show concern for them in a way that meets their need. This involves moving between care that leaps ahead and care that at times involves the therapist leaping in. For the therapist this is often about getting the pace of the relationship right. Remember the story when the therapist gave time to listen "calmfully", when Rosemary a client participant told her story of feeling *fuzzled and fogged up* during a crisis, and the therapist was able to offer a place of calm in response to the clients need. It is through giving time and being open to hearing the client that the therapist can draw a client beyond where they are and into the future.

When a therapist is able to truly be with a client and is open to the uniqueness of that person, when the therapist 'makes time' to draw the client into a calm place, future possibilities will open out before them. Corring and Cook's (1999) study also draws attention to clients' recognition that the therapist's role in fostering and allowing possibilities is a positive aspect of concern for their clients' wellbeing.

Differences in perception of the relationship

Holding the key to the future

Client participants' stories showed awareness that the therapist was a key person, having the potential to open up choices and future opportunities including access to resources. A client describes the therapist providing such opportunities for her: *She always said, "nothing is insurmountable, there is always a way to improve things," and she'd nut the problem out*. At times client participants tell of their wonderment at therapists being able to produce seemingly miraculous outcomes for them … S*omeone says they are going to do something for you and you think 'yeah, a month from now' but it was only two days. It happened so quickly.* Such stories show clients' perception of therapists as instrumental in opening up opportunities for them through such things as following through with actions.

Conversely, when the relationship was not working, when the client and therapist were not attuned to each other, client participant stories tell of waiting to hear, of not knowing when something will happen, of not having options for the future. A client participant says: *Her attitude was, well you're managing to eat, you're not about to die, so it's not urgent.* For another client waiting and needing the therapist's input affected her ability to move forward: *I've just got to be patient. If I had more time to spend with an occupational therapist I'd be asking for a few more things like ramps.* Inherent in these stories of the client and therapist not being connected were aspects of insufficient time given to developing the relationship and the hoped for actions not following the therapist's visits. There is little to indicate in this study that therapists are fully aware of the power inherent in their role. Boylen (1999), in a challenge to occupational therapists, questions their use of the power they hold, saying that therapists sometimes withhold from clients the opportunity for shared decision-making and reduce access to certain resources.

When the relationship did not go well therapists may unknowingly block access to options and future possibilities. While client participants had a deep knowing of this, therapist participants were less likely to be conscious of holding this power. It is the client who is dependent on the therapist's decision in order to gain what they need. They are the people who may 'miss out.' In contrast, the therapist stands to lose little in

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concrete terms when the relationship does not work. Alongside this, client participants judged their relationship with therapists in terms of the therapist's actions. One client participant says: *I'm not sure what a therapist's job description is, but I would have thought that noting ideas that could be of use to me, thinking of me and then passing that information on is an extra. I feel that I'm always with her.* There was only one indication from a therapist participant that connected actions and the speed or delay in acting to the relationship

Clients don't want to rock the boat

Their inability to discuss concerns with therapists when the relationship is unsatisfactory is a theme in a number of client stories. Client participants fear making waves and rocking the boat. They describe not being that sort of person, and preferring to just wait. One client participant did not look forward to visits from a particular therapist: *I'm not one to make a fuss and I don't like to rock the boat ... so I haven't complained. But I used to dread her coming I really did.* It is understandable that clients do not want to challenge therapists. They stand to lose so much when the therapist then perceives them as complaining, or difficult. They fear being harshly judged by a system that they can have little impact in changing. In a study examining occupational therapists responses to patients, Finlay (1997) describes people who fitted the category of 'difficult patients' as making therapists feel powerless, or inadequate and one way that they coped was to distance themselves, with the use of labels such as 'difficult' and 'unmotivated'. Client participants will not want this label on their case-notes, or in health professionals' minds, with the possibility of influencing future interaction. A client participant says: *When you are feeling in need of help and you have an OT like that it works negatively, because you can't ask for the help you need and you have no where else to turn.* It would seem that for a client to raise issues regarding a therapist's actions, or inaction, that cause them concern they must feel quite desperate about their situation.

Clients recognise hidden aspects of the relationship

It was predominantly client participants who showed awareness in their stories of the significant and frequently overlooked aspects of the relationship. Clients have an understanding, a depth of knowing, that the therapist's persona has a major influence on their interaction with them. A client describes the impact of her therapists' persona: *She*

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was outspoken and gave the impression that she did not want to be in the job but for some reason she was. It made me reluctant to talk with her. They see the action taken following face-to-face encounters as signifying their value and the importance of the relationship. For the therapist 'administrative tasks' appear to remain just that. They remain largely invisible in the therapist's description of their relationship with clients. Labels commonly used for work, such as administration, may hide from the therapist the importance to the relationship of actions taken. Yet such things will spell out quite clearly to the client their significance in the relationship, indicating to them their value. A client says of her therapist: *She'd actually officially typed it all up! I felt I was treated with such respect on an adult-to-adult level and taken seriously by someone prepared to treat me as intellectually okay and help. Even professionals don't sometimes do that.* What happens when the therapist is not with the client matters, particularly for the client. The actions that clients see as signifying their importance may not be understood in the same terms by therapists. For them delays, or inaction may be the consequence of overwork, insufficient time and may simply present as a 'fact of their working lives'. However, for the client, not receiving information, equipment or further contact signifies to them their lack of importance. At times therapists' lack of connectedness to the clients they interact with may affect their ability to see this link between their actions or lack of action to the client's sense of being valued.

Broadening the conversation with the literature

A tension in the relationship

Alongside clients' need for therapists' technical practice skills there is their need to have therapists join them in seeing and understanding their subjective world. People with ongoing physical disabilities relate with community occupational therapists out of their own need. This revolves around aspects of their life and functioning and requires the skills and knowledge that the therapist can bring.

Within the relationship when either the therapist's skills, their 'expert knowledge' or the human connectedness between them and their client is missing or deficient, the relationship may deteriorate and become irreparable. With this study's focus on the relationship, the skills of occupational therapy practice are not central to the concerns of participants rather it is the interaction between the client and therapist that is being explored. For therapists, whose involvement with the client will be measured by them

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and others in terms of their skill and the outcome for the client, there is a dilemma between what could be called the professional side of the relationship and what could be described as the personal side. Therapists' education, attitudes and moral codes may result in them carrying positivist 'scientific' influences into their relationships. These influences will be hard to put aside and Van Amburg (1997) describes "compliance with the scientific principle of objectivity," as causing a disengaged relationship, saying that this removes the humanness in the interaction (p. 186). It may be that a perceived need for objectivity in the relationship gets in the way of the therapist being open to the client.

Showing through in themes in this study is that therapists also recognise the need to be attuned and connected to clients for the benefit of clients. These relationships can also be satisfying for therapists resulting in a sense of being valued (Hasselkus & Dickie, 1994). It may be hard for therapists to put their 'objectivity' aside yet subjective involvement is difficult for therapists to avoid when they visit clients in their own home. They enter the client's life-world, to find what matters to them, giving opportunity for closeness and caring to develop in the relationship. Stories from a number of therapists in this study show that entering the client's world, while fraught with complexity, can also be very rewarding, with the closeness that at times ensues seen as very special to them.

At a more fundamental level lies the human need for clients to have those they interact with recognise them as people not just 'conditions,' and to show respect for their situation making connections with them. Frankl (cited in Chevalier, 1997) claimed that one aspect of finding meaning in life is through "experiencing another human being in their very uniqueness" (p. 539). Chevalier describes this as illustrating the central position of the therapeutic relationship within occupational therapy, saying that therapists too seek meaning and ways of defining themselves in their work with clients. Peloquin (1989) calls the human, caring side of practice, 'the art of practice' and describes this art as the foundation for intervention while the treatment procedures and the skills of occupational therapy are conversely called 'the science of practice'. It is the integration of the 'art and science' of practice into a whole that therapist need to reach for in their work.

Connecting and becoming attuned

There are many voices from both within occupational therapy and without that point to a range of ways for connectedness and attunement between the client and health professional to be enhanced. In a variety of studies around the narrative nature of clinical reasoning Mattingly (1991a) puts forward her thinking. She describes therapists as needing to see themselves in the same story with the client and their family, to see it through their eyes, in order to guide their therapy. Alongside this view of the need to enter the client's world is that of Munhall (1993) writing about patterns of knowing within nursing. She describes 'unknowing' as another way of knowing in which lack of knowing is acknowledged in order to be "authentically present to a patient" and sees this as aligned to openness (p. 125). Rogers' (1951) writing about client-centred therapy put forward a notion of 'unconditional positive regard' in which the clinician adopts a stance of openness to the client, listening and being self-disclosing, in working alongside clients. The Canadian Association of Occupational therapy has produced guidelines for client-centred practice and Law, Baptiste and Mills (1995) tell us that a central premise of having the client at the centre of practice is openness and honesty within the client/therapist relationship. Gadamer (1982) writes about how through 'the self being open to the other' we learn new things through a fusion of our horizon with that of the other.

The above theories and notions have in common the idea that in order to be open to the 'unknown' there needs to be a putting aside of pre-judgement, and 'expert knowledge'. Finlay (1997) describes each therapist coming into the therapy relationship "loaded with personal assumptions, preferences, needs, biases and prejudices" (p. 445). How will therapists reduce the impact of such prejudgements? The notion of openness in achieving attunement shows in this study when Elizabeth, a therapist participant, says something that parallels this. She hears and sees all the information about a client and then remains receptive to hearing and seeing the other in the encounter: *The minute I see them I find I can be open to who they are…the challenge is to be open to going in intending to win people over…I will myself towards, I'm just going to offer what I can offer.* Peloquin's (1989) description of the art of practice, within the therapeutic relationship of really 'seeing' the client, reinforces such a view of openness.

Pieranunzi (1997) takes openness to knowing a step further in a study where he describes understanding "based on an intuitive and personal mode of knowing" (p. 158). A participant in his study says, "this is connecting on a person-to-person basis and really touching the humanness, instead of the thoughts"… Pieranunzi's findings are consistent with aspects of this study's. A therapist says: *It was like her and me, we were having quite a history together, and she was letting me get close. The barriers were not there anymore.* The therapist's story shows this human connectedness in her relationship with the client. Much of the openness has come about through waiting for the client to be ready to disclose more of herself. Caring can create a link with another person, and this can be "deeply connected and personal − going beyond the surface beyond the 'clientness' of the person to the person, to their humanness" (Pieranunzi, 1997, p. 160).

Boundaries around the relationship

Professional roles will indicate expectations of the interaction. The role of the therapist, working as a community occupational therapist, has such boundaries. These will come from their personal moral codes and professional Code of Ethics. Alongside this the therapist is involved with the client for a purpose. Within occupational therapy, and other professional relationships, there is a focus that sets differing parameters around the relationship. Sachs and Labovitz (1994) link occupational therapist professional boundaries to their caring and their holistic approach to clients, which they say makes it difficult for therapists to delineate their role. Role boundaries can have a time limiting factor within them linked to the purpose of the relationship. Pairman (1998), a midwifery educator and researcher, describes the relationship between women and midwives as having a professional focus and being of a "time limited nature" that relates to the life event of the woman (p. 6). She believes that the midwife provides continuity of care for as long as is necessary before moving out of the relationship. Christensen (1990), a nurse theorist, in comparison uses the notion of a passage for the experience of the patient/nursing relationship. She describes the patient moving into and out of the partnership, and "resuming control" of their life as they return from hospital care (p. 154).

In some respects the boundaries of the relationship between clients and therapists could be compared to those of the supervisory relationship that I have as a student with my thesis supervisors. When I see my supervisors the time, location and format of supervision have been negotiated prior to our meeting. Just as the therapist gives their time to the client as part of their professional role, my thesis supervisors give their time to me as a student as an aspect of their academic role. There are 'rules' within this contract about what is appropriate in the supervisory relationship and what is not. Yet in contrast to this ordered structure occasionally there will be unexpected urgent requests. Choices will need to be made by them around how much time they can commit to supporting my particular needs.

As the year progresses I disclose more of myself to them, reducing the space between us and with an increasing sense of being comfortable together we become more attuned and connected with each other's life-world. I come to trust them and I am conscious that they have my best interests at heart. The focus is on my thesis – after all, that is what pulls us into this relationship. During a supervisory session there is a degree of intuiting, of just knowing what it is I need from them. My supervisors have the key to opening up possibilities. They have information and knowledge of which I have only a developing awareness. This puts them in a powerful position. But they guide me, showing the way into the future of my thesis and I feel upheld by their apparent faith in me. We connect with each other, becoming friends of a kind. Yet just as when the therapist's intervention with the client has been completed, when my thesis is complete, I will find the relationship changes. I will be less dependent on my thesis supervisors and they will be less committed to me. The boundaries in the therapeutic relationship revolve around the purpose of the relating, with the focus on the client and the challenges they encounter in their life-world as a consequence of their disability.

While therapist participants in the study tell stories about their closeness to clients, of how the client stays with them held in their mind, this connectedness does not appear to distort therapist's ability to be competent. Client participants also tell of their therapist being immersed in their subjective world and yet making reasoned decisions involving skills and resources. It may be that the decisions made in a relationship of reciprocity and caring encompass the client's world to a greater degree.

Partnership or friendship?

A 'professional friendship' has been described in the literature as the partnership relationship between midwives and women (Pairman, 1998). Friendship was generally understood differently by the client participants interviewed in this study. 'Being friendly' was frequently seen as a desirable quality, as through this characteristic in the therapist, clients were able to see the occupational therapist as someone they could be open with and to whom they could disclose their needs. Despite the fact that the therapist visited these people in their own social context, their homes, clients generally did not describe expectations of a friendship, or identify a relationship of ongoing friendship with therapists. However, many stories from clients put forward an aspect of partnership or friendship, with indications of reciprocity within the relating, with the therapist listening and the client feeling heard. Client participants' stories indicated that they felt valued and respected because of therapists' attentiveness or through the mutual sharing in the relationship. Peloquin (1990) describes reciprocity and personal respect as aspects of friendship and while they were present in many clients' and therapists' stories, this was not often named as friendship. Therapists can receive a depth of understanding through knowing the client experiencing feelings of self worth from a satisfying therapeutic relationship. Reciprocity in the relationship was at times described by therapists in terms of 'conscious use of self' where they shared information about themselves with clients in order to balance all they knew about the client. While there are significant notions of partnership in a number of themes in this study, it is questionable whether a true partnership can exist when there are unequal expectations in the relationship. The client needs the health professional in a way that they do not need the client.

What is new in this study's findings?

Unlike client/health professional relationships described in nursing and midwifery literature (Pairman, 1998; Christensen, 1990) where there is a time-limiting factor in the relationship sometimes described as 'a passage,' the relationship in this study has a circular movement dwelling within. The things community occupational therapists bring into the relationship are carried into face-to-face encounters. Aspects of both 'For-having' and 'Being There' will impact on how the relationship is perceived in what follows as part of "After having.' Yet the relationship is also likely to be resumed in the

future and will carry into the next fore-having aspects from being there and after having. In short the relationship is more than what occurs in the client and therapist being together. It is clear in this study that the significant features of 'Fore-having,' such as the persona, the mindset and the stance that may follow show as aspects of the relationship. Within the theme of 'After having' actions taken, or neglected to be taken, the mindfulness of both client and therapist, and their moving on are also key aspects of the therapeutic relationship. This interplay of the parts within the whole of the relationship does not appear to have been addressed in other studies examining therapeutic relationships.

Although the therapeutic relationship is explored and detailed in occupational therapy literature, as the foundation or the heart of practice (Rosa & Hasselkus, 1996), the possibility that when the relationship does not work for the client that they will lose access to resources is not discussed in study findings that I have read. The literature does not explore the relationship's connection to resources.

What does this all point to? It shows the influence of the relationship for both clients and therapists within occupational therapy practice. The view presented in this thesis of the differing facets making up the whole of the client/therapist relationship is a new way of seeing the relationship. It is clients who most clearly identify the hidden facets. What has not been fully recognised as aspects of the relationship are those things that come before and those things that come after the face-to-face encounters. These aspects seem to have remained on the periphery as uncounted, unacknowledged parts of the client/therapist relationship. Within this study, it is client participants who show a greater understanding than therapists of the significance of certain notions and themes. However client participants' understandable reluctance to give feedback and to draw therapists' attention to aspects of the relationship that do not work for them means that some of this understanding lies silent, with the therapist remaining unaware.

Implications of the study's findings

For people with disabilities

People who have ongoing physical disabilities need to understand the significance of their relationship with occupational therapists. This study highlights the ways in which both positive and negative relationships have consequences that are not easy to change.

Client participants have told of their inability to discuss with therapists their concerns regarding unsatisfactory aspects of their relationship with the therapist. It may be that through health consumer groups that they belong to they can have their stories of challenging relationships heard in a depersonalised way. At other times they may need to talk in a deeply personal way in order to have their stories heard and to feel validated. People with disabilities can enable therapists and other health professionals to 'see' through their personal accounts of being a consumer experiencing their services.

For disability agencies

The literature that disability agencies give out to the clients of their service, while comprehensive and informative particularly from health services and medical perspectives, pays little attention to what clients should expect of their relationships with health professionals. Therapists' education includes the need to be client-centred in their relationships and this is an expectation that people with disabilities and agencies that work for them should anticipate. While relationships with therapists will not always meet expectations, clients need to anticipate that therapists will work in partnership with them, will give time to hearing their concerns and will act on those concerns in a relationship of respect and power-sharing.

For occupational therapy practice

Strong patterns within themes in this study give clear implications for occupational therapy practice. This thesis gives messages to therapists about their need to recognise the impact of their persona in relationships with clients, to see the people they visit as individuals, and to be open in attitude to them. Therapists need to understand that what happens when they are not with clients, counts within the relationship. Leaders and managers of services that occupational therapists work within need to assess relationships that occupational therapists have with clients and, when they are not working effectively, understand that it is their responsibility to do something about it. This will be a difficult challenge to meet. For this reason it is important that person specifications outline the qualities that are desirable in an occupational therapist.

When clients have ongoing conditions such as motor neurone disease, multiple sclerosis and other disabilities, relationships with them are likely to be ongoing ones for community occupational therapists. Time spent early on in developing the relationship

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with long-term clients is essential in order to know what matters to them, to understand them in the context of their life-world, rather than having a narrow focus on the reason for the referral. A broader focus will assist in building trusting relationships making the reconnecting that follows a positive experience.

Occupational therapist need to recognise the powerful position they are in as the holder of the key that enables access to many of the future possibilities and choices for clients. They need to realise that when the relationship fails or the client believes it is not working that the client loses out. Therapists must gain awareness of what matters to clients in 'the whole' of their interaction with them. They need to understand that the relationship has a significant role in producing what is needed for clients. Awareness is also necessary of the significant of fore-having and after-having in their relationship with clients. Formal supervision could assist in achieving this.

Reflection and supervision can provide occupational therapists with insight into the role that their own persona, prejudgements and mindset can play in their interaction with clients. While supervision for therapists has become an expectation as an aspect of the Cornerstone Programme (Hocking & Dockery, 1999), a voluntary programme that involves New Zealand occupational therapists' ongoing professional development, some therapists will not have access to this opportunity to critically examine their attitudes and practice. Yet this awareness, this knowing oneself, and the impact that one's own persona and fore-having will have within a therapeutic relationship is needed. The findings of this study recommend that formal supervision be a requirement for all practising therapists. This may involve therapists negotiating payment for this with employers or being prepared to self-fund supervision. Time set aside for reflection on relationships with long-term clients in order to change practice that is not client-centred in focus needs to be an integral aspect of such supervision.

Therapists must learn to be open to the messages clients may be trying to give them about unsatisfactory engagement within the relationship. By being in touch with consumer groups and attending forums for people with ongoing disabilities, therapists will have the opportunity to hear those messages coming from clients in either a depersonalised or personalised way. An evaluation of the therapeutic relationship should occur at the end of a series of interactions, prior to the client's next series of

involvement with a therapist. While reflecting on practice and changing aspects of practice that are unsatisfactory is preferable, and can be undertaken under the guidance of occupational therapy advisors, at times therapists may need to give the long-term clients that they work with the opportunity to work with another therapist. This then offers clients a degree of control within the client/therapist relationship.

For occupational therapy education

There are implications for the selection of occupational therapy students in the findings of this study. The key to selection is to ensure that the people chosen will interact with future clients in the way that this study's findings spell out. How can selectors ensure that the students they choose will be open in attitude with clients? The selectors need to find ways to ensure that the students they choose meet clients' expectations around their persona and attitudes.

Students, like therapists, must gain insight and awareness into the effect their persona, their prejudgements and stances they take will impact on their interaction with clients. Once students commence their occupational therapy education, how can educators ensure their awareness of the effect of their persona and mindset on their interaction with clients? They need to understand that aspects of the relationship that occur outside of being together are frequently considered by clients as significant features of the whole of the relationship and signify to them their value within the relationship. Students need to learn 'good attitudes' towards clients within their education process.

Within fieldwork settings, students need to have access to therapists who understand what is involved in a positive therapeutic relationship. Advisory occupational therapists and leaders within clinical settings need to ensure that students are not placed with therapists who have a pattern of unsatisfactory relationships with their clients. It is within fieldwork placements that students have the opportunity to put the theories they have become familiar with in their education into practice.

In respect of ongoing education for therapists, there will be those not involved in post-graduate, or continuing education other than skills-based education. Aspects of client-centred practice, such as power sharing, partnership, respect, reciprocity, listening, seeing the client as a whole person were strong notions within themes in this study.

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There is a place for therapists to learn, sometimes to relearn, ways of interacting with clients that involve their attitudes and the prejudices they bring to relationships with clients. Therapists need to re-examine the aspects that encompass the foundation for practice – the client/therapist relationship. Yet relearning new ways of interacting will not be easy. Established patterns of interacting may be difficult to change.

Questions requiring further exploration

Many questions arose from this study. The tension for therapists between what they describe as their professional and personal roles was apparent in several stories and is at times linked to boundaries around relationships. Within the notion of relationship boundaries there is the question of who they are set up to protect. There is a need for further exploration in this area in order for therapists to gain greater understanding of the breadth of their professional identity and role.

Client participants' have pointed out the impact of the therapist's persona, attitude and prejudices on the relating. A study that further explores desirable and undesirable personal characteristics in occupational therapists would reveal the habits of practice that need to be avoided.

There remains a major question around how the clients of occupational therapists and other health professionals can be empowered to express their doubts and concerns or question unsatisfactory relationships with health professionals. Alongside this is the need to explore how health professionals can establish relationships in which clients can state their needs openly. These areas require further research.

Limitations of the study

Inevitably a study of this nature has limitations. The use of the chosen methodology has shaped the interview narrative and themes. Aspects of themes have been left unexplored because of time and length constraints.

People from only one culture were participants in this study, limiting its reach. Sometimes therapist participants told stories of their relationship with people from cultures that differed from their own and at times aspects of these relationships were challenging for the therapist. With the focus of the study not being on intercultural

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relationships, these areas were not fully explored. A study with a defined focus on inter-cultural client/therapist interaction, particularly from the client perspective would show this dimension more fully.

All participants in the study were women. Women with disabilities are likely to have different roles and life experiences than men, such as becoming a mother, and the gendered context to their lives will impact on their relationship with therapists. Being women will have influenced the content of the narratives and the nature of the common themes derived from participants' stories. While this study does not seek to examine gendered experience, the impact of client participants' life-worlds and disability on their relationships with therapists shows through in many themes. The study does not attempt to suggest that the male clients of occupational therapists will have the same experience.

The participants in this study were all articulate. It is possible that because of this, the client participants had an increased ability to form satisfactory relationships with therapists, affecting the themes that arose in the study. Some people with disabilities that affect their ability to communicate may have a greater degree of difficulty establishing and maintaining a 'good' ongoing relationship with therapists, when to achieve this involves more effort. A client's inability to communicate clearly could limit that client's connectedness with the therapist. Therefore it is likely that this sample of participants who were able to communicate with ease may not reveal the full story.

There were eleven participants and although this is a not a large number it is sufficient for research using this study's methodology. Phenomenology does not seek to generalise findings to other situations. Rather it is hoped that the findings of a study such as this will give a depth of understanding of the experience for the study participants of being in the relationship. The findings may then guide other people participating in similar therapeutic relationships. While the above features have been described as limitations of this research they do not show a weakness within it but exemplify the boundaries around a study using a methodology of this nature.

A journey of understanding

My immersion as an occupational therapist working in the community, the field that this research took place in, had a depth that encouraged me to think that I recognised much

of the relationship and its context. Alongside this perception were glimpses that said to me, there is more going on here than can be seen without moving beyond appearances. I find that I have followed a path that lead to unexpected places. It has frequently been a time of insight into the phenomenon of a relationship that seemed to be already there, already understood. Every interview, each story analysed, every chapter had its revealing moments for me.

It has been fascinating to discover so much hidden in the familiar, yet this is the journey of doing phenomenology, to see newness in what seems already known. Prior to this study I had not considered that aspects of the relationship that were not part of face-to-face encounters might signify to the client the quality of the relationship. That both client and therapist participants carry so much of the relationship in their minds and memories gave a different way of seeing aspects of the relating. I had not fully understood the therapist's power in holding the key giving access to choice and possibilities for clients. The thrownness for the client in having to relate to whichever therapist turned up at their door, caring or otherwise, was not something I'd seen from their perspective. This research and the thesis coming from it have accompanied me for 14 months, through a time of real learning. When it is complete and a part of my past, it will remain with me and while I will miss the new paths it has led me down, there will be others to follow. My hope is that other people will also similarly benefit from this uncovering.

Conclusion

The ways in which people with ongoing physical disabilities and community occupational therapists relate to each other have been explored in this study. Much that was hidden within the relationship has been revealed, showing the complexity of the whole and its parts. Within the end of their relating lies the beginning of their future relationship.

Clear messages can be seen coming from the client participants about what it is they want from the therapists who they interact with. They ask to be seen as who they are, to be treated with care and concern that will show them a way forward. They ask for the

therapist to be aware of the impact on them of their actions. Clients also recognise that what happens when the therapist is not with them counts within the relationship. Most significantly they want therapists to come to interact with them, with a stance of openness that allows for 'connectedness' between them, that means that they do not meet as strangers in an ongoing relationship.

Therapist participants recognise certain facets of this relationship, while other aspects remain hidden from them. At times there is a tension showing between the integration of their 'professional self' and their 'personal self' within the therapeutic relationship. There is the dilemma for therapists of knowing and understanding so much, yet needing to put this 'knowing' aside to move into a relationship of 'unknowing' that leads them to a stance of openness with clients.

The therapeutic relationship walks hand in hand with the skills and knowledge of occupational therapist practitioners. This is the art and science of practice. However, it is the client/therapist relationship that shows the way, pointing to what it is that matters. Without this revealing light, guiding occupational therapists in what is important in their relating with clients, their practice may lose its way and their skills lie wasted.

To come to the end of the beginning is, for me, a time to recognise the beauty of words, seeing in them the way they show our worlds of lived experience:

In a river of words
The chapter closes
But the book lies open
Pulling me into the current
Carried along by the words
That both show and hide
What others see.

Health Funding Authority

17 February 1999

Ms BA Paddy
15 Beacobfield Street
DEVONPORT

Dear Beatrice

98/12/274   Experiencing the relationship: the client and the community occupational therapist. A phenomenological study

The above proposal was considered by Ethics Committee X at the meeting held on 15 December 1998.
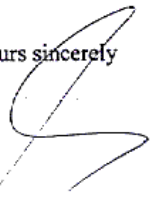
I am pleased to inform you that the study is approved until 17 February 2000. It is certified as not being conducted principally for the benefit of the manufacturer and will be considered for coverage under ACC.

Please note that the Committee grants ethical approval only. If management approval from the institution/organisation is required, it is your responsibility to obtain this. You are required to submit a final summarised report when the research is completed.
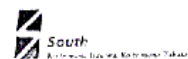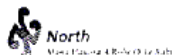
The Committee wishes you well with your research.

Please include the reference number and study title in all correspondence/ telephone queries.

Yours sincerely

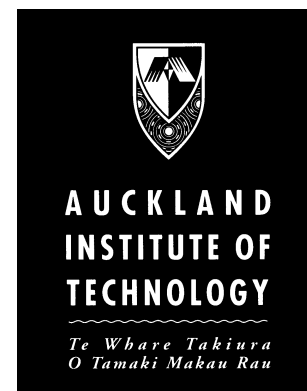Sandra Haydon
Administrator
Ethics Committees

Research Development Office, Auckland Healthcare

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North   Midland   Central   South

AUCKLAND
INSTITUTE OF
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Te Whare Takiura
O Tamaki Makau Rau

Study title: Experiencing the Relationship: The Client and the Community Occupational Therapist

Information for Client Participants

You are invited to participate in this research, and I will value whatever assistance you are able to offer me. Participating in this study is entirely your choice. You can expect that one, to two and a half hours of interviewing will take place at either your home, or at a place of your choice. For most of you there will be one interview. In some instances I will ask to return to you for a second short interview to clarify aspects of the first interview. You will receive the usual care from health-care services and taking part in this study will not affect your future care. You will have no financial costs through being involved in the study.

Researchers name and background:
My name is Ann Paddy. I am a registered occupational therapist with sixteen years experience of working in the community.
I am currently enrolled in the Masters of Health Science programme at Auckland Institute of Technology, Akoranga Campus. As part of the requirements of this course I am conducting this research for the purposes of completing my thesis. The area of interest to me is the relationship between people who live in the community and have a disability and community occupational therapists.

Why this subject?
I have chosen to study this area because I am interested in the changing relationships between healthcare clients and health professionals. One primary concern is whether people with disabilities believe that their relationship with therapists is positive and enabling. Of particular interest are gaps that may be identified between the clients and the community occupational therapists perception regarding the meaning of their relationship. It is my belief that while the findings of this study will not benefit individual participants, they will allow occupational therapists and other health professionals to have a deeper understanding of what matters to the people they work with.

Study Title: - Experiencing the Relationship:
The Client and the Community Occupational Therapist

Information about the study:
The research will take place over 10 months in 1999 in Auckland. Up to 5 of you who are adults between the ages of 25 and 55 years and live in the community and have a physical disability will take part. You will need to have had interaction with community occupational therapists to meet the study requirements. I will also have up to 5 community occupational therapists taking part in the study. I will interview you and will audiotape interviews to ensure accuracy. It will be possible for you as the participant to ask for removal of any interview material that you decide you'd prefer to have taken out. You can also stop the interview at any time. You may withdraw from the study without needing to give a reason. This will not affect your future health-care. If at any point during the study, psychological discomfort is apparent or you feel unsafe, or receive an injury as a result of participating in this study, you can, with your consent can be referred to AIT counselling services or your GP.

Confidentiality:
No material that can personally identify you will be used in any reports on this study. All aspects of this research will be treated with confidentiality and participants' names will be coded to ensure that you cannot be identified. Audiotaped interviews can be returned to you, the participant, at your request. The tapes will be typed into text with coded names given to participants. A typist will have access to audiotapes and will sign a confidentiality document. Research supervisors and an 'expert' community occupational therapist will have access to the analysis of the typed text. The tapes and typed text and written informed consent will be kept securely.

Additional information requirements:
If you require more information about the study you can contact me on the telephone number given. If you have concerns about your rights as a participant you may wish to contact a Health Advocates Trust, telephone 6235799.
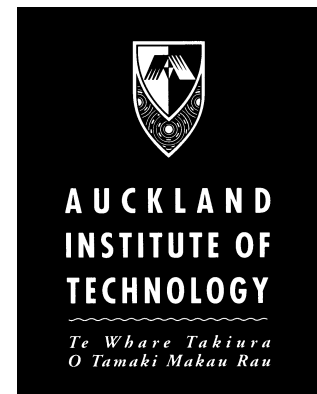
Signed_____ Date_____

Ann Paddy ph 4452453
Student Masters of Health Science Programme
Auckland Institute of Technology,
Akoranga Campus, Auckland.

**AUCKLAND
INSTITUTE OF
TECHNOLOGY**

*Te Whare Takiura
O Tamaki Makau Rau*

Study title: Experiencing the Relationship: The Client and the Community Occupational Therapist

Information for Occupational Therapist Participants

You are invited to participate in this research, and I will value whatever assistance you are able to offer me. Participating in this study is entirely your choice. You can expect that one to one and half-hours of interviewing will take place at either your office or a place of your choice. For most of you there will be one interview. In some instances I will ask to return to you for a second short interview to clarify aspects of the first interview. Taking part in this study will not effect your employment and there will be no costs to you through being involved in the study.

Researchers name and background:
My name is Ann Paddy. I am a registered occupational therapist with sixteen years experience of working in the community.
I am currently enrolled in the Masters of Health Science Programme at Auckland Institute of Technology, Akoranga Campus. As part of the requirements of this course I am conducting this research for the purposes of completing my thesis. The area of interest to me is the relationship between people who live in the community and have a disability and community occupational therapists.

Why this subject?
I have chosen to study this area because I am interested in the changing relationships between healthcare clients and health professionals. One primary concern is whether people with disabilities believe that their relationship with therapists is positive and enabling. Of particular interest are gaps that may be identified between the community occupational therapists perception and the clients regarding the meaning of their relationship. It is my belief that while the findings of this study will not benefit individual participants, they will allow occupational therapists and other health-care workers to have a deeper understanding of what matters to the people they work with.

Study title: - Experiencing the Relationship:
The Client and the Community Occupational Therapist

Information about the study:
The study will take place over 10 months in 1999 in Auckland. Occupational therapists working in the community for Auckland Healthcare and Waitemata Health will be included in this study. Up to 5 of you who have had no direct working relationship with me in the past will take part. I will also be interviewing up to 5 adults aged 25 to 55 years that have physical disabilities and live in the community. I will be conducting the interviews and an audiotape will be used to ensure accuracy. It will be possible for you, as participants to ask for removal of any interview material that you decide you'd prefer to have taken out. You can also stop the interview at any time. You may withdraw from the study at any point without giving a reason. This will have no effect on your future employment. If as a consequence of participating in the study, you experience psychological discomfort or feel unsafe or receive an injury, you can, with your consent, be referred to the AIT counselling service or your GP.

Confidentiality:
No material that can personally identify you will be used in any reports on this study. All aspects of this research will be treated with confidentiality and participants' names will be coded to ensure that you cannot be identified. Audiotaped interviews can be returned to you, the participant, at your request. The tapes will be typed into text with coded names given to participants. A typist will have access to audiotapes and will sign a confidentiality document. Research supervisors and an 'expert' community occupational therapist will have access to the analysis of the typed text. The tapes and the typed text and written informed consent will be kept securely.

Additional Information requirements:
If you require more information about the study you can contact me on the telephone number given. If you have concerns about your rights as a participant you may wish to contact a Health Advocates Trust, Telephone 6235799.

Signed_____ Date_____

      Ann Paddy
      ph 4452453
      Student Masters of Health Science Programme
      Auckland Institute of Technology
      Akoranga Campus

This study has received ethical approval from the HFA Auckland Ethics Committee. 98/12/274

Approved by the Auckland Institute of Technology Ethics Committee on 20.1.99 AITEC Reference number 98/76

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O Tamaki Makau Rau
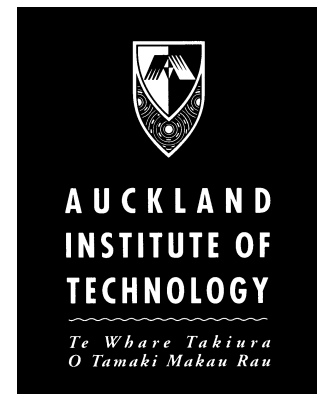
Consent to Participation in Research

Title of project: **Experiencing the Relationship:**

                           The Client and the Community
                           Occupational Therapist

Project Supervisor: Valerie Wright- St Clair contact ph. no. 307 9999, ext.7736

Researcher: Ann Paddy   contact ph. no. 445 2453

- I have read and understood the information sheet dated_____
  for participants taking part in this study designed to examine the meaning of the
  client/therapist relationship.

- I have had an opportunity to ask questions and to have them answered and to
  discuss this study. I am satisfied with the answers I have been given.

- I understand that taking part in this study is voluntary (my choice) and that I
  may withdraw myself or any information that I have provided for this project, at
  any time prior to publication, and that this will not effect my future healthcare or
  employment. After such withdrawal from the study all relevant tapes and
  transcripts, or parts thereof, would be destroyed. I understand that the interview
  will be audiotaped, and written up as text.

- I understand that the information I have given in interviews with the researcher
  will be used by her in her research, in articles she writes about her research, in
  verbal presentations at conferences and for education purposes and as
  paragraphs in her writing. The identity of participants will remain strictly
  confidential and I will not be able to be identified from the information.

- I understand that there is no financial benefit for my participation. I have had
  time to consider whether to take part in this study and know whom to contact if I
  have any concerns or questions.

- I hereby consent to take part in this study.

Participant signature: ....
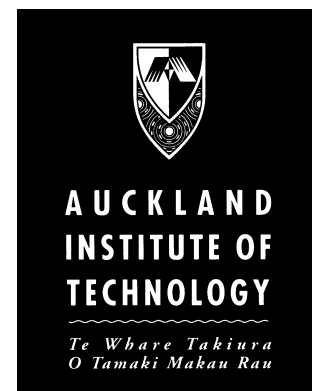
Participant full name: …………………………………………
                        Date………..…….1999

Project explained by……………………Signature…………………..Date…………

This study as received approval from the HFA Auckland Ethics Committee 98/12/274

Approved by the Auckland Institute of Technology Ethics Committee on 20.1.99. AITEC Reference

number   **98/76**

**AUCKLAND
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*Te Whare Takiura
O Tamaki Makau Rau*

Confidentiality Form

I_____

Am involved as a _____typist_____'expert' therapist (circle one)

In assisting with the transcribing and analysis in the research study titled:

Experiencing the Relationship: The Client and the Community Occupational Therapist.
A Phenomenological Study.

I recognise that I have access to information that is confidential under the Privacy Act and undertake to ensure that outside my specific function in this research study I will not discuss or disclose information that I have been privy to.

Signed_____

Printed name_____

Date_____

```
┌─────────────────────────┐
│                         │
│     **Appendix F**      │
│                         │
│     **Participant**     │
│      **Feedback**       │
│                         │
└─────────────────────────┘
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27.2.2000

Dear Ann,

Thank you for asking me to read this. I found it excellent, very interesting and very believable. I often found myself relating to what the other clients had to say and it was also interesting reading the therapists point of view- often we do not realise how our actions (intentional or otherwise) make a person feel.

I certainly think you have treated the stories of all participants, not just those with disabilities in a respectful way.

Thank you for giving me the opportunity to read this chapter. Good luck with the final product.

Best wishes,

Anne

(pseudonym of client participant)

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