Elements of the Art of Practice in Mental Health

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Objective. This qualitative study explored elements of artful practice of therapists practicing in mental health treatment settings.

Method. In-depth interviews were conducted with three occupational therapists practicing in mental health who were considered exemplars of artful practice. Themes pertaining to their perspectives and approaches to practice were synthesized from interview data.

Results. The prevailing themes—therapeutic work as a vehicle for healing, collaborative guidance, and the Zen of therapy—are seen as elements forged by the therapist’s compassion and unique personal style into a dynamic therapist-client interplay that creates a space for growth and healing to occur. Results affirmed the view of the art of practice in mental health as an intricate interplay of personal traits, interpersonal skills, and skilled use of meaningful activities within the context of a client’s environment.

Conclusion. The art of practice is a fluid, experiential process that takes place on a developmental continuum. The therapist’s inner awareness of the subtlety of a multi-layered healing process is an important basis of artful practice. One’s practice art can be informed by knowledge of specific elements that contribute to artful practice and can be developed through education, self-reflection, personal growth, and the maturation process.

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as part of a healing process in which meaning is created, changed, and maintained (Kielhofner, 1983).

Like Kielhofner, Koomar and Bundy (1991) viewed art as emphasizing active participation in meaningful therapeutic activities that elicit adaptive behaviors. They viewed each treatment session as a complex orchestration of science and art, with art being the major determinant of successful intervention. They identified six areas that reflect art: (a) decisions about where to start the intervention; (b) skillful adjustment of activities to provide the "just-right" challenge; (c) creation of activities that tap the client's inner drive while promoting self-direction and growth; (d) the transition, or flow, of one activity to another; (e) the therapist's relationship with the client; and (f) decisions about when to discontinue intervention.

Clinical reasoning, which has been likened to the art of therapy, is concerned with how therapists think and perceive in the midst of practice (Mattingly & Fleming, 1994). It is a complex and subtle process of clinical judgment that involves deliberation about what action to take in treatment with a particular client at any given point in time. It enables therapists to unconsciously shift therapeutic interventions on the basis of relevant cues. The meaning of the illness experience and of the clients' everyday activities is of prime concern. Clinical reasoning studies have focused on how clients engage in the treatment process (Crepeau, 1991; Mattingly & Fleming, 1994); how they make sense of their disability (Mattingly & Fleming, 1994); and what traits and values therapists bring to treatment (Fondiller, Rosage, & Neuhaus, 1990; Hasselkus & Dickie, 1990; Rosa, 1995). For the purpose of this study, the art of practice was viewed as inclusive of clinical reasoning yet considerably broader in scope.

There is unanimity on many of the personal traits of effective therapists; these could influence practice as an art. Empathy is one of the most frequently recurring qualities of effective therapists identified in the occupational therapy literature (Burke & DePoy, 1991; DePoy, 1990; Fondiller et al., 1990; Peloquin, 1990). Empathy is defined as the ability of one person to understand the feelings, thoughts, and needs of another and to communicate this understanding (Lloyd & Maas, 1989–1990; Patterson, 1985; Peloquin, 1995; Storr, 1980). The familiarity of the researcher with this practice area was another important consideration. However, because the therapeutic relationship is critical in all practice areas, this study can suggest ways in which all therapists can bring this awareness and presence to treatment.

Occupational therapy has long been considered to be both an art and a science (Mosey, 1981a, 1981b; Peloquin, 1989, 1994), yet the unique clinical processes documented in occupational therapy have primarily been those of science. There has been more reflection on the science of practice than on the art of practice (Peloquin, 1989). The purpose of this study was to describe elements of artful practice in mental health as a more thorough integration of interrelated elements in contrast to the more isolated elements distilled in the literature. Specific questions of interest were the following: (a) How does an occupational therapist describe his or her art of practice? and (b) What elements make up the art of practice?

Method
The methodology used in the study was based on grounded theory (Strauss, 1987), a form of qualitative research designed to generate theoretical information in order to explicate complex social phenomena. Qualitative inquiry
tightly focuses in depth on relatively small samples chosen selectively. This is known as purposeful sampling or theoretical sampling (Glaser & Strauss, 1967; Lincoln & Guba, 1985; Mariano, 1995; Patton, 1990). The form of purposeful sampling used was extreme case sampling, where exceptional participants or situations are investigated (Lincoln & Guba, 1985; Mariano, 1995; Patton, 1990).

Participants

A basic assumption of the researcher was that the art of practice could best be studied in exemplars who had developed the art of practice to a considerable degree. To identify these exemplars, 20 members of a district chapter of a state occupational therapy association who specialized in mental health were asked to recommend psychiatric occupational therapists who, in their estimation, exemplified artful practice. The three therapists chosen for the study had been cited by more than one member for their practice expertise.

The three participants were all registered occupational therapists with master's degrees who had been practicing in psychiatry for their entire careers. Gene, a white man in his mid-30s, had been practicing for 12 years and had spent the past 6 years as the senior occupational therapist in a psychiatric day treatment program. Maura, a white woman in her late 30s, had been practicing for 13 years and was currently a senior occupational therapist in a psychiatric outpatient clinic. She was pursuing an additional degree in psychology. Cynthia, a white woman in her mid-30s, had been practicing for 5 years and was currently working on an inpatient psychiatric unit. She also held a degree in anthropology.

Procedure

Each participant was interviewed three times over a 3-week period. Each session lasted 1 hour. A general interview guide was used that included questions about the participants' training and background, professional history, a description of their practice, their philosophy of practice, and personal life experiences that they believed had bearing on their choice of profession or practice style. Besides these basic questions, the format was open-ended so that answers could be probed and unanticipated themes developed.

All interviews were audiotaped, transcribed, and coded into more than 50 concept categories. Analytic memos were written after each interview to enable the researcher to reflect on the data, identify emergent patterns and themes, and generate further questions for follow-up. Identified concepts were collapsed into 32 categories, and from these, themes and postulates were distilled. Three interviews with each participant were judged to provide sufficient grounding for the findings and final themes. After in-depth interviews with the three participants, there was sufficient saturation of the data, and themes became both consistent and redundant.

Trustworthiness, or a fair handling of the research data, was established using triangulation, negative case analysis, participant review, and advisory review (Ely, Anzul, Friedman, Garner, & Steinmetz, 1991; Strauss, 1987). For this study, triangulation involved the use of multiple data sources to confirm or disconfirm a concept, theme, or postulate (Lincoln & Guba, 1985). Participants practicing in different sites were selected in order to compare and contrast their backgrounds, beliefs, and therapeutic approaches. Negative case analysis identified data that were inconsistent with patterns or themes to identify phenomena that did not fit into the emerging conceptualization. Participants were asked to review and corroborate findings synthesized from their interviews. Two expert advisors, one in the field of mental health and one in qualitative research, also provided ongoing consultation throughout the study and reviewed the findings.

Themes

Therapeutic Work as a Vehicle for Healing

All three participants viewed their work as more than just a job or a means to improve functioning. Rather, they viewed their work as a vehicle for helping others to heal. The participants all had formative childhood experiences of coping with disabilities of family members and had been sensitized to the meaning of disability. All three believed that these pivotal experiences helped them to develop compassion, sensitivity, and a desire to heal, which was later actualized in their occupational therapy work. Having to deal with psychological and interpersonal issues in family life also strongly influenced at least two participants to gravitate to mental health practice as a means of healing their own personal issues. Subthemes are described as desire to heal, sensitivity, and healing personal issues.

Desire to heal. The participants expressed a desire to heal their clients in a significant way:

I remember being just very, very sad that my brother was so depressed. I wanted to care for people and make them feel better, and help them, and that comes through in occupational therapy. (Cynthia)

It's the people with mental illness who have so many problems and such significant problems. I find that I still only make a small, significant change in their lives, and that I'm still developing more abilities to make a greater impact. (Gene)

Sensitivity. The participants thought that they were sensitive to the needs of their clients. They believed that their life experiences have enhanced their sensitivity:

I think in some way these losses affected my ability to be more sensitive to the fact that my clients are human beings just like me. They're not another object that I can just manipulate. They're actually caring, feeling, important human beings with a family, who should be treated humanely and taken care of in a just and appropriate way. Because of my experiences, I think I'm just a bit more sensitive sometimes than other professionals to the family's needs and the client's needs to be treated with respect. (Gene)

Healing personal issues. Two participants thought that...
The participants all spoke of creating a balance of collaboration and personal issues:

I think in some way [my parents'] divorce has some unconscious connection to why I took an interest in therapy because probably it was an attempt to repair my previous family problems. (Gene)

I think a lot of us go into therapy to heal personal—I don't want to call it wounds—but to heal personal issues and find help for personal problems. I think we also do it to heal family problems. I know my family was not without a lot of issues and problems. (Gene)

I was still somewhat of a shy person who had difficulty asserting myself and had difficulty speaking in public....I'd had performance anxiety.... I realized at some level that mental health practice would be more of a challenge and help me grow more as a person. (Gene)

An unconscious desire to heal personal issues could result in therapist bias and have a deleterious effect on treatment. However, the participants' conscious realization of personal issues appears to have heightened their ability to self-reflect, work through these issues on more subtle levels, and develop empathy.

Collaborative Guidance: “The Bumper in the Pool Table”

The participants all spoke of creating a balance of collaboration and guidance in which the therapist attunes to the needs of the client. Control is replaced by a negotiative process wherein the therapist respects the client's need for independence and the right to refuse treatment. When the right activity is introduced in a safe space and offered in the spirit of skillful guidance and collaboration, a special trust can emerge that facilitates the healing process. The participants described the thematic subcomponents of this balance as shaping, negotiation, the power of activity, and a safe space.

Shaping. Shaping is a process of gentle guidance in which the therapist focuses and directs the client toward emotional movement and goal attainment. Shaping is based on the therapist's understanding of the client and the ability to anticipate and accommodate the client's needs. The therapist is actively initiating an intervention informed by the client's overt or covert communication. The therapist illuminates opportunities that the client has difficulty accessing independently:

Art becomes...a creative way of dealing with a situation. It's a shaping kind of process, or, controlling it with a light touch. Shaping is a word I would rather use than controlling because I think at some point the therapist knows there ain't no such thing as total control. If you're trying to do that, you're not doing science or art, you're doing something else. Rather, it's being able to guide, like being the bumper in the pool table. You know where to place yourself and how to come up with something that the person needs that will...get them in another direction. So it's helping someone reach a goal by being both actively and passively involved in that process. (Maura)

Negotiation. Negotiation involves the active exploration of a client's feelings, thoughts, and goals; respectful feedback and guidance from the therapist; and the client's response to this feedback. Ideally, the negotiative process results in a therapeutic alignment in which client and therapist work together in a mutually agreed-upon manner toward a common purpose:

I think a lot of OTs [occupational therapists] have difficulty with wanting to control the outcome of therapy and what the client wants to do. They want the client to do such and such an activity, and when the client refuses, they get into some kind of battle or some kind of control situation. And I don't think OTs should do that. I think it should be more of a negotiative process, and the OT has to respect the client's right to refuse and the client's right for independence. (Gene)

The power of activity. Participants concurred that a well-chosen activity can be a powerful force in therapeutic treatment. The participants believed that the group activities they regularly facilitated in treatment were particularly powerful in galvanizing persons into a coherent, independent whole by providing a motivational focus, satisfying sensory input, emotional support, and social interaction. Engagement in activity involves trust in the therapist and in one's peers; there is risk involved in attempting unfamiliar activities in new environments. The development of mastery enables a healthy independence to manifest. When this occurs, the therapist can step back and allow the activity process to naturally unfold:

Activity involves people. And that is what's so powerful about OT [occupational therapy]: that we recognize that we're all in this together, that it's a joint enterprise.... You can get an activity going with a group of very regressed, sick patients; you just have to get the right activity...they can take off on it; you don't have to be hovering over them. And it's when that hum starts, that independence starts, when that sense that they really know what they are doing and can do it. Then you know you've got something and that they've taken off in some way. They've trusted you and the moment and whatever is necessary. (Cynthia)

A safe space. The therapist creates a focused and supportive physical and emotional environment in which clients can feel safe. Clients are genuinely respected and accepted for who they are and whatever issues they bring up. At the same time, limits are set when the client cannot exert self-control over actions that negatively affect other group members. Maintaining safety provides a ground for developing the trust that is essential to the collaborative process.

One study participant described a client who was working on a task in craft group and suddenly brought up a disturbing phone call that she had received the night before. While the group continued to work on their crafts, they listened and gave the woman feedback, helping her to work through her problem:

Now to say that this woman has no insight or no ability to understand her own behavior in this situation—I wouldn't say that. She's been in this group for 2 years. She feels comfortable, when working on a task, to talk about something that feels like a risk...to share with people. But to me, that's the environment—and the people in the environment—that's letting those things happen. (Maura)

The Zen of Therapy: Therapist–Client Interplay

Therapeutic moments may be experienced so fully in the present that it is impossible to analyze or understand exactly.
Spontaneity can foster spontaneity among clients, freeing
sweatshirt, but was very disorganized. To assist, the study
abiliry to step our of rigid modes of thinking or behaving
and measured what she wanted. When the result did not
turn out as planned, the client began to shout. Both the
participant and the clients asked her to stop shouting.
When she persisted, the participant then gave her 5-minute
quiet periods as “time-outs.” She described how sponta­
neous play helped to transform this exhausting encounter
into a therapeutic interchange:

We got into this thing where she said, “Well, this is the way everybody
acts in the garment district!” And she said, “You’re my assistant, and
I’m going to fire you!” And I said, “Good, I want to be fired, I don’t
want to work for you.” So we got into a very playful area for her, which
was very safe for her because she knows that stuff. This is where she’s
been for years and years, and play was wonderful for her. This is a
woman who’s beginning to drool, and she was a very attractive, very
functional person, and now she’s really got lots of medical issues. So I
was accepting her as this playful designer who was very bossy, and I
didn’t want to work for her. We did a little bit of role playing sponta­
neously. And it was play…which was so nourishing. (Cynthia)

Discussion
Most of the personal traits and skills reflective of artful
practice (previously described in the literature review) were
found to be traits espoused by the three study participants,
who used different words to describe their experience of
these phenomena in their lived practice.

The trait of empathy (Burke & DePoy, 1991; DePoy,
1990; Lloyd & Maas, 1989–1990; Mosey, 1981a; Pelo­
quin, 1990, 1995) was reflected in the participants’ com­
passionate feelings toward clients and in their attempts to
understand and attune to their clients’ needs and offer
guidance at a level that clients could allow in. The partici­
ants understood the need for respect in the therapeutic
relationship (DePoy, 1990; Gilfoyle, 1980; Lloyd & Maas,
1989–1990; Mosey, 1981a) not just theoretically, but
through their own formative experiences. The trait of gen­
uineness (Lloyd & Maas, 1989–1990; Peloquin, 1995),
was demonstrated by the participants’ honesty and direct­
ness in the interviews. How these traits manifest in actual
encounters with clients is a valuable question for future
studies.

The importance of client-therapist collaboration is a
strong theme in the occupational therapy literature (Cre­
peau, 1991; Fearing et al., 1997; Mew & Fossey, 1996).
This was corroborated by the three participants. Collabora­
tive guidance is akin to the concept of a covenant where
there is a reciprocal, trusting relationship in which the
stronger partner uses skills to empower the weaker partner
(Peloquin, 1990).

The ability to engage in spontaneous play reflects the
qualities of warmth and humor (Peloquin, 1989, 1990) as
well as a creative analysis and synthesis of problems (Burke
& DePoy, 1991; Peloquin, 1990). The participants’ desire
to heal themselves and to improve their skills and knowl­
edge relates to the ideal of self-knowledge (Kelly & McFar­
lane, 1991; Mosey, 1981a) and the quest for self-actualiza­
The participants’ views of the power of activities in the process of inner transformation also paralleled the literature (Piergrossi & Gibertoni, 1995). As the participants described it, the right activity can generate a sense of meaning and aliveness for the client. The client becomes engaged in the doing process so that new modes of experiencing, being, and relating are created. In this way, the activity becomes a catalyst for client independence, mastery, communal connection, and emotional movement.

A compassionate outlook, forged by the participants’ early family experiences, was identified as an important practice element. Although these experiences may not be a prerequisite for developing an artful practice, they do suggest that some level of caring is necessary. But caring alone is insufficient. Compassion—an empathic caring—must be reflected by an environment that engenders trust, goodwill, and social inclusion (Peloquin, 1990, 1995). This environment is created through the therapist’s choice of activities, the quality of guidance offered, and the emotional climate. When the basic preconditions of therapy are present, including a safe space, opportunities for self-expression, and a therapist who is empathic and genuine, the art of practice is more likely to emerge (Peloquin, 1989; Rogers, 1957).

This exploration into the art of practice raised many questions. Does a therapist practice more artfully with a certain population, using certain activities, with a specific approach? The participants chose the specialty area of mental health because of their personal interests and proclivities. Might therapists also choose narrowly defined areas or subspecialties, such as vocational skill development, as a means of developing their expertise or pursuing artfulness? There is also the issue of pacing: Can a therapist be “artful” all the time, or are there routine moments or downtime?

In addition to a therapist’s individual style, skill, and preferences, how much is artful practice context driven? Many external manifestations influence the art of practice. These may include, but are not limited to, the treatment setting, the population, the role of the therapist on the treatment team, and the role delineation within a given facility.

Finally, can the attitudes, skills, and approaches reflective of artful practice be taught? The art of practice as an integration of many disparate, yet interrelated elements can be difficult to embody. Separate subskills, such as interpersonal skills, have been taught in entry-level professional curricula (Furnham et al., 1980; Lloyd & Maas, 1989–1990; Peloquin & Davidson, 1993). The use of an interactive journal that includes students’ written reflections and faculty members’ corresponding written responses has been espoused as one tool that can foster reflection in practice (Crepeau, 1991; Peloquin & Davidson, 1993; Tryssenaar, 1995). Occupational therapists can gain inspiration from exemplars of art, both real (as reflected by the three participants in the study) and fictional (as reflected in the popular literature), and integrate their attitudes and approaches into practice (Crepeau, 1991; Peloquin, 1989, 1990, 1995). Other authors have emphasized mastery of one’s practice art in the context of a mentoring relationship with an experienced therapist (Koomar & Bundy, 1991).

These questions suggest interesting methodological considerations for future studies. Continual observation of treatment sessions in a range of specialty areas would provide information on the art of practice as a lived practice, both as narrative and as it occurs in the moment. Future studies could also amplify our understanding of therapeutic self-reflection and growth, clients’ perceptions of therapeutic interaction and treatment, mentoring relationships, the impact of maturation on one’s practice, and the environmental supports and constraints that influence one’s practice art.

Conclusion

I viewed the art of practice initially as an achievable but static stage; later as a more fluid, experiential process taking place along a continuum; and finally, as many continuums, each reflecting an aspect of artfulness. Yet, perhaps art is more akin to the threads of a tapestry, with intertwining layers of colors, textures, and sizes experienced in endlessly creative combination.

As occupational therapists, our practice art is always alive and everchanging. In addition to our own internal growth as we learn and mature, there will always be external changes and challenges throughout the career cycle. Viewing art as a qualification of practice, an elusive ideal, or an elite label runs counter to the occupational therapy philosophy, which promotes the potential of each person, including each therapist, to grow and develop throughout the life span. Appreciated in context, the concept of art provides a lens to focus and empower us to pursue and actualize our potential.

Although the art of practice is not always easy to articulate, the three therapists interviewed for this study were able to describe and clarify various aspects of the art of practice that they themselves have experienced. Artfulness was uniquely expressive of the person, yet some traits and characteristics were common to all three participants. By gaining an understanding of the art of practice, both individually and collectively, we can better appreciate the meaning, depth, and power of our practice. Through awareness and education, occupational therapy clinicians can find a spark of inspiration to achieve more actualized and therapeutic practice.

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