Realizing a Conscious and Receptive Heart

Community Occupational Therapists' Experiences of the Therapeutic Relationship

A Phenomenological Study

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Abstract

Aim: There is limited understanding of therapeutic relationships in community occupational therapy from a psychodynamic perspective. I explored community occupational therapists' lived experiences of therapeutic relationships with special attention to countertransference. **Methods:** Interpretive and descriptive phenomenology was used. Eight occupational therapists with experience providing occupational therapy to people in their homes completed two qualitative interviews. Epoche and reduction analysis methods were applied during the thematic analysis and phenomenological writing phases of the study. **Findings:** Themes related to the therapeutic relationship illuminated tensions therapists experienced between 1) the need to obtain "buy-in" from clients and insecurity regarding their expertise and the potential effectiveness of occupational therapy; 2) self-disclosure and self-protection, and 3) "planting the seed" and feeling responsible for immediate therapeutic outcomes. Therapists voiced difficulty understanding the concept of countertransference but were able to provide powerful examples. They experienced objective, subjective, positive, and negative countertransference. Themes included: 1) fear: experiencing physical vulnerability; 2) sadness: experiencing emotional vulnerability; and 3) frustration: experiencing social vulnerability, all of which impacted therapists' conscious and unconscious behaviours. **Discussion:** When reflected upon, countertransference appeared to be a powerful source of information during therapeutic clinical reasoning. It informed the therapists' use of therapeutic skills including boundary setting, self-disclosure, compassion, empathy, and containment in a diverse array of therapeutic relationships. **Significance:** Occupational therapy may benefit from a more transparent discussion and acceptance of the emotional dimensions of practice. Integrating a greater awareness and

understanding of the intersubjective dynamics of the therapeutic relationship in practice may be beneficial for community occupational therapists.

Keywords: community occupational therapy, therapeutic relationship, countertransference, intersubjectivity, intersubjective dynamics

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IRM: Intentional Relationship Model

COTO: The College of Occupational Therapists of Ontario

Chapter 1: Introduction

General Introduction

When I first began practicing occupational therapy in the community, I quickly realized the overwhelming complexity of emotions I was faced with while engaging in therapeutic relationships. While this ignited my passion for connecting with clients on a human level, I needed guidance to ensure that I was navigating the intricacies of the relationship in an effective manner for myself and the clients. After several emotional burnouts, my mentors continued to encourage me to "build a shield around myself," to "thicken my skin," to "distance myself" and "harden my heart." I just kept thinking to myself, how? I am never going to be able to do that. There had to be a way to learn how to connect in an appropriate, effective, and therapeutic way with the clients while protecting myself and the client by establishing appropriate personal and professional boundaries. My own experiences seemed to indicate a lack of awareness of the important intersubjective dynamics occurring in complex therapeutic relationships. When a therapeutic relationship went well, why did it go well? And when a therapeutic relationship went wrong, why did it go wrong? I felt at a disadvantage with understanding and examining what was going on in each complex therapeutic relationship. I wondered how I could ensure the most therapeutic experiences for myself and my clients every time I worked with someone and engaged in a therapeutic relationship. I desperately wanted to prevent my clients from any potential harm, and I wanted to prevent burnout. This is what led me to pursue this research -- to be able to assist occupational therapists to preserve their passion for connecting with others and to help them to understand the benefits of recognizing and sharing their humanity with others in a conscious, intentional, and therapeutic way. To this end, in my review of the literature, I first focus on the current understanding of the therapeutic relationship in occupational therapy. I then

explore countertransference and finally I note how countertransference has been acknowledged in the occupational therapy literature.

Literature Review

The occupational therapy therapeutic relationship. The development of the therapeutic relationship has been described as the therapist's artistic ability to establish rapport and empathize to better understand their client's values and meaningful roles in life (Mosey, 1981). The therapeutic relationship is an "essential component in all therapeutic encounters in the field of allied health care" (Lawton, Haddock, Conroy & Sage, 2016, p. 1979). Cole and McLean (2003) surveyed 129 practicing occupational therapists in Connecticut regarding how they defined and used the therapeutic relationship with their clients (Cole & McLean, 2003). They constructed a definition of the therapeutic relationship in occupational therapy "a therapeutic relationship is a trusting connection and rapport established between therapist and client through collaboration, communication, therapist empathy and mutual understanding and respect" (p. 44). Cole and McLean (2003) assert that "the therapeutic relationship is related to functional outcome" (p. 41). In the occupational therapy literature and culture, it is supported that the quality of the therapeutic relationship is associated with successful treatment outcomes attainment for clients (e.g., Cole & McLean, 2003; Crepeau & Garren, 2011; Devereaux, 1984; Fidler & Fidler, 1963; Fuertes et al. 2007; Lawton et al., 2016; Morrison & Smith, 2013). The establishment of a trusting, emotional bond between therapist and client has been "positively associated with treatment adherence and health outcomes" (Lawton et al., 2016, p. 1979).

Fidler and Fidler (1963) emphasized the importance of the therapeutic relationship and believed the relationship itself is as valuable as activity engagement in occupational therapy

treatment (Fidler & Fidler, 1963). They state, “the relationship established with the client can be used as a legitimate therapeutic agent of change in treatment” (Fidler & Fidler, 1963, p. 71). Peloquin (1990) explained that through a thoughtful reflection of both the therapists’ and clients’ perspectives of each other, the occupational therapists could increase their awareness and understanding of their clients as human beings (Peloquin, 1990, p. 13). This remains essential to the development of the therapeutic relationship in occupational therapy practice (Peloquin, 1990, p. 13). Morrison and Smith (2013) state that the “successful attainment of collaboratively established, client-centred goals may positively reinforce the working alliance” (p. 331).

Client-centred practice, a guiding approach in occupational therapy, is closely linked with the therapeutic relationship. Client-centred practice is defined as “an approach to service which embraces a philosophy of respect for, and partnership with, people receiving services’’ (Law, Baptiste, & Mills, 1995, p. 253). Hammell (2013) states, client-centred practice is foundational to occupational therapy; it focuses on “respect for clients; respect for clients’ strengths, experience, and knowledge; respect for clients’ moral right to make choices concerning their lives—and on fostering respectful, supportive relationships with clients” (p. 141). These concepts of client-centred practice and collaboration towards client-centred goal attainment emphasize the significance of and reverence for the therapist’s ability to develop and maintain successful therapeutic relationships with their clients in occupational therapy.

It is accepted in the occupational therapy culture that the development of the therapeutic relationship is achieved through the application of many therapist skills including technical, communication, and reflective skills (Peloquin, 1990). Cole and McLean (2003) have summarized valuable therapist characteristics and therapeutic skills for successful therapeutic

relationship development in occupational therapy (p. 37). Cole and McLean (2003) present six key interaction characteristics presented most frequently in the literature: Collaboration (Bellner, 1999; Norrby & Bellner, 1995; Lloyd & Maas, 1991), communication (Norrby & Bellner, 1995; Peloquin, 1995a; Allison & Strong, 1994; Lloyd & Maas, 1991), empathy (Thomson, Hassenkamp, & Mansbridge, 1997; Norrby & Bellner, 1995; Peloquin, 1995a; Peloquin, 1995b;) and understanding (Low, 1997; Norrby & Bellner, 1995; Lloyd & Maas, 1991; Devereaux, 1984) (p. 37). The fifth characteristic identified was trust (Lindsay, 1997; Giorgi, 1991; King, 1994), and the sixth characteristic was connection (Rosa & Hasselkus, 1996; King, 1994; Devereaux, 1984) (Cole & McLean, 2003, p. 37).

Morrison and Smith (2013), in their mixed-methods study of 4 client-therapist dyads, present therapist skills that are essential to the process of the development of the therapeutic relationship in occupational therapy including: “the fostering of an interpersonal connection; the use of humour as therapeutic modality; an impetus to act that leads to functional enhancements; a shared sense of success and a positive feedback mechanism created through successfully attaining clearly delineated, client-centred therapy goals.” (p. 326). Devereaux also emphasizes the importance of the therapist’s ability to have a caring relationship with themselves, which she states is developed through the therapists’ life experiences (Devereaux, 1984, p. 791).

The literature also presents beliefs and values that support the development of the therapeutic relationship. Devereaux (1984) highlighted the following essential therapist beliefs for developing holistic and caring therapeutic relationships: the “belief in the dignity and worth of the individual,” and the “belief that each individual has the potential for change and growth” (p. 796). Pragmatic components of establishing the relationship were also presented by Crepeau and Garren (2011). In their case study of a therapist-client dyad they provide four essential

components for the development of the therapeutic relationship: "(1) humour to promote reciprocity, (2) ordinary conversation to build rapport, (3) social comparison to promote acceptance and (4) attention as caring" (p. 872). They conclude that the therapeutic relationship is a "mutual exchange" between two equal individuals but that ultimately "it is the therapist who is responsible for establishing the environment for the therapeutic relationship to develop and flourish" (Crepeau & Garren, 2011, p. 872).

Necessary occupational therapist required psychosocial competencies for the therapeutic relationship were summarized in a statement regarding psychosocial concerns within occupational therapy practice by Stoffel (1995). Stoffel (1995) states "values, interests, self-concept, role performance, social conduct, interpersonal skills, self-expression, coping skills, time management, and self-control are all considered when determining the client's psychosocial needs" (p. 1011). Stoffel (1995) highlights the following psychosocial skills required of occupational therapists in the literature for practice: emotional availability (Watanabe & Watson, 1987), empathy (Vargo, 1978), being able to accurately assess the coping practices of the client (Davidson, 1991; Watanabe & Watson, 1987), identifying the role loss of the client (Versluys, 1980), the ability to focus on clients' strengths, capacities, intact skills and interests in therapy (DePoy & Kolodner, 1991; Fidler, 1991), and using space to promote social interaction, engagement and activity participation (Fidler, 1992, p. 1011).

The literature presents many lists of characteristics, skills, values, and beliefs required for successful therapeutic relationship development. However, practitioners are still left wanting a better understanding of how to foster, achieve and apply these components pragmatically. Lloyd, King and Ryan (2007) studied new graduates working in mental health and found that these therapists experienced challenges when developing effective therapeutic relationships and

rapport with their clients, particularly in boundary setting. American occupational therapists surveyed by Taylor, Lee, Kielhofner, and Ketkar (2009), reported that their formal training and education did not adequately prepare or guide them in their professional use of self in therapy (p. 198). Less than one-third of the therapists surveyed believed that there exists sufficient knowledge in the field of occupational therapy regarding the therapeutic use of self or managing challenging interpersonal situations within the therapeutic relationship (Taylor et al., 2009).

The therapeutic use of self is defined in occupational therapy literature as, ‘‘a practitioner’s planned use of his or her personality, insights, perceptions, and judgements, as part of the therapeutic process” (Punwar & Peloquin, 2000, p. 653). The concept of the therapeutic use of self in occupational therapy practice is considered essential to the therapeutic relationship and achieving successful treatment outcomes in practice (Taylor & Melton, 2009). The understanding of therapeutic use of self in occupational therapy is an elusive area of practice and the literature lacks substantiative practical guidance for clinicians (Solman & Clouston, 2016, p. 514). Solman and Clouston (2016) point out that the conceptualization of therapeutic use of self is weak in occupational therapy and that greater education and practical knowledge is required on this topic (p. 516). Solman and Clouston (2016) state that Renée Taylor’s Intentional Relationship Model (IRM) is a framework that may facilitate and guide the application of the concept of the therapeutic use of self in practice (Solman and Clouston, 2016, p. 516).

The IRM is an occupational therapy practice model developed to support occupational therapists in establishing and maintaining positive therapeutic relationships (Taylor, 2008). It aims to increase therapists’ understandings of the therapeutic use of self in practice (Taylor, 2008). The model claims to define the central elements of the therapeutic relationship and presents an interpersonal reasoning guide for the clinical management of relationships in practice

(Taylor, 2008). In her recommendations for the application of the model Taylor highlights the importance of learning self-awareness, interpersonal self-discipline, and "mindful empathy" (Taylor, 2008, p. 60) and encourages therapists to practice with an objective stance while at the same time, emotionally understanding and connecting with the clients' experiences (Taylor, 2008).

The IRM categorizes the relationship between the client and the therapist into two levels: the macro level involving the usual processes, interactions, and ongoing rapport, and the micro-level involving unique processes, influenced by interpersonal events and particular stressors (Taylor, 2008, p. 54). The six therapeutic modes presented in the IRM are: advocating, collaborating, empathizing, encouraging, instructing, and problem-solving (Taylor, 2008, p. 53). Within the IRM the therapist is responsible for bringing three main interpersonal capacities into the relationship: an interpersonal skill base, the therapeutic modes, and the capacity for interpersonal reasoning (Taylor, 2008, p. 51). Essentially, therapists are directed to apply their interpersonal capacities to discern and employ, based on client behaviour, the most appropriate therapeutic mode.

The IRM model by Taylor (2008) is a foundational work that begins to address the challenges and interpersonal difficulties faced by occupational therapists in the therapeutic relationship. It offers readily accessible, practical approaches to communication; however, it does not capture the complexity of conscious and unconscious emotion and vulnerability experienced by occupational therapists in the therapeutic relationship. Other researchers have started to explore these areas of practice in the literature.

Therapist emotional reactions and interpersonal situations were also presented in a study by Horton, Hebson, and Holman (2021). In their longitudinal, retrospective study of therapist-

client dyads they found turning points in the therapeutic relationships between occupational and physical therapists and their clients (Horton et al., 2021). This study provides some insight into the emotional reactions to client content experienced by therapists and presents some of the emotional situations and challenges in maintaining and navigating professional boundaries that therapists experience during the development of the therapeutic relationship (Horton et al., 2021). They state that "interpersonal problems with patients was the most prevalent type of turning point in therapists' descriptions of low-quality relationships" (Horton et al., 2021, p. 6). I believe this indicates occupational therapists' lack of knowledge in the interpersonal skills required in this type of relationship. They also state that "interpersonal affective bonding with patients was identified in therapists' descriptions of high-quality therapeutic relationships. This type of turning point was not identified in therapists' descriptions of low-quality therapeutic relationships" (Horton et al., 2021, p. 10). These findings can be interpreted as explaining that the emotional connection or bond is an essential aspect of the development of a high-quality therapeutic relationship. I believe the question becomes how to emotionally connect professionally with all clients in every therapeutic relationship.

This study points out that, "relational events cause actions, reactions, emotions, and thoughts that affect each dyadic partner's ongoing perception of the relationship" (Horton et al., 2021, p. 2). The authors report that setbacks in progress towards goals "provoked negative emotions, such as anger, frustration, and embarrassment and had a negative effect on the quality of the relationship" (Horton et al., 2021, p. 6). Interpersonal problems with clients caused therapists to experience negative emotions that negatively impacted the relationship quality and the communication between therapist and client (Horton et al., 2021, p. 6). They state that progress towards goals "facilitated positive emotions in patients and therapists and had a positive

effect on the quality of the relationship" (Horton et al., 2021, pp. 5-6). They conclude that "a better understanding of the nature of these influential events within therapeutic relationships can lead to a better understanding of how therapists can navigate such events successfully and therapists' ability to resolving conflict within therapeutic relationships has an important impact on patient outcomes" (Horton et al., 2021, p. 12). Therapists need a greater understanding of these emotions, and interpersonal events that occur in the relationship.

Other recommendations for more deeply considering therapist emotional reactions include the use of emotional intelligence skills (Andonian, 2017) and critically reflexive reflection skills (McCorquodale & Kinsella, 2015). A case presentation by Andonian (2017) states that occupational therapists struggle with establishing and maintaining therapeutic relationships in the face of high emotional content, including anger, frustration, or impatience with clients (Andonian, 2017, p. 299). She proposes that emotional intelligence skills including perceiving, understanding, and managing emotions, are required for occupational therapists to "support use of self, promote client-centred care, and foster communication skills within the workplace" (Andonian, 2017, p. 299).

McCorquodale and Kinsella (2015) critically reflect on the first author's experience of receiving detached care after a car accident, and her realization that she had provided such care while working as an occupational therapist. Through this reflection, they identified four key issues that limited therapeutic, client-centred relationships: dichotomous thinking, objectification, the economic imperative, and knowledge generation (p. 314). They recommend therapists engage in critical reflexivity about the cognitive, emotional, social, cultural, economic, and political aspects of occupational therapy practice (McCorquodale & Kinsella, 2015, p. 316). They state that "conceptions of caring, warmth, and engagement may be uncomfortable for some

occupational therapists, though these are the very qualities that may be necessary for authentic relationships" (McCorquodale & Kinsella, 2015, p. 315).

The requirements for therapeutic relationship development in occupational therapy have largely been described as lists of personal characteristics, skills, values, and beliefs. Therapists are left wanting a greater understanding of how to develop, apply and integrate these skills into practice. The IRM is a foundational step in helping therapists integrate their pragmatic skills into their relationship development and use of therapeutic self. However, the model lacks a deeper understanding and application of interdisciplinary knowledge that I believe is paramount for occupational therapists' successful practice of therapeutic relationship development, maintenance, and disengagement. Despite other skills and suggestions being added to these lists of therapist competencies, there remains little acknowledgement of or a deeper understanding of the occupational therapists' emotional responses in the intersubjective dynamics that occur in the therapeutic relationship.

The therapeutic relationship evokes thoughts and feelings in occupational therapists (Mackenzie & Beecraft, 2004, p. 533). Nicholls (2013a) states the therapeutic relationship in occupational therapy has the potential to be as emotionally complex, challenging, and close as other important relationships (p. 18). Mackenzie and Beecraft (2004) state that if the therapist does not reflect upon these thoughts and feelings, they may hinder therapy (p. 538). Understanding the unconscious processes, including countertransference, in practice is a significant dimension to professional development for occupational therapists (Mackenzie & Beecraft, 2004, p. 538). Countertransference in occupational therapy is an understudied and underacknowledged topic that is seminal to the pragmatic understanding of the use of therapeutic qualities and skills. This valuable psychoanalytic concept has been widely explored and

investigated in the psychoanalytic and psychotherapeutic literature.

Countertransference. Countertransference is a psychoanalytic concept that encompasses the therapist's emotional and physical responses as they process and respond to the verbal and non-verbal communication of their clients (Jacobs, 1991, p. xvii). Countertransference occurs in all therapist-client interactions and relationships (Geslo & Hayes, 2007, p. x). The concept of countertransference was originally devised by Freud, and it has evolved and diversified throughout the history of psychoanalysis. Freud (1910) recommended that countertransference be avoided and eliminated as it was solely based in the analyst's unresolved conflicts, and it would be only problematic for treatment. This is now described as the classical perspective of countertransference (Tansey & Burke, 1989, p. 11).

> We have become aware of the countertransference, which arises in the physician as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize his countertransference in himself and overcome it. (Freud, 1910, p. 144)

> I cannot advise my colleagues too urgently to model themselves during psychoanalytic treatment on the surgeon, who puts aside all his feelings, even his human sympathy, and concentrates his mental focuses on the single aim of performing the operation as skillfully as possible. (Freud, 1912, p. 115)

Freud then contradicted his recommendation that analysts should put aside all their feelings and he suggested instead that analysts be in tune with and able to use their unconscious thoughts and feelings in practice. Freud (1912) states, "the analyst must strive to turn his own unconscious like a receptive organ toward the transmitting unconscious of the

patient" (p. 116). Freud appeared to have conflicting ideas about how the experience of countertransference could be used as an informative source of information during treatment (Tansey & Burke, 1989, p. 12). He initially recommended that analysts rid themselves of all emotional reactions to perform analysis surgically, however he also recommended therapists be in tune with their unconscious in order to be receptive to the client's unconscious as well (Tansey & Burke, p. 12).

The classical view remained that countertransference feelings were solely the therapist's unresolved conflicts and responses to the patient's transference feelings (Tansey & Burke, 1989, p. 12). Transference was defined as the redirection of a patient's feelings for a significant person or relationship to the therapist or therapeutic relationship (Freud, 1910). Freud concluded that countertransference feelings should be identified and eliminated (Tansey & Burke, 1989, p. 13). Freud came to see working with transference as helpful, but he continued to see countertransference as problematic (Tansey & Burke, 1989, p. 13).

The subsequent absence of discussion of countertransference reflected the psychanalytic movement's desire to achieve a strict objective approach to analysis, uncorrupted by the analyst's personal countertransference (Roland, 1981). There were notable exceptions including Helene Deutsch's work, she argued that countertransference included unconscious identifications with the patient through similar developmental experiences and memories prompted by the patient's content during the analysis process (Deutsch, 1926). Deutsch established that countertransference was not solely the analyst's pathological response to the patient's content (Deutsch, 1926). Additionally, Reik (1937) encouraged analysts to attend to internal affective signals and referred to them as sources of information that are important for helping an analyst to understand the patient's unconscious processes during analysis (Reik, 1937).

Throughout the 1930's and 1940's, the theory of object relations provided a shift in viewing development from a drive structure model to a more relational model (Greenberg and Mitchell, 1983). Klein (1940) proposed object relations theory with the concepts of projection, projective identification and proposed that the therapist becomes a container for these projections. In 1946, Klein introduced the concept of "projective identification as a defense mechanism by which the infant attempts to rid the self of destructive, aggressive impulses by projecting these impulses in fantasy into an internalized object which in turn is experienced as persecutory" (Tansey & Burke, 1989, p. 20). Sullivan (1930, 1931, 1936, 1938, 1940, 1953) explored the "interpersonal field theory" which included both an acknowledgment of the patient's intra-psychic defenses, as well as an understanding of the interpersonal, sociocultural, and environmental aspects of the human response (Tansey & Burke, 1989, p. 21). Sullivan shifted the focus from mental illness to "difficulties in living" and he argued that we are all much more simply human than otherwise (Tansey & Burke, 1989, p. 22). Sullivan laid the groundwork for further researchers to explore the importance of the quality of a patient's past interpersonal relationships in the formation of their personalities and their methods of managing their anxiety in subsequent relationships (Tansey & Burke, 1989, p. 22).

The inter-personalist view described the analyst as a "participant-observer" (Tansey & Burke, 1989, p. 22). This view acknowledged and valued the influence of the therapist on what was observed in therapy; the therapist's experience of the patient provided a source of information about the patient and the therapeutic relationship (Tansey & Burke, 1989, p. 22). This period of study throughout the 1930's and 1940's helped analysts to realize that the non-verbal, unconscious, and emotional responses of the therapist were channels of communication and extremely useful sources of information for understanding their patients (Tansey & Burke,

1989, p. 22). These developments in thinking about countertransference helped provide the foundation for an increase in exploration of the topic of countertransference that occurred in the 1950's (Tansey & Burke, p. 19).

The totalistic perspective of countertransference was first introduced by Paula Heimann (1950), she described the analytic situation as "a relationship between two persons" characterized by the presence of strong feelings in both partners (Heiman, 1950, p. 81). She stated that countertransference should refer to all the feelings that the therapist has for the patient, including accurate and distorted responses given the difficulty involved in determining each (Tansey & Burke, 1989, p. 23). Reik (1948) encouraged analysts to be in tune with their unconscious perceptions of the patient and discussed the potential for manifestations of these unconscious perceptions. Reik (1948) discussed how a well-functioning analyst applies both human sensitivity and therapeutic objectivity simultaneously.

The totalistic perspective was further supported by Racker (1953, 1957). Racker contributed to the totalistic perspective of countertransference by recognizing concordant identification with the patient's self, and complementary identification with the patient's internalized objects and emphasized that both should be considered when examining countertransference from a totalistic perspective (Racker, 1953 & 1957). Racker encouraged analysts to engage in consistent and continuous self-reflection and strive to increase their self-awareness (Tansey & Burke, 1989, p. 26). Winnicott (1954) described how the therapeutic relationship can serve as a reparative structure for the mother child relationship and that the therapist may be perceived as a maternal figure helping to establish a more secure attachment. Bion further explains that the patient forms an alliance with the therapist motivating the patient

to engage in self-exploration, introspection, and examination of their transference distortions in the dynamics of the relationship (Bion, in Britton, 1998, p. 71).

Throughout the 1960's major contributions to the understandings of empathy and projective identification brought about another period of focused study on the subject of countertransference in the 1970's referred to as the *specifist* movement (Tansey & Burke, p. 29). Tansey and Burke (1989) explain that the countertransference *specifists* introduced five dimensions of differentiating types of therapist identifications:

> The degree of consciousness of the experience, the degree of control over the intensity of the experience, the degree of separateness or differentiation of ego boundaries maintained by the therapist through the different stages of the identificatory process. The type of introjection involved, and the question of whether the identification is with the patients internalized self-representation (concordant identification) or with the patients internalized object representation (complementary identification). (p. 35)

The prevailing totalistic perspective of countertransference has continued to be studied through the 1980's, 1990's and 2000's. The totalistic view is that the therapist's identification experiences fall along an all-inclusive continuum (Tansey & Burke, 1989, p. 34). This continuum ranges from identificatory experiences that are reflective of the patient's concerns to those that are reflective of the therapists' subjective experiences (Tansey & Burke, 1989, p. 34). Mitchell (1997) states that the acknowledgement of the psychoanalysts' emotional struggles, including their self-doubt and uncertainty in the relationship, is critical if they are to accomplish replacing their perspective of being all-knowing therapists, with being intersubjective therapists. Hinshelwood (2018) states that countertransference is now most commonly considered from a totalistic and relational perspective (p. 1418). Notable contributors to this understanding of the

self and the other in the intersubjective field include Winnicott, Klein, Mitchell, and more recently Jessica Benjamin.

Benjamin (2004) provides great clarification about the intersubjectivity involved in the therapeutic relationship. Benjamin (2004) emphasizes, "both developmentally and clinically, how we come to the felt experience of the other as a separate yet connected being with whom we are acting reciprocally" (p. 5). Benjamin (2004) defines intersubjectivity as "a relationship of mutual recognition—a relation in which each person experiences the other as a 'like subject,' another mind who can be 'felt with,' yet has a distinct, separate center of feeling and perception" (p. 5). Benjamin (2004) defines the term *recognition* as, "being able to sustain connectedness to the other's mind while accepting his separateness and difference" (p. 8). Benjamin (2004) further explains that the intersubjectivity between client and therapist creates what she calls a "*thirdness"* and she discusses the therapists' experiences in the relationship as a continuous process of self-separation, self-integration; she makes the distinction "between *giving in* or *giving over* to someone, an idealized person or thing, and letting go into *being with* them" (p. 8). She explains that the development and growth of this "*thirdness*…always collapses into twoness…we are always losing and recovering the intersubjective view" (Benjamin, (2004), p.12). Countertransference is experienced by therapists as an integral part of the intersubjective dynamic.

Paul Geltner, in his book *Emotional Communication Countertransference analysis and the use of feeling in psychoanalytic technique*, discusses how emotional communication is present in all human interactions (Geltner, 2013). He explains that there are psychodynamic underlying currents in the inter-subjective field of the relationship including objective,

subjective, positive, and negative countertransference (Geltner, 2013, p. 28). I discuss each of these in turn.

Objective countertransference is defined by Geltner (2013), as the therapist's physical and emotional responses in response to the client's emotional communication in the relationship that is rooted in the client's content (p. 24). Objective countertransference is used to "generate hypotheses about the relationship between the analysts' feelings and repetitive interpersonal patterns of patient life that can be of value in clinical practice" (p. 25). The therapist can better understand the client's experience by examining these induced responses in conjunction with the client's explanations and descriptions of their experience (Geltner, 2013). Geltner (2013) explains "everyone's relationships when viewed across time can be seen to contain interpersonal patterns that continually repeat with a wide range of people" (p. 24). When patient interpersonal patterns are understood accurately, with verification from the client, this can be extremely informative to the therapists' clinical reasoning (Geltner, 2013). An accurate understanding of the client's experience can also help guide the therapist in implementing their interpersonal skills effectively in each therapeutic relationship (Geltner, 2013).

Subjective countertransference "comprises the feelings that the analyst experiences, either towards the patient or in relationship to the patient, that are shaped by and rooted in the analyst's emotional life story and not the patient" (Geltner, 2013, p. 24). Subjective countertransference provides no accurate information about the client's experience and may cause misinterpretations and disproportionate responses that may be detrimental to the relationship (Geltner, 2013, p. 21). Therapists must consider and be aware of which feelings are primarily induced in the therapist by the client's content and behaviour and which feelings are "rooted primarily in the analyst's own subjectivity" (Geltner, 2013, p. 25). Geslo and Hayes

(2007) have called the therapist's subjectivity their "inner world" or "experiential world" (p. 71). They explain that "the therapist's internal reactions that are shaped by his or her past or present emotional conflicts and vulnerabilities…the internal aspect of countertransference" (p. 71). They state that the therapist's inner world also "contains all the thoughts, images, affects, and even the visceral sensations that the therapist possesses at any given time…this subjectivity exists in each and every psychotherapist in the interactions with each and every patient" (Geslo & Hayes, 2007, p. 71).

The therapist's subjective countertransference also encompasses repeated dynamics from the therapist's life that they may bring into the therapeutic relationship "primarily caused by analyst's idiosyncratic reactions to the patient" and "most usefully understood in the context of the analyst's life" (Geltner, 2013, p. 53). Left unexamined, feelings associated with past, or unresolved personal or professional experiences may cause distortions to the optimal, accurate understanding of client content in the therapeutic relationship (Geltner, 2013, p. 24). The therapist needs to be able to reflect on any incongruent or disproportional responses to their client's content (conscious or unconscious), to ensure that subjective countertransference is not interfering in an accurate understanding of their client in the therapeutic relationship (Geltner, 2013, p. 66).

While objective countertransference is rooted primarily in the client's content, and subjective countertransference is rooted primarily in the therapist's content, Geltner (2013) also acknowledges feelings unique to the relationship (p. 53). Geltner (2013) explains that these feelings are created together between the therapist and the client, they "are different from those experienced in the analyst's other relationships" and most are "most usefully understood in the context of current mutuality between the analyst and the patient" (p. 53). While

countertransference can be experienced through both objective and subjective inductions, Geltner (2013) explains that these responses may also be experienced on a spectrum of positive and negative countertransference responses.

Positive countertransference can be described as an intense, disproportionate, positive regard for a client (Geltner, 2013). This may lead the therapist to over-nurture, over-support, over-expect, over-identify, and create dependencies with the client in the therapeutic relationship (Geltner, 2013). When positive countertransference is left unchecked, it may manifest, and the therapist may perceive a greater understanding of the client's content or experience than may be accurate (Geltner, 2013). Negative countertransference can be described as an intense, disproportionate, negative regard for a client (Geltner, 2013). This may be caused by a strong dislike, intolerance, judgement, disagreement, or frustration with a client (Geltner, 2013). It can lead the therapist to become defensive with the client, to distance themselves from the client, withdraw, avoid, or label the client as uncooperative or non-participatory (Geltner, 2013). It may cause them to unconsciously lower their expectations for the client's therapy and as a result, the therapist may lessen their efforts in the therapeutic relationship (Geltner, 2013). Unexamined countertransference left to unconsciously manifest, without reflection and self-awareness on the part of the therapist, may result in a therapist misusing their interpersonal skills, making unverified assumptions or decisions based on misinterpretations or distortions of accurate client content (Geltner, 2013).

Although these specific types of countertransference can be polarized into these categories, it is understood that they are not mutually exclusive experiences and that combinations of these types of countertransference may be at play in the relationship (Geltner, 2013). All subjective, objective, negative and positive countertransference feelings should be

examined (Jacobs, 1991, p. 17). Only by reflecting on countertransference responses to the client's content in the relationship are therapists able to determine what responses may be disruptive to optimal boundary setting, expectation management, and an undistorted understanding of our clients in the relationship (Jacobs, 1991, p. 17). The occupational therapy literature has just begun to recognize the importance of these intersubjective dynamics in the therapeutic relationship. To further this recognition, some attention to related concepts is also needed.

Two important interrelated concepts to countertransference in the therapeutic relationship are projective identification and containment. Projective identification was originally conceptualized by Klein (1940). In therapy, this occurs when painful characteristics and feelings that the client associates with themselves, are projected onto the therapist who then may unconsciously internalize this projection and act out these characteristics (Bateman & Holmes, 1995). Bateman and Holmes (1995) explain that "projection is the mental mechanism underpinning the process and projective identification is the specific phantasy expressing it" (p. 84). In the occupational therapy literature, Mackenzie and Beecraft (2004) discuss the benefits of psychodynamic observation in clinical occupational therapy with clients (p. 533). They discuss how projective identification when properly recognized, can enable the therapist to gain an awareness of what the client may be unconsciously feeling or rejecting about themselves (p. 535).

Containment is another fundamental psychoanalytic concept that Mackenzie and Beecraft (2004) feel is valuable for occupational therapy education and practice (p. 533). Bion (1961) further explored Klein's work and discussed the concept of the mother providing physical and emotional containment for children, absorbing, and processing the child's painful or unwanted

experiences, and ultimately facilitating a sense of safety and comfort for their child. Containment involves the therapist's ability to reserve a mental space to preserve the client's projective identifications where they can be stored, processed, and examined accurately (Nicholls, 2000, p. 42). This is a vital ability for therapists as "this act may allow the patient to feel understood and if given sufficient thoughtfulness (a mixture of personal experience, theoretical knowledge, and tolerance of these painful experiences) can be brought to bear on these projections, meaning may emerge" (Nicholls, 2000, p. 42).

The benefits of a greater understanding of the experience of countertransference include most prominently, reducing and preventing the negative impact unexamined countertransference may have on clients and on the therapeutic relationship and increased emotional self-awareness on the part of the therapist (Geslo & Hayes, 2007, p. 93). Another benefit is increased insight and knowledge regarding the interpretation of the client and therapist's emotions, which informs the therapeutic communication and fosters trust in the relationship (Geslo & Hayes, 2007, p. 93).

Internal feelings of countertransference can manifest, and they may lead to behaviours such as "mistakes of omission, not enforcing a rule or policy, not responding to a verbal or emotional contact, not changing the treatment when the patient gets worse, relying on routine interventions (even if they aggravate the patient), starting late, ending early, falling asleep, in-attention and confusion" (Geltner, 2013, p. 75). These behaviours represent deviations from healthy therapeutic behaviour and should be examined appropriately to determine if they represent manifestations of the therapist's internal countertransference experience (Geslo & Hayes, 2007, p. 29).

Unrecognized countertransference can also distort the therapist's use of clinical skills appropriately and effectively in the therapeutic relationship. In psychotherapy, frequent

misconceptions and misuses of empathy can occur in the therapeutic relationship (Book, 1988, p. 420). Unexamined countertransference may be a cause of these misuses and misinterpretations of empathy (Book, 1988). Empathy can be misused to act out the therapist's needs if the therapist is lacking effective "self-other differentiation" (Book, 1988, p. 420). These misuses can result in clients feeling misunderstood or unsupported and may be detrimental to the integrity of the therapeutic relationship (Book, 1988, p. 420). Alternately, when therapists accept a client's perspective without question, they are stuck subjectively in the "participant stance," seeing things only from the client's perspective without helping them to objectively examine and consider the situation from different perspectives (Book, 1988, p. 422).

If a client's interpretation of their situation is met with complete acceptance by the therapist, the client may feel understood, but this comes at the cost of the client's diminished self-awareness (Book, 1988, p. 424). The client may not be able to acknowledge or recognize therapy as an opportunity for reflection and broader insight into their experience (Book, 1988, p. 424). It is also at the cost of the therapist's objective knowledge and expertise (Book, 1988). Rather than empowering the client to process and understand their experience from a different and sometimes more well-rounded perspective, the therapist may only serve to fuel the clients' emotional distortion of their experience (Book, 1988, p. 421).

Alternately, when a therapist is too uncomfortable with the clients' content and experience, it may be too painful, emotionally draining, or unfamiliar to identify with the client's experience. The therapist remains stuck objectively in the "observer stance". They are unable to alternate between thinking with and about the clients' pain (Book, 1988, p. 422), and as a result their responses will be less empathic and may be perceived as skeptical, critical, and judgemental

by their clients (Book, 1988, p. 422). The occupational therapy literature has started to explore countertransference and its impact on the therapeutic relationship in the literature.

Countertransference and the occupational therapy therapeutic relationship.

Countertransference is a complex and fundamental concept not only for occupational therapists practicing psychotherapy or in mental health practice, but for all occupational therapy practitioners engaging in therapeutic relationships. Countertransference is established as an important concept in occupational therapy practice. It has remained, however, an infrequent area of study or discussion in the field (Nicholls, 2007, p. 56). The Standards for Professional Boundaries by the College of Occupational Therapists of Ontario (2015), discusses the significance of countertransference knowledge for its registrants:

> Just as clients transfer attitudes to the therapeutic relationship, OTs themselves may experience countertransference. Countertransference is the emotional reaction of the OT to the client's attitudes. Countertransference may take the form of negative feelings that are disruptive to the client-therapist relationship but may also encompass disproportionately positive, idealizing, or even eroticized reactions. Client and therapist expectations, conscious or unconscious, may be influenced by transference and countertransference. (p. 4)

The College of Occupational Therapists of Ontario (2015) expects occupational therapists to be able to anticipate, identify, and manage professional boundaries in the therapeutic relationship (p. 9). COTO (2015) also recognizes the importance of occupational therapists achieving a conscious awareness of their unconscious feelings and emotions through active ongoing reflection (p. 9). Standard 3 of the COTO (2015) standards for professional boundaries states "the OT will understand the causes and effects of transference and countertransference and

will anticipate, identify and manage them as they relate to either conscious or unconscious vulnerabilities in the therapeutic relationship" (p. 9). COTO (2010 & 2015) places significant importance on the awareness, understanding, and management of countertransference in the occupational therapy therapeutic relationship. However, it provides limited practical information regarding how to recognize, understand and manage countertransference responses in the context of occupational therapy practice.

There is a paucity of research in occupational therapy regarding the importance of working knowledge of countertransference theory and the related psychoanalytic concepts involved with intersubjective dynamics in the therapeutic relationship. However, there a few notable studies that help to inform a preliminary pragmatic understanding of countertransference and its related concepts for occupational therapists.

The literature supports that to build effective therapeutic relationships, therapists must be aware of their attitudes and biases (e.g., Bonder, Martin, & Miracle, 2001; Freda, 1985, Lloyd & Maas 1991, 1992; Wells & Black, 2000). Mackenzie and Beecraft (2004) state that if the therapist does not reflect upon these thoughts and feelings, these feelings or biases may "limit or undermine practice" (p. 533). I believe this has led some therapists to deny their judgements and feelings in their attempts to be completely neutral, objective, and non-judgemental as a celebrated goal. I believe the piece that is missing for most therapists is an understanding of how acknowledging their emotional responses and subjective feelings and biases will allow them to better consider how their subjectivity may be consciously or unconsciously impacting the therapeutic relationship dynamic. I believe that rather than understand and address their subjectivity, therapists deny, and avoid their subjectivity.

It has been demonstrated that occupational therapists experience personal biases, prejudices, and attitudes in the therapeutic relationship (Finlay, 1997, p. 445). Finlay (1997) states, "the individual therapist comes into the therapy relationship loaded with *personal* assumptions, preferences, needs, biases, and prejudices" (p. 445). This is like Geslo and Hayes' (2007) description of the "inner world" experienced by the analyst (p. 71). Finlay (1997) demonstrates through phenomenological interviews with 9 occupational therapists that, "whilst occupational therapists endeavour to be *non-judgemental*, they frequently utilise social evaluations to characterize their patients/clients" (p. 445). These biases and prejudices may manifest in a tendency to label and categorize their clients in terms of social evaluations, commonly perceiving clients as good, bad, or difficult (Finlay, 1997, p. 445). Left unexamined, this labeling has proven to be detrimental to therapy, treatment, the relationship, and the client's well-being (e.g., Jeffrey, 1979; Lorber, 1975; Murcott, 1981; Stockwell, 1984). Finlay brought to light the use of moral and social evaluations occupational therapists inevitably make regularly in practice (Finlay, 1997, p. 445).

In her study, occupational therapists described good clients as, "warm, responsive and made the therapists feel valued and effective" (Finlay, 1997, p. 440). Conversely, bad clients were described by therapists as, "manipulative, threatening and resisted change" (Finlay, 1997, p. 440). Participants suggested in an additional category defined by therapists, "difficult clients," reflecting ambivalent stance in some cases, with some clients as "positively challenging but hard work" (p. 440).

There are consequences for the therapist, client, and the therapeutic relationship if the therapist denies their judgements and biases, including the tendency to apply such labels to clients. If the therapist remains unaware of their unconscious feelings, they risk a manifestation

of these feelings that may result in behaviour that could be detrimental to the therapeutic relationship. For example, Finlay (1997) explains that social evaluations of clients made by therapists may be perceived by the client as "stigmatizing, stereotyping and disempowering" (Finlay, 1997, p. 440). Roth (1972) states that a possible outcome of therapists applying negative labels to their clients, including the label of uncooperative, may lead to premature or swift discharge from the therapeutic relationship. Finlay (1997) suggests that therapists work on recognizing situations that lead individual therapists to construct social evaluations that are potentially detrimental to the development of the therapeutic relationship (Finlay, 1997, p. 444). The risk of socially evaluating clients in this manner is only one of the many possible outcomes of unconscious countertransference manifestation in the therapeutic relationship.

Occupational therapists are not limited to emotions related to perceiving clients as solely good, bad, or difficult. Therapists experience a variety of complex emotional responses in response to their client's content including hope, concern, insecurity, distrust, dependency, withdrawal, and fear of rejection or abandonment (Linehan, 1993, pp. 138-141; Sher & Sher, 2016, p. 294).

I think occupational therapists may also feel obligated to completely accept clients' perspectives as client-centred practice is highly valued in occupational therapy (Law, Baptiste, & Mills, 1995). As a result, therapists may experience anxiety regarding their ability to question or explore or challenge a client's viewpoint on their situation or experience to not disrespect the client's experience or feelings. In doing so, the therapist runs the risk of only identifying with the client's experience and offering no objective analysis or clarification for the client (Book, 1988). This results in the therapist's countertransference response intensifying the clients' use of denial and projection (Book, 1988, p. 422).

Competent occupational therapy practice requires therapists to have both a technical understanding of practice as well as the ability to enter the client's lifeworld to bring about positive change so that the techniques can be individualized to meet each unique client's needs (Blesedell Crepeau, 1991, p. 1016). Blesedell Crepeau (1991) highlights the importance and complexity of this process, stating that it is reliant on the therapist's ability to read the client's verbal and nonverbal cues appropriately and to adjust and calibrate the nature of the sessions in response to these cues (p. 1019). Clients provide feedback through their behavioural responses and therapists rely on their observational skills and their emotional responses concerning client's behaviour to reflect upon and interpret this feedback (Taylor, 2008, p. 237). Understanding and processing countertransference responses, may help the therapists to interpret client feedback more accurately to inform their clinical reasoning skills.

Countertransference responses may provide a source of information that is both subjective and objective; therapists need the skills to delineate, analyze and apply this information to practice accurately. Tapping into this process opens channels for communication and clarification with the client. This is essential to help therapists identify, understand, and reduce the impact of potentially harmful labels, categorizations, generalizations, prejudices, and judgements interfering with or preventing the development and maintenance of a successful and positive therapeutic relationship.

In an occupational therapy study by Mackenzie & Beecraft (2004), the authors present their support for incorporating psychoanalytic concepts into occupational therapy education and practice. They state, "it is agreed that having an understanding of the processes of transference and countertransference is an essential aspect of thinking about what is occurring within the therapeutic relationship in occupational therapy" (p. 534). They acknowledge that understanding

transference provides the therapist with an opportunity to understand what is occurring within their clients' internal worlds, which subsequently impacts the clients' responses in the occupational therapy therapeutic relationship (Mackenzie & Beecraft, 2004, p. 534). They state that thinking about countertransference can help therapists "understand what may be blocking or getting in the way of providing appropriate emotional care and support, especially if these demands, which may be unconscious, are stimulating uncomfortable feelings in the carer or therapist" (Mackenzie & Beecraft, 2004, p. 534). The experience of countertransference, in part, is as means of gathering and interpreting information about the client, the occupational therapist, and the relationship that can be analyzed and applied to our clinical reasoning in developing and maintaining therapeutic relationships (Mackenzie & Beecraft, 2004). They conclude that "by using the psychoanalytical concepts of transference and countertransference, these experiences can be thought about in such a way as to help the understanding of what is being experienced," in the therapeutic relationship in occupational therapy (Mackenzie & Beecraft, 2004, p. 537).

Similarly, the importance of understanding and applying these psychoanalytic concepts in manual therapies was recognized by Sher and Sher (2016). They argue that "practitioner-patient relationships in the manual therapies would be strengthened by a deeper understanding of the psychodynamics and emotions of those relationships" (p. 293). Sher and Sher (2016) state that clients must be provided with opportunities to discuss their emotions openly, to be guided in processing their anxieties so that they may gain confidence in their capacities for self-recovery (p. 294). With knowledge and training, transference and countertransference can be effectively examined and utilized by therapists in manual therapies to identify the client's emotional needs (Sher & Sher, 2016, pp. 294-295).

Occupational therapists are required to support their clients through challenging emotional times by creating therapeutic relationships. Therapists are not exempt from feeling strong emotions or resorting to the use of defensive mechanisms to relieve the emotional intensity aroused by these interactions (Daniel, 2013, p. 131). Due to the emotionally demanding aspects of this work, therapists must remain knowledgeable of and receptive to the transference dynamics within the relationship (Daniel, 2013, p. 137). Occupational therapists will benefit additionally from examining their countertransference responses to clients (Mackenzie & Beecraft, 2004; Nicholls, 2013a, p. 24; Sher & Sher, 2016). The occupational therapy literature strongly recommends this practice; however, without formal training therapists will continue to be in the dark about how exactly to achieve this.

Working with clients in a therapeutic relationship is a complex emotional process that involves understanding clients, interpreting the emotional content of the therapy, developing insights, and dedicating sufficient time to addressing and resolving conflicts (Nicholls, 2013a, p. 29). This involves a more comprehensive understanding than that which may be offered from an occupational therapy model or framework. Healey (2017) indicates “although the profession has begun to (re)acknowledge the role of emotions in our practice, we need to explore alternative concepts of emotion other than just those underpinning emotional intelligence and benefit from important work being done across paradigms and across disciplines” (Healey, 2017, p. 682). Occupational therapy researchers suggest that occupational therapy should aim to broaden the knowledge base of therapists as they may benefit from the wealth of research and theory on emotional management and psychodynamics that have been established in other disciplines (e.g., Healey, 2017; Nicholls, 2013a). The occupational therapy therapeutic relationship requires

therapists to become more aware of themselves, their conscious and unconscious communication, as well as that of their clients (Nicholls, 2013a, p. 29).

Although self-reflection and awareness of personal biases are mentioned in the literature (e.g., Freda, 1985; McCorquodale & Kinsella, 2015), there is little attention to a deeper understanding of the psychoanalytic components of self-reflection of the therapist's unconscious thoughts, behaviours, and influences in practice. This is an important consideration in occupational therapy however, how occupational therapists experience, identify, and manage countertransference remains an understudied topic in the literature.

Many therapists working in the community continue to struggle to understand how to integrate appropriate interpersonal skills and countertransference management skills into the therapeutic relationship to address their clients varied emotional and psychological needs concerning their occupational performance. It is my opinion that a greater knowledge of the therapists' experiences of the therapeutic relationship and their countertransference responses is essential for greater reflection and understanding of how these responses may impact the therapeutic relationship. Further study of the therapists' experiences may begin to connect the conceptual literature with their lived experience in the therapeutic relationship.

Limitations of the Literature and Rationale for Further Study

To date the literature has had a limited focus, examining the therapeutic relationship solely from a superficial, cognitive, and technical perspective. There are many references to the need for occupational therapy to acquire more in-depth and interdisciplinary understandings of psychoanalytic concepts including countertransference (e.g., Mackenzie & Beecraft, 2004; Nicholls, 2007; Taylor, 2008), but there remains a lack of investigation and understanding of how therapeutic relationship can be informed by the therapist's emotional, psychological, and

physiological experience of client behaviour, content, and communication in occupational therapy.

Nicholls (2007) states that occupational therapy lacks a deep consideration of the unconscious aspects of communication and how this impacts practice (p. 56). Such a deep consideration is relevant to improving our understanding of the communication and clinical reasoning processes in the therapeutic relationship in occupational therapy practice. The more complex, emotional, lived experiences of occupational therapists within the therapeutic relationship with their clients have been neglected aspects of the research on this subject. To gain a more comprehensive understanding of the intersubjective dynamics in the therapeutic relationship, therapists must pursue more advanced training in psychoanalytic theory (Taylor, 2008, p. 233). Taylor (2008) acknowledges that the IRM offers a basic approach to managing difficult client behaviour to focus on occupational therapy goals however further study is necessary for these areas of practice (p. 233).

Although there exists acknowledgement of occupational therapists experiencing countertransference in the therapeutic relationship, there remains limited practical guidance regarding countertransference identification and management. A more interpretive and descriptive, lived through, experiential presentation, specific to community occupational therapists, may prove informative in a more complex, nuanced, and integrated way. I believe it is imperative to fill this knowledge gap so that occupational therapists may begin to integrate the two perspectives of technical skill and emotional competence for optimal therapeutic relationship development, maintenance, disengagement, and for optimal therapeutic outcomes to be achieved in practice. This knowledge may strengthen therapists' capacity for resilience in the difficult work that they do. The therapist's experience of their internal world in the relationship is an

understudied and potentially informative area of study. To date, there exists little to no literature in this discipline that describes the meaning and essence of this complex phenomenon from a lived-through perspective.

Chapter 2: Overview of Philosophical Assumptions and Research Methodology

Contemporary Phenomenology

My research objectives were to provide a human science understanding of community occupational therapists' experiences of developing, maintaining, and disengaging from the therapeutic relationship and provide a human science understanding of the community occupational therapists' experience of countertransference in the therapeutic relationship. To address my research objectives, I used a phenomenological methodology. My research questions were: what are the community occupational therapists' experiences of developing, maintaining, and disengaging from the therapeutic relationship in occupational therapy? And what are the community occupational therapists' experience of countertransference in the therapeutic relationship?

To gain a deeper understanding of the therapeutic relationship, a human science philosophy and a contemporary phenomenological research methodology were applied to explore community occupational therapists' lived experience of their inner world dynamics within the therapeutic relationship. Phenomenology aspires to expand the knowledge base on subjects that tend to be complex, obscure, and of great depth beyond conceptualization (Van Manen, 1984, p. 4). Such is the case for the intangible, ineffable, and enigmatic experiences of developing, maintaining, and disengaging from the therapeutic relationship and the experience of countertransference. Phenomenology allows for the necessary engagement in a reflective exploration of these lived experiences and meanings (Van Manen, 2001, p. 467).

I am deeply interested in this topic. Being a community occupational therapist and having lived these experiences professionally, I turned to this subject of interest with great fascination and wonder. Phenomenology encourages the researcher's immersion in the subject matter and

does not limit one to traditional observation and objective distance (Bentz & Rehorick, 2009, p. 3). As Van Manen (1997) suggests, through the phenomenological lens, practitioners are encouraged to continue to "discover and rediscover" different, relevant sources of information to provide "continual clarification of the guiding principles" and theories of practice (p. 155).

The therapists' experience of their humanity within the therapeutic relationship appears to be lacking in the literature. Although we have started to acknowledge it, what we appear to be lacking in our literature is the therapists' experience of their humanity within the relationship, an investigation of the experience "as we live it rather than as we conceptualize it" (Van Manen, 1997, p. 30). This methodology asks, "what is the nature of this phenomenon as an essentially human experience?" (Van Manen, 1997, p. 62). Phenomenology is a way of enriching knowledge through embodied awareness; it directs researchers to the holism of an experience and away from reductionist accumulations of information (Bentz & Rehorick, 2009, p. 3). The contemporary phenomenology methodology is appropriately aligned with the need to fill this research gap in the literature. The purpose of phenomenological human science is, "re-achieving a direct and primitive contact with the world" – the world as immediately experienced (Merleau-Ponty, 1962, p. vii, as quoted in Van Manen, 1997, p. 36). Van Manen explains that "this then is the task of a phenomenological research and writing: *to construct a possible interpretation of the nature of a certain human experience*" (Van Manen, 1997, p. 41). This research strives to maintain an orientation to the question of how community occupational therapists experience their inner world in the therapeutic relationship as human beings (Van Manen, 1997, p. 5). Phenomenology describes the researcher's "inseparable connection to the world, the principle of intentionality" (Van Manen, 1997, p. 5).

The preferred methods for human science studies involve description, interpretation, and self-reflection (Van Manen, 1997, p. 4). Ultimately, the overarching method of this research is producing a textual reflection on lived experiences and practical actions (Van Manen, 1997, p. 4). Van Manen explains, "phenomenological reflection is not *introspective* but *retrospective.* Reflection on lived experience is always recollective; it is reflection on experience that is already passed or lived through" (Van Manen, 1997, p. 10.). By applying this human science approach, through the collection of and reflection upon lived experiences, rich, in-depth descriptions with existential meanings, currently missing from the occupational therapy literature were revealed (Van Manen, 1997, p. 11). By remaining oriented to this topic of interest, I was able to describe and interpret the experience, while remaining "faithful to it" with a phenomenological subjectivity "in a *unique and personal way"* (Van Manen, 1997, p. 20). Human science research and writing were applied to welcome a purposeful dialogue and discussion with those for whom this text will resonate, to shed light on the unspoken ineffable parts of this experience (Van Manen, 1997, p. 21). As Van Manen (1997) states, "a good phenomenological descriptions is an adequate elucidation of some aspect of the lifeworld – it resonates with our sense of lived life" (p. 27).

The goal of a phenomenological study is teaching an increased awareness and thoughtfulness, practical resourcefulness, or tact (Van Manen, 1997, p. 4). Phenomenological human science inquiry offers plausible insights about the experiences that have the power to inform both the intellectual competence and practical capabilities of practitioners (Van Manen, 2014, pp. 67-68). This is possible by using phenomenology to generate both cognitive conceptualizations of a phenomenon and the existential and experiential aspects as well. This type of research can explore how a phenomenon is experienced in both practitioners' personal

and professional lives (Van Manen, 2014, p. 69). I aim to explore occupational therapists' lived experiences, to stimulate further reflection, discussion, wonder, and education (Van Manen, 2014, p. 270).

Personal reflection. Bracketing personal experiences and self entirely from the findings of the study is an impossibility in an interpretive approach to phenomenology (Van Manen, 1990). Phenomenology recommends that the researcher conduct thorough self-reflective exercises before engaging in data collection with the participants (Van Manen, 1990). As an occupational therapist, I was familiar with and had experienced first-hand the phenomena of interest in this study. I reflected on my own personal and professional experiences with this subject matter throughout the study. As well I reflected upon my assumptions, judgements, memories, perspectives, feelings, expectations, thoughts, knowledge, beliefs, ideals, morals, values, and assimilations with regards to these subjects. I continuously engaged in reflection upon what I believed was relevant and irrelevant about these topics and why throughout each stage of the research.

Recognizing and acknowledging that we as humans, always bring prior knowledge and typification from our past can be a means of rehabilitating prejudices (Bentz and Shapiro, 1998, p. 113). This typification can be assimilated into new situations (Bentz & Shapiro 1998, p. 113). The importance of this awareness is essential, as La Caze (2008) explains, it is necessary to approach the participants with a sense of both non-judgemental wonder and respect. She states, "wonder involves openness to the unfamiliar while respect involves the acknowledgement of similarity or common humanity" (p. 121). La Caze (2008) argues that it is respect and wonder united that will provide the researcher with a foundation for analyzing their ethical relations with others (p. 122). Bentz and Rehorick (2009) support that it is this sense of wonderment, that

invites phenomenological exploration and challenges us to have a different perspective on taken for granted and seemingly ordinary aspects of our daily practice (Bentz & Rehorick, 2009, p. 5). They state that phenomenological wonderment provides the freedom and opportunities required for transforming the self and others (Bentz & Rehorick, 2009, p. 6). This understanding was integrated into the data collection approach, analysis, and presentation of the findings.

My subjectivity is documented throughout the study through the personal reflection exercises recorded in field notes and a research journal. The personal reflective data was examined throughout the study and was included as information for the experiential epoche and reduction analysis. It was used to determine the appropriate integration of my subjective knowledge and experience into the research analyses and findings. I believe this research modality and source of information was valuable to the study as I have a great deal of associated knowledge from a personal, clinical, and research perspective as an occupational therapist.

Identification as an insider. I identify as an insider to the population of interest, community occupational therapists. I share a mutual understanding of language, terminology, and meaning expressed by the participants were applied effectively to discuss and communicate the findings of this study (Morgan, 2007). Rapport with participants is highly recommended in phenomenology so that participants are more comfortable disclosing information authentically (Creswell & Miller, 2000, p. 128).

I state transparently that some of the participants include past and present colleagues who have worked indirectly with me. That is, we have worked together as occupational therapy colleagues (discussed cases, provided peer support, attended educational and team meetings together with this individual). Phenomenology focuses on the “merits to a researcher having

subjective knowledge of the setting and, at a macro level, the cultural norms and values of the health care professionals involved" in the study (Hanson, 1994, p. 940).

There are many benefits and pitfalls to being familiar with the research setting and the participants' perspectives. For me, some benefits of the researcher being familiar with the research setting and the participants' perspectives included increased participant co-operation, reduced misinterpretation, greater trust and understanding Ashworth (1986), sharing in the participant culture, and a heightened awareness of the social setting (Hanson, 1994).

Hanson (1994) also acknowledges that potential pitfalls can be appropriately prevented and minimized with the application of appropriate strategies. In this case, I reduced the potential researcher distortions presented by my familiarity with the researcher with the experiences and the participants of the study in the following ways. I used deep explorative questioning to reduce overlooking or taking for granted participant information. A series of interviews was completed to allow for secondary explorative and reflective interviews to be conducted after the participants' first interviews. Research committee discussions were conducted throughout the study. These measures aimed to reduce overrepresentation or distorted interpretations of the information collected. I also engaged in journaling and writing field notes to identify subjectivity and potential biases throughout the research process. These methods were aimed at assisting me in recognizing and understanding my own subjective influence on this study and maintaining a phenomenological research lens.

Participant sample. A sample of community occupational therapists in Ottawa with a variety of work experiences engaged in this study. By sampling strategically from participants with a variety of experiences and contexts, data from the sample more authentically captured the similarities and differences relevant to their experience of the therapeutic relationship (Mason,

2002, p. 125). Strategically, the sample generated a relevant, varied range of contexts and experiences of the phenomena of study. This enabled me to engage in both cross-sectional and non-cross-sectional comparisons and analyses (Mason, 2002, p. 123).

Determination of the sample size followed recommendations in the field of phenomenology. Polkinghorne (1989) recommends a sample size of 5-25 individuals who have experienced the phenomena of interest. The sample size of this study was eight participants. The sample size supported the goal of achieving a detailed and nuanced focus on the particularities of the therapists' experiences of the therapeutic relationship (Mason, 2002, p. 136).

Inclusion criteria. The sample included participants with a variety of personal characteristics, attributes, qualities, complex and differentiated life experiences, years of practice, educational backgrounds, and varied experiences with different areas of practice and populations. These variations in the sample population allowed for variation in the data to be generated. This ensured differing and disconfirming data generation to be compared and analyzed. The sample selected provided access to descriptive and interpretive information about the phenomena of study. Occupational therapists were invited to participate who:

- Were registrants of the College of Occupational Therapists of Ontario.
- Practice independently or through community agencies in the region of Ottawa, Ontario.
- Held a bachelor's or master's level of education (degree) in occupational therapy.
- Had a minimum of 3 years of community practice experience.
- Worked with an adult population with various diagnoses including physical, cognitive, and mental health conditions.
- Worked in a variety of community settings i.e., client homes, retirement homes, and convalescent homes.

- Had at least 3 years of experience developing and maintaining both short-term and long-term successful therapeutic relationships with their clients.
- Believed that they have rapport-building skills and respect for the therapeutic relationship.
- Believed they have sufficient self-awareness personally and professionally for practice.
- Believed the therapeutic relationship is a relevant aspect of practice for producing positive therapeutic outcomes.

The exclusion criterion of this research study was simply the opposites of the inclusion criteria.

Recruitment procedure. Participants were recruited through convenience and purposeful sampling methods. I completed convenience sampling in the Ottawa region as this is the location of the university where the research took place. Purposeful sampling was implemented by applying the above criteria to the screening process (Creswell, 2007, p. 125). Multiple therapists were asked to participate and the first eight individuals to respond who met the study criteria were included in the study as participants (Please refer to Table 1. Participant Demographics).

Preparatory documents. I provided each participant with the preparatory documentation one week before completing their first interview. These documents included the participant consent form (Appendix B), a list of countertransference definitions: objective, subjective, positive, and negative countertransference (Appendix C), and the participant interview guide #1 (Appendix D). Participants were encouraged to review these documents before the interview and were also allowed to reference these documents during the interviews.

Interviews. I engaged in two interview phases with the 8 participants. In the first phase, the same interview questions were asked to each participant. In the second interview phase, each

participant's second interview guide was tailored to explore and clarify more thoroughly specific examples from their first interview. At all stages of the interviewing, I reviewed and discussed the process with my committee, and they provided appropriate feedback as required.

The interview guide consisted of two parts. The first section explored the occupational therapists' experiences of the development, maintenance, and disengagement from the therapeutic relationship and the second section explored their experience of countertransference in the therapeutic relationship. These interviews were semi-structured, with open-ended, reflective questions, and conducted in a conversational style. The content and flow of the interview were flexible and dependent on the participants' responses. I audio-recorded and transcribed each of the interviews. Interviews were conducted in the participants' preferred locations where they felt most comfortable thinking about their experiences, as recommended by Van Manen (2014) (p. 315). These locations included in their homes, and in coffee shops, or over the phone in the evening or on the weekend.

The interviews were on average approximately two hours in length. The interview guide generated detailed, experiential accounts of significant events and moments concerning their experiences of the therapeutic relationship and countertransference (Van Manen, 2014, p. 315). The existential aspects of experience (lived corporeality, lived spatiality, lived temporality, and lived relationality) were explored through these interviews (Van Manen, 2014). The therapists' interpretations, reflections and attributed meanings to these experiences were also explored (Van Manen, 2014, p. 317). Data generated by these interviews included: anecdotes, narratives, stories, lived experience descriptions, interpretations, memories, reflections, emotions, feelings, thoughts, actions, conversations, and interactions (Van Manen, 2014, p. 239).

After the first phase of interviews, I transcribed the audio recordings and reviewed the

transcripts. The transcripts were reviewed by the research committee. I discussed these transcripts with the committee, and I reflected on each participant's first interview transcript to develop each participant's second interview guide. The committee also provided additional guidance regarding my interview techniques and skills. Information from the first interviews in combination with my field notes were used to formulate the second interview guides. The second interview guide was individualized for each participant and sought to achieve further exploration into questions left unanswered, and components of the conversation that evoked a sense of wonder or desire for more detail from the participant's first interview. The second interview provided me with an opportunity to confirm my understanding of the participants' examples, and it allowed them the opportunity to clarify and confirm their responses, interpretations, and descriptions of their experiences. It also allowed for more in-depth exploration of specific examples of interest closely oriented to the therapeutic relationship and countertransference experience.

The second interviews were completed on average approximately six months after the participants' first interview dates. The second interviews provided an opportunity to collaborate in interpretive and reflective conversations about specific aspects of the participants' first interview transcripts, to explore more in-depth, the meanings and themes of these experiences (Van Manen, 1997, p. 99). Participants were provided the opportunity to confirm or disagree with some of the researcher's interpretations and proposed themes based on their first interviews. This assisted me in ensuring an optimal understanding of the participants' content from their perspective. It is highly valued by human science phenomenology, that the highlighted points and emerging themes resonate with the participants of the study, the second interview phase allowed for some of this confirmation to occur. The average length of the second interviews was

approximately one and a half hours. Again, my interviews were audio-recorded, and I transcribed all 8 interviews to fully immerse myself in the data.

Researcher field notes. Field notes were used to document my subjective interpretations and reflective material generated by the interview conversations. While the participants responded to the questions, I wrote down my own impressions, interpretations, ideas, memories recalled, and emerging insights about the experience. Preliminary meanings, connections, and questions I desired to further explore were jotted down. I documented my opinions, feelings, and physiological responses to the participants' responses. I used these field notes to inform changes to the subsequent phases of data collection, to inspire the deeper reflection completed in my research journal and inform the suspension of the epoche and reduction phase. Finally, the researcher's field notes were integrated appropriately as raw data in the analysis phase of the study.

Researcher journal. Phenomenology acknowledges, the inherent subjectivity of the researcher, the participants, and the inevitable influence their subjectivity has throughout the research process (Munhall, 1994, p. 14). It maintains that subjectivity enhances, rather than deters from, an authentic understanding of a phenomenon (Munhall, 1994, p. 14). Porter (1993) explains that the researcher should invest their efforts into acknowledging and understanding their impact on the research, instead of trying to eliminate or suppress them.

I engaged in constant reflective practices, both personally and professionally, throughout the data collection and analysis processes. This was completed to promote an open mind, increased awareness, consciousness, and acceptance of the unexpected, disconfirming, or different perspectives that emerged from the study (Nicholls, 2013b, p. 181). I used this journal

to document my values, beliefs, and biases during each phase of the study. In this way, the risk of my personal experience causing unconscious distortions was minimized.

It is recommended in phenomenology that the researcher maintain a reflective journal throughout the research process to engage in reflective activity, completing in-depth reflections of their experiences, stories, memories, emerging insights, and themes throughout the research process (Van Manen, 1997, p. 73). In the journal, I reflected and considered the nature of the researcher-participant relationship developed with prolonged interaction. I made notes from exemplary phenomenology texts and research to foster a phenomenological research lens and perspective.

Data analysis. I transcribed each of the interviews to fully immerse in the data as recommended in phenomenology. I also converted my field notes from hand-written notes and integrated these into the transcripts.

Epoche and reduction. The epoche and reduction process occurred simultaneously with the thematic analysis process. These complimentary phenomenological analytical techniques, introduced by Husserl (1931), serve to extract the meaning of an experience. The epoche suspends or removes that which obstructs access to the phenomenon (Taminiaux, 1991, p. 34). The reduction in the remaining interpretation of the data, which provides insights, "*pre-reflective meanings*," and reveals the very essences of the experience of the phenomena (Van Manen, 2014, p. 217). Phenomenology seeks to reduce distortion in our perspective of a phenomenon (Bentz & Rehorick, 2009, p. 4).

> It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. We try to come to terms with our assumptions, to forget them again, but rather to hold them deliberately at bay and even to turn this knowledge

> against itself, as it were, thereby exposing its shallow or concealing character (Van Manen, 1997, p. 47).

The epoche and reduction process clears the focus, reflecting a deeper and truer image of the phenomenon of study, revealing hidden elements and possible new pathways of understanding (Bentz & Rehorick, 2009, p. 4). This process helped me to connect with the direct experience as a source of knowledge while gaining fresh perspectives untainted by previous conceptualizations and evaluations (Bentz & Rehorick, 2009, p. 6). I applied four types of epoche-reduction simultaneously during this phase of the analysis: heuristic (wonder), hermeneutic (openness), experiential (concreteness), and eidetic (whatness) epoche-reductions (Van Manen, 2014). This process was completed over several months as Van Manen explains that this phase of analysis requires patience on the part of the researcher and a willingness to allow themes and insights to emerge without actively probing for them or constructing them (Van Manen, 2014, p. 239). I consulted my research journal throughout the data analysis process.

The heuristic epoche-reduction (wonder). This consisted of the epoche or suspension of an attitude of "taken for granted-ness" to maintain a sense of wonder while I reviewed the seemingly expected or ordinary components of the data about the therapists' experience of the therapeutic relationship (Van Manen, 2014, p. 223). Van Manen explains that the researcher should not confuse this sense of wonder with "curiosity, fascination or admiration" as these views may distort the analysis, however, a perspective of objective wonder may help ensure that those seemingly ordinary components of the phenomenon are investigated and questioned more objectively and thoroughly (Van Manen, 2014, p. 223).

The hermeneutic epoche-reduction (openness). This consisted of the epoche or suspension of all interpretive and explicative data (Van Manen, 2014, p. 224). Van Manen

(2014) instructs that the researcher's pre-understandings, frameworks, and theories should be suspended to enhance a perspective of genuine openness to emergent new ideas and discoveries about the phenomena of study (p. 224). Interdisciplinary lenses of psychology, psychoanalysis, and occupational therapy were consciously suspended while analyzing the data for this step.

The experiential epoche-reduction (concreteness). The experiential epoche-reduction (concreteness) suspends abstract conceptualizations in search of concrete experiential descriptions that include the existential material about the phenomenon (corporeality, temporality, spatiality, and relationality) (Van Manen, 2014). This required the suspension of theorizing, generalizing and assisted in the suspension of the cognitive abstractions and scientific conceptualizations regarding my previous knowledge (Van Manen, 2014, p. 226). These methods helped ensure that my previous knowledge did not block discoveries from being unearthed in the data about the therapists' experiences of the therapeutic relationship (Van Manen, 2014, p. 226).

The eidetic epoche-reduction (eidos or whatness). This step focused on what is distinct or unique in the phenomenon, from a Husserlian perspective, the eidos of a phenomenon is the variations that make something what it is, in that without these elements, it would not be what it is (Van Manen, 2014, p. 229). The eidetic reduction was partially accomplished by comparing the phenomenon with other related but different phenomena including other important relationships such as with a close friend, a colleague, or a relative. It is important to clarify that the eidetic reduction does not seek to describe a universal generalizable essence of the experience (Van Manen, 2014, p. 230). Rather, phenomenological principles encourage the discovery of possible human experiences and possible meanings, discovered by ongoing questioning and returning to how the experience is lived through (Van Manen, 2014, p. 230).

Thematic analysis. Van Manen explains, that grasping and formulating the thematic understanding is not a rule-bound process but a free act of highlighting meaning that is driven by the epoche and the reduction (Van Manen, 1997, p. 79). Van Manen emphasizes that "the meaning or essence of a phenomenon is never simple or one-dimensional. Meaning is multi-dimensional and multi-layered" (Van Manen, 1997, p. 78). Thematic analysis is the process of reading and reviewing the data collected, and applying the epoche-reduction lenses, while extracting the meaning structures of the human experiences represented in the text (Van Manen, 2014, p. 319).

A distinctive element of phenomenology is that it honours both the unique and the intersubjective features of a phenomenon as co-present and of equal value (Bentz & Rehorick, 2009, p. 14). These authors also emphasize the practice of "*horizontalization,"* a perspective that assisted me to view each element of data with equal value and fostered the possibility for changes in long-held perspectives regarding relevancy (Bentz & Rehorick, 2009, p. 16).

Phenomenological themes are, "the experiential structures that make up that experience" (Van Manen, 1997, p. 79). I engaged in holistic, selective, and line-by-line readings of all sixteen transcribed interviews with integrated field notes. While reading, I consciously applied the epoche and reduction methods to establish phenomenological meaning structures that were analyzed to establish themes to describe the phenomena of interest. In the holistic reading approach**,** I read and reviewed the text as a whole and considered its phenomenological meaning and significance of the text (Van Manen, 2014, p. 321). After several readings of the text, with the different methods of epoche applied, the statements or phrases that seemed particularly essential or revealing about the experiences emerged. Expressions, anecdotes, reflective, descriptive, and interpretive statements that seemed particularly meaningful were highlighted for

further line-by-line analysis (Van Manen, 2014, p. 321).

Finally, I applied the detailed reading approach. I looked at each sentence or phrase to examine what it revealed about the development, maintenance, and disengagement of the therapeutic relationship and the experience of countertransference in the relationship. I identified and underlined powerful thematic expressions, phrases, and statements that allowed the phenomenological meaning of the experiences to show themselves expressively in the text (Van Manen, 2014, p. 321). Through the whole, selective, and detailed reading approaches, "we study the lived experience descriptions and discern the themes that begin to emerge, then we may note that certain experiential themes recur as commonality" (Van Manen, 1997, p. 93). Van Manen (1997) explains that each researcher and reader makes their judgement of what the various fundamental meanings within a text are, and that no one interpretation is necessarily more accurate than another (Van Manen, 1997, p. 94).

Phenomenological themes. Phenomenological themes are the structures that make up the experience (Van Manen, 1997, p. 79). The narrative phenomenological text aims to help the reader understand the themes while remaining oriented to the essence of the experience (Van Manen, 1997, p. 97). "We try to unearth something 'telling,' something 'meaningful,' something 'thematic' in the various experiential accounts, we work at mining meaning from them" (Van Manen, 1997, p. 86). Van Manen (1997) states that while a single statement points to or highlights an aspect of meaning, the phenomenological theme involves a full description of the structure of the lived experience (p. 92). I continuously engaged in a "back and forth" method of interaction between reviewing the themes established, the research questions, and the data generated to ensure a comprehensive connection and resonance between all three was achieved (Mason, 2002, p. 159).

Interpretive themes emerged revealing cognitive and reflective meaning in the experience of the therapeutic relationship for occupational therapists. These themes revealed how the therapists made sense of the experience (Van Manen, 2002). The descriptive themes emerged revealing the pre-reflective meaning in the experience of countertransference in the therapeutic relationship. These themes revealed descriptive aspects of the experience from an existential perspective through lived corporeality, lived temporality, lived spatiality, and lived relationality including their actions, emotions, and physiological responses in the experience (Van Manen, 2014, p. 239).

I applied a cross-sectional comparison analysis after the themes had been established. The logic of cross-sectional data analysis, or Gadamer's (1976) first level of hermeneutics, was applied to explore patterns and commonalities that occurred across the established themes (Gadamer, 1976). By conducting this analysis, the common meaning structures of the experience of developing, maintaining, and disengaging from the therapeutic relationship and countertransference, experienced by most of the participants, were identified.

Following that step, a non-cross-sectional analysis, or Gadamer's (1976) second level of hermeneutics, was applied to search for the unique, different, and rare instances represented across the themes generated in the data (Mason, 2002, p. 165). As is common practice, both cross-sectional and non-cross-sectional analysis approaches were used simultaneously (Mason, 2002, p. 168). Cross-sectional data organization provided only part of the descriptive and interpretive information about these experiences (Mason, 2002, p. 168). Applying the non-cross-sectional analysis allowed for the development of greater qualitative complexity in the description and understanding of these experiences (Mason, 2002, p. 168).

Finally, the third level of Gadamer's (1976) hermeneutics was applied. This involved reflecting upon and revealing my own sense of transformation throughout the process of this study. My subjectivity, personal and professional growth documented in the researcher's journal, was reflected upon throughout the thematic analysis and phenomenological writing process. As Porter (1993) indicates, it is valuable to acknowledge this part of the researcher's experience rather than suppress or neglect the reality of this valuable transformative process.

I reserved the option of completing a negative case analysis if this was determined to be appropriate. The entrance to this type of analysis were opinions or situations that were in staunch opposition to the opinions or situations provided by the participants established in the cross sectional and non-cross-sectional analyses. The cross sectional and non-cross-sectional analyses highlighted a variety of similarities and idiosyncratic aspects of the experiences of interest. During the analysis phase of the data, I actively searched for examples of opinions or situations that were markedly different from others. However, I was unable to detect any and therefore could not do a negative case analysis.

Phenomenological writing. I used a "*convocative* pathic method" which aimed for the text to possess the empathic power (Van Manen, 2014, p. 267). The written text includes experiential stories and provides opportunities for reflection on practice involving the practitioners' emotions, their physiological responses, and descriptions of the more difficult to understand "*pathic knowledge"* referring to the immediately felt presence of experience (Van Manen, 2014, p. 268). Through pathic significations, imagery, and metaphor the more non-cognitive aspects of the experiences are conveyed and communicated. I met with my research committee and discussed my progress and insights at all stages of the data collection and analysis.

Ethical Considerations

Ethics approval was gained through the University of Ottawa Research and Ethics Board to ensure this project research was conducted ethically and with scientific responsibility. The initial approval from the University of Ottawa office of Research Ethics and Integrity was received on March 21, 2018. The approval was subsequently renewed on March 20, 2019, and April 2, 2020. It was closed officially on March 21, 2021, when the study was completed. I followed the expected procedures determined by the approval process of the Research Ethics Board of the University of Ottawa. I ensured that audio recordings and transcript records were kept in encrypted files and stripped of all identifying demographic information. Each participant was assigned a pseudonym for confidentiality purposes.

I acknowledge that this study did involve some emotional and psychological risks to the participants. The study's investigation involved significant personal reflection and discussion of emotional content, both personal and professional. The subject matter evoked strong emotional content, reactions, and realizations that may have been experienced as surprising or conflicting for the participants during the data collection process. The study required time and effort on the part of the participants; involvement was intermittent but required on average a six-month commitment. I recognized that this may have risked causing the participants some stress on top of their regular workloads and schedules. This project may have a prolonged effect on the participants as they have participated in powerful conversational interviews and reflections that may lead to new levels of self-awareness and possible changes in their style of practice (Van Manen, 1997, p. 162). It was acknowledged that this study may also produce prolonged feelings of anxiety or psychological distress (Van Manen, 1997, p. 163). These risks were explicitly discussed and provided in the written consent form to participants to read and understand

thoroughly before I obtained their informed written consent.

The University of Ottawa Research and Ethics Board recommends that, on top of explicitly stating these risks in the consent form, participants should also be presented with a list of psychological resources that they may access at their discretion at any point during or after the study. These resources were provided to the participants with the consent form before each of their interviews were conducted. Consent was regarded as an ongoing process and was obtained for the participants' involvement in both interview phases. It was also stated clearly that I intend to use the data from this study for this doctoral thesis and publications in peer-reviewed journals. It was made clear that the participants have the right to withdraw from the study at any time.

I monitored and reflected upon the power dynamic in the interview-interviewee relationship to mediate the impact this may have had on their feeling obligated to participate. Participants were explicitly asked not to provide or share examples of reprehensible misconduct, illegal or criminal acts, or professional boundary-crossing. My biggest ethical concern was the duty to report a participant to the College of Occupational Therapists of Ontario if any type of sexual misconduct was reported. Therapists were made aware of this detail explicitly in writing when signing the consent form.

Chapter 3: Interpretive Findings and Integrated Discussion

The analysis process of this study yielded two sections of findings; I present with a discussion of its findings. In the first section (Chapter 3), I present the interpretive and reflective themes of the participant's experiences of developing, maintaining, and disengaging from the therapeutic relationship will be presented. I explore how the participants made cognitive sense of the phenomenon of developing, maintaining, and disengaging from the therapeutic relationship (Mason, 2002, p. 149). I illustrate the meaning and essence of this lived experience through imagery, metaphor, interpretation, and anecdotes included in the first section.

In the second section (Chapter 4), I explore the descriptive, pre-reflective themes revealed through the participants' lived experiences of countertransference in the therapeutic relationship. I explore the existential quality of these experiences in occupational therapy is explored through the participants' stories, anecdotes, imagery, and metaphors. I recognize that subjective and objective countertransference are not always mutually exclusive. However, for the pedagogical purposes of this study, objective and subjective countertransference categories were applied to facilitate the participants' and the readers' access to this preliminary understanding of these complex intersubjective dynamics.

Participant Profiles

Eight female occupational therapists participated in this study. Below, I describe each of the participants. All names are pseudonyms.

Victoria was in her late 30s. she had approximately 15 years of community occupational therapy experience, in both the private and public health care systems in Ontario, with adults with physical, cognitive, and mental health conditions. She had worked for rehabilitation agencies, in hospitals and she has worked as an independent contractor. She completed her

master's degree in occupational therapy and has extensive research experience in the field of occupational therapy. I perceived Victoria as very confident in her knowledge and understanding of occupational therapy practice and highly self-aware. I viewed her as a very conscientious and careful practitioner. She described herself as highly susceptible to emotional exhaustion and burn out and this was why she was so adamant about maintaining distance between herself and her clients. I perceived her as deeply insightful about occupational therapy and the therapeutic relationship.

Caroline was in her late 20s. She had approximately 5 years of community occupational therapy experience solely in the private sector of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions and solely for rehabilitation agencies. She completed her master's degree in occupational therapy and has some research experience in the field of occupational therapy. I perceived Caroline as a therapist still struggling to find her confidence in occupational therapy practice and still working on her self-reflective practices. She was desperately searching for concrete answers in her work but was discouraged by the fact that occupational therapy does not provide that type of formulaic approach. She very much wanted to be viewed as competent by her clients and admitted her struggles openly regarding the holism of occupational therapy practice.

Riley was in her early 40s and had approximately 20 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked for rehabilitation agencies, and she has worked as an independent contractor. She completed her bachelor's degree in occupational therapy and has some research experience in occupational therapy. I perceived Riley as someone who wanted to be viewed as an absolute expert and authority in occupational

therapy. Riley stated she always wanted to the best at anything she did and strived for perfection in her work while also admitting frustration with occupational therapy causing her confusion and frustration. I perceived her as always wanting to do the right thing. Riley gave me the sense that she needed to project that she had mastered therapeutic relationships while she also revealed she struggled with these same aspects of practice she felt she was expected to be an expert in.

Marianne was in her early 30s and had approximately 10 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked for rehabilitation agencies, and she has worked as an independent contractor. She completed her master's in occupational therapy and has some research experience in occupational therapy. I perceived Marianne as very self-assured, down to earth, and grounded. Marianne was very open about and aware of her limitations and was ready to identify where the education system fell short for her and what she had learned from her years of practice experience. I viewed her as having a very go with the flow attitude, a great deal of confidence with her scope of practice and high level of self-awareness. I perceived her as highly skilled and knowledgeable about relationship dynamics.

Dianna was in her early 40s and had approximately 20 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked for rehabilitation agencies, and she has worked as an independent contractor. She completed her bachelor's in occupational therapy and has limited research experience in occupational therapy. I perceived Diana as wise, kind and very caring. She was highly conscientious and detail oriented. She described her tendency to perseverate and mull situations over from all possible angles which

was very time consuming for her, but which ultimately increased her confidence with decision making. I viewed her an extremely knowledgeable, experienced, and holistic occupational therapist. I perceived her as self-aware, alert, attentive and conscious of many unconscious aspects of practice and the therapeutic relationship.

Judy was in her late 30s and had approximately 10 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked for rehabilitation agencies, and she has worked as an independent contractor. She completed her master's in occupational therapy and has some research experience in occupational therapy. I perceived Judy as having a very matter of fact, common sense approach to her work as a practitioner. She was very procedural and highly knowledgeable regarding her personal and professional boundaries and her scope of practice. I perceived her as very likable, down to earth, and I could picture her clients appreciating her upfront, straight forward, yet friendly approach.

Leah was in her early 40s and had approximately 20 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked for rehabilitation agencies, and she has worked as an independent contractor. She completed her bachelor's degree in occupational therapy and has some research experience in occupational therapy. I perceived Leah as extremely confident personally and professionally. I viewed her as highly knowledgeable about her scope of practice. Leah operated from the perspective that she was completely non-judgemental and able to emotionally detach from her work quite easily. She described herself as being very client centered and highly skilled in conducting therapeutic relationships. I perceived her as highly competent and extremely hardworking.

Jennifer was in her late 30s and had approximately 15 years of community occupational therapy experience in the public and private sectors of health care in Ontario. She worked with adults with physical, cognitive, and mental health conditions. She has worked solely for rehabilitation agencies. She completed her master's in occupational therapy and has some research experience in occupational therapy. I perceived Jennifer as a deep feeler and thinker, exploring conceptual and abstract thoughts in our discussions. I perceived Jennifer to be highly empathetic and that she really wanted to "make a difference" in her clients lives. I perceived her as very much seeking purpose and meaning through her work as an occupational therapist. She had a great desire to continue to learn about herself and occupational therapy and she described how she experienced intense emotions during many therapeutic relationships in her practice.

The Experience of the Therapeutic Relationship

What does it mean for therapists to experience the therapeutic relationship in occupational therapy community practice? What is the nature of this experience for community occupational therapists? How do they make sense of this experience in their inner subjective world? What is this experience like for therapists? In this section, I explore the meaning of the experience of the development, maintenance, and disengagement from the therapeutic relationship in occupational therapy for community occupational therapists. I will discuss the participants' interpretive understandings of the therapeutic relationship as well as the interpretive themes that were developed in the analysis.

The participants discussed the imagery and metaphors they believed described their experience of the therapeutic relationship process. From an interpretive lens, what participants stated was meaningful was a sense of shining a light on the client, supporting, and contributing to their journey for a temporary period. What was also emphasized by therapists was the necessity

of removing themselves with as little disruption from the clients' lives as possible when the appropriate time arrives. There was a meaningful recognition that the clients' lives are theirs to live, their choices are theirs to make, and therapists conveyed a humble recognition and acceptance of their valuable, yet secondary role in the clients' lives. Victoria provided a poignant description of this experience through a metaphor for the occupational therapy therapeutic relationship:

> You're walking together…but then you walk away (Line 287) …and they keep going (Line 289) …I'm just walking beside you and then I exit stage left on your stage of life. I am just coming in and going out and you stay on the stage. This is your life, I'm just visiting. (Victoria Interview 1, Line 423)

In Leah's first interview, she made a statement that I believe represents a clear interpretation of Victoria's metaphor in the context of the occupational therapy therapeutic relationship:

> My goal at the end of the day is not for them to say, 'I did really well while the OT was with me.' I want them to say, 'yeah the OT is gone but I've carried forward,' even if it's one or two things they can bring with them, or their quality of life is just a little bit better then that's my goal. (Leah, Interview 1, Line 321)

Victoria's metaphor of walking onto the client's stage conjures the imagery of one human being supporting another without re-focusing the spotlight away from the "star performer." The therapist fosters the client's ability to achieve the performance for themselves for a temporary timeframe, the spotlight remains on the client during the therapeutic relationship as well as after the therapist has left the stage. Leah provided a metaphor that also highlighted the emphasis on

client-centeredness in the relationship for the therapists. Her metaphor offered insight into the supportive nature of the therapist's role in the collaborative achievement of successful outcomes:

> It's a blank puzzle. It's just fitting the pieces together, it's not so much the final picture…every client you work with has a different picture…it's more the pieces coming together that's an ideal outcome (Line 379) …sometimes pieces are missing or the clients a little withdrawn, they're not going to give you maybe all the things that you need to fill it in (Line 381) …it's not my picture, I want the puzzle to fit together but it's not my picture. (Leah, Interview 1, Line 383)

This represents the recognition by the therapists, that the client is their own decision maker; they decide how they would like to be assisted and when they are ready to participate in the collaborative process with the therapist. This represents the therapist's respect for each client's unique process. All the participants described in some sense the meaningful mystery of the process and the collaborative journey representative of the nature of the therapeutic relationship.

Victoria described the process of developing rapport in the relationship with another metaphor. She provided an account of navigating the relationship with the client as if she were using a key ring with all different keys to unlock the doors to where the clients' most private, sensitive, and meaningful information is kept. To unlock these doors, therapists must find and use the right key and each time they find the right key, they gain a better understanding of that person. Victoria emphasized the meaning in recognition of each client as a unique human being. She described that the deeper you travel through the doors, the more you continue to absorb all the sources of information presented to you from this unique individual. When you have reached

a point where you have enough information to contribute to the individual, after you have accomplished this, you then carefully and quietly walk back out through the doors.

She emphasized the importance of the therapist not disturbing anything on their way out. This imagery underlined the temporary time frame and careful removal of the relationship from the client's life. It also highlights the meaningful respect and privilege therapists feel to have entered their clients' personal space and the sense of meaning they attribute to being able to contribute in even a small way to their client's lives. It resonated with me that this participant's self-perception was that of a "visitor" which connotates a sense of being welcomed by the client, as opposed to a trespasser or an intruder. It highlighted the intricate sensitivity, respectful conscientiousness, and boundary setting required in the process:

> You're just visiting the room, seeing what's around, trying to understand the person, through what they've got on their walls and what sofas they have (Line 94) … don't pick out your own chesterfield chair and sit down (Line 108) …You can go all the way to the little rooms to very deep stuff but in the end, you have to walk backwards, close the doors…probably tiptoeing…. walk all the way out the front door again. You can't stay, you can't disturb anything. (Victoria, Interview 2, Line 118)

This highlights the openness and wonder with which the therapist approaches their clients' content, to absorb even the smallest reverberations and communications from their clients' responses and environments to successfully access their deepest thoughts and feelings.

Victoria also emphasized the challenge of connecting with each client therapeutically in trying to use the keys on her key ring and the time and effort it can take to try and try again to unlock the doors and gain access to a client's most guarded information. She concentrated on the significance of the short-term nature of the relationship and the idea of minimal disruption as a

respectful visitor in the client's life. This imagery represents the many qualities and traits at work in combination to successfully achieve a deep connection to contribute meaningfully to the client's life, while maintaining the ability to disengage successfully.

All participants highlighted the meaningfulness of not having all the answers, that the client has the answers. Therapists discussed the therapeutic relationship as moving in one small step at a time, which involves collecting and assessing all the information from the client content, their communication verbal and non-verbal, from their family, from their environment, to select their next step carefully and thoughtfully. Whether it is a key or a puzzle piece, like playing chess, navigating a maze, or dancing it was described consistently as a highly refined and mindful process. One small move or piece at a time and then reassessing the whole chessboard or puzzle picture. The outcome is envisioned and shaped by the client.

Integrated Discussion. The participants' imagery and metaphors were consistent with how a successful relationship is illustrated in the occupational therapy literature. Here the emphasis is placed on being virtuous, competent, and client-centred (e.g., Cole & McLean, 2003). In my opinion, this does not accurately or respectfully portray the therapist-client relationship and is designed to encourage therapists to deny their vulnerability and humanity in the therapeutic relationship. The therapists in this study described an idealized recognition of client-centredness, a minimalist, and secondary nature of their role with efforts to shine the spotlight on and collaborate with their clients in the relationship. I think the participants' imagery represents their ideal of what is expected of them in a successful therapeutic relationship. Their emphasis was focused on client-centredness, reducing the power dynamic, and reflected their intense anxiety of dependencies being created.

Participants seemed fearful of boundary-crossing or distorting the roles of the relationship to the extent that they aimed to remove themselves as quickly as possible to avoid any problems. This mirrors some of the occupational therapy literature, in which the viewpoint seems to be, simply be so virtuous and skilled that you can engage in therapeutic relationships without experiencing any challenges or barriers to remaining completely client centred. When asked to describe their practical experience, a greater understanding of their reality experienced in the relationship came to light. This supports McCorquodale and Kinsella (2015) who state that contradictions between occupational therapy's theoretical standpoint and its practical approaches create tension within the therapeutic relationship (p. 315).

I will present the interpretive themes that emerged through the application of the analysis process in this study. These include the participants reflective conceptualizations about their experience of the development, maintenance, and disengagement phases of the relationship. Therapists experience inherent tensions between these opposed but related concepts. Interpretive themes that will be discussed include: 1) "buy-in" and insecurity, 2) self-protection and self-disclosure, and 3) responsibility and "planting the seed." Lasty, the nature of the therapeutic relationship will be discussed.

Interpretive theme 1: "buy-in" and insecurity. The experience of the inherent tension between these opposed but related concepts was described by participants as most often associated with the development phase of the relationship.

Buy-in. The participants described their difficulties achieving what they referred to as "buy-in" with clients. Participants explained that they attempted to achieve "buy-in" with their clients by projecting their confidence in themselves personally and professionally, and their confidence in occupational therapy. Simultaneously, they described experiencing an intense level

of insecurity and uncertainty in their professional scope of practice and personal capabilities. According to the participants, the process of achieving "buy-in" represented successfully "convincing" the client to trust in their competence and expertise, as well as "convincing" the client to believe in the effectiveness of occupational therapy. The participants conveyed a sense of urgency in establishing buy-in in the relationship; they recognized that they needed to devote the appropriate time to acquire it, but that it also needed to be secured quickly. Participants spoke about the process of getting buy-in as if they were delivering a sales pitch to their clients, that occupational therapy would be beneficial for the client and would assist them in reaching their desired treatment outcomes. Buy-in was therefore achieved when they perceived that the client was willing to engage in occupational therapy with the therapist.

Buy-in was described by participants as one of the most meaningful achievements in the establishment of the occupational therapy therapeutic relationship. All participants shared the experience of having to explain what occupational therapy is and what it could assist their clients with, within their scope of practice. All participants talked about the importance of being present in the moment, actively listening, and forming rapport to gain the client's trust. Many participants described difficulties establishing "buy-in" with clients who regarded the profession as ridiculous or worthless to them. They described the necessity of having to explain why occupational therapy is worthy of the clients' time and efforts:

> You're sitting there listening to develop that rapport so that you can get the buy-in or the acknowledgement that yes I'm an important profession, I'm here to help, it's key (Line 42)…otherwise you don't get the buy-in, you could just go in there and make the recommendation, they're going to look at you and say who was that person, why does it

> even matter that they're here…but if you can gain their trust…then you can make a difference. (Jennifer Interview 1, Line 45)

The participants insisted this initiation of trust was required for the trial and error, exploration and collaboration that follows in the therapeutic relationship.

Insecurity. All participants shared the experience of uncertainty and insecurity in developing the therapeutic relationship and in the profession of occupational therapy. They shared a common desire to be experts in their field but felt in many cases they lacked the necessary skills needed to manage the situations they were presented with and wound up relying on experiences from their personal lives rather than their professional skills, to assist them in practice. The participants felt their studies and education in occupational therapy, the bachelor's, or master's programs, did not fully prepare them for developing therapeutic relationships in practice.

The participants expressed frustration about the ambiguity, abstract nature, and lack of appropriate concrete approaches in the profession. The participants emphasized their mixed feelings for the necessity in the profession to operate in what they referred to as the "grey zone." They wanted to clearly understand what they could help with or were permitted to assist with within the boundaries of their scope of practice, but they found the boundaries and scope of occupational therapy confusing and overwhelming at times. All participants questioned their abilities and their knowledge; they expressed a sense of feeling like a "Jack of all trades and master of none." Although they desired the "right answer" or a formulaic approach they could be confident in, they acknowledged that a concrete approach is rarely the reality for the therapists:

> They're looking at me to give them concrete direction and I'm not always doing that with people, because I'm more [likely to use an] approach where it's a conversation, and I try to get them to figure out what way they want to go. (Riley, Interview 1, Line 302)

> I want to know the right answer…and that is not occupational therapy whatsoever…our clients are so unique…so diverse, it's hard to know that you're doing the right thing from person to person. (Caroline, Interview 1, Line 20)

Riley and Caroline expressed their desire to be perceived as very competent and knowledgeable professionals. They both expressed their desire to be able to have formulas and correct answers, but they also recognized that this is not what is happening in the therapeutic relationship process in occupational therapy. The therapeutic relationship process is very client-driven, and it is a trial-and-error exploration at times. Therapists rely on the trust, or "buy-in" in the therapeutic relationship process to explore what the profession can offer the client within its scope, to collaborate, and hopefully arrive at the clients' desired outcomes.

Many participants expressed feeling reliant on external validation and confirmation about their approaches from their clients to know whether they were doing the elusive "right thing" in the relationship and in treatment. Insecurities regarding their professional skills and relationship dynamics were commonly shared. Caroline stated, "I'm like, what would somebody else be doing in the situation? Am I doing the job that was intended...What am I doing?...I don't know, you just start thinking about like your abilities" (Caroline, Interview 2, Line 68). Riley stated, "sometimes if I think about the session after, it's like OK did that go well? Did that not go well? What do I have to do next?" (Riley Interview 1, Line 346). Marianne highlighted the experience of not feeling adequately prepared and insecure. Marianne stated, "it also comes back to that

uncertainty of I don't know, should I be helping them with this or not? Am I confident in what I'm supposed to be doing?" (Marianne, Interview 2, Line 338). Caroline shared a description of her experience which captured most of the therapists' understandings of their experience of insecurity and internal questioning personally and professionally:

> I have insecurities specifically about my capabilities in certain aspects of occupational therapy…when that is questioned, or when that is highlighted by a client, or if that insecurity is brought to light…I cower and I'm like, oh my god I'm a terrible OT. I don't know what I'm doing. (Caroline, Interview 1, Line 259)

Insecurity was a common sentiment that participants expressed. Riley and Caroline expressed feeling insecure about their and their personal and professional capabilities. Riley stated, "…maybe I don't know what I'm doing…you go through that phase of insecurity, and you don't feel like an expert in your area…I don't want to be known as making mistakes" (Riley, Interview 2, Line 46). These therapists' statements illustrate their insecurity within their practice skills and in the therapeutic relationship, as the two are intertwined, in the profession of occupational therapy. There was a palpable sense of shame for therapists and a sense of extremely high expectation for themselves to be experts. Peer support with their most trusted therapist colleagues was a shared strategy for managing the insecurity they experienced in practice, even regarding small decisions about the relationship dynamics or aspects of their clinical reasoning.

Integrated discussion. I was fascinated that all therapists using the term "buy-in," and that from their perspective, other professions do not have to go through this step. They were envious believing that nurses, doctors, and physiotherapists for example, usually have an instant "buy-in" from their patients and clients. Occupational therapists know that they will most likely

have to spend a good deal of time, explaining what occupational therapy is, what our role and scope are, and then establishing a therapeutic relationship to engage in the holistic assessment process necessary to determine exactly how the therapist may be able to assist the individual client. This idea of convincing clients, selling the profession of occupational therapy like a commodity and themselves as individuals, was viewed as an essential part of establishing rapport and trust in the relationship - as if forming the relationship is used as a tool to "retain" the client. Maybe therefore, the relationship is viewed as the "glue" and the "main ingredient" to achieving outcomes. You cannot begin therapy in the first place unless the client "buys in" and agrees to work with you. It makes sense then that the therapists expressed how afraid they were to lose "buy-in" because of the amount of work and effort they described it takes to establish this with a client.

Occupational therapy is highly individualized, and it is not always concrete; the importance of creating a safe space where the therapist and client can explore the scope and holism of the profession is made possible through this level of trust to weather the uncertainty. Although more challenging, the individuality of each relationship could be our strength, our expertise. Rather than resisting and feeling ashamed of this uncertainty, therapists may consider embracing this part of our practice; celebrate the mystery and creativity in the process. I was left thinking, no wonder we struggle with this tension between "buy-in" and insecurity. How do we convince others if we are still trying to convince ourselves?

Benjamin (2004) raises a point in the psychoanalytic literature that I believe will resonate in the occupational therapy culture as well. She states that the "bad-analyst" feeling and the therapists' fear of feeling ridiculed and ashamed in front of their peers, is what inhibits our communication about these topics (Benjamin, 2004, p. 29). Benjamin (2004) states that

consequently, “the community and its ideals become persecutory rather than supportive” (Benjamin, 2004, p. 29). Correspondingly, all the therapists in this study voiced this opinion in our field of practice as well. They expressed their reservations to openly discuss their insecurities due to their fear of appearing incompetent in front of their clients, their funding sources, their peers, their supervisors, and their regulatory college. Benjamin (2004) suggests that psychoanalytical practice may benefit from accepting the value in the uncertainty, humility, and compassion experienced in therapy (Benjamin, 2004, p. 34).

Similarly, I believe that Mitchell’s (1997) guidance also resonates with the current occupational therapy culture. Mitchell (1997) encouraged psychoanalysts to find individualized solutions for each unique client and accept this as the goal of therapy, rather than look for generic approaches to treatment. The occupational therapy profession may benefit from integrating these understandings and adopting a more open acceptance of the therapists’ uncertainties in the relationship and practice. Mitchell (1997) states that the acknowledgement of the psychoanalyst’s own emotional struggles, including their self-doubt and uncertainty, is critical if they are to accomplish replacing their perspective of being all-knowing therapists, with being intersubjective therapists. I believe that this is the occupational therapist’s exact dilemma. Rather than focus on the futility of searching for the ultimate right answer, a knowledge of intersubjective dynamics is required to assist therapists to understand and navigate their inevitable uncertainties in the therapeutic relationship. I believe occupational therapists may benefit from embracing this idea of working in the grey zone, the only place where creativity, exploration, and dynamism are allowed to thrive. As Benjamin (1990) states, “a relational psychoanalysis should leave room for the messy, intrapsychic side of creativity” (p. 45).

Interpretive theme 2: self-protection and self-disclosure. The experience of the inherent tension between these opposed but related concepts was described by participants as most often associated with the maintenance phase of the therapeutic relationship. This internal tension between these two concepts experienced by participants was associated with the maintenance of professional boundaries in the relationship. The participants described an internal struggle. On the one hand, they expressed their desire to hide and protect themselves, establish boundaries, and maintain professionalism in the relationship. On the other hand, they expressed a desire to disclose their stories, histories, backgrounds and share aspects of their personalities to nurture and maintain therapeutic rapport. Participants revealed how their decisions differed in each client and relationship context. They conveyed that it is impossible for therapists to successfully approach every relationship in the same way. They experienced applying varied clinical reasoning and rationales for their use of self-protection and self-disclosure methods in each therapeutic relationship in which they were engaged.

Self-protection. This was a very meaningful part of the experience of building rapport in the therapeutic relationship for participants. All participants attributed high value to the requirement to protect themselves physically and emotionally in the relationship through the maintenance of professional boundaries. They described a sense of "hiding behind a mask" or the use of a "therapeutic face" to protect their personal information and personal selves from their clients. Participants all understood that professional boundaries were not only necessary to keep themselves and their clients safe but that these professional boundaries were the thing that made the therapeutic relationship unique from other significant relationships in their lives.

Participants expressed concern for their physical safety and well-being in the relationship and for health and safety of the therapeutic relationship overall. They were all decidedly

concerned that that the College of Occupational Therapists of Ontario (COTO) may be punitive towards them should they overstep their professional boundaries. Participants placed the greatest emphasis on self-protection as it refers to protecting their "personal selves," emotionally from being vulnerable with their clients. Many participants discussed the need to "compartmentalize" their emotions and expressed how they suppressed their humanity in the therapeutic relationship. Victoria provided the vivid metaphor of a "shield" for self-protection, "the shield…it's the self-protection for myself, but also the other person…We can have a therapeutic relationship, but they're never going to know me (Victoria, Interview 2, Line 226). Victoria continued her description of the use of a metaphorical "shield" to maintain boundaries in the therapeutic relationship:

> You pretend that you're there with the person but really, you've got this like metal shield all around and you're standing over here and the client is over there, and you just have this hole where you put the imprint of your face...it's like a mask…the therapeutic face…I put on my big metal suit and my face insert and I go in. (Victoria, Interview 1, Line 537)

Victoria's example brought to light a commonly experienced perception of self-protection in occupational therapy. The language used, "shield" and "armour," items that would be used to protect an individual from physical harm, were used to refer to the protection and guarding of their emotional and personal selves in the relationship. Victoria's statement, "they're never going to know me," lingered in my mind. Many therapists expressed a similar need to project a façade of strength and impenetrability while simultaneously choosing to suppress and deny the existence of their humanity and vulnerability. All participants believed this was a favourable method of maintaining professional boundaries in the therapeutic relationship.

Self-disclosure. Participants also expressed their desire to share their humanity with their clients. Diana stated in her first interview, "I'm human, you're human…I appreciate it, I value it" (Diana, Interview 1, Line 294). Most participants expressed their desire to effectively use self-disclosure to share of themselves to connect and develop rapport with their clients in the therapeutic relationship. All participants stated they lacked formal knowledge and understanding of how to conduct therapeutic self-disclosure effectively and appropriately in occupational therapy practice. However, they all articulated their recognition that self-disclosure was a meaningful part of the relationship to create a "human connection" with their clients. Caroline spoke about her difficulty with this concept in a way that reflected how most participants felt:

> That's one I struggle with a lot…how much to divulge and what to divulge…is it appropriate? …Should I be saying this? Is it too much? …That's definitely an area of practice that I struggle with (Line 142) …clients are so different right? There might be one client where you say something that you feel is completely appropriate…and then the next thing you know you're fired from the file…and you're like what did I say? ...You don't realize it. (Caroline, Interview 1, Line 144)

All participants expressed an internal struggle with knowing exactly where to draw their boundaries regarding self-disclosure in each client interaction. Although some participants had stricter boundaries than others, all of them stated that they used therapeutic self-disclosure to varying degrees in the therapeutic relationship. They highlighted that as community therapists, they are working in their clients' homes, without a clinical environment to unconsciously prompt the implementation of certain boundaries, and it can be more challenging to appropriately determine and maintain the professional boundaries of communication with clients within their

homes. They also desire to make their clients feel comfortable with having them visit them in their home environments and sometimes used self-disclosure towards this end.

Participants stated they frequently shared aspects of their sense of humour, common language, superficial personal information, life experiences, and some of their basic interests to build rapport. They all stated they tried to limit personal information sharing as much as possible. They all emphasized that they believed their decision to use self-disclosure was always in the best interest and benefit of the client, not for the therapist's benefit. Many recognized, if they were going to share a deeper personal emotional experience, it had to be something the therapist had fully healed or recovered from to be able to discuss it more objectively. Some participants also believed this assisted the quality of the rapport by diffusing the power differential. That it humanized the therapist, fostered trust, authenticity, and emotional connection, and open dialogue. Caroline and Jennifer explained how they understood the benefits of sharing a more emotional personal story when they "associated" with their clients' situations or experiences:

> I too have lived through that and it allows me to associate to them more… there's always going to be those moments (Line 98)…I think that [self-disclosure] is useful in the sense where it helps to maybe like normalize some stuff…maybe that client feels like they're living with it alone, that nobody else has ever experienced that similar situation …With those clients, I'm going to be a lot more open to share maybe more personal experiences to…help them see that they're not alone in it (Line 100)…I think that it facilitates the therapeutic relationship and it instills trust in the client. (Caroline, Interview 2, Line 104)

> It's usually about that emotional connection (Line 104) …I have to be at a stage where it's not raw. If I describe it as if I have my own emotions, that's a cracked shell. My shell, if it's open and exposed, I don't share a lot of information. Whereas, if I can close my shell a little…I can figure out a way to cover it and feel comfortable in my emotions, then I say you know what, it's OK for me to share because I'm not there to offload on my clients. (Jennifer, Interview 1, Line 108)

It was commonly expressed by participants that they believed the use of self-disclosure would accomplish a human connection and provide support to their clients in face of challenging experiences. The therapists' desire to self-disclose effectively, underlined the importance of remaining consciously aware of their emotional experiences. They intended to only share of themselves if they had successfully reflected, healed, accepted, and learned from their experiences before clinically deciding to disclose these experiences therapeutically in the best interest of a particular client. Participants also mentioned being able to identify with their clients' life roles including being mothers, wives, sisters, daughters, granddaughters, working professionals, and human beings. They explained that in these instances when they related to or "associated" with the client, they may be more likely prompted to empathize and self-disclose personal information to the client related to their experiences of those roles.

Integrated discussion. In the current occupational therapy culture self-disclosure is regarded as a taboo in violation of regulatory requirements and there is little to no guidance on how and when to implement self-disclosure safely and effectively in the therapeutic relationship. The COTO (2015) Standards for professional guidelines acknowledge the wide variety and complexity of influences at play in the relationship and state clearly that it is the responsibility of the occupational therapist "to use their professional judgement to prevent boundary issues from

arising and to establish and manage boundaries in a wide variety of circumstances" (p. 2). COTO (2015) recommends that occupational therapists should engage in "ongoing self-monitoring in therapeutic interactions and interpersonal relationships with clients to ensure appropriate boundaries are maintained" (p. 2). The College provides limited to no guidance on how to accomplish this in practice but emphasizes the importance of prevention of boundary crossings becoming boundary violations where the relationship becomes more personal which "may subject the client to harm" (p. 3). COTO (2015) encourages "professional detachment". This may indicate why the therapists' shared that they felt compelled by their college and culture to hide their personal selves and suppress their humanity and emotions as a means of protecting themselves, their clients, and the therapeutic relationship (p. 2).

COTO (2015) indicates that therapists are expected to have "reflective insight into intended and unintended interpretations of interpersonal relationships, words, or gestures during interactions with clients" (p. 3). All therapists in this study explained that they struggled with this in practice and felt disadvantaged by a lack of education and resources for how to accomplish this in practice in a wide variety of complex situations and interpersonal therapeutic relationship dynamics. The participants shared a great desire to self-disclose effectively with their clients but revealed they experience intense insecurity and uncertainty about how to practice this skill in each situation.

Participants felt they lacked discipline-specific knowledge about how to engage in safe and effective therapeutic self-disclosure. It was also revealed that in the community working environment, in clients' homes, there are little to no clinical environmental cues to assist in maintaining professional boundaries. I believe therapists have a great desire to make the client feel comfortable with their presence in the client's home and so also may be prompted to be lax

or change their boundaries depending on their clinical interpretation of clients' needs. How do they make these decisions? When to share? How much to share? What is it like to develop a clinical rationale for what to self-disclose with different clients? Is this always happening? Is it always conscious? Theoretically, participants understood they should only share personal emotional experiences if they had fully healed from them, but are they consciously able to achieve this in every relationship or are there other unconscious dynamics in the relationship that may impact their decision to self-disclose?

Occupational therapists receive limited formal training and support in the areas of counseling, relationship dynamics, self-psychology, intersubjectivity, and communication approaches and skills including empathy, required to engage in clinical reasoning regarding the safe and effective use of self-disclosure with a greater sense of preparation and consciousness. I support recommendations made by others, that occupational therapists would benefit from a more interdisciplinary education regarding these subjects (e.g., Nicholls, 2007). Taylor (2008) states that for occupational therapists to gain a greater understanding of these relationship dynamics and the use of self it is necessary to seek further education through a more interdisciplinary education (Taylor, 2008). Seymour (2012) acknowledges the need for more self-directed education in counseling and psychotherapeutic theories to achieve effective therapeutic use of self in occupational therapy (p. 58). My findings also strongly support that occupational therapy would benefit from more integrated education about intersubjectivity in the relationship; how to sustain their connectedness with their clients to allow the rapport to grow, while maintaining the individuality and perspective of two separate individuals in the relationship.

Benjamin (1990) states, “connection and separation form a tension, which requires the equal magnetism of both sides” (p. 38). This sentiment was expressed by the participants experiencing the tension between connecting with and individuating from the client; through both disclosing openly and guarding their personal self from the client. Benjamin (1990) states:

> What we find in the good hour is a momentary balance between intrapsychic and intersubjective dimensions, a sustained tension or rapid movement between the patient's experience of us as inner material and as the recognizing other. (This suspension of the conflict between the two experiences bears on the understanding of transitional space as well.) The opportunity to engage at both levels is, in part, what is therapeutic about the relationship. (p. 44)

Benjamin, (2004) discusses emotional authenticity in the relationship and clarifies the use of self-disclosure as, “more properly considered in terms of its function, which is to acknowledge the analyst's contribution…to the intersubjective process, thus fostering a dyadic system based on taking responsibility, rather than disowning it or evading it under the guise of neutrality” (Benjamin, J. 2004, p. 34). Many participants described compartmentalizing their feelings and emotions and denying their humanity as a common strategy used to maintain professional boundaries in the therapeutic relationship. I believe that occupational therapy is also striving to achieve this ‘guise’ of neutrality; instead, as Benjamin (2004) advises, therapists, require the understanding of their contribution to the intersubjective process. Occupational therapists too may benefit from acknowledging and allowing ourselves to become informed by our humanity and its impact on the clarity of our clinical reasoning.

Interpretive theme 3: responsibility and "planting the seed." The experience of the inherent tension between these opposed but related concepts was described by participants as most often associated with the disengagement phase of the relationship. This tension was related to the confusion and insecurity experienced by participants regarding their professional role in the therapeutic relationship. The participants experienced an immense sense of responsibility for the therapeutic relationship itself, for their client's well-being and safety, and for achieving successful treatment outcomes in therapy. At the same time, participants grappled with their obligation to respect their clients' autonomy, decision making, and responsibility for themselves. Therapists felt compelled to "empower" their clients, in the sense of guiding and supporting them to make their informed decisions and to collaborate and share responsibilities in the relationship with the client. In cases where clients declined a participant's recommendation, participants were comforted by the idea that their primary objective was only to "plant the seed". The concept of "planting the seed" was defined by participants as contributing information and education to advance the client's state of readiness to work towards their goals. Participants' perspective of "planting the seed" was that these "seeds" of knowledge and education were a contributing factor to clients' "empowerment." They hoped this information would assist the clients to make more informed decisions, when and if they were ready, even if it was not within the context or timeline of the therapeutic relationship.

Responsibility. Participants discussed their sense of responsibility to "do their job well," for the relationship itself, establishing professional boundaries, working within their scope and role, as well as setting realistic expectations for therapy. They all expressed an immense sense of responsibility for the facilitation of successful outcomes for their client. For this reason, therapists expressed experiencing internalization of the clients' successes and failures during treatment.

Participants commonly expressed feeling "guilt" that they hadn't helped their client the way they were obligated to within their role if the desired outcome was not achieved. Participants commonly experienced having great "sympathy" for their clients' situations and admitted to instances where they had stepped outside their role slightly to help the clients with something they were not certain they were responsible for. They justified these actions by stating it was because they are "caring" people who desire to help their clients in even some small way to provide a tangible outcome for them. Marianne explained her understanding of this experience which represented most of the participants' interpretation:

> I think guilt and responsibility is really tied into knowledge or confidence for that matter, so if you're not feeling confident or knowledgeable about what you're doing I think you're more prone to putting guilt on yourself because you're even unclear about what your responsibilities are (Line 52) …You're putting pressure on yourself; you're supposed to have all these great outcomes but then part of you isn't really certain what your role is, what you're supposed to be doing. (Marianne, Interview 2, Line 54)

Jennifer provided an example that reflected most participants' feelings of guilt, of not being able to impact or change someone's life for the better. She used the phrase "make a difference" many times during her interviews and explained she internalized a sense of guilt or failure when she felt unable to contribute something tangible for her client:

> It is guilt, it's sad for them, it's that you want to provide the absolute most care that you can and you can't do that as therapist (Line 230)...some of us want to go the extra mile to help and there's only so much we can do but you want to give everything and yes there is

> guilt there, it's that sense of failure, you're failing your client if you can't provide them with basic needs. (Jennifer, Interview 1, Line 232)

Most of the participants discussed how they experience internalization of clients' "successful" goal attainment and clients' inability or "failure" to achieve their goals. Many reported feeling that clients' abilities to reach their outcomes were a reflection on their performance as a clinician. The participants all viewed themselves as solely responsible for the therapeutic relationship which they understood to be the catalyst for the client to reach their desired outcomes (Crepeau & Garren, 2011). Marianne made an interesting comment, "we credit them more when they succeed but fault ourselves more when they fail" (Marianne, Interview 2, Line 44). Caroline described internalizing and manifesting the success of a client incorporating one of her recommendations:

> I did this! I helped with this (Line 138) …I always have this sense of excitement if a client integrates a strategy…there's actually been…a measurable functional outcome that benefitted the client…you're happier for the client but you're also happy for the fact that…you did something right! ...Something that helped (Line 140) ...I'll be smiling more, or I'll be more animated! ...It propels things more or it gives you momentum. (Caroline, Interview 2, Line 146)

Most participants shared that despite their wealth of knowledge, they still question themselves and blame themselves when things do not work out ideally in the relationship or treatment outcomes are not achieved. Marianne expressed how it felt to internalize a client not achieving their goal of preserving their skin integrity, despite her best efforts:

> I took on so much where I was like wow, if that wound doesn't heal for that client, that's my fault. Maybe I didn't give good enough direction? Maybe…I didn't get the best

> quality mattress that they needed with the funds? (Line 120) …You definitely do [take responsibility]! ...You build more associations with people in your life and compare and then feel like you have to do more. (Marianne, Interview 1, Line 122)

Marianne highlighted that she not only struggled with a sense of responsibility for the client's outcomes but she identified another interesting aspect of this experience. Marianne remarked that the intensity of her feelings of guilt were also influenced by her experience of building "associations" and "comparisons" of the client's situations to other people in her life. Most participants described the experience of being reminded of a grandparent, or family member while visiting a client, and that this caused them to reflect upon how they hoped their loved ones would be helped in a similar situation. This response influenced their desire to be "caring," to "go above and beyond," while also influencing their sense of guilt when they could not achieve desired outcomes with their clients. Most of the participants found it challenging to know in each different client situation and context, just what exactly they were responsible for in the relationship and their professional role. They found this particularly challenging during the disengagement from the relationship and with the decision to close a client's file. Herein lies the tension they experienced; the internal struggle between the therapists' sense of responsibility for the therapeutic relationship and subsequently the successful treatment outcomes, while respecting the client's decision-making, autonomy, and responsibility for their lives.

"Planting the seed." A meaningful aspect of the therapeutic relationship for the therapists was the experience of "planting the seed" for their clients. All participants discussed the value they placed on "planting the seed" which they defined as meeting a client "where they are at," in their current "state of readiness," "empowering" their clients to be autonomous and responsible for themselves and to "go at their own pace." Participants also emphasized their

difficulty in some cases with accepting clients as their own decision-makers, because the clients' choices may be perceived as placing them at significant risk of injury or illness. The concept of "planting the seed" appeared to alleviate the sense of internalized failure therapists experienced when treatment goals were not achieved, or clients declined their recommendations. This concept was described as helping provide the client with recommendations, resources, and education regarding the risks and benefits of their options to contribute to the clients' informed decision-making process, even if that did not happen in the context or timeline of the therapy. Diana illustrated her understanding of this sentiment by sharing an example of recommending a walker for a client who declined her recommendation at the time, but was ready to pursue the recommendation later:

> I suggested it, you didn't want it, now you've fallen, you ended up in hospital and now you want it…I've reflected on that, I guess it's something I should be pushing? Like no! Someone has a choice (Line 217) …Even if they have it, it doesn't mean they'll use it (Line 219) …But that's human, that's reality...There's readiness and acceptance…we specify the OT goals but when there's no more client goals why are we there? (Diana, Interview 2, Line 232)

The participants explained how there can exist discord between the occupational therapist's goals and the client's goals, even as client centred as therapists. Clients and professionals have different understandings of what constitutes client-centred practice (Townsend, Britnell, & Staisey, 1990). Many times, from our perspectives, our clients are not making the best decisions for their safety and well-being. Diana's example caused me to reflect on how we as therapists can best respect our clients' autonomy.

Like Diana's reflection I wondered, is it better to enforce a safety precaution that may not end up being used anyway? Or is it in fact, more therapeutic to respectfully accept the client's decline of the recommendation? This presents a challenge for therapists; the participants explained how they experienced "wrestling" with this difficulty that they may "know better" than their client, but that the client "knows themselves better." Participants described how they ultimately reconciled this tension by "planting the seed," which allowed them to achieve some sense of goal attainment while also respecting their client's state of readiness and decision-making autonomy. When "planting the seed" was accomplished, participants explained they could more confidently disengage from the therapeutic relationship with the hope that eventually their clients would be ready to consider and pursue their recommendations in the future.

Marianne felt the need, from day one, to help her clients be "empowered" to achieve their goals on their own. She believed that fostering any kind of dependency on her as a therapist was not going to prove helpful to the client in the long run. Many therapists emphasized this idea that "if I'm only helpful to you when I'm with you, when I leave you, what will I really have done for you?" In response to the anxiety created when clients decide not to follow the therapists' recommendations, the idea of "planting the seed" alleviated the concern they felt for the clients' safety and having completed their responsibilities in their role in a satisfactory manner. Marianne explained her understanding of this experience which represented most therapist's perspectives:

> I've still given them the information that's important to them that they could sit on and…hopefully planting the seed, eventually they'll utilize that information (Line 14)…I've done my role (Line 18)…I think part of our job is providing that education for people…we need to empower our client (Line 24) …So a big part of that isn't doing the

> goals for them, but it's giving them the information, so they can make those decisions for themselves. (Marianne, Interview 2, Line 26)

> Maybe they're not fully ready to receive it, but then you planted that seed (Line 283) … I think gauging that is important and knowing that, because then you feel like, well even though we didn't develop this long-term relationship you still developed a good therapeutic relationship…[That's] all that you needed to be able to help that person (Line 297) …It's big knowing when to close a chart. (Marianne, Interview 1, Line 299)

Gauging the client's readiness was viewed as a meaningful part in the therapists' decision-making for what "planting the seed" would mean for each client to meet their needs at that moment. This process was difficult to articulate for participants, they described needing to "read between the lines," and analyze the verbal and non-verbal cues of their clients to aid in their clinical reasoning. Jennifer illustrated this experience with the use of a metaphor:

> The therapist is holding one end of the rope, the client's holding the other end of the rope and the therapist is giving a little nudge…he gave a little slack and so I understood that as a cue saying wait a minute, if I just dive a little deeper into this then I can understand what's going on (Line 152)…reading between the lines (Line 162)…as soon as he gave me a little slack…that kind of tweaked some interest in him or disinterest, reading the body language…but what are those cues?...I'm sure there's about a million that are going on through that interaction. (Jennifer, Interview 1, Line 164)

Jennifer described the process of "gauging readiness" or interest in treatment recommendations as a multidimensional experience. The therapists' experience demonstrated

that this is a challenging decision-making process therapists undertake, to determine when it is appropriate to remain involved in the therapeutic relationship. It highlighted the clinical reasoning required in deciding whether to remove themselves and how to accomplish this in an optimally therapeutic way while respecting each client's needs and state of readiness. The participants described their attempts to reconcile this tension between these components required in the professional therapeutic relationship, using analogies like "a tug of war" or "a teeter-totter" that they must consider very consciously to keep balanced.

Integrated discussion. The current occupational therapy literature correlates the success of treatment outcomes to the nature of a successful therapeutic relationship, that the therapist is responsible for developing and maintaining (e.g., Cole & McLean, 2003). As Crepeau & Garren (2011) state, the therapeutic relationship is a mutual exchange between two individuals and that it is the responsibility of the therapist to establish and maintain an environment that will foster the development of the therapeutic relationship (p. 872). Therefore, it naturally follows that those occupational therapists would be at risk of internalizing their clients' success or failure in achieving those treatment outcomes and view the outcomes as a reflection on their ability to successfully establish a therapeutic relationship.

Benjamin (1990) states that internalization is, "a constant symbolic digestion process that constitutes an important part of the cycle of exchange between the individual and the outside…the loss of balance between the intrapsychic and the intersubjective," (p. 41). She states this is problematic because it is indicative that the therapist has lost an accurate perspective of reality (Benjamin, 1990, p. 41). Benjamin (1990) goes on to state that, "it is this appreciation of the other's reality that completes the picture of separation and explains what there is beyond internalization—the establishment of shared reality" (p. 42). There exists a shared responsibility

in the therapeutic relationship for each participant's role and contribution to achieving treatment outcomes. The therapists in this study were hesitant to acknowledge that truth. Although they appreciated that the client must be ready to engage and participate in therapy, they all felt an overwhelming sense of sole responsibility for the success of the occupational therapy relationship and treatment outcomes.

Gauging client readiness is another little investigated topic in the occupational therapy literature and remains elusive and difficult to define for therapists. Blesedell Crepeau (1991) highlights the importance and complexity of the therapist's ability to read the client's verbal and nonverbal cues appropriately and to calibrate the nature of the sessions in response to these cues (p. 1019). Therapists agree this is vital, but the occupational therapy research lacks a description of how this is achieved in practice. All participants discussed the difficulty with gauging the appropriate times to challenge clients to move outside of their "comfort zones" therapeutically while maintaining respect for client autonomy. However, all expressed a reverence for the process regarding the concept of "planting the seed" to make a tangible contribution to the client's well-being and alleviate their sense of responsibility and their concern that they had not fulfilled their roles, and to disengage from the therapeutic relationship more confidently. COTO's (2020) code of ethics highlights the values of respect and autonomy in the therapeutic relationship. Ultimately the most ethical and client-centered thing therapists can do is to accept that clients are their own decision-makers and that is where our professional role and responsibility ends. However, gauging client readiness to accept therapists' ideas was described by participants as an elusive part of this process and remains another unexplored part of the therapeutic relationship in occupational therapy research.

I believe that therapists experience a tension between their desire to do their job and fulfill their obligation through providing education and recommendations to maintain a client's safety and independence while respecting the clients' decisions which may place them at great risk of injury or illness. Hammell (2013) states, client-centred practice is foundational to occupational therapy; it focuses on "respect for clients; respect for clients' strengths, experience, and knowledge; respect for clients' moral right to make choices concerning their lives—and on fostering respectful, supportive relationships with clients" (p. 141). Therapists may find themselves in situations where they experience a sense of being torn between respecting their clients' decisions and trying to improve their client's environment or situation to increase their safety and independence. This is where "planting the seed" appeared to provide an alleviation of this tension for therapists. Participants explained they could fulfill their responsibility to provide the client with their recommendations, accept the client's decision to decline them, and still feel a sense of contribution to the client's knowledge of their available options for increased safety.

The nature of the therapeutic relationship. What was discovered to be the essence in the experience of developing, maintaining, and disengaging from therapeutic relationships for therapists, was "making a difference" or making "positive therapeutic change." Therapists expressed that feeling they had contributed to their client's quality of life, however nuanced, was essential and purposeful for them in the therapeutic relationship. It could be the smallest gesture, the correct interpretation of a cue from a client, or a more overtly tangible piece of equipment or treatment service. I was left wondering how therapists define successful outcomes or relationships. What is it like to successfully "make a difference" in occupational therapy? All the therapists expressed that what was meaningful to them about the therapeutic relationship in practice, was that "it meant they could do their job." The relationship was the means through

which they were able to "make a difference." Whether in the development phase working to achieve client "buy-in," in the maintenance phase employing self-disclose to maintain rapport and connection, or in the disengagement phase while "planting the seed," the therapist's inherent desire to contribute meaningfully to the relationship and treatment was unanimous.

Another essence that emerged regarding the nature of the community therapists' experience of developing, maintaining, and disengaging from the therapeutic relationship for occupational therapists was a profound sense of self-doubt. The occupational therapy literature emphasizes the association between the therapeutic relationship and successful treatment outcomes (e.g., Cole & McLean, 2003). Therapists are encouraged to use their virtuous qualities, therapeutic techniques, and skills to avoid challenges or boundary crosses. The essence of this experience for participants was a palpable sense of doubt. Within each tension, within each phase of the relationship, participants expressed an essential, ever-present, and meaningful sense of doubt. This aspect of the experience proved to be problematic, frustrating, and informative for therapists. Throughout each phase of the therapeutic relationship, they experienced doubt in their professional scope, boundaries, and role within each unique relationship. It is a doubt that is experienced as shameful because therapists expect themselves to be confident, competent, experts. The participants shared that they suffered in silence, for the most part, hiding this doubt from not only their clients, but from their employers, funders, supervisors, and peers. I was left wondering how such an inherently supportive profession could completely lack a safe and compassionate, cultural environment for their own support needs?

Chapter 3 summary and discussion. The current occupational therapy literature paints a rosy picture of the beauty and reverence for the therapeutic relationship. Occupational therapists expect themselves to be experts in developing and maintaining therapeutic relationships with

their clients. It is well established in occupational therapy culture among therapists, that the relationship is the cyclical cause and catalyst for the successful outcomes in therapy (e.g., Cole & McLean, 2003; Crepeau & Garren, 2011; Morrison & Smith, 2013). Therapists are expected to be responsible for the relationship and therefore their clients' successful outcomes are understood to be reliant on the nature of the relationship (Crepeau & Garren, 2011).

As evidenced in this study, therapists do not experience being "experts" in this subject matter. Therapists experience a great sense of self-doubt in the therapeutic relationship, compounded by their sense of doubt in their professional scope of practice, and in their ability to clinically reason in each client interaction to establish and maintain professional boundaries. They experience doubt in their professional role, obligatory responsibilities, ability to gauge client readiness, and when to discharge a client from therapy. Although there exists a cultural expectation of neutrality, the participants expressed that they are not neutral, virtuous entities but human beings with valuable emotions, life experiences, and an inextricable drive to contribute to their clients' lives thoughtfully and meaningfully.

In the current occupational therapy literature, Taylor (2008) has presented a formulaic approach to the use of basic communication styles in the therapeutic relationship. Therapists in this study revealed that from their perspective, it is never that simple and an approach that works for one client may be catastrophically wrong for another in a similar situation. This study provides insight that every client's therapeutic needs in the relationship, as well as every therapeutic relationship, are unique. The therapists' descriptions of their experiences indicated that a limited number of basic approaches, suggested by Taylor, (2008) do not provide the knowledge that is necessary for successful intersubjective dynamics and communication in the therapeutic relationship in occupational therapy. This study demonstrates the reality of the

greater mysterious, nuanced, cumulative gestalt of each unique relationship. Therapists are highly attuned, careful, and conscientious beings who are attempting to thrive in the exploration, creativity, and mystery of the therapeutic process.

Communication approaches are not always formulaic or mutually exclusive, as the IRM suggests. Categories of communication approaches will not work with everyone for every unique situation presented to the therapists. Such a limited and basic introductory view of communication approaches does a great disservice to the depth and complexity of the occupational therapy therapeutic relationship. Therapists are being asked to engage in therapeutic relationships that require a great deal more advanced knowledge and skills regarding intersubjective dynamics. This idea is also proposed by e.g., Taylor 2008, 2009, Seymour 2012, and Nicholls, 2013a. The participants recognized that a more comprehensive, complex dynamic between two human beings is occurring in these interactions. Occupational therapists would benefit from a more thoughtful interdisciplinary education regarding the associated concepts and skills required to navigate the complexity of these interpersonal dynamics.

In the therapeutic relationship, occupational therapists do not operate in black and white but in a constant state of grey. The relationship involves a dynamic process of constant reflection, assessment, re-assessment, analyzing, rationalizing, and communication to inform ourselves and our clients. Occupational therapy must be reassured that as Henry James states, "excellence does not require perfection." Excellence can include our ability to embrace and celebrate being in the grey zone, the only place where creativity, exploration, and dynamism are allowed to thrive. As Benjamin (1990) states, "a relational psychoanalysis should leave room for the messy, intrapsychic side of creativity" (p. 45).

The findings of this section begin to open a conversation about how clients and occupational therapists are multifaceted human beings, engaging in complicated intersubjective relationships. Neutrality in occupational therapy may be futile and as Buddhist teacher, Ethan Nichtern states:

> Neutrality…is based on the safety of not having perspective. Neutrality comes from the privileged myth that we might get away with nonparticipation. But we are already participating, and we are already implicated in human experience. That's why we feel so much. (Nichtern, 2019)

By assuming that we should already be experts, we limit our exploration to learn and better understand the therapeutic relationship. It is necessary to explore the reality of the good, the bad, and the ugly of the therapeutic relationship in occupational therapy if we want to improve our understanding of this experience and our practice. All participants expressed their shame in admitting they are the most confused about an aspect of practice in which they felt the most obligated to have expertise - the development, maintenance, and disengagement from the therapeutic relationship.

Chapter 4: Descriptive Findings and Discussion

The Experience of Countertransference

Countertransference can be defined from a *totalistic* perspective, as a concept that encompasses all the therapist's emotional and physical responses as they process and respond to the verbal and non-verbal communication of their clients (Jacobs, 1991, p. xvii). Countertransference is a complex interplay of life history, repetition of emotion, thought, and behaviour within this intersubjective field (Geltner, 2013). What does it mean to experience countertransference and strong emotional responses to client content in the therapeutic relationship? The phenomenon of strong emotional responses to client content is illustrated through the therapists' embodiment of these experiences. This section explores the visceral, physiological, and lived-through aspects of the therapists' experiences and presents how they interpreted those signals to inform their clinical reasoning and decision making. In some cases, the therapists seem to have allowed these responses to manifest unconsciously in ways that impacted the therapeutic relationship. These physical responses representative of the embodiment of the experience in this study include, heartbeat increasing, cheeks flushing, feeling hot, feeling heavy, and drained. These responses manifested in behaviour that impacted the therapeutic relationship including for example transferring a client prematurely, over-identifying with a client, or experiencing physical exhaustion and mentally "breaking down."

To remain true to a phenomenological method, I did not engage in psychoanalysis of the therapists' experiences. I present the examples of lived through countertransference and its manifestations in the therapeutic relationship in occupational therapy, in the therapists' own words. Throughout the interviews, due to the nature of the subject matter, some therapists did self-reflect while providing their answers which allowed them to achieve greater insight into the

potential subjective, unconscious influences at play in their relationship dynamics. True to phenomenology as well, I recognize that my own subjectivity will always be present and integrated into the phenomenological writing of these accounts.

All occupational therapists in this study admitted they lacked comprehensive knowledge of countertransference. Many understood, after reading the preparatory document I provided, that countertransference occurs when the subconscious mind influences our communication and behaviour in the therapeutic relationship and that it is occurring all the time, without our full awareness. The participants recognized the requirement to self-reflect, to reflect on the different relationships, client contexts, and their interactions experienced in practice to better understand this topic.

Most participants said they were very confused by the concept of countertransference or that they were not familiar with it before the short introduction I provided in the study's preparatory document. Diana's statement reflects the participants' overall sentiment on the subject, "transference and countertransference, I think it's one of those things that does need to be defined better for us because it does make you more reflective," (Diana, Interview 1, Line 368). She later added, "it's checking, knowing boundaries, asking questions, reading what's going on…it's intense" (Diana, Interview 1, Line 386). Marianne stated, "we all have different coping skills and baggage, biases, past life experiences that we've come through" (Marianne, Interview 2, Line 146). All participants shared that they are not actively engaged in examining potential countertransference in the therapeutic relationships they engage in. As Judy declared, "I would never sit down by myself and think in my relationship with client A, is there countertransference happening? ...You're never taught that, why would you ever think that?" (Judy, Interview 2, Line 38). This supports a study by Bright et al. (2012), who state that a

limited number of occupational therapists engaged in serious reflection about or felt confident in their abilities to create therapeutic relationships.

The word “baggage”, with its negative connotation, was used by multiple participants regarding countertransference. The use of this word indicates that these participants perceived countertransference as unresolved emotional experiences that may weigh down the therapist and hinder the relationship. All participants expressed not thoroughly understanding how countertransference may impact the relationship but seemed wary of its ever-present potential for distorting the roles and relationship dynamics. All participants expressed they did not confidently know how to recognize when it is happening, and when it may be helpful or harmful in the relationship communication or dynamic. Caroline explained she thought she did not have enough insight and admitted not having reflected enough on what makes her frustrated and why.

> I don’t think that I have enough of an awareness…to think why am I frustrated? Where does that come from?...I don’t think that I’ve thought about it enough or reflected on it enough, like for me personally to know why it makes me frustrated. (Caroline, Interview 1, Line 229).

Caroline later added that she was unaware therapists were required to have a working knowledge of how to recognize and manage countertransference or that this is a standard of practice for professional boundaries required by the College of Occupational Therapists of Ontario (COTO, 2015). This underlined the fact that despite the cultural notion that occupational therapists do not have to deal with their clients’ strong emotional content, in fact, therapists are faced with it frequently and we are at a loss as to how to deal with it (Daniel, 2013). Caroline emphasized this cultural distinction between professions and associated skill sets:

> We're less trained like a psychologist or a social worker…they have training on how to manage it…there are so many complexities and things that we don't kind of expect to have to deal with and then when you're in those situations you're like, 'oh my God I'm not a psychologist.' (Caroline, Interview 1, Line 285)

The point being community occupational therapists are in clients' home environments and faced with similar relationship dynamic complexities that psychologists or social workers would encounter. The participants all reported having received no formal education about countertransference, nor had they spent any time studying this subject themselves. All participants believed they discovered some related skills for countertransference management intuitively on their own over time. Jennifer stated, "it's not talked about, it's not engrained where I know exactly what that is (Line 214) …it's a disadvantage that we don't understand it enough to say this is what's impacting my practice" (Jennifer, Interview 1, Line 218).

Victoria highlighted the issue that exists in occupational therapy culture that countertransference, particularly subjective countertransference identification, is solely seen as something to avoid, deny and repress. Participants expressed great fear of being emotionally vulnerable in the relationship or identifying too much with clients. This was understood by participants as being taboo and risky behaviour and they did not even acknowledge having to deal with it. Initially many outright denied that they ever allow themselves to identify with clients. This emphasis on the ability to suppress their human emotions was expressed by most participants and captured in Victoria's statement:

> It's always a risk every time you have a therapeutic relationship. For me, it's always the biggest risk, every time and I prime myself…not to identify…because I really truly

> believe that's the way to burn out…it makes you emotionally vulnerable again. (Victoria, Interview 1, Line 757)

The statement "it makes you emotionally vulnerable again" lingered with me, it indicated that this is a cycle for therapists of experience and suppression. They have let their humanity and vulnerability show in the past and they fear they will do it again. They discussed experiencing great discomfort with their emotions in therapy as if they were "forbidden" in practice. They expressed confusion about how and when to apply self-reflection and self-awareness rather than suppression and denial. They expressed not always feeling prepared to therapeutically explore or contain the intense emotional content of their clients' lives that they were frequently faced with. Interestingly, all participants began to disclose, predominantly in their second interviews, that they recognized that there were times when they were not able to suppress their emotional responses to their clients.

> Clients…may be going through super emotional times that resonate so deeply with you…you step away from that session and you just feel so off, or you feel completely emotional, or that it affects your mood, or the rest of your day…we deal with a lot of sensitive subjects…yes we're clinicians but we're also people…you can't take the person out of the Clinician. (Caroline, Interview 1, 216)

Integrated discussion. The College of Occupational Therapists of Ontario expects that all occupational therapists have a working understanding of how to recognize and manage countertransference responses in the relationship, not just those practicing psychotherapy. The 2015 Standards for Professional Boundaries of the College of Occupational Therapists of Ontario discusses the significance of countertransference knowledge for its registrants. COTO (2015) provides the following definition of countertransference:

> Just as clients transfer attitudes to the therapeutic relationship, OTs themselves may experience countertransference. Countertransference is the emotional reaction of the OT to the client's attitudes. Countertransference may take the form of negative feelings that are disruptive to the client-therapist relationship but may also encompass disproportionately positive, idealizing, or even eroticized reactions. Client and therapist expectations, conscious or unconscious, may be influenced by transference and countertransference. (p. 4)

As per "Standard 3" on the topic of professional boundaries, the theory of transference and countertransference are important considerations for occupational therapy practice (COTO, 2015, p. 9). COTO (2015) states that it is important that occupational therapists are consciously aware of their feelings and emotions and reflect on what may be the result of transference and countertransference in the relationship (p. 9). They support that conscious awareness of this process will assist occupational therapists to manage these feelings and not act on inappropriate emotions, thereby preventing possible boundary violations (p. 9). It is therefore a requirement of COTO that occupational therapists understand the causes and effects of transference and countertransference to anticipate, identify and manage these reactions as they relate to either conscious or unconscious vulnerabilities in the therapeutic relationship (COTO, 2015, p. 9). Occupational therapists are expected to meet performance indicators to recognize dependence, co-dependence, transference, countertransference and to effectively manage the presence of these dynamics (COTO, 2015, p. 9).

The results of this study support Nicholls's (2007) statement, that currently, occupational therapy lacks a deep consideration of the unconscious aspects of communication and how this impacts practice (p. 56). It also supports Nicholls's (2013a) contention that it is important to

recognize that the therapeutic relationship in occupational therapy has the potential to be as emotionally complex, challenging, and rewarding as other close relationships can be (p. 18). It is important that therapists be in tune with their inner world of emotions, through reflection personally and professionally, accepting and understanding our humanity, not suppressing, or denying it. There is a depth and wealth of knowledge that remains untapped for occupational therapy regarding how countertransference reflection may inform our clinical reasoning. It may help us achieve optimally undistorted, proportional, and accurate responses to client content in the relationship.

Gathering accurate information for clinical reasoning is necessary to be, as COTO (2016) describes a conscious decision-maker. COTO (2016) expects occupational therapists to have "conscious competence" which serves as a fundamental concept within the College's Quality Assurance Program:

> The College defines a consciously competent practitioner as one who knows his or her strengths and limits, knows the standards, guidelines, and rules, and the values behind them; makes good choices consciously and deliberately, and is able to explain why he or she took a particular course of action. (COTO, 2016, p. 2)

The participants in the study all agreed that awareness of countertransference provided valuable knowledge they would benefit from in practice. The examples presented in this chapter provide an introductory understanding of how occupational therapists experience their countertransference responses in the intersubjective dynamic of the therapeutic relationship. These experiences fell under three descriptive themes: fear (therapists experience physical vulnerability), sadness (therapists experience emotional vulnerability), and frustration (therapists experience social vulnerability). I will discuss each of these themes in turn.

Descriptive theme 1: Fear: "A canary in the coal mine" (therapists experience physical vulnerability). Fear was a meaningful part of the greater experience of countertransference in the therapeutic relationship. Emotions provide us with a medium of information that can be used to evaluate external threats as beneficial or threatening, these interpretations are shaped by our survival instincts and life experiences. The descriptive, pre-reflective theme of fear describes the emotional and visceral fear therapists feel for their physical safety in the therapeutic relationship. Although it is important to acknowledge this was the rarest response to client content, it is also significant as every participant had at least one example to share. Participants all described instances of experiencing the protective "fight or flight" response of their sympathetic nervous system and expressed how they felt physically vulnerable. Participants struggled with having to place themselves in harm's way at times as they attempted to assist their clients. The participant emphasized the importance of preparation, intuition, and maintaining their physical safety as meaningful parts of their practice.

The language participants used to describe these encounters included, "discomfort," "red flags," being "creeped out," feeling the "heebie-jeebies," feeling "whole body shivers," finding themselves in "dicey situations," and getting "bad vibes," when interacting with certain clients. All participants discussed concerns for their physical safety while working in the community. They all had experienced at least a few instances of strong emotional fear responses resulting in a "hypervigilance," the "fight or flight or freeze response," and feeling "threatened" (overtly or potentially) when responding to client aggression (verbal and physical). They all experienced instances where they had a powerful sense of urgency to "get out of there" immediately.

They all expressed concern in some situations for their health and safety when entering extremely unhygienic or dangerous environments including spaces with infestations, cluttered

garbage, cigarette smoke, weapons, illicit drugs, and drug paraphernalia. They also reported concern regarding aggressive animals, other aggressive family members, or unexpected visitors in the clients' homes during their sessions. The participants illuminated the reality of risk that exists in their community practice environment and the importance of protecting themselves, advocating for their occupational health and safety while accepting some risk in doing their job.

Some participants described being stalked online, harassed over the phone or through text, and receiving inappropriate comments or behaviour from clients or their family members. It resonated powerfully with me that multiple therapists shared that they would not even tell their husbands about some of the places they have been because they would make them "quit their job." They also felt they lacked a sense of security in the current occupational therapy culture to openly discuss these concerns for their safety for fear of appearing judgemental towards their clients. Most participants described how occupational therapists normalize this fear as part of their job and minimize their level of risk. Many participants, including myself, had experienced being sent in somewhere, only to speak with the referral source afterward who judged that it was never safe or appropriate for the therapist to have been sent there in the first place. All participants reported being upset by these instances and feeling that their safety as human beings was overlooked by their referral source.

I will present the participants' strong emotional and visceral countertransference responses to client content and behaviour. The examples demonstrate how fear was experienced as an objective countertransference response related to situations where serious, physical danger seemed imminent. Although all responses will always be in some part influenced by the therapists' subjective knowledge, feelings, and beliefs, I believe these examples illustrate genuine fear-invoking stimuli as described.

Victoria provided a description of her fear experienced in response to an encounter with a client from her community practice. She introduced her example by stating that this client had led her to the back of his house in the middle of the woods. She described the client as "really challenging…you didn't feel quite safe with him...Oh I had the heebie-jeebies you wouldn't believe it" (Victoria Interview 1, Line 671). She stated she sat in the "classic" chair nearest the door. This was a commonly expressed manifestation of a sense of feeling distrust of the client, wanting to be close to the door, and accessing a clear path to "escape" immediately if required. She described this client's behaviour as aggressive, swearing and pounding his fists on the table, demanding that she assess his basement. Victoria elaborated more on her visceral response to this client's verbal and nonverbal communication and content:

> I was feeling nauseous suddenly…my entire body's…shaking on the inside…there is something really wrong…you're suddenly really attuned to what the person is saying, the way he looks at me, the way he positions himself…it was gross…if there was ever going to be a dangerous situation in my life it's right here today. (Victoria Interview 1, Line 671)

Victoria shared an anecdote that was very poignant and represented most therapists' experiences of fear; it brought into focus the sense of child-like vulnerability therapists experience in community practice:

> It felt like…when your mom tells you when you're a kid, if something doesn't feel right…if it doesn't feel good you know it's wrong, get out of there… it's a gut feeling…you feel your blood pressure going up and you're not sure why…Is it a smell in the house?…Is it something I'm observing?…Maybe I need to take it serious…it's fight

> or flight and suddenly I feel like I need to run…you need to pay attention…I need to be aware, I need to be careful. (Victoria, Interview 1, Line 671)

Victoria explained that in response to this client's verbal and physical behaviour, her visceral fear manifested in a flight response, "I worked my way out of it…weaseled my way around this whole thing, went out and I went I am never going in that house alone again" (Victoria, Interview 1, Line 669). Victoria continued her story, sharing that she did formulate a plan to go back to the client's home, accompanied by the social worker. The case manager was also involved and was going to call the police if they had not called her an hour after the session had started. She explained that during this visit, they saw the other side of the basement door, where the client had so adamantly demanded Victoria go to assess him, and it was covered in locks. Victoria stated she had many stories like this, and she made a statement that lingered in my mind; it clearly articulated the genuine fear community therapists experience. "I'm in somebody's house and it's winter and I'm in my socks and I'm thinking, how far can I run in my socks in the snow?" (Victoria, Interview 1, Line 685). Victoria provided a metaphor that captured the unconscious aspects of the interaction as well:

> The red buttons (Line 142) …the alarm's going off…sometimes I don't even know if I have red buttons that are lurking under something else, and I don't even know if they're there and I find that I can be surprised by myself. (Victoria, Interview 2, Line 144)

Victoria's example represented elements of many stories shared by therapists, notably that they all had experiences where they felt objective fear response evoked by a client's behaviour, and that they struggled with an overwhelming drive to assist their clients despite the risks to their physical health and safety. Many participants reported using strategies like texting a trusted co-worker before and after appointments or returning to the client's home accompanied

by another provider such as a social worker. Participants experienced a strong sense of obligation and responsibility to help their clients while considering their physical safety and experienced difficult decision-making processes to determine if it was appropriate to disengage from the relationship.

I had shared a similar experience in my interview. While practicing in the community, there was a situation where I felt most at risk and fearful for my physical safety. I remember being scared from the second I walked into this client's home. I was taken by his family member through multiple doors into a room; due to the client's condition, the room needed to be completely dark. Sitting in a pitch-black room, I immediately felt that I should not be there, that I had misstepped. All I could focus on was how I was going to get myself out of there immediately. When I reflect on this experience, I can still feel the hair on the back of my neck stand up and my shoulders shudder. In the dark, I had only my other senses to rely on, I could only hear him. I could hear his heavy breathing and movement as he transferred from his bed to sit in a chair next to me. I had no idea where the door was in the room. My ears were straining to hear, and my eyes were straining to see. He sat close to me, hearing his voice next to me, up higher than me, I could sense he was tall. As he spoke about his pain and anguish, I remember tears rolling down my face. I felt deep compassionate sympathy for this client and his family. At the same time, I felt as though, if I'm ever in trouble, it is right now. He was so angry, yelling and pounding his fists on the arms of his chair. I was aware he was not angry at me but at his situation, although being unable to see his movements or read his non-verbal cues, I felt a strong need to pacify him and remove myself. I thought I've got to stay in the moment and carefully listen to him. Like Victoria, I experienced a fight or flight response as well as hypervigilance in

the moment and a sense of urgency to remove myself. This was determined to be an inappropriate occupational therapy referral and I was asked to discharge the file.

Integrated discussion. Participants discussed the reality of unconsciously suppressing their humanity, their safety needs, and the level of risk they accepted in community occupational therapy practice. I believe the emphasis on client-centredness and compassion in occupational therapy may be a contributing factor that prevents therapists from openly discussing these experiences as they may be misconstrued by their peers or supervisors as the therapist being judgmental or uncaring. A greater understanding of this countertransference response may provide therapists with a deeper knowledge to inform their clinical reasoning in these significant moments, where both the health and safety of not just the client but the therapist becomes a concern.

The occupational therapy therapeutic relationship involves both a physical and emotional vulnerability, an open acceptance, and trust of the client. All participants agreed and expressed the common experience that their desire to help people was so great that they were willing to put themselves into reasonably unsafe situations out of both a "drive" to help others and a feeling of obligation to do their job. Even before therapists open the door, they have a preconceived idea that this client needs their help; however, it is imperative that both the client and therapist feel safe for the therapeutic relationship to be established and thrive.

The participants in this study were all women, and many discussed being taught from a young age to protect themselves physically, particularly against men. They recounted being told by their mothers to never walk alone at night and to hold their car keys to be used as a means of protection if they were attacked. Although I believe this topic requires a separate research project to thoroughly investigate, it is significant to mention this was a meaningful concern for the

participants in this study. All participants acknowledged this as their reality and a noteworthy component of the therapists' experience in community practice. I also acknowledge that there were no male participants in this study, which is a limitation of this study, and their voice and experience of fear is not fully captured by female therapists' experiences in this study.

Descriptive theme 2: sadness: "a heavy heart" (therapists experience emotional vulnerability). Sadness was a meaningful part of the greater experience of countertransference in the therapeutic relationship for the participants. The emotion of sadness is another one of our most basic and universally experienced emotions. All participants expressed examples of objective and subjective sadness as an emotional response to their clients' content in the relationship. Participants reported difficulties in understanding how to engage in therapeutic empathy and preventing countertransference manifestations from distorting their empathic response.

Victoria noted how occupational therapists are connecting with their clients at the most vulnerable and unhappy times in their clients' lives. Clients' feelings of grief and loss, in a variety of contexts, were commonly experienced in the therapeutic relationship. The participants shared objectively sad situations that caused them to feel sadness in response to their clients' content including working with dying clients, clients living in low income, subsidized housing, shelters, or hospices. As well as clients who had committed suicide, experienced the death of a loved one, divorce, abuse, addictions, mental health crises, families breaking up, relationships disrupted, poverty, homelessness, loneliness, neglect, and clients living in unhygienic or severely cluttered environments. Participants commonly used descriptive language including, "heavy," "too much," "exhausting," "draining emotionally," "hold your ground," "bothered morally," and "depressing" to describe some of these responses.

All participants agreed it is often not just the client they are counseling or educating. They also communicate with the clients' caregivers, loved ones, family, and other health care providers. All participants had experiences of having files where the situation made them cry in private. All participants had experiences where they felt emotionally connected to their clients, especially long-term clients with whom they had spent years working. It is important to acknowledge, as noted above the many situations occupational therapists face that are objectively sad, all situations in the therapeutic relationship that cause the therapist sadness, have the potential to be influenced in some ways by the therapists' subjective thoughts, feelings, beliefs, or memories. The sadness appeared to be attributed to a particularly high frequency of subjective countertransference experiences in the therapeutic relationship.

To demonstrate strong emotional and visceral countertransference responses to client content and behaviour, the theme of sadness will be described including participants' manifestations of subjective countertransference experiences of sadness. Subjective countertransference identification, unexamined misuses of empathy, and overinvolvement were common manifestations of subjective countertransference experienced in the relationship. I was left wondering, why do we become more emotionally attached to or saddened by certain client content?

Marianne described the role distortion in the relationship that came to her mind when picturing countertransference in the relationship:

> Two people sitting down and crying together (Line 456) …You're feeling too much of what they're feeling…they don't want me to break down, people don't want to feel pitied. They want to be able to cry to somebody else (Line 458) …I don't want them to

> feel like they need to comfort me (Line 460) …It makes them the parent and you the child. (Marianne, Interview 1, Line 462)

Jennifer provided one such example. She described sharing something very personal she normally would not share with any of her other clients, but because she identified with this client and their situation, she disclosed personal private information. She described the situation; it was a young client who was pregnant, and she had experienced multiple miscarriages beforehand. Jennifer shared that she had just gone through a miscarriage, just months before working with this client. She discussed how she decided to disclose this information to her client and reinforced that she would not share that information with any of her other clients. Jennifer thought about why she had decided to share personal information that was uncharacteristic of her to share. She stated it was because the client was pregnant currently and did not want to lose her baby and so Jennifer felt compelled to share her story to provide the client with understanding and empathy. Jennifer further elaborated that she decided at that moment to share this private story because she identified with this client's struggles and emotions. She explained that in that counseling piece of the therapy session, she just felt it was "appropriate:"

> She was struggling with the thought of it, the emotion of it, the impact of it and I just wanted to share with her that she wasn't alone and…to make that connection with her (Line 96) …I saw that she was struggling, and I've been there, and I can totally relate to that situation she was in. (Jennifer, Interview 1, Line 98)

Jennifer further described how this subjective countertransference identification manifested into the act of giving this client a gift. She realized this is something she normally would not have done for other clients. In her reflection, she began to doubt herself and felt unsure if she had done the right thing for this client in the relationship, had she crossed a

boundary? She described feeling pulled by this client to give something to her to alleviate her pain. Jennifer explained how the client discussed her discomfort in her pregnancy, so Jennifer brought her a pregnancy support pillow that was gifted to her, but she had never used. She clarified that although she did not physically go out and purchase the pillow it was in her ownership, and she doubted her reasoning.

> I feel like I am justifying it right now (Line 238) …I can't put a pin on it to say why would I help this person versus this person, I think it's something within us that triggers that emotion to say I need to do something, or I need to say something. (Jennifer, Interview 1, Line 242)

This example of subjective countertransference and identification resulting in both a personal sharing of information and an act of gifting a personal item that the clinician normally would not do with her other clients, was intriguing. I further explored this example with Jennifer in her second interview. Jennifer discussed the "connection" she felt to this client because she identified with her, as a "young mom." She expressed the guilt of having more resources than this client did, and she expressed her recognition that it would have been difficult for this client to receive funding for this type of item. Jennifer stated, "she couldn't go out and purchase all the wonderful things that she would like to" (Jennifer, Interview 2, Line 98). Jennifer also emphasized her drive and desire to make a tangible difference in this client's life, a helpful contribution to her assist her in her struggles. She stated, "that was my driving force in giving it…such a simple gift would be so impactful for this individual's life" (Jennifer, Interview 2, Line 98). Jennifer described how the client was thrilled by the gift, and it provided her with a great deal of additional comfort and increased quality of sleep:

> I think that empathetic nature towards her, I kind of felt bad that she was experiencing so much pain…and if I could make a difference just by alleviating some of that pain, helping with the comfort relating to that pain that would just make a world of a difference…to help her out. (Jennifer, Interview 2, Line 102)

Jennifer's responses highlighted her confusion around whether she did the appropriate thing in this instance. She was unsure whether it was about relieving the client's discomfort or alleviating her need to do something for the client in this difficult situation. Jennifer stated, almost defensively, that it was her professional and emotional opinion, she did not think she had crossed a boundary in this instance, she acknowledged that there is a regulatory college and literature about professional boundaries that may indicate that she has crossed a boundary causing favouritism, but Jennifer said she did not see it that way. She acknowledged that she experienced some personal relief in gifting the item to her client as well. What was very meaningful in her story was that she said it also made her "feel good":

> It made me feel good and I say that with hesitation (Line 108) …I just felt as though this woman was in need and I needed to help her, and this was the best way that I could help her in such a quick, easy, and effective manner and honestly, it made me feel good (Line 112) …why do we go above and beyond for some clients? I think it depends on how they impact us as an individual. Some people pull on our heartstrings much more and that's when we just try to go above and beyond for whatever reason. (Jennifer, Interview 2, Line 116)

When Jennifer said, "some people pull on our heartstrings for whatever reason," it resonated with me. Jennifer emphasized her good intentions, the relief she felt, the validation in being good at her job, and the recognition that something happened here that caused her to go

"above and beyond" for this client. She transparently admitted that therapists do experience instances where "our heartstrings are pulled" which made it more clear to me that therapists are lacking an intersubjective understanding and language to apply to their reasoning in these situations. Therapists can and do emotionally identify with their clients and as a result, are sometimes "pulled" to act in ways they normally would not.

Riley provided another example of this subjective countertransference and identification with a client who was going through a struggle with her mother. Riley felt uncharacteristically pulled to physically connect with this client either by hugging her or taking her hand to show her support.

> As she was talking, in my head I was thinking I just want to hug you right now and that's what my mind was saying. So, I think that when I made the decision to just take her hands and saying I acknowledge you are working hard, I acknowledge you are doing as much as you can right now (Line 184) …I just felt her pain, I felt her struggle (Line 188) …in terms of her frustration and anger…I think I picked up on… she's having a lot of struggle. (Riley, Interview 2, Line 190)

Riley stated this is not something she normally feels with other clients, she initially denied it but then she slowly realized, as she reflected, that she did identify with this client's struggles. The client was taking care of her mother who was ill and had an extremely difficult personality. Riley stated when the client spoke about her mother, Riley recalled memories of her grandmother. Riley described witnessing her father go through a similar struggle with her grandmother.

> Maybe I do identify with her struggle with her mother…maybe that's what I identified with, I never really thought of it like that, but I never had to deal with my grandmother…I

> was distant from her because of how she was, but I watched my parents have to deal with my grandmother. So, I guess I did identify with her (Line 190) …So, the question then becomes did I make a mistake?" (Riley, Interview 2, Line 196)

Riley described the turmoil she went through after this client appointment when she took this woman's hands in her own, the manifestation of her unconscious subjective countertransference identification. She described how she never behaves this way with clients, and she struggled with whether she had made the appropriate professional decision afterward. She wondered if at that moment she had crossed a boundary. She struggled in her reflection on this story with acknowledging the unconscious identification she experienced, she insisted it was a conscious choice and credited herself for making a conscious choice, but she still wavered about whether her decision was appropriate:

> I've got to let it go because the bottom line is I'm an intuitive person and I read the situation and that is how I felt that I needed to handle it in that moment (Line 200)...I know exactly what it was now…it was dealing with a sick difficult mother and I watched my dad do that…so that's where the compassion came in…that's where I could feel myself wanting to reach out (Line 206)….is that bad? (Riley, Interview 2, Line 208)

Riley shared how she wanted to feel confident but that making this decision caused her a lot of self-doubts. This example also highlighted the therapists' lack of understanding of the influence of subjective countertransference identification in the therapeutic relationship. Riley continued to question herself:

> Did I mutate the relationship by doing that? That's what goes through my head (Line 171) …I question myself…there's these small things that I question myself (Line 172) …Like how much time have I spent thinking about this? At least half an hour at home, 20

> minutes today, at least another 20 minutes earlier this week…I've spent about an hour on this, on whether or not I should've touched her hand. (Riley, Interview 2, Line 182)

Riley, like many therapists, acknowledged, "I always struggle with how much to offer of myself" (Riley, Interview 2, Line 208). Riley was left thinking about touching someone's hand for hours after that client session, wondering if she'd done something wrong, and I wondered why didn't she talk about this with the client at the time, clarify it, resolve it openly? She said it was because she did not want to look incompetent. I wondered if that doubt could have been a key that opened a whole channel of communication for this client. Riley's example clearly illustrates how occupational therapists are left without the understandings and language to fully grasp and appreciate the countertransference response and how it may have influenced their thoughts and behaviour in the therapeutic relationship. Maybe having this knowledge would have saved Riley some of the turmoil she experienced regarding her reasoning around her decision to take the clients hand in that moment. A metaphor came to mind from my interview:

> A film or a screen that distorts the truth like those funhouse mirrors! ... [It's] totally not what you should be reflecting back clearly or accurately, it's distorted in some way…whether it's the communication, whether it's the perspective, whether it's the feelings or thoughts or roles, it's distorted from the reality. (Rebecca, Interview 2, Line 170)

> Things that are kind of subterranean, and not that they're landmines…they're things that are lurking underneath the surface and we have to use a metal detector…to figure out where they are and safely excavate and disarm them so that we can safely walk on this

> pathway together without being blindsided by something really unexpected. (Rebecca, Interview 2, Line 170)

In my interview, I shared an example of subjective countertransference where I experienced an intense sadness in response to a client's situation and content. I identified with this individual as he was so hardworking, highly motivated, optimistic, family-oriented, he had young children, a new home and he was around the same stage of life and age that I was at the time. I had submitted a request for equipment funding for him and I was so certain the request would be approved. The evidence and rationale were indisputable. I felt an overwhelming desire to provide hope and support for this individual, and in doing so, I did not properly prepare him for the possibility that a claims adjuster might decline the request and send it for an independent examination, which is exactly what happened. This delayed the process for a month or so and eventually it was all approved by the independent examiner. When I received the decision, "I cried when I saw it get declined, which is bizarre, and I was like why am I crying? I never cry over an OCF-18, they get declined all the time. Why this guy?" (Rebecca, Interview 2, Line 223). I was left questioning why I had such a strong reaction to the news of the decline. I experienced deep personal sadness, a feeling that I had destroyed the hope I so badly wanted to foster for this individual. I realized the mistake I had made, the position I had put myself and the client in now that I had to deliver this unanticipated news.

When I reflect on this experience, I can see now that he was projecting an overwhelming sense of positivity towards his recovery. I focused on all the positive aspects of treatment I could contribute at the time while avoiding any negative information the client did not want to hear. This is uncharacteristic of my practice. I missed the opportunity for communication to manage his expectations, to be transparent about all possible options and outcomes. I thought, what a

disservice I had done him when the request came back declined. I had fed off his transference and responded in kind with unexamined, unconscious countertransference. My subjective countertransference manifested in uncharacteristic avoidance behaviour that impacted the relationship communication.

Integrated discussion. Nicholls (2013a) presents the importance in occupational therapy to connect with our clients and the idea that therapists and clients must understand their experiences before they can share or use them, "I had to tell myself first" (p. 20). Nicholls (2013a) explains the importance of recognizing that clients are working through their emotional processes and recoveries and may not yet have recognized their needs (p. 20). She also highlights how therapists unresolved or unconscious emotions may also be a barrier to a true connection and understanding of the client in the relationship:

> In other words, the client may be either unwilling or unable to tell us what concerns them, and for our own inner reasons, we may not be able to hear them or respond with sensitivity and/or an acknowledgement of their hurt or shame. (Nicholls, 2013a, p. 20)

Jennifer identified with her client's situation and was unconsciously pulled to provide a gift to her to alleviate her pain while also alleviating her own sadness for this client's situation and her guilt that this client was unable to access all the things she wanted and needed during her pregnancy. Her subjective countertransference manifested in her gifting a personal item, a very uncharacteristic response that may have risked distorting the relationship roles and professional dynamic. The unconscious aspect of the experience for Riley was that she could not see her identification with this client's situation and her own sadness she experienced when witnessing her own father deal with a similarly difficult relative. Riley behaved uncharacteristically by

reaching out and taking this client's hands and stating she felt the urge to hug her. In her reflection, she admitted that her identification may have distorted her clinical reasoning or "mutated the relationship" with this client and she questioned if she had done something wrong. In my example, I could not recognize at the time how I identified with this client's personal qualities, enthusiasm, optimism, and commitment to his rehabilitation. I unconsciously could not face the possibility that this request would be declined when he had all the necessary medical documentation and was working so hard to recover from his injuries. He insisted on keeping the conversation concentrated on the positive and on his improvements, which I did not recognize initially, I was swept up in the client's overwhelmingly positive attitude. This manifested in avoidance behaviour which distorted my characteristic communication patterns with this client. Was it too sad for me to accept the unfairness, the injustice of the decline?

In reflection on my example of subjective countertransference, Finlay's (1997) revelation of the "good versus bad client" labeling came to mind and how that subconscious labeling manifests in therapist behaviour and engagement. I identified with my client and viewed him as a "good client," deserving with legitimate medically documented injuries, highly motivated, engaged in therapy, and optimistic. I let his transference attitudes and my feelings towards him, although good and positive, hinder the relationship communication. I felt like I was allowed to be the "good therapist," I wanted to contribute towards positive change for him. My need to be a successful competent therapist influenced my communication in the relationship as well. I neglected to help manage his realistic expectations and prepare him for the independent examination process.

In Jennifer and Riley's examples, they may have left their subjective countertransference unexamined. Empathy can be misused to act out the therapist's needs if the therapist is lacking effective self-other identification and differentiation (Book, 1988, p. 420). Therapists may over-identify with their clients, behaving sympathetically with unexamined acceptance of their clients' experiences; here therapists may become stuck subjectively in the "participant stance," seeing things only from the client's perspective not helping them to objectively examine and consider the situation from different perspectives (Book, 1988, p. 422). Even the most skilled use of empathy is not fully representative of the clients' experience and therapists cannot assume the capacity to understand or imagine someone else's perspective entirely through symmetric reciprocity (Young, 1997). When therapists assume they can, they fail to recognize or examine their subjective lens that is applied to the experience or situation, and this will distort their perspective (Young, 1997).

Young (1997) encourages therapists to fully acknowledge and explore these limitations, for listening to and communicating effectively with their clients to avoid making assumptions that may hinder practice through over-identifying with a client's experience. As demonstrated in the examples of lived through subjective countertransference in this study, unexamined this unconscious identification can be the source of uncharacteristic behaviour and or communication in the therapeutic relationship. Like Jennifer said why do our heartstrings get pulled by certain clients? And how can therapists be better aware of these dynamics? We guilt ourselves and we use this very punitive language "I made a mistake," "I mis stepped," we are so hard on ourselves. Therapists lack the professional rhetoric for these interactions, for reflection and consideration of how they arrived at their decisions. I do not believe there is an absolute right or wrong; the most appropriate and therapeutic decision is relative to the individual client, therapist, and

relationship. Thorough reflection, understanding, and consideration of all the influences that contribute to the therapists' rationale and decision making is key.

Descriptive theme 3: frustration: "learning to fly in the dark," (therapists experience social vulnerability). Frustration was another meaningful experience within the experience of countertransference in the relationship. All participants reported experiencing examples of objective and subjective frustration as a strong emotional response to their clients' content. There were many common objective frustration countertransference responses to client content but there were also examples shared where subjective countertransference may have influenced the therapist's emotional and behavioural responses. Common sources of frustration included clients' manipulative behaviour, clients' expressing entitlement, clients' rude or disrespectful language and behaviour, clients missing appointments or consistently rescheduling, clients disrespecting or devaluing the therapists' profession, and clients' resistance or lack of participation and collaboration in treatment. Some participants expressed feeling frustrated by relationships where they felt like they were "doing most of the work." Most participants expressed frustration working with clients they described as "never satisfied" or "demanding," or those that "questioned their competency."

Participants used language to describe this part of the experience including "annoyed," "irritated," and "unappreciative of your efforts and extra efforts," describing clients as "stubborn" or "ungrateful." Marianne provided a metaphor regarding the shift in roles that can happen because of unconscious, unrecognized, and unmanaged therapist responses to frustration in the relationship:

> A mother scolding a child…the parent-child relationship that can tend to form…'this is what you should be doing,' or 'you need to listen to me if you want to do better!' (Line

> 416) …I don't want to be a mother to my clients; I want to be an OT to my clients (Line 418) …if I had a really needy client that was straight up saying…'give me the answers, what can you do? What would you do?' Then I'd feel like, oh maybe I have to take on that role, but I think it's important to avoid that and say well what do you think *we* can do? (Marianne, Interview 1, Line 420)

In terms of subjective countertransference manifestations and responses to client content. Judy illustrated the visceral response of conflicting feelings of both sympathy and frustration for a client who she felt she could never please. Judy explained that this client was extremely demanding and despite all her hard work, Judy felt anxiety and frustration about what the new issue was going to be every day for this individual. This frustration manifested in a therapeutic relationship rupture and Judy transferred the file after investing her efforts and working with the client for a year.

> I couldn't deal with her anymore (Line 95) …just listening to her voicemail, I was like stop calling! (Line 95) ...I would just get anxiety driving to her house thinking…what's going to happen today? Who's she going to fire? What's she going to yell about today… nothing's going to be good enough, it's like there's just no pleasing her and again she was transferred to me from somebody else so it's just an ongoing cycle. (Judy, Interview 1, Line 101)

Judy's example highlights how therapists are faced with complex conflicting emotions and how difficult it can be to manage their annoyance, frustration, tolerance for lack of accomplishment, and compassion towards their clients. Judy expressed her frustration with this client's attitude towards those she worked with, being demanding and critical of the therapist's work and approach. Judy expressed some personal judgement towards the way this client was

being “mean” to everyone around her. Judy felt that it was unjustified for this client to behave in such a manner towards those trying to help her. The fact that this client did have a very challenging life history and no support was maybe the deeper emotional issues left unrecognized in the relationship. Judy stated that the client had also been transferred to her by another therapist. This client has a pattern of behaviour of emotionally distancing herself that ultimately may have been missed or not addressed. The client had seen a cycle of people come and go in and out of therapy and had so much anger and sadness; she pushed everyone away, maybe due to lack of trust as so many people had abandoned her. In turn, Judy’s unconscious countertransference response to this behaviour was to push away from this client, alleviate herself of this frustration and transfer her to yet another therapist; ultimately repeating the pattern. Judy’s experience caused her to disengage from the relationship; she had decided this was the most therapeutic decision for the client and herself.

Caroline shared an experience where she was able to recognize and resolve the challenges, she had experienced due to her frustration in a relationship with a client. Caroline discussed a time where she was so frustrated by a client’s content and behaviour that she experienced an emotional breakdown. She described the client as “needy,” “manipulative” and “never pleased” with any of her efforts. On one occasion she described how this client had bombarded her with text messages, criticizing her abilities and competencies as a therapist:

> I actually broke down because of this client. It affected my mood…I had a full-blown meltdown (Line 267) ...I took it personally and I made it my truth essentially…I internalized it and it was true to me and it affected me. (Caroline, Interview 1, Line 271)

Caroline discussed how impacted emotionally she was by this client’s behaviour towards her in the relationship. She recognized her disproportionate reaction and her emotional response

helped signal her to reach out to colleagues and her supervisor for support. Ultimately, she was able to come up with a plan to address the client's behaviour in the relationship. Caroline continued her story and explained the next steps she took in her responsibility to repair the relationship and move forward with this client. She set clear communication boundaries and respectful behavioural expectations for the therapeutic relationship to move forward. By acknowledging and transparently addressing her countertransference response to this client she was able to recover the relationship. "Actually, sitting down face to face and bringing those things to light completely cleared up the situation and he's never said any of those things to me like that again" (Caroline, Interview 1, Line 267).

The subjective countertransference is that disproportionate "break down" response; the internalization of this projected negativity that resulted in Caroline feeling like a "terrible therapist," manifesting consequently in a "break down." Caroline recognized her emotional response which impacted her so deeply, and thorough communication with colleagues, she trusted she explored her feelings and explained she was able to gain a more objective perspective on the situation. She stated that her colleagues, who also worked with this client, explained that he had said and behaved similarly with the client, which helped Caroline to stop internalizing and personalizing his feedback. From a more equanimous standpoint, she was able to determine a plan of action to resolve the communication issue in the relationship. Caroline described the following imagery thinking about the experience of countertransference in the therapeutic relationship:

> A tug of war game…it's like this back and forth…give and take essentially…the therapeutic relationship is unbalanced when one of the sides go over (Line 98) …. where there's a complete disconnect between the two in the relationship and you're almost like

> spinning your wheels in mud, not getting anywhere with the client anymore. (Caroline Interview 1, Line 100)

I also shared an experience of frustration with a client during my interview. The experience caused me deep pain because I had come into the situation intending to be the most caring therapist I could be for this person. I admittedly had made a few missteps during an appointment with this client. I transparently shared some written unflattering information about her written by the referral source, and I had made the mistake of taking an important phone call from her social worker during our session because I felt pressed for time. I apologized for my mistakes but what ensued was the most disproportionate, violent verbal outburst I have ever experienced from a client. I knew that her response had more to do with the unflattering information reported about her in her referral, but it still caused me to have a breakdown:

> My body was on fire…she was absolutely furious, enraged…it wasn't I'm upset with this action you just did, or this referral information, it was a complete annihilation of my character…inside I felt the tears welling up, I felt so personally attacked and my face was red and I was very mad internally and defensive in my head like how dare you?…I remember feeling like my face was so hot and my palms were getting sweaty and I'm just sitting there being violently berated by this woman verbally… I got into my car, I drove away, and I wept…I was so devastated and…personally offended because I believed what she was saying to me. (Rebecca, Interview 2, Line 190)

This client had great difficulty emotionally regulating her verbal responses and I had triggered her by letting her read an unflattering description of herself in her referral information. I had insulted her, by talking about her on the phone with the social worker in another room. Although I sympathized and understood she could be upset about those mistakes, I was angry,

insulted, and frustrated with her disproportionate response. I felt so defensive, I had this very distorted reaction that was complicated and clouded by many subjective experiences, fears, and insecurities that had little to do with what was going on in the reality of the situation. My response to what happened with this client caused me so much frustration and consequently, I experienced a near burnout. I was not able at that time to forgive myself for the errors I had made, and, on some level, I believed that I deserved her disproportionate reaction. I felt solely responsible; I could not factor in the client's frustration or her emotional lability due to her condition. Instead, I internalized everything she said to me, all her criticism personally and professionally and I sat listening to it for much longer than I should have.

I was not able to contain the client's frustration. At the time, I was still operating with an external locus of control and poor confidence in my abilities as a therapist. Therefore, if a client was unhappy with me, then their feedback defined me as a therapist. I just wasn't fully aware of what was going on in that interaction and that is why this was such a powerful example of my unconscious subjective countertransference before, during, and after this client interaction. I started to wonder if there was a way that I could have prevented all this suffering? Could I have been taught some of these dynamics beforehand so that I could have managed this situation better? When we are unaware, exhausted, and overworked we are more vulnerable to unexamined thoughts and behaviour that may send powerful messages to clients, especially those with a high sensitivity to the behaviour of others.

Integrated discussion. Caroline described her unconscious insecurities taking hold and causing her to experience an uncharacteristic breakdown in response to a client's negative content towards her, which then impacted the relationship communication. Caroline expressed that with peer support she was able to commit to a therapeutic communication plan moving

forward to correct the distorted communication in the therapeutic relationship. Judy also shared her unconscious judgements towards her client's attitude and treatment of others and her frustration response manifesting in repeating a cycle of transferring the client to another therapist. My unconscious insecurities manifested in a near burnout reaction to my client's content. I was not prepared enough for the level of tolerance, compassion, and containment I would need to apply. Instead, I further distorted my client's disproportionate reaction and internalized her criticism. Just as Benjamin (1990) states, this internalization was indicative that I had lost an accurate perspective of reality (p. 41). This further distorted my behaviour and communication in the relationship.

I returned to see my client, but l felt guarded and hypervigilant, worried that any small misstep could cause an inflated disproportionate response from my client. I felt infantilized and that I had lost any kind of clout as a professional in the relationship. I had lost all confidence in myself and questioned my abilities as a therapist. I went through the motions but my disservice to that client was that I was not able to therapeutically resolve my subjective countertransference feelings about that client in that relationship. Like Finlay (1997) first revealed of occupational therapists labeling their clients as good and bad, I think we place blame on our "difficult" clients because they make us look bad and cast a shadow on the competency and effectiveness of our profession, which I this study has demonstrated therapists are deeply insecure about.

McCorquodale & Kinsella, (2015) states that "professionals tend to gravitate towards and spend more time with clients who hold similar values and lifestyles" (p. 314). This may be because therapists perceive like-minded clients make their job easier for them in achieving a successful therapeutic relationship as well as successful treatment outcomes and these clients reinforce their self-perception as good therapists.

My example and Caroline's example of experiencing "breakdowns" in these situations supports that burnout can be related to emotional exhaustion in occupational therapy. Gupta, Paterson, Lysaght, & von Zweck (2012) completed a mixed methods study of occupational therapists, they identify contributing factors that influence occupational therapists' risk of burnout. Gupta et al. (2012) state the most frequent causes were "emotional exhaustion," "high levels of cynicism" and "low professional efficacy" (p. 86). Practice issues related to therapist burnout included conflict, lack of respect and the results indicate that a lack of control over one's work responsibilities and a lack of self-awareness can also be detrimental for therapists (Gupta et al., 2012, p. 86). McCorquodale and Kinsella (2015) state that "burnout and cynicism are common consequences of over-adherence to economic considerations" (p. 315).

Therapist's risk internalizing what they perceive as a failure on their part when client outcomes are not attained quickly and easily. Therapists experiencing a deep sense of frustration with the client because they are a barrier to these economic considerations (efficiency, successful outcomes) increases the risk of practitioners behaving in a manner that may impact the therapeutic relationship negatively. It is well established in the literature that therapists who practice solely from an economic perspective, neglecting to consider the unique contextual factors of each clients' case, will see this method result in ineffectiveness and inefficiencies in treatment and at times unethical practice by the therapist (e.g., Hammell, 2013; Allen, Griffiths, & Lyne, 2004; Mortenson & Dyck, 2006).

The internalization of failure and resulting frustration and shame they experienced seemed to make the participants feel isolated from their peers, supervisors, and the occupational therapy culture. However, the participants experiencing this type of situation unanimously

indicates this may be a more universal experience and therapists would benefit from a more open discussion and acceptance of these experiences in our social system and culture.

Containment is a key therapeutic skill in dealing with both clients' frustration and sadness:

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

I believe the inability to endure or tolerate stressors places therapists at risk of burnout. I believe the lack the intersubjective knowledge and skills required for countertransference identification and management increases the risk for therapist burnout in the relationship. Cultural and social support from peers and supervisors is required to overcome these frustrations not in isolation but with peer support.

The nature of countertransference. The essence of the experience of countertransference in the therapeutic relationship for occupational therapists is the meaningful power of the unconscious leading to distorted and uncharacteristic responses. This is inextricably linked to the experience of countertransference in the relationship and has been demonstrated in distorted or uncharacteristic thoughts and behaviours, which impact the therapeutic relationship. Shame was a meaningful aspect of this experience for therapists. There was an intense, palpable cultural undercurrent that stressed neutrality and objectivity as characteristics of a good therapist. Experiencing strong emotional responses was a considered taboo and a potential boundary violation. Participants stated that they only shared these experiences with their most trusted

peers. The descriptive pre-reflective themes of this section, demonstrate the experience of countertransference by occupational therapists in the therapeutic relationship. These experiences were deeply meaningful for the participants when reflected upon, they proved to be a medium of communication about the client, the therapist, and the relationship which informed their reasoning, decision making, and practice. Occupational therapists must find ways and safe spaces to identify, examine and process these experiences.

Chapter 4: summary and discussion. The objective of this study was to describe the occupational therapists' experiences of countertransference in the therapeutic relationship. My findings show that occupational therapists are faced with complex interpersonal challenges in the relationship, and they do experience strong emotional responses to their clients' content in the therapeutic relationship. These findings support Mackenzie and Beecraft's (2004) assertion that thinking about countertransference can also help the therapist to understand what unconscious or uncomfortable feelings may be interfering with the provision of appropriate emotional care and support; "by using the psychoanalytical concepts of transference and counter-transference, these experiences can be thought about in such a way as to help the understanding of what is being experienced," in the therapeutic relationship in occupational therapy (Mackenzie & Beecraft, 2004, p. 537).

The findings also echo Sher and Sher's (2016) belief that with knowledge and training surrounding these concepts, the transference and countertransference can be effectively examined and be utilized by therapists to identify the client's emotional needs (Sher & Sher, 2016, pp. 294-295). The benefits of a greater understanding of the experience of countertransference include most prominently: an increased emotional self-awareness on the part

of the therapist and prevention of the negative impact unexamined countertransference may have on clients and the therapeutic relationship (Geslo & Hayes, 2007, p. 93).

Thematic Synthesis

The participants expressed a perceived expectation to be experts in the therapeutic relationship. Participants showed that their experience in the therapeutic relationship is fraught with tension, doubt, emotion, and a genuine desire to figure out the most therapeutic way to contribute to the clients' lives. Therapists want the profession to be valued and their efforts to be beneficial for their clients but experience a great deal of confusion in the process.

The findings of this study also demonstrate that throughout all stages of the therapeutic relationship, therapists experience strong unconscious emotional responses to their clients' verbal, non-verbal, environmental, and behavioural content. Therapists do experience objective, subjective, positive, and negative countertransference in the therapeutic relationship and lived through examples were presented. The participants' subjective countertransference responses may influence or distort the therapists' thoughts and actions unconsciously. Therapists are challenged to reflect on these encounters accurately and appropriately to allow their emotions to inform their therapeutic skills of compassion, empathy, and containment. The findings support that for therapists to continue to develop their expertise; it is not about denying and suppressing our humanity and emotions but recognizing them, reflecting upon them, understanding their influence, so they may be interpreted as a clear channel of communication to inform the therapeutic relationship.

Chapter 5: Next Steps for Practice and Research

Implications for Practice

I believe knowledge of the intersubjective dynamics in the therapeutic relationship and the associated interpersonal skills are of paramount importance for occupational therapists to engage in effective therapeutic relationships. Increased professional reflection, self-awareness, and knowledge of psychodynamic concepts may prove to be beneficial for therapists in the development, maintenance, and disengagement from the therapeutic relationship. I believe these abilities will assist therapists thoroughly inform their clinical reasoning, to be conscious decision-makers (COTO, 2016) in the therapeutic relationship and practice.

Therapists require a safe culture to explore and appreciate the mystery and creativity that can thrive in the therapeutic process in occupational therapy. We may benefit from embracing and discussing this part of therapy as a relevant aspect of practice for each client and relationship. Occupational therapy may benefit from an attitude of open acceptance regarding the immense self-doubt experienced by therapists in the therapeutic relationship to support open discussions on this subject. Increased opportunities for peer support are encouraged for therapists to continue to learn and grow from their inherent experiences of doubt regarding their professional boundaries, roles, and clinical reasoning in the therapeutic relationship. Increased recognition of the personal risk community therapists take in practice is recommended, to promote the value of therapists' physical health and safety. I believe occupational therapy will benefit from the continued integration of greater interdisciplinary knowledge and understandings to inform their practice in the therapeutic relationship.

Study Strengths and Limitations

I believe that the methodology selected for this study was appropriate and strength of this research endeavor (Van Manen, 1997). It served to open a dialogue that addressed the questions of meaning in the experiences of the phenomena of interest, and this goal was accomplished. I was committed to strive towards the use of both reflective cognitive interpretations as well as pathic pre-reflective descriptions that would transcend the cognitive function of language by using the phenomenological techniques available (Van Manen, 2014, p. 243). Interviewing therapists twice allowed for additional reflection, clarification, and confirmation of therapists' responses to reduce misinterpretations.

I believe that the application of the human science philosophy and a phenomenological methodology for this study assisted in acquiring new realizations and understandings regarding the mysteries of the occupational therapists' lived experiences of the therapeutic relationship and countertransference in occupational therapy practice. My reflection and honesty regarding my thoughts and experiences, written throughout the study, may be viewed as a strength as this increases my transparency with the reader. First, I reviewed occupational therapy literature surrounding the topics of the therapeutic relationship, and countertransference was completed. From a phenomenological perspective, Van Manen (2014) highlights that the literature and theories need to be reviewed by the researcher to determine the extent to which this literature provides a description of concrete experiences and to determine where this experiential description is lacking (p. 226). From a phenomenological standpoint, being aware of the existing theories and scientific knowledge regarding these subjects was also necessary for the hermeneutic epoche and reduction phase of the analysis. This existing knowledge was reflected upon while analyzing the data and I actively worked on suspending these scientific ideas,

frameworks, and conceptualizations during the epoche and reduction phases (Van Manen, 2014, p. 226). Gathering a basis of theoretical and analytical information on these subjects of interest informed the study's discussion section as well.

The varied data sources used in this project included the occupational therapist participants' interviews, the researcher's field notes, and the researcher's journal. Van Manen (1990) states participants must be carefully chosen to be individuals who have all experienced the phenomena in question. Primarily the sample is illustrative, in that the sample provided vivid and illuminating illustrations of human experiences of these phenomena; however, the research acknowledges that the findings in the phenomenological study are not necessarily to be generalized and they may not represent the experience of the greater population while still bringing forth valuable insights (Mason, 2002, p. 126). Meaningful comparisons of complex sets of experiential processes, social processes, and meaning structures concerning the research questions were achieved (Mason, 2002, p. 136).

I committed to conveying interpretive understandings and pathic, descriptive accounts to revealing the nature of the community occupational therapists' therapeutic relationship, and countertransference experiences in occupational therapy practice. (Van Manen, 2014, p. 243). I hope that the pathic aspects of the experiential text will help to encourage a reflection, discussion, and continued evolution of our knowledge about the therapeutic relationship, and countertransference.

I believe that the use of this human science philosophy and phenomenological methodology offered insights into multiple therapists' experiences in an informative and relatable way that may resonate with therapists and inform their reflection and practice. However, I recognize, and I am humbled by the reality that pure experience, in comparison to a

written account, “is always more immediate, more enigmatic, more complex, more nuanced and more ambiguous than any description can do justice to” (Van Manen, 2014, p. 242).

There are some notable limitations of this study that I would like to highlight and discuss. First, the purpose of this study was to describe the occupational therapists’ experience of the therapeutic relationship and countertransference. However, this question relates to only one side of the relationship. I understand that I have presented only one side of a two-sided story. This study does omit an exploration of clients’ experience of the therapeutic relationship and an exploration of their transference experiences in the relationship.

Second, phenomenology instructs the researcher not to engage in psychoanalysis of the results and therefore this study was limited to a presentation of the interpretive and descriptive elements offered by the participants as opposed to a psychoanalysis of their experiences. Further studies with methodologies applied that allow for more psychoanalytic interview and analysis approaches, involving multiple client therapist dyads may glean even more thorough information about this experience of interest.

Third, convenience sampling was used. Although after reviewing the results of this study I would have liked to have approached my sampling methods more strategically. If a more purposive approach had been applied, perhaps a more thorough range of experiences may have been captured. For instance, there were no male occupational therapists included in the sample and a male perspective may have contributed additional insight into these experiences.

Fourth, the sample was limited to eight participants and data collection was limited to two interviews per participant. The participants continued to reflect upon the unconscious aspects of their experiences after their first interviews. This reflection led to more in-depth examples being provided during their second interviews. This may have been because the participants’ trust in the

interviewer increased, and they began to appreciate the value of discussing their experiences. If the sample size had been larger and third interviews had been conducted with each participant, it is possible that the examples could have been more deeply explored or even more sensitive examples may have been shared.

Fifth, an example of a staunch opposing view to be used for a negative case analysis was not found in the data. This may speak to the limitations of the sampling methods used, or it may be a statement regarding the deeply held, culturally acceptable understandings and beliefs shared by occupational therapists. It may highlight a fear they experience to stray from those socially acceptable norms. Additional interviews with the participants may have helped them move beyond their potential self-censorship.

Anticipated Knowledge Translation and Next Research Steps

I plan to share the findings of this study with knowledge users through publication in a peer-reviewed journal. I also plan to translate this knowledge through presentations at community rehabilitation clinics and universities.

I believe that the next steps for further research include closer explorations of the psychodynamic aspects of occupational therapy practice, through therapist case studies, using reflective psychoanalytic interviews, as well as a more collaborative, reflective, and psychoanalytic approach to the analyses. This step may further help to integrate and translate the psychological knowledge of the relationship dynamics into occupational therapy practice and increase our access to these sought-after skills through language and understandings. An ethnography of the occupational therapy culture with a concentration on specific countertransference recognition, management and utility in practice would provide great additional insight into this experience for occupational therapists. This may involve studies of

therapist-client dyads using real-time observational methods in combination with reflective methods. This step may further help occupational therapists to translate the theory into pragmatic applications and gain a greater understanding of how to implement these skills in the therapeutic relationships with their clients.

Closing Synthesis

The literature is plentiful with the cognitive, conceptual, objective, and measurable features of the therapeutic relationship. The existential quality of these experiences has not yet been documented from a phenomenological lens in the current literature. The study's findings produced a corporeal, relational, temporal, situational, and actional kind of knowledge that cannot necessarily be translated back or captured into conceptualizations and theoretical representations (Van Manen, 2014, p. 270).

The Ontario College of Occupational Therapists (COTO) expects that therapists can identify and manage countertransference in the therapeutic relationship (COTO, 2010). My research shows that therapists continue to struggle with their understanding and recognition of their subconscious minds and unconscious countertransference responses. Therapists lack a basic understanding of countertransference, how to recognize, manage, and be informed by their responses in the relationship. My findings suggest that due to the emotional nature of relationships, a formal and discipline-specific understanding of these concepts should be made available to occupational therapists.

Most participants denied any judgements or prejudices towards their clients, but upon reflection almost immediately, they reported instances where they had described judgement toward their clients, indicative of the "guise of neutrality" and suppression of the therapists' humanity. The participants seemed to view good therapists as completely non-judgemental, and

that being non-judgemental was the right and virtuous way of approaching the relationship. If the profession continues to praise neutrality, therapists will continue to falsely identify as non-judgemental. Consequently, they will be denied the ability to grow, reflect and explore more consciously potentially harmful unconscious biases that may impact the relationship. They will also be denied the ability to identify and interpret the intersubjective communication in the relationship that may prove informative for their clinical reasoning skills.

This study supports suggestions that occupational therapy should aim to broaden the knowledge base of therapists to benefit from the wealth of research and theory on the topics of intersubjectivity and psychodynamics that have been established in other disciplines (e.g., Healey, 2017; Mackenzie & Beecraft, 2004; Nicholls, 2013a). As Nicholls (2013a) states, "Perhaps what is unique in an occupational therapy response, and different from an analyst who uses words, is that the occupational therapist communicates through doing and words" (p. 17). Community therapists work with clients in their varied home environments, and I believe this knowledge of psychodynamics is seminal for engaging in effective therapeutic relationships in this immersive and holistic type of treatment. Each therapist, client, and relationship are complex. Each resulting client therapist relationship dynamic must be examined on an individualized basis based on their unique characteristics. Occupational therapy continues to strive to achieve genuine excellence in the practice of the therapeutic relationship, and therapists continue to strive to be conscientious and reflective practitioners.

The greater psychological understanding of our role in the relationship has helped me to understand my own experiences in practice. This knowledge has increased my confidence in my clinical reasoning and judgement skills. Gaining a greater understanding of countertransference in the relationship dynamics has been an enlightening, explorative ongoing journey for me. I

believe enough material has been presented by the therapists in this study to demonstrate that occupational therapists do experience countertransference, strong visceral and emotional responses to their clients' content rooted in their subjectivity. I strongly believe the profession of occupational therapy, and more specifically the occupational therapy therapeutic relationship, would be well informed by a greater understanding and language of these intersubjective components of relationship dynamics and unconscious communication.

I believe that occupational therapy culture is glorifying the concepts of neutrality and objectivity and being all-knowing as celebrated goals of skilled therapists. I believe the piece that is missing for most therapists is acknowledging and reflecting on their unconscious, subjective influences in the relationship dynamics and how this may impact the relationship, rather than denying and suppressing these factors. I believe that both a technical understanding of practice as well as an understanding of the intersubjective psychodynamics in the relationship are required for therapists. Rather than trying to know the right answer, therapists may do better to strive to achieve the most appropriate therapeutic decisions relative to the individual client, therapist, and relationship. This study demonstrated that when reflected upon, countertransference appears to be a powerful source of information during therapeutic clinical reasoning. It informs therapists' use of therapeutic skills including boundary setting, self-disclosure, compassion, empathy, and containment in a diverse array of therapeutic relationships. I believe this topic should be included in the occupational therapy educational curriculum in an interdisciplinary way. I believe a greater incorporation of knowledge from psychology and psychoanalytic literature will provide occupational therapy students with a greater understanding of the therapeutic relationship dynamics. I also believe that all practicing occupational therapists should be informed and capable of applying their countertransference knowledge to both their self-reflective and therapeutic

practices. For example, The Canadian Association of Occupational Therapists and other supportive organizations for occupational therapists could offer training courses and resources to support increased knowledge of these concepts and how they impact practice and the therapeutic relationship. I believe this knowledge of countertransference and therapeutic relationship psychodynamics should be incorporated into what occupational therapists are recommended to practice regarding their ongoing personal and professional self-reflection and increased self-awareness practices as well.

This study allowed me to explore and to better understand the human connection and the intersubjective realm of the therapeutic relationship in occupational therapy. My experience has now come full circle. I have acquired a greater understanding of the therapeutic relationship in occupational therapy. I no longer need to attempt to build a shield around my heart, as my mentors once told me to do. Although this presents new challenges, I now realize how to develop and maintain a conscious and receptive heart. My increased self-awareness of my subjectivity now allows me to better understand and reflect upon the intersubjective dynamics ever-present in the therapeutic relationship. I am now more capable of receiving and interpreting emotional signals and communication from my clients and myself as part of my comprehensive conscious thought process to applying my personal qualities and therapeutic skills in the therapeutic relationship.

Tables and Appendices

Table 1

Participant Demographics

Participant Pseudonym	**Gender**	**Age Range**	**OT Education**	**Years of Community Practice**
P1. Victoria	Female	35-45	Doctorate	10-15
P2. Caroline	Female	30-35	Masters	5-10
P3. Riley	Female	40-45	Bachelors	15-20
P4. Marianne	Female	30-35	Masters	5-10
P5. Diana	Female	45-50	Bachelors	20-25
P6. Judy	Female	40-45	Bachelors	15-20
P7. Leah	Female	35-40	Masters	5-10
P8. Jennifer	Female	35-40	Masters	5-10

Appendix A Ethics Review Board Approval

21/03/2018

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE I CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-03-18-310
Titre du projet / Project Title	The Occupational Therapist Experience of Developing and Maintaining Therapeutic Relationships
Type de projet / Project Type	Thèse de doctorat / Doctoral thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	21/03/2018
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	20/03/2019

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Rebecca VAN SCHYNDEL	École des sciences de la réadaptation / School of Rehabilitation Sciences	Chercheur Principal / Principal Investigator
Mary EGAN	École des sciences de la réadaptation / School of Rehabilitation Sciences	Superviseur / Supervisor
Suzette BREMAULT-PHILLIPS	University of Alberta	Co-superviseur / Co-supervisor
Lindsey NICHOLLS	University of Essex	Co-chercheur / Co-investigator

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

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21/03/2018

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l'*Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completedfour weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Daniel LAGAREC** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

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Appendix B Participant Consent From

The Occupational Therapist Experience of Developing and Maintaining Therapeutic Relationships

Researcher: Rebecca Van Schyndel, MSc. OT, Rehabilitation Sciences Ph.D. Candidate
Organization Address: University of Ottawa, Roger Guindon Hall, 451 Smyth Road, Ottawa, ON, K1H 8M5

This research study is being conducted in the context of a PhD thesis by PhD candidate Ms. Rebecca Van Schyndel, and her co-supervisors.

Professor Mary Egan, Faculty of Health Sciences, University of Ottawa, Mary.Egan@uottawa.ca

Professor Brémault-Phillips, Faculty of Rehabilitation Medicine, University of Alberta
suzette.bremault-phillips@ualberta.ca

Invitation to Participate: I am invited to participate in this research study conducted by Ms. Rebecca Van Schyndel, PhD candidate and her co-supervisors Professors Egan and Brémault-Phillips.

Purpose of the Study: The purpose of the study is to gain a better understanding and description of community occupational therapists' experiences of developing and maintaining successful therapeutic relationships resulting in positive treatment outcomes. This study also aims to provide an understanding and description of the community occupational therapists' experiences of countertransference in the occupational therapy therapeutic relationship.

Participation: My participation will consist of two 1.5 to 2 hour, audio-recorded interviews, over a 6-month period. In these interviews, I will be asked to describe my experiences developing and maintaining therapeutic relationships with my clients. I will be asked to describe my experiences with countertransference emotions, thoughts and feelings in professional practice. These interviews will take place at my place of residence or at the University of Ottawa. I will also be invited to participate in reviewing the preliminary results and providing feedback to the researcher at various stages of the research project, which may require an additional 1 to 2 hours of my time up to 6 months after the second interview.

Risks: My participation in this study does involve sharing personal reflections and professional experiences and this may cause me to feel some emotional and psychological discomfort. The subject matter may evoke strong emotional responses, reactions, and realizations that I may experience as disturbing, surprising or conflicting. I have received assurance from the researcher that every effort will be made to minimize these risks. Measures to reduce risk have been considered by the researcher including: reasonable time and effort requested in addition to my regular workload (approximately 5 hours over a 6 to12 month period), a list of psychological resources is attached to this consent form that I may access at my own discretion at any point during or after the study if required. Lastly, in order to prevent social repercussions, I am being asked explicitly not to disclose any reports of sexual misconduct with my clients during this

study.

Benefits: There are no anticipated benefits to my participation in this research study for me personally. It is anticipated that the results of this study will help advance occupational therapy knowledge regarding the development and maintenance of therapeutic relationships and regarding countertransference, which could inform educational programs and professional OT practice.

Confidentiality and Anonymity: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents of the interviews will be used only for the analyses of the study. I understand I may be quoted in presentations or publications, but I will not be identified. I will be assigned a pseudonym for anonymity purposes.

However, I understand that Ms. Van Schyndel is a registered member of the College of Occupational Therapists of Ontario and that she must report to COTO if I disclose any sexual misconduct with clients.

I understand _____

Conservation of data: All data collected in this study will be kept in a secure manner and will only be accessed by Ms. Van Schyndel or her supervisors. Ms. Van Schyndel will ensure that the consent forms, contact information, and handwritten notes will be kept in a locked cabinet, in her locked home office. Further, she will ensure that the audio recordings and transcription records are kept in encrypted files on a password-protected computer. Transcription of the interviews will be stripped of all identifying information (names and places of employment). All documentation associated with this study will be retained securely for 10 years, after it will be destroyed by shredding or by secure deletion.

Compensation: As a token of the researcher's appreciation for my participation in this study, I will receive a 20$ gift card to Staples or Starbucks (my choice). My decision to withdraw from the study at any point will not affect this compensation.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study or refuse to answer any questions, without suffering any negative consequences. There will be no consequences for me now or in the future if I choose not to participate.

Acceptance: I, _____ agree to participate in the above research study conducted by Ms. Rebecca Van Schyndel, PhD candidate of the Rehabilitation Sciences Department, of the Faculty of Health Sciences, of the University of Ottawa, whose research is under the supervision of Professor Mary Egan and Professor Suzette Brémault-Phillips.

If I have any questions about the study, I may contact the researcher or her supervisors.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

List of Psychological Support Resources

<table>
<tr>
<td rowspan="2">

Phone Services

1. Ottawa Emergency Services: (9-1-1)

2. (2-1-1) Ontario Community and Social Services Help Line:
Free 24-hour helpline provides confidential referrals and mental health resources.
https://211ontario.ca

3. Distress Centre of Ottawa and Region:
A 24-hr confidential distress line for adults in Ottawa.
613-238-3311
www.dcottawa.on.ca

4. Mental Health Helpline:
MHH provides free, anonymous, confidential information and referral services and supports for people experiencing mental health issues.
1-866-531-2600
www.MentalHealthHelpline.ca

</td>
<td>

Walk-in Counseling Clinic Services

1. Carleton University Health and Counseling Services:
1125 Colonel By Dr., Ottawa, ON, K1S 5B6
613-520-6674
carleton.ca/health/counselling-services/

2. Ottawa Counselling and Psychotherapy Centre (OCP):
356 Woodroffe Ave, Ottawa, ON, K2A 3V6
Map
613-263-2344
ocpsychotherapycentre.com/

3. The Counselling Group:
2255 Carling Ave, Ottawa, ON, K2B 7Z5 Map
613-722-2225 x352
www.thecounsellinggroup.com

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Professional Psychologists

1. Ricci & Associates Psychology Professional Corporation:
955 Green Valley Crescent, Suite 105
Ottawa, Ontario
K2C 3V4
Phone: 613-722-3222
Fax: 613-722-4652
Email: info@riccipsych.com
http://www.riccipsych.com

2. Queensview Professional Services:
2725 Queensview Drive, Suite 600
Ottawa, Ontario
K2B 0A1
613-596-2000 x230
http://www.qps-on.ca/en/index.shtml

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</table>

Reference:

eMentalHealth.ca
Mental Health Services, Help and Support in Your Community
http://www.ementalhealth.ca/Ottawa-Carleton/Crisis-

andEmergency/index.php?m=heading&ID=3#21

Appendix C List of Countertransference Definitions

Countertransference

Countertransference can be defined as a concept that encompasses all of the therapist's emotional and physical responses as they process and respond to the verbal and non-verbal communication of their clients (Jacobs, 1991, p. xvii). It is important to acknowledge that it is well established that countertransference is not merely the therapist's response to the client's own subjective transference thoughts, feelings and behaviours. Geltner (2013) describes the psychodynamic underlying currents in the inter- subjective field of the relationship including objective, subjective, positive and negative countertransference (Geltner, 2013, p. 28).

Objective Countertransference

Objective countertransference is defined as the feelings, repetitive patterns and emotional communications that the client contributes to the relationship; these may be rooted in the client's past life experiences, or their transference feelings, thoughts and behaviours (Geltner, 2013, p. 24). The therapist's emotional inductions, caused by objective countertransference, are realistic and proportional emotional reactions to the client's content and may be used to better understand the client's experience (Geltner, 2013). The therapist can better understand the client's experience by examining these induced feelings in conjunction with the client's explanations and descriptions (Geltner, 2013). When understood correctly, with verification from the client, this can be extremely informative to the relationship and can assist the therapist in implementing empathy effectively.

It is important to determine which feelings are primarily induced in the therapist by the client's content or behaviour and which are rooted primarily in the therapist's own subjectivity (Geltner, 2013, p. 25). Geslo and Hayes (2007) have called this the therapist's *inner world* and they explain that it is composed of the therapist's countertransference feelings, thoughts, emotions and physiological responses (p. 71).

Subjective Countertransference

Subjective countertransference is defined as the feelings and repeated dynamics from the therapist's life brought into therapy; these therapist feelings with or about the client are unrelated to the client's content (Geltner, 2013, p. 70). Left unchecked, these feelings may cause distortions to the optimal understanding of the client due to the therapists unexamined past experiences in life or practice (Geltner, 2013, p. 24). Unlike objective countertransference, which can inform therapy and help the therapist understand their client's experience, subjective countertransference provides no accurate information about the client's experience and may cause misinterpretations that may be detrimental to the relationship (Geltner, 2013). All countertransference experiences that are congruent (when the therapist's feelings are proportional to the client content) and incongruent (when the therapist's feelings are disproportional to the client content) should be treated as potentially objective (conscious or unconscious) until determined to be subjective (Geltner, 2013, p. 66).

Positive Countertransference

Positive countertransference can be described as an intense, disproportionate, solely positive regard for a client. This may lead the therapist to over nurture, over support, over expect, create dependencies, and over identify with the client, causing them to perceive a greater understanding of the client's content or experience than may be accurate (Geltner, 2013). This runs the risk of therapists misusing empathy, making

unverified assumptions or decisions without first collaboratively discussing these decisions with their clients. Even the most skilled use of empathy is not fully representative of the clients experience and the therapist cannot assume the capacity to understand someone else's perspective entirely. When they assume they can, they fail to recognize or examine their own subjective lens that is applied to the experience or situation and this will distort their perspective (Young, 1997). Therefore the practice of *symmetric reciprocity* is not realistic or attainable for therapists (Young, 1997). Rather, they must fully acknowledge and explore this limitation and both listen to and communicate effectively with their clients to avoid making assumptions that may hinder practice by mistakenly over identifying with a client's experience.

Negative Countertransference

Negative countertransference can be described as an intense, disproportionate, solely negative regard for a client. This may be caused by a strong dislike, intolerance, judgement, disagreement or frustration with a client. It can lead the therapist to distance themselves from or avoid the client, to become defensive, label the client or perceive the client as different, separate or maladaptive (Geltner, 2013). It may cause them to reduce their expectations for the client's therapy (Geltner, 2013).

Although these specific types of countertransference can be polarized into these categories, it is understood that they are not mutually exclusive experiences and that combinations of these types of countertransference may be at play. For instance, an external act of positive countertransference (over-involvement) may stem from a therapist's subjective countertransference feelings and thoughts about a client who reminds them of a close relative with similar issues. Another example would be a therapist's external act of positive countertransference (over encouragement) of a client to meet their expectations in therapy due to the therapist's own subjective feelings of anxiety regarding their skill level in relation to the client's success in therapy.

Appendix D Participant Interview Guide #1

Introduction:

i. Would you tell me about your educational background and how you became an OT?

ii. Would you give me an overview of your OT career/experience working as an OT and describe where you are currently working/current roles?

- What clientele do you work with?
- Where in the community do you work?
- How long have you been practicing occupational therapy in the community?

Part 1: Therapeutic Relationship:

1. What is the therapeutic relationship in occupational therapy?
   - How do you understand the therapeutic relationship?
   - What does the therapeutic relationship mean to you?
   - Is it an important part of your OT practice? Why/How so?
   - What metaphors or imagery would you use to describe the experience of therapeutic relationship in occupational therapy?

2. a) How does the therapeutic relationship in occupational therapy differ from other important relationships?

b) How might you differentiate this relationship from a relationship with a close friend? A colleague? Or a relative?

3. a) What is it like to develop a successful therapeutic relationship with your client?

b) Can you provide some examples of times you developed a successful therapeutic relationship with a client?

Explore examples/experiences:

- How did you go about this?
- What happened?/ What does this experience look like?
- How? Why was it successful?
- What thoughts do you experience during this process?
- What feelings to you experience during this process?
- What makes this example/experience meaningful to you?

4. a) What is it like to maintain a successful therapeutic relationship with your client?

b) Can you provide some examples of times you successfully maintained the relationship with a client?
Explore examples:

- How did you go about this?

- What happened?/ What does this experience look like?
- How? Why was it successful?
- What thoughts do you experience during this process?
- What feelings do you experience during this process?
- What makes this example/experience meaningful to you?

Part 2: Countertransference:

1. What is countertransference in the therapeutic relationship in occupational therapy?
    - How do you understand countertransference in the context of occupational therapy?
    - What does countertransference in occupational therapy mean to you?
    - Does it factor into your OT practice? Why/How so?
    - What metaphors or imagery would you use to describe the experience of countertransference in the therapeutic relationship in occupational therapy?

2. How does the experience of countertransference differ from other feelings, thoughts, reactions or behaviours in the therapeutic relationship?

3. a) What is it like to experience strong feelings/emotions or emotional reactions to the content or behavior of your clients in the therapeutic relationship?

b) Can you provide some examples of these experiences (both strong positive and strong negative emotional experiences)?
Explore examples/experiences:

- What happened?
- What does this experience look like?
- What thoughts did you experience?
- What feelings did you experience?
- What behaviours did you engage in (verbal/nonverbal)?
- Was your experience subjective countertransference or objective countertransference?
- What makes this example meaningful?

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