Running Head: MILITARY AND CIVILIAN DIFFERENCES IN THERAPEUTIC USE OF

SELF

Differences in the Utilization of Therapeutic Use of Self

by Occupational Therapists in Military and Civilian Settings

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This research, submitted by Connie Gill, has been approved and accepted
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Abstract

The purpose of this study was to examine the implementation of therapeutic use of self, and the factors that may influence that implementation in military and civilian settings, as described by occupational therapists who have experience in both settings. A semi-structured qualitative design was used to interview two practicing occupational therapists. Analysis of the audio transcripts resulted in two themes on the comparison of implementation of therapeutic use of self in military and civilian settings: Knowing your Population (identifying differences between the military and civilian settings) and Some Things Do Not Change (identifying similarities between the military and civilian settings). Factors influencing the implementation of therapeutic use of self in the military setting included the themes of The Military Medical System, The Military Structure and Purpose, and The Importance of Intimately Knowing about the Military as a Military Practitioner. Many of the underlying concepts of therapeutic use of self agreed with previous literature and theoretical concepts regarding therapeutic use of self. This was the first study investigating differences between military and civilian settings. Implications of this study are that a therapist should know his or her client base, be prepared to employ many means of creating rapport and promoting "buy-in," and become familiar with the client population language or jargon. The military as a community unto itself has a distinct language, jargon, and culture that influence the implementation of therapeutic use of self.

Keywords: therapeutic use of self, therapeutic relationship, military, civilian

Differences in the Utilization of Therapeutic Use of Self

by Occupational Therapists in Military and Civilian Settings

A world unto itself, the military often provides an all-encompassing and exclusive community for its inhabitants. Military identification is required to enter a military base, shop at a military store, or even see a movie in these communities. Work, education, and daily expectations for members of the military are very different from those in the civilian world. The differences between the military and civilian experience create an opportunity and establish a preference for many military members to develop a family or brotherhood within the military. The commonalities of a shared military life help define the individual military member, just as the individual helps to shape his or her military community. These commonalities may differ from those found in the civilian world, and this dichotomy is often highlighted in the media, military health literature, and military focused government programs (Fillman, 2008; Ricks, 1995, 1997). It is these commonalities and differences that create public stereotyping, which can be both helpful and harmful when interacting with unfamiliar populations.

Practitioners moving from one setting to another may find information on the new setting to be helpful in providing for the smoothest possible transition for client care and practitioner comfort (Thobaben & Sullivan, 2005). As therapeutic use of self and its components play a significant role in determining positive rehabilitation experiences particularly in occupational therapy (Pellatt, 2004), as well as feelings of competence among therapists (Hasselkus & Dickie, 1994), research identifying differences in the therapeutic use of self techniques used for different populations could be very useful to occupational therapists and other medical professionals as they move from one practice setting to another. Information on military and civilian settings will become even more crucial as both civilian and military occupational therapists will see

increasing numbers of combat veterans as military personnel return from the conflicts in Iraq and Afghanistan.

Therapeutic use of self in occupational therapy is a concept most commonly defined in present-day literature as "planned use of his or her personality, insights, perceptions, and judgments as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). Taylor, Lee, Kielhofner, and Ketkar (2009) asserted that the subject matter seen in the research on client-therapist interactions is contained by the breadth of therapeutic use of self as previously defined. In addition, the client-therapist relationship is perceived as a fundamental component of the occupational therapy process (Lyons, 1994; Price, 2009). Collectively, client-therapist interactions and relationships fall within the scope of therapeutic use of self.

Research on the topic of therapeutic use of self in occupational therapy is limited (Leber & Vanoli, 2001; Taylor et al., 2009), and the research that is available does not compare therapeutic use of self across different populations or settings. However, an emphasis in making practitioners aware of the importance of therapeutic use of self is apparent from current occupational therapy curricula and the 2004 American Occupational Therapy Association's list of research priorities (American Occupational Therapy Foundation & American Occupational Therapy Association, 2004).

History provides a view of how the emphasis on different aspects of therapeutic use of self has fluctuated to mirror the models and needs of the times. Prior to the conception of the field of occupational therapy, moral treatment of individuals was introduced in Europe in the 1700s, where the approach was one of humanitarianism encouraging engagement in occupation as treatment. As the medical model took hold in the mid-twentieth century making medications, surgeries, or technology-based treatments a focal point, occupational therapy paralleled this shift

in philosophy and therapists focused on the underlying impairments of a client's body or mind. Late in the twentieth century, the field has re-embraced its holistic roots of focusing on the individual as a whole person and enabling occupation through a wide range of treatments. Although the emphasis on different aspects of therapeutic use of self has changed with the times, the overarching belief in the benefit of therapeutic use of self has remained a central tenet in the field of occupational therapy (Taylor, 2008).

Much of the information available on therapeutic use of self reflects the models and relationship theories in psychotherapy, as many of the theories that guide psychotherapy are similar to those that guide occupational therapy. Taylor (2008) has noted, however, that the relationship between an occupational therapist and client should not just emulate the relationship between a psychotherapist and client in a psychotherapy model. In a psychotherapy model, the predominant interaction is between the psychotherapist and the client, however, in the intentional relationship model, the occupational therapist-client interface is only one of the interactions that occur. The main focus remains on the client, while other interactions including occupational engagement, interpersonal relations, and employment of therapeutic strategies are also deemed important (Taylor, 2008).

In occupational therapy, the client-therapist relationship has been found to be an important factor for clients (Darragh, Sample, & Krieger, 2001; McKinnon, 2000; Peloquin, 1993), resulting in a positive rehabilitation experience (Pellat, 2004), as well as helping therapists foster feelings of competency (Hasselkus & Dickie, 1994).

Research exploring components of therapeutic use of self as perceived by the client has found the client-therapist relationship to be an important factor in the therapy process (Darragh et al., 2001; McKinnon, 2000; Palmadottir, 2003, 2006). Darragh et al. (2001) used a qualitative

methodology in seeking out the qualities of the experiences of 51 people that influenced their healing and rehabilitation after a brain injury as they traversed the continuum of care. The clients used descriptions including friend, mentor, team member, and advocate to describe the roles that their practitioners played in their lives. Other study findings suggested that attention to the client-practitioner relationship enhanced the services provided by the practitioner. Furthermore, clients reported that they wanted professionals to listen to them and understand their issues (Darragh et al., 2001), which directly speaks to the need for positive client-practitioner interactions. Similarly, through a qualitative and quantitative phone survey of 107 clients, McKinnon (2000) found that clients identified a therapist's practice characteristics, including interest and respect toward the client, not only as the most valued by the client but also as eliciting open and clear communication. Qualitative studies by Palmadottir (2003, 2006) found the client-practitioner relationship to be facilitated, in part, by factors described as informal, including the client-practitioner interaction, environment of interaction, and type of service provided. This informality allowed for the development of trusting relationships, which were described by the client as a close friendship or equal relationship.

Occupational therapy practitioners also feel that components of the therapeutic use of self are helpful in the client-practitioner relationship (Cole & McLean, 2003; Leber & Vanoli, 2001; Rosa & Hasselkus, 1996; Taylor et al., 2009). Both Cole and McLean (2003) and Taylor et al. (2009) found that therapists felt that there was a strong relationship between the therapeutic relationship and outcomes of therapy. In fact, Taylor et al. (2009) reported findings from their descriptive and qualitative survey that most therapists list therapeutic use of self as the most important skill in occupational therapy practice. Cole and McLean (2003), through their survey, found that therapists emphasized the importance of rapport, communication, and empathy.

These data supports the qualitative findings of Rosa and Hasselkus (1996) where therapists described many of the same attributes to be of importance in their relationships with clients. Leber and Vanoli (2001), using a survey, studied a specific aspect of the therapeutic use of self, and found that clinicians also perceive humor as positive, and that it has a place in clinical practice.

Many of the same themes connected to therapeutic use of self were consistent across practitioner and client opinions in qualitative and quantitative studies. The small sample size in quantitative studies can have limited generalizability, and the lack of consistent survey use has limited the comparison of results. Regardless, the current research on therapeutic use of self supports its implementation in therapy, and has shown the positive implications its use can have on a client's perceived recovery. Differences between the experience of men and women clients in occupational therapy suggest that more attention may need to be given by occupational therapists to differences of preference according to gender (Palmadottir, 2003). The same may be true for other sub-populations; however, no research on therapeutic use of self and different populations has been published. Little research has been done on possible changes in therapeutic use of self as a practitioner changes practice settings or patient populations. Sinclair (2003) stressed being informed before making a change in practice, and Thobaben and Sullivan (2005) emphasized the negative implications of not adjusting to a new practice setting, specifically for nurses. Knowing differences in therapeutic use of self and the strategies that are most effective with a particular population may help the occupational therapy practitioner adjust to placement in a new setting, and assist in a smooth transition between practitioners for the client.

Transitioning between the military and the civilian medical settings may be more common than is realized. The military offers options for school debt repayment and training that

encourage medically educated individuals to serve their country. A good starting salary and the

opportunity for experience can make the military an attractive option. However, pay in the

civilian medical field surpasses that of the military as experience increases, but active military

benefits can rival or surpass those working in civilian jobs. Although some medical

professionals enjoy the camaraderie of being in the military and working with other military

medical professionals, for many others the demands of the military, specifically the transient

lifestyle, can outweigh the benefits, thus encouraging them to serve their term and enter the

civilian world (Galvin, 2001).

According to Ricks (1995, 1997), there are major differences in the values between

military and civilian communities. Although research has found little to no difference between

military and civilian medical practices, no research has been done comparing military and

civilian client relationships with medical providers (Jackson, O'Malley, & Kroenke, 1999).

However, complications have been identified for medical providers in the military pertaining to

the demands of playing multiple roles and potential conflicts with cohorts or superior officers.

Problems identified included a gap between the relationship created with a client and the

relationship created with the same individual outside the medical setting. Studies and military

tradition indicated caution over the types of relationship that can be allowed (Johnson, Bacho,

Heim, & Ralph, 2006). Currently, there is a great deal of attention given to helping military

members transition back to civilian settings (Fillman, 2008). This information, along with the

military's use of a different medical system, suggests the need for data on therapeutic use of self

techniques used by practitioners in the military compared to those used by practitioners in

civilian settings to identify possible differences. Therefore, the purpose of this study was to

examine the implementation of therapeutic use of self, and the factors that may influence that

implementation in military and civilian settings, as described by occupational therapists who have experience in both.

Method

Research Design

This study was conducted using a semi-structured qualitative design in order to explore the differences in occupational therapists' perceptions of implementation of therapeutic use of self in the active duty military setting compared to the civilian setting. Participants in the study were each interviewed once using pre-determined interview questions. Participant interviews and the researcher's field notes were recorded and analyzed. This design allowed a comparison to be made between two different practice settings, and the ability to more thoroughly investigate occupational therapists' perceptions of therapeutic use of self in military compared to civilian settings.

Participants

The participants of this study were two occupational therapists who have worked in a military setting with a majority caseload of active duty military personnel for at least one year, have worked in a civilian setting with a civilian caseload for at least one year, and have worked in both a military setting and civilian setting in the last 30 years. Both participants served in the military as active duty military personnel. In order to protect the privacy of the study participants, given the limited number of occupational therapists meeting the inclusion criteria, limited demographic information, collected as part of the study, has been included. Exclusion criteria for the study included occupational therapists who were unable to meet with the researcher face to face or by phone for approximately 30 minutes to one hour, occupational therapists who had not practiced as a clinical occupational therapist in the past two years,

occupational therapists who work primarily with children, and non-English speaking

occupational therapists. Occupational therapists that were thought to meet the inclusion criteria

for the study were identified by University faculty and contacted by the researcher. A snowball

method was used to identify and contact other occupational therapists meeting the study criteria.

Procedures

This study received approval from the University of Puget Sound Institutional Review

Board. Individuals thought to meet the inclusion criteria for the study were provided with basic

information about the study (such as the topic of interest for the study, why they were contacted

as a potential participant, inclusion and exclusion criteria for the study, and expectations of the

participant if they choose to participate) as well as the contact information of the researcher.

Potential participants were asked to contact the researcher if they were interested in participating

in the study. Due to participant concerns, approval was obtained from the Judge Advocate

General's Office granting permission to participate in the study. Meeting times and places for

interviews were then arranged for each participants. Prior to starting the interview, the

participant was asked to sign a consent form for participation in the study and demographics

information was collected including gender, a list of all practice settings they have worked in,

active duty or reserve military service, total number of years of practice, and number of years in

each practice setting. The participant was then asked to discuss his or her perceptions on how

therapeutic use of self is different in the military setting compared to the civilian setting, using a

list of questions that were derived from the Therapeutic Relationship Survey used in Cole and

McLean (2003), and other areas of therapeutic use of self identified in definitions of the terms

'therapeutic use of self' and 'the therapeutic relationship' (Cara & MacRae, 1998; Cole &

McLean, 2003; Price, 2009; Peloquin, 1993; Punwar & Peloquin, 2000; Rosa & Hasselkus,

1996; Taylor, 2008). The interview questions were reviewed by a fourth year clinical

psychology doctoral student and the university research advisor. Interviews were structured to

be between 30 minutes to one hour long and were recorded and later transcribed for analysis.

Data Analysis

Data analysis using audio recordings, transcriptions, and field notes was first attempted

according to a pattern-matching schema given the semi-structured interview style of this

research. This type of analysis allows each participant's responses to be compared to the

corresponding responses of the other participant. However, the pattern-matching schema was

ineffective in creating themes organized around the purpose of this study. Therefore, a coding

system was employed to identify recurrent themes in the data in order to allow for investigation

of unplanned themes.

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Results

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The collected data formed two groups of information addressing the two purposes of this

study. The first group included two themes with a number of interrelated sub-themes associated

with therapeutic use of self. The two over-arching themes of therapeutic use of self were:

Knowing your Population, and Some Things Do Not Change. The theme of Knowing your

Population identified differences between the military and civilian settings by defining the

military as its own culture, and identifying the commonalities and differences between the

settings, specifying the following sub-themes: Finding Common Ground, Creating Connections,

Communication, Selling it, and A Team Approach. The theme of Some Things Do Not Change

encompasses all of the sub-themes of therapeutic use of self that the informants identified as

unchanged by the population being served including Empathy, Procedural and Conditional

Reasoning, and Therapeutic Use of Touch.

The seconding grouping of information created from participant data was the underlying factors that influence the application of therapeutic use of self in military compared to civilian settings. The underlying factors are represented by the themes of The Military Medical System (both its structure and its free medical care), The Military Structure and Purpose, and The Importance of Intimately Knowing about the Military as a Military Practitioner.

Therapeutic Use of Self

Knowing your population. Participants emphasized the importance in recognizing that "the military is a culture." Samantha (her assigned pseudonym) explained that the active military population is generally younger, in better shape, and thus heals more quickly. Jane (her assigned pseudonym) described a similar view of the military saying "The military is the largest corporation in the United States. They have a physical fitness plan that three days a week or five days a week you exercise. Do we have that in the civilian community?" Samantha also discussed the attitudes of clients regarding their injury in the military compared to the civilian setting by saying "I think with the military guys, they are more likely to go, 'I am here. Fix me'…whereas the civilians are more likely to go, 'Oh, woe is me.'"

In discussing areas that may be different in a military compared to a civilian setting, Jane spoke about pain as an area that may be different from one setting to the other,

> In the military, you have standards of fitness so I think there is a difference in their perception of pain, there may be a difference there sometimes culturally—you have individuals that pain is really important to their culture of how you deal with pain. The military is a culture. It may be that you are an infantry guy—you are supposed to be tough. But you still have pain, how you verbalize it may be a little different context than that little grandma in the clinic, so I think there is probably some differences there.

Additionally, Jane spoke about the emotional issues, interpersonal issues, and counseling topics that arose from military and civilian settings as being partially dictated by the person's job.

Samantha identified emotional issues as often being connected to the injury and the background on how the injury was sustained.

The most recurrent topic throughout the interviews when identifying differences in military and civilian settings was the medical system. Jane identified the military medical system as being a socialized system that operated on a hierarchy where the active duty military members are given the highest priority. This enables providers to see some clients as often as necessary without the influence of how many visits insurance will cover. Samantha compared the military system to an "open credit card", allowing continued care for the military service members who need it. The military medical system also plays into the "promise that the military would provide free medical care" and promotes the expectation among military members that medical care is free. Conversely, the civilian population expects to pay for medical care and is more aware of the limitations and restrictions that medical insurance puts on a person's medical care. This was expressed by Samantha as:

> Soldiers learned that while they were in the service that they get free medical care. They are shocked when they leave that it is not free anymore and it is a mindset that is different because on the outside, most people know that their insurance company won't pay for something and that is the limit—anything beyond that comes out of their own pocket. Or if they don't have insurance, they know they have to pay for it out of their own pocket. I think that is a big difference in their attitude towards participating in any kind of medical treatment, whether it is therapy or going to the doctor.

Samantha continued by speaking about how this system of free medical care influences the attitude that military members have towards medical care. This idea is reflected throughout many of the following sub-themes.

Finding common ground. Rapport is an integral part of therapeutic use of self, and was discussed by both participants at length. Jane said that in every setting the therapist has to find the common ground between therapist and client. For instance:

> If it's a topic—making wine. I have patients that make wine. I don't make wine, so tell me how you involve yourself in that process- what is step one? And if you get them talking about their hobby and their interests, their lifestyle—you get that therapeutic use of self, you get them invested in you, in the clinic and we can get to that endpoint which is going back to making wine.

However, finding that common ground in the military may be easier to do if the therapist has experience in the military and can therefore understand situations the client has been in, and perhaps the therapist has been in his or her self, as expressed by Jane in the following:

> I think if you are going to work in the military environment or even in a VA type of system, it would behoove you to have been on active duty because have you ever slept in a foxhole? And so, if you have someone who is a combat arms soldier—type of person, how do you come back and explain 'my arm hurts because I slept on that hard metal surface'? So, if you have a concept of what they are talking about-and that goes back to that language and communication skill.

Jane discussed that past military experience of the therapist may influence the military clients to have more trust in their provider, and that a practitioner may be more effective in creating a therapeutic relationship with their military clients because of this connection. She also commented that a civilian practitioner who has a great reputation may accomplish a similar type of trust just as quickly with civilian clients depending on the situation.

Finding common ground between the therapist and client was expressed by Samantha as she discussed the importance of knowing the structure of the military as well as someone who has been in the military does, and using that insight to influence how clients are addressed in the therapy process in order to optimize success.

> We have one therapist who has had no military service at all—had a little trouble understanding the difference in rank stars and knew it existed, but what I see is that she tends to treat everybody like it doesn't matter whether you wear the uniform or not—you are a patient. I think because of my background in knowing that there are differences, I tend to treat some people just a little bit more carefully than others—it is easier to tell an active duty soldier this is what you have to do, now do it, as opposed to a senior supervisor officer where you have to kind of cajole them and basically convince them they have to do it.

She feels that it is beneficial to be more direct with the younger military personnel because they are used to following orders and because they have an understanding of the importance of tasks given in orders rather than providing choices, whereas it is advantageous to finesse the higher ranking officers into participating in the elements they need to do as part of treatment. Her experience viewing other occupational therapists who did not have the benefit of previous military experience, is that their limited understanding of the structure of the military impacted their ability to consistently obtain the best results from their military clients.

Creating connections. Creating connections with the clients is influenced by a number of factors, including finding common ground as previously discussed. Jane and Samantha also identified the medical system as a time-dependent factor in creating rapport with clients. Jane commented about the limitations on the number of visits approved by civilian medical insurance companies: "I think that's (rapport) incumbent upon you, the therapist, to be creative in how you establish that rapport. If you only have six visits you better have a dynamic personality."

Both Samantha and Jane expressed the sense that the military health care system allowed them to more readily focus on clients. They felt that the military system is structured to provide care, while the civilian system is income driven and therapists are measured on productivity as it relates to money rather than client care. Samantha described this in a civilian setting as

> Every patient you see is an X-number of dollars that you are seeing and the more people you see, the more money comes in for the facility or for your job. So, you get measured by your productivity. That is a terrible word that we use a lot in whatever setting—it doesn't matter whether it is military, but the civilian world is driven by numbers and in the military it is not so much driven by numbers because we also have a duty to serve and we are supposed to see them regardless.

Communication. Communicating with clients was expressed by participants as being both dependent on the therapist's skill level and his or her knowledge of speaking to the client in

a manner appropriate to that client's context. Jane expressed this as being able to speak their

language:

> I think if you can speak their language. And I don't mean Spanish, I don't mean
> French—I mean that truck driver that comes in, you can talk to him about tie—
> downs and you can talk to him about load shift and you can talk to him about
> what he needs to do for his job or that little grandma who sews and is very
> worried about it because she can't see quite as well—how is she going to be able
> to make that quilt for her kids or her great grandkids?

Both informants compared the language of some military clients compared to that of civilian

clients. Knowing the acronyms and military jargon that are used by military personnel and

appropriately addressing expectations for use of words, phrases, or jokes that may be offensive in

a clinic setting were expressed as an important skill for a therapist. Being able to speak a client's

language enables a therapist to effectively communicate with a client while also enabling clients

to express himself or herself and be understood. Open communication with clients in all settings

takes time and trust. Samantha expressed that being able to effectively communicate with the

client seems to decrease the amount of time necessary before someone will open up. In the

military setting it was reported as being both simpler and harder to create a clear line of

communication. It was described as simpler in that the military has a language of its own, and

once a therapist is fluent, it can be used effectively with a majority of clients, however, it is also

more difficult because of the background of some of the clients, coming from all male units

where open communication about things like emotions is not commonplace or socially

acceptable. Samantha articulated this idea as

> Stereotyping it, I would say it is more difficult because if they are outpatients,
> they are going back to their unit during—when I don't see them. And I keep
> telling them, you know, I see you three hours out of a 7-day week, you have to
> live with yourself and the other people. And they have to go back to an
> environment where it is considered to be bad for a guy to cry or for a guy to feel
> that he has problems with his emotions.

Selling it. Getting the client to collaborate, buy in to treatment, and participate

effectively in sessions requires selling the treatment plan and yourself as a therapist to the client.

In the civilian setting, getting the 'buy-in" from clients also requires the therapist to employ his

or her therapeutic use of self; however, in the military setting, military personnel are compelled

to attend and participate in sessions by their chain of command making therapy more of an

obligation. Jane expressed this by saying:

> I do think there are differences in that (collaborating). I cannot demand that you
> the civilian come into the clinic for therapy. And soldiers can refuse, airmen can
> refuse treatment; however, their command may require that they attend this class
> or that class or this therapy session. So again, by sheer nature of the occupation,
> the military is not a democracy.

Samantha spoke of military clients coming into therapy after missing a session and being upset

that they had been recorded as a 'no show' because their command had seen the attendance

report and the client had gotten into trouble for not attending. In the military, someone besides

the client has an invested interest in that client getting better, and has the power to require that

client to attend therapy. Samantha expressed this as:

> I would say that the military setting as far as the patients are concerned versus
> working in the clinic environment—the patients who are active duty have a
> supervisor, a boss, a commander who is very interested in their soldier's health.
> They want the soldier to get better. They demand that the soldier participate and
> get very angry if the soldier doesn't. The soldier will come and say, "You put me
> down as a 'no show' and I wasn't a no show—I showed up but nobody was there,
> so I left." They will have all kinds of excuses but it is an excuse that is because
> somebody else is riding their shoulders. That I think is the biggest difference
> because of that supervision.

In the civilian world, clients may have guardians or other family members who encourage the

client to attend and participate in sessions, however, they don't have the same authority as a

military member's command. Therefore, the civilian population requires the therapist to be more

conscious of getting the person's "buy-in".

A team approach. The military medical setting has many advantages working as a team over the civilian medical setting as described by Jane and Samantha. The authority that the military has on its service members to require them to attend therapy was emphasized by Samantha multiple times to impress upon the author how the military works as a team to ensure that its members meet the physical fitness requirements. Additionally, both Jane and Samantha expressed that the military medical system offers more autonomy for the clinician in their practice while also providing the occupational therapist a position in a cohesive team of medical personnel that treats a client as a group. The ease of interaction between medical professionals in a military setting was emphasized by Jane, as she discussed having direct access to a client's physician in the military medical setting, but her experience in the civilian setting required her to first communicate with the physicians nurse before accessing the physician. Additionally, because the military works as one large organization, the medical system and its staff are able to refer clients to services in the military community, which may be more accessible than in the civilian setting, in a more direct manner than is available in the civilian setting.

The military's structure requires its service members to work together to accomplish military maneuvers and other aspects of the job. This experience of working in a team was recognized as an asset while working with the individual client by Jane

> I think probably the military—the individuals tend to work in a cohesive team and once you have interacted well with them, they will interact back with you quite well. So you already have kind of a firm footing as far as a trust that is developed.

Both informants felt that previous experience working as a team in the military provided a foundation in which to employ therapeutic use of self.

Some things do not change. The military culture creates unique situations where implementation of therapeutic use of self for occupational therapists differs from the civilian

population. However, a number of the core elements of therapeutic use of self were understood

and reported as the same regardless of whether a clinician working with a military or a civilian

client.

  Empathy. Empathy was described by both participants of this study to be unaffected by

working in a military or civilian setting. It is an integral part of being an occupational therapist.

Having empathy with a client does not change according to the client's job, background, injury,

or experience. Jane explained it by saying "A client is a client, a patient is a patient. I think you

can be empathetic – one versus the other (military compared to civilian), I don't feel makes a

difference."

  Procedural and conditional reasoning. Much of clinical reasoning includes the use of

"procedural reasoning" (defined as "addressing functional limitations") and the use of

"conditional reasoning" (defined as "creating meaningful experiences") (Cole & McLean, 2007),

and were identified as being similar across settings and clients by both participants. The

reasoning behind addressing a client's functional limitations does not change from a military

setting to a civilian setting.   These areas of clinical reasoning are dependent upon a client's

injury and dictated by the outcome required for adequate function. Additionally, the need to

create meaningful experiences as part of therapy does not change from working in a military

setting to a civilian setting, meaning that clients will always respond better to experiences that

are specifically meaningful to him or her; therefore the need to create a meaningful experience

for a client does not change according to the practice setting.

  Therapeutic use of touch. The use of touch in therapy was described as changing

according to the individual client's needs, and possibly according to the age of the client,

however, the military compared to civilian therapy setting does not influence how therapeutic

use of touch is employed. Samantha described therapeutic use of touch by saying "I don't think there is a difference between active duty and civilian. I do think it has more to do with age. Older people appreciate the touch, younger people are kind of like, 'Why are you touching me?'"

Thus in summary of the theme of therapeutic use of self, the overall responses from participants regarding the areas of therapeutic use of self identified as similar for both military and civilian settings were that these areas were exclusively client specific. This indicates that therapeutic use of self is influenced both by the specific client as well as the practice setting.

Underlying Factors Influencing Therapeutic Use of Self in a Military and Civilian Setting

The military medical system. The military medical system was represented by the participants to be the single most important factor affecting the differences in a therapist's therapeutic use of self in a military compared to a civilian setting. The military medical system was described as being hierarchical in providing client care first to active duty personnel, cohesive in providing a team environment for its staff while also enabling autonomy, unrestricted by caseload productivity, as well as being compared to a credit card in the lack of limits on care given per client. Its free services were described as encouraging the idea amongst its active duty soldiers that medical care is free, providing a disservice to those military members who later re-enter the civilian world. The differences between the military and civilian medical system were presented as influences that changed the way clients and practitioners interact in one setting compared to the other.

The military structure and purpose. The military's structure and purpose was represented by the study participants as another important influence that impacts a therapist's use of therapeutic use of self in the military compared to the civilian setting. Also, both participants discussed that the individual jobs that a military member performs and the environment in which

he or she performs it are parts of the military structure and purpose. For example, a majority of

the military are young men, many of whom are employed and trained as combat soldiers who

work and are housed with a majority of men in the same line of work. This type of day-to-day

environment influences some military members to speak differently from civilians and

sometimes interact differently with others, hence becoming a culture.

   The importance of intimately knowing the military. Intimate knowledge of the

workings of military culture as a military practitioner was described as critical in working with

the population, and was the final overarching theme discussed by the study participants. The

study participants discussed how their experience as an active duty military member has been

beneficial to their abilities to create therapeutic relationships with their clients as well as some of

the difficulties that therapist without military experience seem to have while working in a

military setting.

<div align="center">

Discussion

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   The current literature on therapeutic use of self focuses specifically on a therapist's

utilization of his or her skills in the implementation of therapeutic use of self (Cara & MacRae,

1998; Cole & McLean, 2003; Price, 2009; Peloquin, 1993; Punwar & Peloquin, 2000; Rosa &

Hasselkus, 1996; Taylor, 2000). The results of the current study, on the other hand, move the

focus of therapeutic use of self from the therapist to the client and the practice setting. The

results of the current study followed the intentional relationship model presented by Taylor

(2008), where the occupational therapist-client interface is only a part of the system and the

client is the focus. Taylor's (2008) intentional relationship model also includes the client's

occupational engagement and interpersonal relating as key factors. These factors parallel the

findings of the current study in regards to the influence that the military lifestyle and job have on

military clients, as well as the communication style and team approach that impacts a military member's interactions with others.

Fillman (2008) and Ricks (1995, 1997) wrote of the military and its members as being different from the civilian world in their work, education, and daily expectations. Samantha and Jane repeatedly and specifically discussed the differences between a military member's work and daily expectations in contrast to those of the civilian population. These differences were reported as influencing some of the differences in implementation of therapeutic use of self among the military and civilian settings. Jane spoke of these differences calling the military its own culture, concurring with Fillman (2008) and Ricks (1995, 1997) in their descriptions of military communities. History has provided recent examples of how therapeutic use of self has evolved according to the models of the medical field and the needs of the times (Taylor, 2008), therefore, it seems reasonable to expect differences among cultures as well.

Military culture and military regulations create restrictions on the types of relationships that should be formed between members of different ranks (Johnson et al., 2006). These restrictions were discussed by Samantha, when she spoke of treating ranked clients in a different manner in order to achieve optimal results from therapy. The therapist's treatment of clients according to rank may be connected to the regulations that strive to prevent certain types of relationships or limit the level of interpersonal interaction in the military. She also spoke of how a fellow occupational therapist with less understanding of the military rank system appeared to be less effective with military clients. This indicates that the military clients may respect regulations that influence relationships and expect them to be followed in the medical setting. These rank specific interactions in many cases may formalize the relationship between therapist and client. Palmadottir (2003, 2006) found that clients in a civilian setting appreciated the

informal atmosphere of the therapy setting and felt that it allowed for trusting relationships to be developed. In the military setting, however, the formalities of the rank system allow for a different type of trust that may be inherent among military members.

The participants of this study also conformed to the ideas of Fillman (2008) and Ricks (1995, 1997) in regards to the military being a brotherhood. Participants were willing to identify differences in the implementation of therapeutic use of self, but repeatedly defended those differences with explanations identifying the underlying factors discussed in the results section. They also highlighted aspects of the military medical system that enabled them to do more for their clients than the civilian system allows. Areas where the military system could improve were also noted, the participants presented the military medical system as different from the civilian system in positive ways.

Jane requested, in order to prevent misrepresentation, that the study data be carefully analyzed due to the way in which therapeutic use of self, a complex concept in occupational therapy, has been dissected into pieces to be configured and studied. By analyzing individual aspects of therapeutic use of self and requesting information from participants according to those individual aspects, a number of themes were extrapolated from the data providing an itemization of differences and similarities in therapeutic use of self among the settings explored. However, therapeutic use of self is not an aspect of occupational therapy that can be employed in pieces. As specified earlier, therapeutic use of self is a process, one that is likely different for each therapist, and according to the analyzed data, may also be different in a military compared to a civilian practice setting. These differences are influenced by a number of factors including the medical system, the client's culture, and a therapist's experience. Therefore, the results of this study are not meant to infer that one medical setting is better than the other, rather the results are

meant to provide information and understanding to practitioners who may be transitioning from one setting to the other in an attempt to provide the best possible client care during transitions.

Limitations

This research was performed using the input of two occupational therapists from the same area of the country working for the same military facility. Due to privacy, limited participant demographic information has been included, restricting the readers ability to consider the participants' experience level in each setting while interpreting results. Due to time constraints no member checking was performed and the data were not able to be coded by another researcher for peer checking.

Suggestions for Future Research

The areas of therapeutic use of self that have been identified in this study as different in the occupational therapy military setting compared to the civilian setting should provide a guide for practitioners who may be transitioning from one setting to the other. Additionally, the aspects of difference between settings and the factors that influence those differences may have the potential for generalization to many different settings, although future research would be needed to support those generalizations.

Implications for Occupational Therapy

There are a number of implications for the field of occupational therapy that can be gleaned from this research. When working with clients in different settings, be aware of and know the client base, prepare to employ many different means of creating rapport and advocating for "buy-in" from the client, and become familiar with the client population language or jargon in order to communicate most effectively. Conversely, some aspects of therapeutic use of self are more ingrained in occupational therapy and do not change with differences in clients

including: displaying empathy, the need to address functional limitations and meaningful

experiences, and therapeutic use of touch. Therapeutic use of self is a concept that includes

many different aspects of working with a client. Individually these aspects address some of the

different needs of each client or client population, but when employed together they enable the

creation of a relationship with a client upon which therapy can thrive.

Conclusion

This study gathered the opinions and experiences of different aspects of therapeutic use

of self from occupational therapists who have worked in a military and in a civilian setting.

Results have been presented according to the areas of therapeutic use of self that were discussed

and the underlying factors acknowledged as influencing the differences in military and civilian

use of therapeutic use of self. Many of the findings of the study parallel findings from previous

research and theoretical concepts regarding therapeutic use of self. Additionally, the identified

differences among military and civilian populations and settings that influence the

implementation of therapeutic use of self in the military setting mirror those reported in the

literature. The implications of the findings of this study call for a therapist to know his or her

client base, be prepared to employ many means of creating rapport and promoting "buy-in", and

become familiar with the client population language or jargon.

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