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Adapting to a Challenging Fieldwork: Understanding the Ingredients

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Adapting to a Challenging Fieldwork: Understanding the Ingredients

Abstract

Two occupational therapy students were assigned to an inpatient psychiatric unit for their first Level 1 fieldwork. With limited on-site supervision provided, they looked to each other for peer support and collaboration in assisting one patient with severe depression who was considered the “sickest patient on the unit.” The students were able to work together and make a positive intervention with this patient despite their novice status. Understanding what each of them brought personally to this experience as well as the nature of their working relationship and their use of concepts taught in the classroom has important implications for occupational therapy education. One of the profession’s goals in acute psychiatric settings is to engage clients in meaningful occupations to facilitate rehabilitation and the recovery process. The two students skillfully employed the concepts of emotional intelligence, cultural competence, and therapeutic use of self and demonstrated their comfort with technology and spirituality to facilitate his occupational reengagement. By examining this case report through the lens of the literature on emotional intelligence, cultural competence, and therapeutic use of self, the ingredients of their clinical reasoning becomes more transparent and available to other occupational therapy educational programs.

Keywords

mental health fieldwork, emotional intelligence, cultural competence, therapeutic use of self

Complete Author List

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Two first-year master-level occupational therapy (OT) students were placed on an acute psychiatric inpatient unit for their first Level I fieldwork, which consisted of 12 days at a large, urban public hospital. There was no occupational therapist on the unit to which they were assigned. Their on-site supervisor provided limited supervision. The students worked as a team and chose a patient for their case study who was referred to as “the sickest patient on the unit.” After the fourth week of their fieldwork, the patient’s psychiatrist expressed disbelief in morning rounds about the patient’s significant improvement. The purpose of this article is to describe and analyze how the students worked together as a cohesive team to achieve a positive outcome with this challenging patient.

It is a revealing story that has important implications for OT education. This case report demonstrates the importance of providing our students with the tools necessary to enable them to work effectively with all patients in different treatment environments when there are varying levels of supervisory support. This story also underscores the need to balance the practical and performance-based aspects of graduate clinical education with the academic.

In order to understand the most relevant elements of effective OT education and to capture the ingredients of the students’ resourceful clinical reasoning, we begin by describing the background of the case. This is followed by evidence from the literature on the three underlying components of the students’ clinical reasoning process: emotional intelligence, cultural competence, and therapeutic

use of self. Portions of the students’ Google document that they created to reinforce their learning depicts the students’ actual interactions and interventions with the patient and further illustrates their use of these three concepts. The implications of this case for OT practice and education conclude the article.

Background

The case has been disguised to protect the identities of the patient and the students. Pseudonyms were created for this narrative. Nand is the patient, who was a middle-aged medical professional of Asian descent. His diagnosis was major depressive disorder. The students are Carolina and Meg, and both were in their mid twenties. Carolina had recently moved from South America and had a history of depression in her family; Meg was from the West Coast and, prior to admission to OT school, had volunteered in a hospital where she observed occupational therapists providing services to psychiatric patients. Carolina had two experiences in common with Nand: familiarity with depression and the experience of being a foreigner in the American culture. Both students possessed naturally high levels of empathy, emotional intelligence, and cultural competence, which are clearly expressed in the notes and discussions that occurred as part of their peer support and collaboration. Carolina recorded all observations, questions, and comments about the patient on a daily basis in a diary, which became the basis of a Google document. The students shared many conversations about Nand, including how to assess him and how to design their groups to include him. The verbal and written processing that occurred as they shared their

observations and questions served as a form of peer support. Carolina and Meg also participated in a weekly fieldwork seminar at the university where they reflected on their experiences with peers and an experienced OT mental health clinician.

The students used the Comprehensive Occupational Therapy Evaluation (COTE), a standardized behavioral observational checklist, to evaluate the patient's activities of daily living (ADLs), social interactions, and task functioning. Based on their observations, team rounds, and a chart review, the intervention plan for this patient was designed to address his self-care skills of grooming, hygiene, and eating; compliance with medication; depressed mood; and social isolation. The students conferred to decide which frames of reference (FOR) should guide their interventions. They combined two: Cognitive Behavior Therapy (CBT) and Mosey's Reconciliation of Universal Issues. CBT, a frequently used frame of reference in behavioral health settings, helps to uncover discordant cognitive distortions and substitute alternative thoughts to change a patient's behavior (Brown & Stoffel, 2011; Cole, 2012). From the CBT, the students chose Beck's negative triad, which describes the thought patterns of depressed patients, linking negative beliefs about the self, world, and future. The negative triad helped them to understand Nand's shameful, guilty beliefs that he had hurt many people in the past and hence his decision to terminate all communication with friends and family (Clark, Beck, & Brad, 1999). The students focused on self-compassion to counter his exaggerated self-loathing, providing a variety of ways occupationally for Nand to be more forgiving

toward himself. They actively encouraged him to participate in ADLs, past hobbies as leisure activities, and social interactions with other patients to reengage him and help him improve his mood.

The universal issue that this patient needed to reconcile was loss (Mosey, 1986). Nand came to the United States as a teenager to study, and he lost his connections to his close-knit family, his religion, and his national affiliation. The issue of loss was not reconciled for the patient and resurfaced in his most recent psychological crisis when he lost his ability to function in his many roles of doctor, neighbor, friend, traveler, and ethnic dancer. The students enlisted treatment strategies from the Reconciliation of Universal Issues FOR, including identifying activities that enable people to talk about difficult matters; the past, present, and future; and occupational engagement to remind the patient of what he or she can do. Mosey's description of the emotion of loss provided Carolina and Meg with the tools and vocabulary to help the patient become aware of his feelings of emptiness and loneliness. Carolina and Meg encouraged the development of a therapeutic alliance with Nand, which enabled him to begin to reconnect with others.

Some of the knowledge and skills displayed by the students were derived from their personal experiences prior to coming to an OT program. Their emotional intelligence is very much in evidence, as was their sensitivity to cultural differences, which allowed them to understand and contextualize some of Nand's behaviors, which others on the treatment team failed to understand. They also displayed high levels of resilience when supervision did not provide them with the knowledge

and skills necessary to negotiate a complex inpatient environment. They developed their own system of peer support and collaboration, using personal diaries, conversations, and a Google document to process and learn from each other as they navigated these unfamiliar waters. They had also completed their academic training in psychosocial OT before beginning fieldwork. They were familiar with psychopathology and psychopharmacology, the Occupational Therapy Practice Framework, 3rd Edition (OTPF-3), OT Frames of Reference, clinical reasoning, therapeutic use of self, group dynamics, and the steps of the OT Process. They felt confident that they had the tools to carry out OT assessments and interventions in a mental health setting.

Literature Review

Emotional Intelligence and Implications for the Case

Emotional intelligence is the ability to accurately reason about emotions and use emotional information to enhance one's thinking (Mayer, Roberts, & Barsade, 2008). One's own emotions, as well as others' emotions, form the basis for this reasoning. This ability includes being able to manage one's own emotional responses; understand one's own emotions and display empathy; appraise emotions in different situations; use emotion for reasoning; and identify emotions in voices, faces, and postures. Emotional intelligence focuses our attention on the functions of emotions (Mayer et al., 2008). Medical educators have evaluated the emotional intelligence of their students and found that higher emotional intelligence contributed to an improved patient-doctor relationship.

There is still a debate whether emotional intelligence can be taught to improve empathy, communication skills, and teamwork (Arora et al., 2010). A study of 100 dental students revealed that the level of student empathy decreased as the students progressed through the academic program and were exposed to more patients. The authors explained this finding by observing that during dental school, student expectations shift from forming relationships with patients to rotating rapidly through a number of internships and completing dental exams and procedures efficiently (Victoroff & Boyatzis, 2013).

This finding resonates with the experience of the OT students. Meg expressed her feelings about their high levels of empathy as follows:

This was our first fieldwork experience.

Both of us had a strong humanistic sense of empathy that was not yet fully informed by our knowledge of occupational therapy.

This led to our being able to more easily and fully empathize with this patient.

There is growing consensus that empathy is a brain-based evolutionary tool for survival involving mirror neurons, which allows us to inhabit the feelings of fellow human beings (Siebert, 2016). It appears that both students were naturally endowed with empathy, which allowed them to form a close collaboration with each other as well as with their patient.

In her writing about the development of conscious use of self, Mosey (1986) suggests a similar conclusion: An occupational therapist's knowledge of body structures and functions should not make a client feel lessened or devalued. Because OT, unlike other medical professions, is always

focused on the individual patient's strengths and not his or her pathology, OT education can ensure ways to maintain students' natural empathy throughout a rigorous and demanding academic and clinical educational process.

Cultural Competency and Implications for the Case

According to Bonder, Martin, and Miracle (2002), the best approach to understanding culture is an inquiry-centered approach, or "learning how to ask" strategy, which is closely identified with the study of ethnography (p. 9). The ethnographic attitude is characterized as one of empathy and good interpersonal skills, curiosity and capacity for surprise, patience and tolerance for ambiguity, and reflexivity. When you watch people doing something that you do not quite understand and then reflect on what you have observed, you are employing an ethnographic methodology. It consists of close observation and inquiry. We observe (or hear) something that does not make sense to us; usually, this "not making sense" is the observer's problem, not the doer's. One hypothesis is that the doer's behavior is meaningful in some (cultural) framework that the observer does not share and thus cannot understand (Bonder, Martin, & Miracle, 2002). The students demonstrated a finely attuned ethnographic attitude when they expressed curiosity about the patient's personal experience of shameful guilt and exaggerated self-loathing and tried to make sense of this overlooked aspect of his clinical condition by contextualizing it in the patient's values, spirituality, and cultural beliefs.

Cultural brokering and mutual accommodation are other important concepts drawn

from Bonder et al.'s (2002) work on cultural competence that is relevant to this case. A self-monitoring health provider who is observant and consciously reflective with a routine practice of analysis, evaluation, and checking will be able to act as a cultural broker to the benefit of patients. A cultural broker is the person who functions as a go-between at the edge of cultural groups in contact (Bonder et al., 2002). Curiosity, tolerance, a certain degree of willingness to entertain ambiguity and incomplete information, and the experience to recognize and interpret patterns are all part of the mix of attributes that characterize the potential cultural broker. Both students operated as cultural brokers with the patient when they checked in with him about his reactions; built connections between his previous hobbies and the groups on the unit; and used diaries, discussion, and a Google document to monitor and reflect on their responses.

Treatment is a process of negotiation. It is neither expected nor possible for the clinician to have complete and entirely accurate information about the patient's multiple cultural affiliations, but it is essential that the clinician recognize the possibility of conflicting vantages and the need for mutual cultural accommodation (Bonder & Martin, 2013). According to Bonder and Martin (2013), health care is a social activity, and the clinician is a facilitator. These authors believe the therapist-patient relationship is the most important aspect of health care. Developing a relationship with patients who do not share your cultural orientation requires special consideration. Bonder and Martin's advice is to come to know your patient, establish rapport, understand the patient's life as well as his or her

clinical condition, recognize the patient's goals, assess effective modes of therapy, and gain the patient's loyalty and confidence. In order to truly understand the patient's condition and satisfy the patient, the therapist may need to understand the patient's perspective on his or her condition. Both Carolina and Meg placed a high value on Nand's perspective on his suffering and illness. Although his medical background may have contributed to this valuation, it appears that Carolina and Meg were displaying their understanding of therapy as a social activity, the importance of the patient-therapist relationship, and their sensitivity to the cultural meaning of pain and suffering.

Willingness to engage in treatment may be influenced by cultural beliefs. Objective pain appears to be similar among individuals regardless of culture, but behavioral expression of pain differs significantly across cultures. In one study, American college students were far more likely to express pain openly than college students from India (Bonder et al., 2002). If the patient believes suffering plays an important role in his or her future life, he or she may be less eager to remediate the causes of the suffering. The patient who believes his or her suffering will lead to a better future life may experience the greatest subjective well being while experiencing discomfort. Carolina and Meg affirmed Nand's stated need to suffer and tolerate the pain of depression. Carolina also understood and accepted Nand's suffering because of her personal knowledge of a family member's experience with depression. When Nand expressed his ambivalence about his medication as "artificial happiness" the students accepted his need to suffer and convinced the staff

that he not be penalized for not taking his medication. In addition, the students helped the patient recall former activities and experiences he had once enjoyed to counterbalance his suffering and negativity.

Carolina and Meg were keen on delivering culturally relevant interventions, which Bonder and Martin (2013) emphasize when they remind rehabilitation therapists to not ask patients to practice putting on pants if they, in real life, do not wear them. An example of the students' fine tuned sensitivity to culturally relevant interpretations and interventions was to notice and value Nand's idiosyncratic approach to his ADLs. His style of wearing his hair long and "shaggy" was behavior he had adopted before coming to the hospital. Carolina and Meg advocated for him and his ability to make choices about his ADLs and his appearance. Other hospital staff considered his unruly hairstyle to be just another act of noncompliance akin to his refusal to take medication. Carolina and Meg accepted his hairstyle and valued his ability to make choices because they viewed his participation in hygiene and grooming activities through a culturally sensitive lens.

Therapeutic Use of Self and Implications for the Case

Mosey's (1986) definition of conscious use of self is using oneself as a tool in evaluation and intervention. She viewed it not as a spontaneous response but rather as one that requires forethought, knowledge, and efforts to incorporate rapport. Conscious use of self requires the therapist to transcend sympathy to empathy. Mosey viewed its acquisition as ongoing and resulting from therapists

learning to change their responses to clients in order to help them. Mosey reminds us that therapists are made, not born. A therapist's personal style

develops throughout the first year of practice. See Table 1 for a list of the components of Mosey's concept of conscious use of self.

Table 1
Three Approaches to Therapeutic Use of Self

Mosey (1986)	Conscious Use of Self	Respect for the individuality and dignity of patients, appreciation of culture, empathy, compassion, humility, unconditional positive regard, honesty, a relaxed manner, flexibility, self-awareness, and humor.		
AOTA (2014)	Therapeutic Use of Self	Therapists' planned use of personality, insights, perceptions, and judgments that are part of the therapeutic process.		
Taylor (2014)	Intentional Relationship Model (IRM)	12 Categories to describe Core Interpersonal Characteristics	11 Categories of Interpersonal Events	6 Therapeutic Modes
		<ol style="list-style-type: none"> 1) Communication style 2) Capacity for trust 3) Need for control 4) Capacity to assert needs 5) Response to change and challenge 6) Affect 7) Predisposition to giving feedback 8) Capacity to receive feedback 9) Response to human diversity 10) Orientation toward relating 11) Preference for touch 12) Capacity for reciprocity 	<ol style="list-style-type: none"> 1) Expression of strong emotion 2) Intimate self-disclosures 3) Power dilemmas 4) Nonverbal cues 5) Crisis points 6) Resistance and reluctance 7) Boundary testing 8) Empathic breaks 9) Emotionally charged therapy tasks and situations 10) Limitations of therapy 11) Contextual inconsistencies 	<ol style="list-style-type: none"> 1) Advocating 2) Collaborating 3) Empathizing 4) Encouraging 5) Instructing 6) Problem solving

Communication strategies must be adjusted to the cognitive level and cultural style of each patient. Mosey (1986) was an early proponent of emotional intelligence as a component of conscious use of self, emphasizing that a patient's feelings must be acknowledged, including both negative and positive feelings. She did believe that overinvolvement by the therapist could lead to a loss of objectivity but could be corrected with good supervision, while fear of overinvolvement can lead to unemotional, detached therapists. Mosey also recognized the importance of culture and its influence on everything people do. The patient and

the two students were from three different cultures. The students made conscious use of cultural knowledge and worked with different norms for the patient's emotional expression, particularly his expression of pain and sadness, and his desire for involvement in the patient-therapist relationship. Meg monitored Carolina's tendency toward overinvolvement in the therapeutic relationship through conversation and daily writings in the Google document.

Mosey (1986) linked the development of conscious use of self with the presence of adequate supervision and support systems. Collaborative

supervision increases a new therapist's ability to function independently to meet client needs and can help avoid burnout. Mosey emphasized that students must have feedback. She viewed peer supervision as something that happens ideally after the "formal supervision" process ends and as a means to continue the learning and growth as a therapist. Peer-assisted learning using electronic blogging has been found to heighten student learning, build trust, and support learners, as well as integrate theory and practice (Ladyshevsky & Gardner, 2008). There is also evidence of high levels of professional and personal development found among students when they use peer-assisted learning and long-arm supervision in role emerging practice placements where there is no OT supervision (Boniface, Seymour, Polglase, Lawrie, & Clarke, 2012).

Carolina and Meg derived personal and professional support from each other. This collaboration allowed them to tolerate ambiguity and demonstrate greater resiliency. Their shared respect for the patient and his culture and their exquisite ability to mirror his emotions allowed for the growth of empathy. Their trust in each other's knowledge, skills, and emotional intelligence informed their practice. They derived additional support from the medical team as well as their fieldwork seminar leader, whom they consulted on a weekly basis.

Therapeutic use of self is an important OT skill that defines the therapist's deliberate efforts to develop relationships with clients. The American Occupational Therapy Association's (AOTA, 2014)

official definition is the therapist's planned use of personality, insights, perceptions, and judgments that are part of the therapeutic process (see Table 1). Therapeutic use of self is understudied. Taylor, Lee, and Kielhofner (2011) researched the interpersonal strategies of 563 therapists and found the preferred approach to be an emphasis on strengths, instillation of hope, and use of positive reinforcement. The second preferred approach consisted of collaborating with clients to make more decisions and recommending that they set their own goals in therapy. A Swedish study by Eklund and Hallberg (2001) found that there is a real need to increase therapists' self-awareness, power sharing, and empathy to improve the OT relationship and treatment outcomes.

Rehabilitation is marked by negative feelings expressed by patients as they undergo treatment (Taylor, 2014). Some occupational therapists ignore these disturbing feelings and focus on functional impairments and environmental barriers. Some occupational therapists view such feelings and psychological complexities as outside their role and scope of practice. Taylor's Intentional Relationship Model (IRM; 2014) provides much-needed guidance for the profession in this area. When therapists do not adequately attend to psychosocial issues, clients usually feel alone and unsupported. If the therapist does not address psychosocial issues, this may exaggerate maladaptive coping or other psychological difficulties. The IRM was specifically developed to help therapists navigate the complexity of interacting with clients, in particular those with

comorbid psychiatric diagnoses and psychological difficulties (Taylor, 2014).

According to the IRM, the therapeutic relationship between therapist and client is fostered through rapport building, conflict resolution, emotional sharing, collaboration, and partnership building (Taylor, 2014). Client-centered care is a form of collaboration, which refers to mutual participation by both the client and the therapist. This involves choice and client-generated goals; an egalitarian relationship is implied. Taylor's (2014) approach is based on education of the client about treatment procedures and their rationale. The IRM provides a skill set and interpersonal reasoning approach necessary to sustain positive communication and a beneficial client-therapist relationship. It recognizes that it is a therapist's responsibility to build a relationship with each individual client. The IRM focuses on four components of the client-therapist relationship: the client, the interpersonal events, the therapist's use of self, and the occupation. The IRM enables the therapist to observe the interpersonal aspects of clients, be able to respond to interpersonal rifts, and communicate in a mode matching the client's interpersonal needs at that moment. The purpose of the IRM is to understand the meaning of any communication and interpersonal behavior that takes place in therapy and to provide guidance to the therapist on how to respond in the moment.

Each therapist should attempt to gain an understanding of each client's interpersonal characteristics. See Table 1 for Taylor's (2014) 12 categories of core interpersonal characteristics. The

students paid heed to many of Nand's interpersonal characteristics, especially to his communication style, capacity for trust, need for control, affect, response to human diversity, and capacity for reciprocity.

Taylor (2014) describes the importance of inevitable interpersonal events of therapy, which she describes as emotion-laden and uncomfortable situations that frequently occur in the everyday practice of OT. These interpersonal events have the potential to strengthen or weaken the therapeutic relationship, depending on how they are handled. See Table 1 for a list of Taylor's 11 categories of interpersonal events. Nand experienced and Carolina and Meg used many of these interpersonal events to build a stronger therapeutic relationship, including allowing for the expression of strong emotion, intimate self-disclosure, power dilemmas, and nonverbal cues. When Nand expressed his suffering, Carolina and Meg affirmed and validated its importance; when he refused to take his medication and was barred from going to the roof, the students reasoned that this was a power dilemma, and roof time was beneficial for his mood and recovery and advocated for him. When the other staff did not note the patient's non-verbal behaviors or when he could not communicate verbally, Carolina and Meg problem solved with him and devised a way to communicate using gestures. When Carolina shared music with Nand on her i-Phone, they genuinely communicated, which encouraged him and broadened his connections with other people as well as his connections to past interests and future possibilities.

Taylor (2014) has also identified six therapeutic modes or specific ways of relating to a client, which are consistent with the therapist's personality and employed depending on the client's interpersonal characteristics of the situation or the interpersonal events (see Table 1). Carolina and Meg employed interpersonal reasoning to decide which mode to use in the moment with Nand, and they conferred with one another about when to shift to an alternative mode.

Highlights from Carolina's notes from the students' Google document provides a more detailed understanding of their creative clinical reasoning and joint decision-making process as well as specific examples of their use of emotional intelligence, cultural competence, and therapeutic use of self.

Highlights from the Google Document

Day 1. I was curious to know about this man who would spend his days quietly in the hallway or crying in his room. He wakes up early, and depending on his mood, he sometimes refuses to eat or to take medication. He remains in his pajamas all day, often lying on his bed and staring at his ceiling. He does not interact with the other patients and avoids the community room. He is selectively mute. I asked to view his chart to gain a sense of who he was and from where he came. He came to the United States from another continent to attend college and complete medical school. He had been working as a doctor but quit his job to travel to spiritual places. He loved ethnic dancing and participated in dance groups on the weekends. He ran out of money and stopped eating, believing

that it would enable him to foster his spiritual enlightenment. He feels he needs to be in the hospital to work on himself.

I wanted to find more information that would allow me to relate to him. I began by researching the meaning of his name. Also, I sought the aid of my friends who shared his cultural background to help me gain more insight about his culture and religion. Building rapport with the patient started with small gestures. I walked up to him in the hallway and introduced myself; he smiled and timidly gestured "Hi" with his hand. I told him I would join the music therapy group and that he could come. He did not say much, but when I left, he waved "Bye" to me.

Day 2. The patient looked through the window and saw me in the community room, and we waved "Hi" to each other. I gestured for him to come inside, but he didn't want to. Instead, I went outside to him and asked him, "How are you feeling today?" He then responded in a very low tone that he was well. I started talking to him about the groups we would start next week and asked him if he would be interested in participating; he nodded affirmatively. I asked him if he was participating in other groups. He gestured guitar playing, and I asked him if he played any instruments. He pointed to his ears, letting me know that he only listened. I shared with him that my favorite instrument was the Tibetan bowl (it actually was my favorite instrument, but it was also a religious instrument, and I wanted to have more conversation with him about his spiritual travels). I told him that supposedly the instrument was used for prayers, and

he smiled and agreed. I asked him what was his favorite instrument, and he gestured drums. As we engaged in more conversation, I noticed he would speak louder (normal tone) but would then go back to whispering.

Humor really worked with him. At one point he told me he did not want to talk, so I told him that was not a problem and suggested we use sign language to communicate (that made him laugh). It also served to engage him in more conversation. I told him I was interested in learning his native language. I shared what I found about the meaning of his name, and he told me the story of its origins. We shared our favorite passages from a religious text we had both read. He described his spiritual travels, his interest in meditation, and some of the sacred places he had visited.

Day 3. The patient was not in the hallway as usual, so I went to find him in his room. He was in a fetal position on his bed. His gaze was focused on the wall, and he was smiling. I moved a chair by his side and asked him if he wanted to tell me what was going on. In silence, he started crying. I told him, “Only people with great hearts have space to cry.” He smiled. I spoke to him about self-compassion and meditation. As I talked, he would smile and move his head in agreement. Before leaving the room, I told him everything would be all right; it’s just a matter of time. I encouraged him to leave his bed, but he whispered that he didn’t want to at the moment. I told him that I would go to the music group and that if he wanted, he could look for me there.

He came to the music group and chose my favorite instrument. I chose the drums (the instrument he liked). The music therapist was surprised to see him play an instrument and move to the beat of the song, as he would normally just sit and listen. At the end of the session, we had to say a word to describe what we felt during the group. I said joyfulness, and when his turn came, he said joy. The therapist was even more surprised to hear him say a word. At the end of the group, he helped us to reorganize the room, and we shared a story from a sacred text. While talking about music, he said he liked ethnic songs. Using my i-phone, we started searching for songs and videos, and he would laugh a lot. He was making eye contact while eagerly engaging in the conversation. Other patients came by, curious about the music, and stood by our side. I introduced all of them in an effort to get him to relate to others.

Day 4. During the afternoon, I tried doing an OT assessment with him, but he did not want to do it. Instead, we started talking, and I asked him about his studies. He answered my question and immediately got sad. I inquired, “You did not like what you studied?” He said “No.” I asked, “What would you have done instead?” He said, “Dancing used to be my hobby.” He shared that he used to participate in a professional dance group every Saturday. In response to his comment that it has been too long, I said, “It’s never too late to start and dance again!” He laughed. He joined our sensory group and made coffee dough sculptures. Members of the group praised his work, which made him smile. He shared that he really liked the group.

Back in the hallway, he greeted other patients. We were standing looking at videos on my phone, and I pointed out to him that his nails were long and that's why he was having difficulty typing on my phone. I asked him if he would like to clip his nails, and he said yes.

Day 5. I visited the patient in his room to have a one-on-one. He stated, "It has been four months since I last shaved and cut my nails." I encouraged him to get groomed today. The hairstylist stopped by; regardless of his instructions to just shave him, he was shaved, and his hair was cut. Later on, the patient changed into his clothes, went to the roof, and played soccer with the other patients. He had good balance and posture and made energetic kicks and even shared some tricks. He seemed a little fatigued when he had to run for the ball, but he completed the game. At the end of roof time, he thanked us and said it was a good day.

Day 6. The patient was outside his room and started talking to me. He said, "Yesterday was a mess. I just wanted to die. It's not worth talking about now because it's a happy day today!" I told him how I worked on myself whenever I felt sad, which might work for him. I also told him that it was good that he could talk about how he was feeling, and it was also good to identify things that could make him feel better. I told him to change so we could go to the roof, but he said he was not allowed because he had not taken his medications. He said, "Medication is artificial happiness."

I discussed this situation with Meg, who encouraged me to speak with the nursing supervisor to advocate for his going to the roof despite not

taking his medication, because being active outdoors would benefit his emotional state. He received permission to go, where he played soccer and engaged in conversation with the other patients. When we were going down the elevator, he started singing the elevator song. Later, he actively participated in our movement group, often leading the group and making up steps. Other members were impressed and praised him, making him smile.

Day 7. When I got to the unit he was just arriving from the roof along with other patients. As we started talking he commented that he needed to shave tomorrow. He was talking in a normal tone and told me that he has had his ups and downs but has been noticing that he gets out of the downs faster. After lunch, I was surprised to see him in the community room playing cards with other patients, who explained that they had made a pact to keep each other distracted and to not allow each other to feel sad.

Implications for Practice and Education

Students, faculty, fieldwork educators, and practicing occupational therapists can learn from Carolina and Meg's evolving relationship with Nand. Both students entered this challenging Level I fieldwork experience well equipped with empathy, cultural sensitivity, self-efficacy, a strong background in psychopathology, OT theory, mental health assessments, and intervention strategies. Without their background coursework in mental health, these students do not believe that they would have had the confidence in their skills to be able to handle this situation. They viewed this fieldwork as a laboratory component of their mental health

course, which contained several assignments that had to be completed in the clinic.

Falk-Kessler, Benson, and Hansen (2007) have researched the value of teaching-learning experiences that provide students with regular opportunities to participate in the clinical use of theory with advice from classmates, clinicians, and faculty. Both Carolina and Meg felt empowered to use their emotional intelligence and therapeutic use of self. Carolina could empathize with the patient's depression, providing him with hope that depression is a treatable illness, knowledge she knew firsthand from her family experiences. Because she was raised in a different culture, with which she continued to identify, she was able to understand Nand's outsider viewpoint and broker connections between his private world and hers. Meg provided an invaluable relationship with her classmate by means of insightful peer support, her newly acquired knowledge of OT theory, and a moderating influence on Carolina's tendency to become overinvolved emotionally with Nand. Both students facilitated communication and social participation between the patient and other patients on the unit, using shared occupations and technology.

This case underscores the importance of continuing OT's strong tradition of educating our students with a solid mental health curriculum that includes a humanistic orientation, knowledge of psychopathology, and firsthand clinical experiences in mental health settings. The case emphasizes the impressive OT literature on building relationships based on humanistic therapy with our clients.

Occupational therapists Mosey (1986) and Taylor

(2014) teach us about empathy and the importance of emotional connections between therapist and patients, pushing the profession to get beyond a tendency to focus narrowly on function and environmental barriers. Peloquin (1993) noted in her work on the relationship between competence, caring, and patient health that occupational therapists are not viewed as helpful if they are not considered personal and only provide protocols, procedures, and skills instead of themselves.

This case also highlights the positive results produced when our students are carefully trained to trust in their own efficacy as well as to believe in the importance of forming peer relationships. The students' trust in themselves and each other provided a viable peer support system. The students were also comfortable with the client's spirituality. Peloquin (1997) encourages us to be aware of the spiritual dimension of occupation when we view our patients in therapy as making themselves stronger, not just doing and performing. What is most exciting about this case is that the students felt intellectually and emotionally equipped to turn a challenging situation into a positive collaboration, which benefitted themselves as well as the patient.

Mental health fieldwork placements are notoriously difficult for programs to find. The students' use of peer support and collaboration provides a useful example of how students can flourish in a placement without an on-site occupational therapist. These students were able to process what they were seeing and learning at fieldwork with each other as well as with an

experienced clinician in a fieldwork seminar when they required additional support. The use of Google documents allowed the students to communicate outside of fieldwork, processing patient interactions and planning for future groups and individual sessions. These students were able to provide an essential service for the patient through a developing therapeutic use of self and attributes of culturally competent and emotionally intelligent interactions.

Mosey (1986) contends that therapists are made, not born. It is through dynamic fieldwork experiences, such as illustrated in this case, that students grow into themselves as therapists. These early patient exposures help to solidify knowledge learned in coursework and the classroom to assist student therapists in the clinic to develop their own way of caring for clients using emotional intelligence, cultural competence, and therapeutic use of self.

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