The Humanistic Approach to Occupational Therapy

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By

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To Yehuda Fried, in his memory

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For the radio station, “Galay Tzahal”, which hosted, in 2010, a course called “Occupational Therapy: Humanistic Approach“. The course was part of a radio program called “The Broadcast University”, and I lectured one episode a week.

It was the first time on the airwaves in Israel that the profession of Occupational Therapy was discussed in this way - on such a stage and on this national scale.

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CHAPTER 1

THE HISTORY OF OCCUPATIONAL THERAPY: THE BEGINNING OF THE PROFESSION

The beginnings of the profession of occupational therapy (OT) date back to the start of the last century, the period that began after the First World War. At the end of that terrible war, in all the European countries that took part, tens of thousands of disabled and handicapped people flooded to the medical centers. These traditional medical centers could not bring relief to all those patients by way of traditional medical care. Those disabled veterans, most of whom were actually long term, chronic patients, who had lost the ability to function for a long period of time, needed long-term treatment, thus becoming a heavy financial burden on the state. The socio-economic damage was severe in Western and Central European societies, which held themselves responsible for supporting those who were injured in the war, and saw it as a moral obligation not to leave those patients helpless at the margins of society. On the other hand, it was clear that traditional medicine was not able to solve the problems of so many chronic patients, and even less so when it came to providing appropriate answers to such a large number of chronic patients requiring treatment as a result of the war. In this predicament, the people involved started to focus on providing treatment designed not to bring the patient to a full and spontaneous recovery, but simply to assist the patient to continue with his daily routine, and to stick with it despite his limitations, and despite experiencing a certain sense of deficiency and trauma, regardless of the dramatic change in his lifestyle resulting from his injury. Such treatment, in an established and professional setting, did not exist at that time. That is how the "physical occupational therapy" given to people with a physical disability has been termed ever since the inception of the profession. But in fact, even before the First World War there was a large number of chronic patients who needed this type of treatment, and the treatment they received was not termed "physical occupational therapy", because the injury they suffered was a mental disability, and therefore the needs of such a disability were different from those of patients suffering from a physical disability.

The beginning of the Treatment of the Mentally Handicapped

Until the end of the 18th century, and in fact right up until the French Revolution and the winds of change that accompanied it, the mentally ill in European society (and its American counterpart) were not treated as sick. But by the end of that century and the beginning of the 19th, a French doctor by the name of Philippe Pinel (1745-1826) changed all that. Pinel removed the mentally ill from the inhumane prisons they were held in, and transformed those institutions into shelters that were actually more like a sort of hospital. There they were released from the chains that had bound them. This act was the beginning of the humane treatment of the mentally ill, who before this time had not been perceived as ill. Pinel stipulated that the mentally ill were to all intents and purposes patients, and called them "alienated", because according to his perception they were alienated from their natural essence as human beings-that is, to freedom, which was perceived by the people of that time as expressing the spirit of a free person. Pinel defined the treatment of the mentally ill as "moral therapy" and gave it the role of "re-education", thus opening up a new medical chapter in the history of psychiatry. But the chapter of Occupational Therapy of the mentally disabled, or as it is called today "psychiatric occupational therapy ", was initiated by the Swiss psychiatrist Adolf Meyer (1866-1950), who was the President of the American Psychiatric Society, and is considered to be one of the pioneers of psychiatry after World War I, in the early twenties of the last century. Meyer was a contemporary of Freud. Meyer developed a new approach for the treatment of the mentally ill, in a concept he called "mental hygiene", which focused on treating all relationships of the patient with the society that surrounds him. In doing so Meyer opened up a new direction in the treatment of the mentally ill, not completely based on medication but which also includes therapy, offering the patients **activity**, and first and foremost **labor,** but also activities that take place during leisure time. This perception created by Meyer was an historical turning point, and is seen by researchers as the beginning of "psychiatric occupational therapy". Meyer termed the way he outlined therapy "rebuilding", and he believed that beyond medication, it is possible to assist the mentally ill to build new and improved relationships with those around them.

"Rebuilding" in Israel

By way of illustration, I would like to give an example of how very important and relevant Meyer's "rebuilding" was to the profession of occupational therapy in its early days in Israel. A young OT started working in a closed ward for women in a mental hospital in the center of Israel in the 1960s', she was allocated to treat a group of twenty women of various ages residing in the ward. At the time, the working and hospitalization conditions were harsh. It brought to mind the Middle Ages, with the sick women dressed in hospital garb of a uniform color, made from a heavy coarse fabric, with no buttons or belt. They walked around in circles in a room that was also used as a mess hall; the concrete floor smelled of disinfectant and the walls were bare, with no pictures or decoration. In the background the radio played Israeli music that added grief to the melancholy image that faced the young OT. She wondered how she could begin work in the face of this reality? What should she do? These questions sprang from her belief that something different from what she saw happening in the ward could and should be done. It was a reality that reflected a similar situation faced by Adolf Meyer at the beginning of the century. Like him, she too had to "invent" the treatment plan at this particular moment, in the new situation. The therapist wanted to bring together the sane reality she lived in with the unrealistic reality, the "different" reality she met there in the ward. **The necessity** to do something to improve the situation came from the intersection between everything she had learnt about psychiatric occupational therapy and what actually confronted her in the ward. This meeting gave birth to the next action: she set herself a goal to make eye contact, or a form of conversation with some of the patients or with a whole group of them. With no other means at her disposal, the therapist chose the radio as the therapeutic device, and she started singing along to the songs that were coming out of the radio, as loudly as she could, so the music could be heard clearly while she walked amongst the patients. At the same time, she also started to talk to the patients and to tell them about all the things she wanted to do with them, and with their help. For example, she decided that she and the group would untie all the old mattresses that were at the side of the room waiting to be thrown away, and after they had done that as a group, they would use the cotton wool inside to stuff dolls. And so, in an activity of only three hours and with very limited means, the therapist created a group of women that sang, laughed and gradually, listened. That was the beginning. The encounter with the physical reality in the closed ward created the necessity. And thus, a therapeutic activity "was invented", and in fact the terms of "rebuilding" were created, just like Meyer predicted

at the start of the previous century. I suggest seeing the description of this activity as an example of a situation in which the need to do something was present. The need was accompanied with a strong belief, but also a naive one, that change can be made. The young therapist who was tasked to give those patients some occupational therapy treatment invented "something" out of nothing. She experienced the **need** and the **necessity** to act in a given reality. What she did can be used to illustrate a process parallel to f the situation that society was in at the beginning of the previous century. Society faced the need, and "invented" the answer in the form of the profession today called "occupational therapy". Today, at the dawn of the new millennium, we, the professionals, find ourselves again asking questions about the beginning of the profession. However, our starting point is the complete person, albeit damaged and lacking, but whole as a unified body, mind and spirit.

New Directions in the 20th Century

From the beginning of the 1930's, the process of assigning scientific criteria to the profession of occupational therapy began. Questions were asked and assumptions were made that sought either confirmation or rebuttal. This process contributed to the development of the profession, and continues to do so to this day. In the middle of the 20th century, due to scientific development and socioeconomic changes there began to appear professional specializations (or specialties). Pediatric and geriatric treatments together with the development of modern and diverse treatment modalities. As we know, the profession of OT is defined as an interdisciplinary profession based on knowledge from natural sciences and medicine, from the humanities on the topic of human science, and also knowledge from the social sciences (psychology, sociology and anthropology). Being a therapeutic profession, it is expected to provide for people in different stages of the life cycle. In the 1980's an additional voice was beginning to be heard in the mission statement of this developing profession. This voice determined the goal as **assisting the sick person to achieve quality of life for himself.** The appearance of this goal again proves how important it is to examine the essence of the profession against the background of the changes taking place in social perception and economic development. After all, it is not possible to see the dynamic development of the profession, other than against the background of the general development that takes place around it, as it operates within a society, and meets emerging needs within that society. How can we speak about quality of life if that society does not permit the demand of such quality of life for all of its members? If that is

the way things are, we may wonder what is the fate of chronic patients in the context of this progressive thinking. OT treatment sees quality of life as a central and important topic. The awareness of changes that have occurred in medical and social perception since the inception of the profession dictate the treatment methods that are derived from social worldview, and from the state of chronically ill patients. Awareness of changes and the development of knowledge ultimately dictates ideology, with the specialty of the occupational therapy profession focusing on the special need to help the chronic patient not only live his life in society but also provide him with the tools to give this life meaning, and content-the desired quality of life. Today the general trend is to integrate the chronically ill and the disabled into society and into public life, and not to impose any stigma on them or present them as a separate and distinct group. On the contrary, the goal is to encourage the chronically ill and disabled person to contribute to society and see his contribution as of special importance to its well-being. It is a concept derived from a humanistic worldview, which places the individual and his needs at the center of the discussion, and it is this that gives meaning and validity to the work of occupational therapists. The purpose of this is therefore to help the chronic patient, for whom a complete cure cannot be found, to live a full and complete life, while contributing to those around him and those giving to him of themselves.

Body, Mind and Spirit

The humanist worldview sees man as a whole being-wholeness of body, mind and spirit. However, while the body and mind are currently receiving clear scientific research, which is objective and universal, the human spirit is perceived as a subjective entity that is difficult to define, which cannot be measured and quantified. Nevertheless, while the spirit cannot be **explained**, it will always enjoy the right to be **understood**. The problematic nature of understanding a person's spirit is particularly striking in light of the fact that today it is possible to clearly assist the body and mind through conventional pharmacological treatment and mental health treatment of all kinds. But how is the spirit treated? In order to clarify this question, I will use the example of a person who was injured in a serious accident and remained disabled, and in assessing his condition, he is also described as someone whose "spirit has fallen." This is a statement that comes to express a given situation that there is no other way to describe other than with this description alone. How do you understand the meaning of this situation, when it is clearly subjective? It does not state that he is depressed, since a state of reactive depression can be treated with medication, and there is also

mental-psychotherapeutic treatment. The question still remains-how does one treat someone whose "spirit has fallen".

After all, this statement expresses a situation that has no definition in the objective medical language. There is no method for treating the "fallen spirit." For the very phrase "his spirit has fallen" is in fact a literary expression for a description of a private experience and a subjective situation. No one really knows what the spirit looks like and where it "falls", so-and here is the place to point it out-the unique principle of occupational therapy stems from our own treatment; we, the therapists, consider the fact of an **existence of a spirit**, essential-and see spiritual therapy as the most important principle of our therapeutic intervention. It appears that the discussion of the human spirit is conducted mainly in the field of philosophy. As therapists of the chronic patient, the disabled, those that are different and the "other", we treat the disabled body, the emotionally unstable soul, and his spirit that can only be described as a private experience of the person himself. Therefore, the treatment of the spirit will always be part of his most personal feelings and of the things that the person says to himself. Over the hundred years of the profession's existence, the way we express and define our treatment goals have changed. The changes which took place were subject to changes in society and its ideals. The images of social success and personal achievement also contributed to the definition of goals. Today, in the 21st century, as part of the statement of purpose of the profession which is to enable chronic patients to be a part of their society, along with all society's goals and ideals, there is another aspiration-to help the patient to be what they want, and to realize what they can be. In order to accomplish this, it is our duty to meet the sick person first and foremost as a person, and if "his spirit has fallen", we must study his condition not only in the objective clinical context, but also and especially in his own personal context. This is a starting point for the treatment of occupational therapy of the spirit.

The unique principle of therapy of the spirit existed, in fact, with the birth of the profession as a humanistic profession. Listening to the individual's distress, personal experiences and suffering are conditions for the realization of the unique goal of occupational therapy-to enable the chronic patient, the disabled, the injured individual, to realize himself as an individual and as an integral part of society. That is to say that, after a hundred years of the development of occupational therapy, this profession has formulated a distinctly humanistic conception and has set itself the goal of placing the sick person in the center and assisting him in addressing his distress-also and especially in his personal and subjective context. This is

the unique approach of occupational therapy, and it makes it possible to present the occupational therapist as an “advocate of life”.

When did the Beginning of Occupational Therapy Occur?

I have already emphasized earlier that occupational therapy was created out of the acute social need that arose at the post-World War I turning point. This point, however, somewhat narrows our historical vision, for it is quite possible that this field of occupational therapy has existed since the moment humanistic medicine was “born.” Sir William Osler (1849-1919) was a Canadian physician, who is seen as the father of modern medicine. He said “It is much **more important to know** what sort of a patient **has** a disease **than** what sort of a disease a patient **has”.** This, of course, placed the person at the center of the medical debate. This view, which posits that it is the sick person and not necessarily his illness that is the subject, poses the great challenge facing occupational therapy treatment. Occupational therapy is the clear way to help a person where traditional medical treatment has actually failed, and is unable to bring about his complete healing. It is important to mention that society aspires to integrate the long-term and disabled patients into its general fabric, and does not want to see them as a group separate and distinct from it, and also sees their contribution as significant and able to influence what happens in it. This aspiration also derives from a humanistic worldview, which has recognized the necessity of caring for disabled people in order to help them continue to live a full life in their society, and is also the one that gives validity and meaning to occupational therapy treatment. Johann Wolfgang von Goethe, a German intellectual said: If you treat an individual as he is, he will remain how he is. But if you treat him as if he were what he ought to be and could be, he will become what he ought to be and could be.

CHAPTER 2

"BEING SICK": BETWEEN PRACTICAL TO SPIRITUAL THERAPY

"Lack of Health"

Hippocrates, the father of Western medicine, who lived during the 4th century BC, said in the context of treating illness that "Nature heals itself". Meaning that "the course of an illness includes within itself the healing process". The notion of nature being capable of healing itself occurs of course in nature too. This claim acknowledges and distinguishes between two types of symptoms and signs: one is the "meaningful"-those that are an integral part of the disease or trauma, which are intrinsic to the disease; the other one is the one based on secondary symptoms and "accompanying signs"-meaning the signs that appear as a result of the body's reaction to the illness or trauma, marking the process that takes place after the outbreak of the illness. These are part of the body's spontaneous reaction. They express, in fact, the act of "nature healing itself". These definitions give us, the occupational therapists, a way of delineating the framework of our therapeutic intervention, which in most cases treats only the **accompanying** symptoms and signs, those that appear as the body's reaction to the illness. An illness is a phenomenon that occurs in nature, and its presence upsets the balance of nature. Balance is necessary for a normal life.

To further establish this claim, I would like to use the definition of the German Jewish neurologist Kurt Goldstein (1878-1965), one of the most prominent doctors of humanistic medicine during the first half of the 20th century, whose outlook was also characterized by negation: determining that illness is a state of "lack of health". Goldstein assumed that this seemingly simple definition helps to understand the nature of a disease better than a complicated one based on knowledge drawn from definitions in the natural sciences. He claimed that it is impossible to understand the state of "lack of health" **only** with the help of tools from the natural sciences, as most of us are accustomed to doing. Therapists in the medical professions, occupational therapists among them, always think about health or lack of it

in terms of clinical-medical language. The solutions and treatment plans are also always conceived of within the natural sciences. While health according to Goldstein's claim is a "value", and this concept belongs to the realm of the humanities. In accordance with this claim the therapeutic approach can be perceived in a completely different perspective. "Health" according to Goldstein, is a completely humane concept, in the sense that the healthy person will be in a position that allows him to choose between many options to fulfill his aspirations and to decide on the course of his life and its direction on his own. "Lack of health"-, as in disease and chiefly chronic disease, is a situation whereby these options are excluded or delayed from the person. "Being sick", beyond the factual situation, means losing at once the "value" that comes with being healthy-the ability of the person to choose and fulfill himself and decide about his life freely. And thus, his basic freedom is taken away from him. If this is the case, "health" is a first-degree humane value, and the loss of it is a terrible event not only in the physiological sense, but also and mainly in the spiritual sense. This is Kurt Goldstein's claim.

Using occupational therapy, we treat a patient population which is composed mostly of chronic patients-those that have lost the chance to be fully or spontaneously healed. As therapists we have a unique role in this state of affairs. We must identify their options with them and in cooperation with them. Dealing with their options that exist despite the limitations. As occupational therapists we don't give up in any situation; we must be very attentive to the patient's situation and examine him with regard to the question of whether he has the tendency to give up. Our job is not to allow him to "give up"-we must be present in this situation and reflect to the patient that he has a way to continue and participate in life. This approach is a very important part of our therapy with the sick person in general, and with the chronically ill in particular. Goldstein proposes a direction to therapists in this situation, and it is this: to give the patient who is experiencing such a loss the all-important "value" that health gives-" a **new orientation**", an orientation that will help him to sense again the "value" of his existence. It is important to emphasize that this is a proposal that comes on the behalf of a doctor acting in the framework of humanistic medicine, a way of thinking that sees the patient as a subject-as an individual case and not just as a statistic.

Here I would like to pose a question: what happens in the intermediate state that occurs between the traumatic event (the one that breaks the balance) and the news that there is no chance of a full recovery and that things will not go back to the way they were. The question focuses in fact on the

experience of illness, that is-what happens to the patient who on the one hand hopes for the best, and on the other hand has the unambiguous knowledge that his state won't change? From the aspect of our therapeutic actions, it is essential to consider this intermediate state, where the transition occurs between-merely acknowledging-and fully experiencing-this state as a fact. This is when the therapist has to choose the methods of treatment. What things are said? What does it mean? It means that the state of the patient **experiencing** this **fact** can only be tested at the subjective level. And therefore, in principle the therapeutic approach must relate to the private history and lifestyle of the sick person. A subjective perspective is an attempt to see the patient as an individual case that responds only as he responds, and not to relate merely to the explanation of the patient's behavior based in most cases on general knowledge however qualified that may be. We often come across a patient in a state that necessitates only one question or one point of reference in order to come closer to him. Close in a proximity that will allow a conversation at the substantial level, at the subjective level. A conversation that will determine how the therapy will continue.

The Illness is an "impaired spiritual state"

Interestingly, the perception of health as a spiritual state and not necessarily only as a physiological state can also be based on philosophical methods that seemingly have nothing to do with medicine. The unique treatment of Occupational Therapy is the treatment of the essence of the patient who experiences himself as a patient. The treatment of the essence is the treatment of the human spirit, which is distinguished from body therapy or mind therapy. The father of the Existentialist system, the Danish philosopher, Soren Kierkegaard, (1813-1855) claims that the essence of man is the "spirit" and that the "spirit" is a synthesis of finite and not finite-the eternal and the necessary. Man is allowed to be a synthesis of opposites. He was created in The Image and has a divine foundation in him, but he is not eternal: he is finite and he lives subject to the conditions of necessity in nature, and he is free and struggles within his limitations. Characteristic of human-subject life is despair, which originates in the experience of life towards death, towards its finitude. The experience of finitude is constantly present for the eternity (entireness) of a person's life. The expression of the spirit in this state of affairs is matter is **anxiety**, defined as "**existential anxiety"**, which differs from clinical anxiety. Existential anxiety is the "normal anxiety" which accompanies the life of a free person who has self-awareness. He is responsible both for his choices which are his alone, and

the price he pays for those choices. Kierkegaard claims that in this state the spirit transcends the body and the mind. The spiritual content is elevated above the real-earthly level, and moves to an ideal level, to the subjective space in which man is separate from himself-as an individual experiencing his life. It's "terrible", says Kierkegaard, and the price of this is "anxiety".

In treating the essence of the sick person, the treatment is aided by Occupational Therapy, with its philosophical thinking that brings us closer to understanding the other/the fellow man-the patient. He is in a situation where it is important, indeed it is in his favor, that his difficult physical condition and accompanying emotional turmoil be removed from the real situation to the spiritual-idealistic area of being. At this stage experienced therapists engage in a therapeutic discourse alongside the practical treatment. This is the stage where they offer a "new orientation" to the patient, to allow him to see the light and to find hope.

A New Orientation-in Practice

In order to attempt to illustrate the meaning of a "new orientation "and the difficulties in adopting this orientation, I want to share a therapeutic intervention that demonstrates the great importance in this unique treatment of Occupational Therapy.

A man in his forties came to the occupational therapy ward in a rehabilitation center. He was a family man that was active and functioned wonderfully until he was involved in a bad car accident that left him paralyzed in his lower body. Prior to the accident the man had been sick with a degenerative eye disease, that threatened to cause him to become completely blind within a few years, and to add further suffering to the pain, his wife was also sick with a disease of the joints. She was diagnosed with a process that threatened to significantly limit her mobility. And yet the husband, wife and two kids radiated a special optimism, and in an unusual manner they all showed a willingness to cooperate well with the therapeutic staff, and by doing so they naturally facilitated the long and arduous therapeutic process. Also, the fact that the man's cognitive functions were not damaged was an immense help to the physical Occupational Therapists, who started the therapy after the hospitalization in the rehabilitation center. The personal therapist who was referred to treat the patient knew the family very well, and she was well aware of the wife's health. The therapist came to help the patient choose a new direction for his life, taking into account the vision limitation that had started in the past which he had adapted to, alongside his new physical state that resulted from the car accident. That is,

there had been an attempt to choose" a new orientation". At this stage the patient cooperated with the different therapists. He stayed in a rehabilitation ward, and for the whole period of the practical-intensive treatment he responded positively to anything that was suggested to him, and planned with his therapist his future activity. It is also important to note that he had many plans. His mental state seemed to be completely balanced.

The Occupational Therapist, as well as other therapists, were amazed by the positive attitude that the patient displayed and by his willingness to listen to explanations and cooperate. This generally facilitated the treatment and promoted the process. This was the situation for several months. As is well known, rehabilitative treatment is a relatively long treatment. Surprising in the process was the patient's immediate positive response and his excellent collaboration with the therapist, which encouraged him and the rest of the staff to think that things were moving in the desired direction for successful rehabilitation. After a few months of treatment, the therapists started speaking to the patient about housing adjustments for his return home. Housing adjustments are recommended for people who are wheelchair reliant or use other assistive devices in order to allow as much independence as possible in the current situation.

However, the therapist was surprised by the patient's reaction. He seemed completely surprised by the subject being brought up. It was as if he had suddenly discovered that his disability was permanent, that there is no chance of his situation changing and that he will remain permanently disabled. But the greatest surprise was reserved for the therapist. The patient burst out into heartrending tears accompanied by continuous uncontrollable sobbing. The therapist's spontaneous response was to ask him, the obvious question of nothing what he thought was going to happen at the termination of treatment in the rehabilitation ward. Now for the first time we come to the heart of the confined area of occupational therapy and what is really its essence-that is, to treat a person's spirit while facing the recognition that he has lost the important value in his life, the freedom that health grants him to choose and live according to his will. The patient responded to this question in simple words: It is simply not fair that I remain in an awake, alert and lucid state all my life, and yet I am so limited. "This emotional response stemmed from the depths of the patient's heart, as a response to the therapist's simple question.

The patient's unexpected response to the fact that the practical treatment had ended-a response that was marred by bitter crying-was not the body's response to trauma but the spirit's response, a substantive response. This is

the response that stems from the patient's personal experience in the face of. In the face of what is missing as a definite state. The experience is also a secondary phenomenon; it is accompanied by the actual traumatic event. This response was echoed by the therapist, who heard him state this from a place of the experience of "being sick." The therapist, by asking this question entered the unique occupational therapy therapeutic space, treating the essence of the sick person, treating his spirit. Moreover, the therapist understood through the patient's response that he actually both simultaneously knew **and did not know**. He knew what his situation was, nonetheless he planned the remainder of his rehabilitation **as if** it was not a final state. A situation where a person knows and yet acts as if ignorant can certainly be defined as a state of denial. We have knowledge from the discipline of psychology regarding the phenomenon of denial. Denial is a defense mechanism, which serves to protect the person facing reality with facts that he does not have the mental strength to face as they really are. This is a situation that comes to protect the person temporarily in a given situation. Occupational Therapy does not address the phenomenon of denial from a psychological point of view. As I have already mentioned, we try to understand such a phenomenon also from the point of view of the existentialist philosophy (Kierkegaard), according to which man as a subject determines and decides for himself, and to help him it is important to know this state as a therapist-as an individual encounter with a patient as an individual. Experiences like this occur within the essential therapeutic space provided by occupational therapy. Such treatment is always adjunct to the functional and practical treatment, as part of the unique principle of our treatment.

The continuation of the conversation brought up issues that were the essence of the matter. That was because the therapist did not give up on the patient, and asked him, taking into account his existing situation, what would he do if he had the choice not to live the life that he will be living from now on. The patient replied with complete negation. His answer enabled a different conversation to take place, for example to dwell on the idea of the meaning of life in general and of his life specifically. That as well as the question of life at any price, and the ability to continue despite it all-though **differently (**with the emphasis on different**) and** that there is something and someone to live for. "To live differently" is "the new orientation" that Kurt Goldstein suggests. And we Occupational Therapists are in this position due to the first basic tenet of our profession which is: for all states of illness or trauma that disturb one's balance and leave the person with a disability, the previous possibilities that the person had no longer exist. But living a meaningful life is still an option for him. It is the individual who gives

meaning to his life; each person for himself. At that moment when the patient is **discovering** the difficult situation and says to us "I don't believe this has happened to me, I don't deserve it, it cannot be "-it is important to know that this is the very moment in which the patient has lost his ability to see the opportunities ahead of him, this him. This is the moment that his spirit is wounded. As Occupational Therapists we understand a situation like this, and we need to relate to it accordingly. Treatment based on "the new orientation" is expressed in this case with a willingness on behalf of the patient to acknowledge the fact that one can only continue living in a **different way**. His decision to continue living for himself and for those around him demands that he chooses for himself a new way, different from the past.

The Practical Treatment and the Spiritual Approach

The case described above is intended to illustrate the complexities involved in occupational therapy treatment. These complexities are due to the fact that occupational therapy treatment has two facets which are in effect two sides of the same coin-one being the "practical therapy". Practical therapy was illustrated by the case above as improving the patient's ability to move around as well as giving him the most appropriate tools and means so that he can deal with or bypass his physical limitations. With this in mind, the home adaptations were planned in order to ease his day-to-day life while living with his family. The patient responded to this facet of treatment as described by his therapists exceptionally well, and he cooperated with enthusiasm. However, the moment the patient understood his true condition-the loss of value that full health can confer on him, and all that is implied **for him** (and the emphasis is **for him**, since the trauma or illness affects everyone in a unique way)-that was the moment in which the patient gave expression to the injury in his **soul.** At this stage, the unique therapeutic approach is needed, the other side of the coin-the spiritual therapy. This spiritual therapy demands an entirely different approach to the patient, sometimes much more challenging than any physical therapy because it extends beyond the fact "of him being sick" but also relates to the traumatic accompanying experience. This approach cannot be used without an individual point of reference. You cannot rely on general knowledge, however objective and qualified you may be. An unmediated intimacy is needed here to get to the root of the patient's soul, so that the therapeutic program will suit him and its results will be effective. In summary, however effective the physical occupational therapy may be, it is still not enough to be complete if unaccompanied by a spiritual-intrinsic treatment.

"Primary Symptoms", "Secondary Symptoms" and the in-between

In the beginning of the chapter, I mentioned the distinction between "primary symptoms" of the illness, those essential signs resulting from the existence of the illness, and "secondary symptoms and accompanying signs", those accompanying signs that appear as a result of the body's response to the illness or trauma. The "secondary symptoms and accompanying signs" are those indicating that the illness is in fact following its natural course, and that the body is responding in a natural way and is on its way towards recuperation. Occupational therapy relates to the stage when the secondary signs appear, and also puts an emphasis on those signs that are connected to the patient's mental response.

In the case described above I laid out the private experience of a patient who was suddenly faced with the deficiency appearing in his life, and understood that this is a final and irreversible situation. This experience is also a secondary symptom accompanying the traumatic event. It is also found in his spiritual-intrinsic level. But in this case, as in many other cases, a hiatus occurs. Hiatus between the period of the onset of illness and the appearance of the "primary symptoms" and the appearance period of the "secondary symptoms" on the other. This gap is the space that exists in the time between the onset of the disease and the understanding that things won't go back to normal and that the "natural balance" has been irrevocably violated, or in other words it's about the gap that is formed between the patient's hope and his acknowledgement that this expectation will not be realized.

Indeed, this intermediate space in which the body's response to the cause of the illness takes place, is when the therapist must decide on the therapeutic strategy with which to treat his patients, who frequently suffer from prolonged illness or from a chronic disability. At this point he, together with the patient, must identify the existing possibilities within the framework of the existing limitations, and be attentive to the voices of despair and loss of hope for a different life. The therapist must show a deep and genuine understanding of the "fallen spirit" and the process that the patient is undergoing, and recognize that the patient is realizing that he will not be a person with the same abilities as before. The therapist's reference in this situation should be to a subject (individual). The meaning of this reference should be "**being with the patient",** understanding the terrible loneliness he feels, and trying to release him by any means necessary from the despair he is in. This is because the main role of the Occupational Therapist, as I understand it, is to instill in the chronic patient or the disabled person the

understanding that despite the trauma he experienced, and despite the disability forced upon him and the abilities and options denied him from the past, the option of a life full of meaning and hope is still open to him.

The therapist must diagnose as quickly as possible what the patient's breaking point is. When the patient and the OT are on the brink of a negative "enlightenment"-this is the starting point, this is the basis for any effective occupational therapy-the revelation to the patient of his real situation. This point might be the patient's mental breakdown, if the therapist doesn't reveal to him his true state. This does not mean that approaching the patient's spirit is in lieu of the physical treatment, which is intended to give the patient the means that will allow him, as much as possible, to circumvent his physical limitations. However, aside from the essential physical treatment, the therapist must relate to the essence-that is to the patient's spirit, with the purpose of discovering the strength motivating the will to participate in life and give them new taste and substance. This is the direction to take on the road to rehabilitation. This is essential of course to the approach whose importance I emphasized already, the claim that the therapist is "**the advocate of life**" and part of his job as such is the great mission of helping the patient to find **in himself** mental guts that will allow him despite his severe physical disabilities to try and participate in life and to find meaning from it.

CHAPTER 3

OCCUPATIONAL THERAPY: AN APPROACH TO THE HUMAN ESSENCE

Liberty as the Human Essence

In every discussion about the human essence, we must first understand the concept of "essence". "Essence" is defined as a basic element that underlies all things and is in fact the essence of the thing itself. It is subjective (belongs to the thing itself), inherent (found in the thing itself), and never disappears and the discussion of the essence of man belongs to the area of human science. This field is also philosophical and began with the German philosopher of the 1800s, Emanual Kant, who defined the essence of man as liberated. He stated that the nature of liberty is found in the ability of the individual to be the master of himself, mentally or as he says "to think boldly in his own mind". Occupational Therapy treatment relates to the physical ability of man and the spiritual ability with equal seriousness, whether the person has a disability of his mind or body, or both. First of all, the treatment is, of course, an attempt to find ways to compensate for lost abilities, in order to allow as much as possible, the continuation of independent physical functioning, with the help of technical aids. However, the treatment of spiritual ability is a more complex treatment-because it stems, as mentioned, from the essence of the person-that is, the injury to his spirit.

Cerebrovascular Accident (CVA)

How does the Occupational Therapist relate to the essence of a sick person? I will attempt to answer this question with the following example: In the CVA ward a fifty-year-old patient was hospitalized suffering from severe difficulties in walking. After his hospitalization it became apparent that prior to the CVA he had been experiencing a gradual process of dementia-an illness that is characterized by gradual decline in cognitive abilities, memory disturbances, difficulty in orientation and personality changes. The fact that it was a double disability-CVA and the beginning of dementia-made it difficult to diagnose the patient as it was necessary to isolate the

defects pertaining to the CVA from those that were due to the dementia, and that made it very hard to make a practical therapy plan tailored to this specific patient.

As accepted in these types of cases, in which a patient that had a stroke arrives at a therapeutic establishment, an occupational history was taken from the patient-a document specifying his resume from an occupational perspective until the time that he got sick: Series of tests to evaluate his physical and cognitive abilities were carried out to facilitate a precise as possible cognitive diagnosis: An assessment of his cognitive abilities, or in the professional language, a picture of the patient's intellectual functions.

Here we should point out that this process may be interpreted at times as redundant for a significant portion of the patients, in the best-case scenario, and as demeaning, in the worst case. The patient is at this time in a sensitive state in which he feels that he has to participate in what he perceives as "children play", and may claim that this humiliates him, because it serves as a type of proof that the therapists think that his original ability and his past achievements are no longer relevant to his present life. This is a state that can contribute a lot to increasing the mental stress on the patient, who is already under extreme mental pressure anyway, and this of itself can damage the patient's ability to meet the requirements of the diagnosis and its results.

Indeed, in the case in question, it seemed that the tests in which the patient was placed were, for him, unacceptable. He did not respond appropriately to most of the questions asked, nor was he able to perform the tasks that accompanied the test questionnaire. Throughout the process he stated repeatedly "Why are you asking me to do things like that? It will not help me walk again". It is indeed a legitimate remark, however, in my opinion, in these things the patient told us something more. He said something beyond the overt claim quoted above. In referring to a claim that is not overt, I am addressing the essence of the patient, since his claim is in fact, derived from the essence that has been harmed. We do not and cannot have an answer to the question "Will it help him walk?", but we certainly have an answer to the anxiety that accompanies his question. And this is the place and time to turn to the essence of the patient, and to treat accompanying spiritual therapy, a treatment that addresses anxiety whose content is the implicit question "What will happen?". It is also the time to find out for ourselves what is bothering the patient beyond what we have heard, and how, and in what language we can respond to him at the level and place where he currently finds himself. Therefore, the question "Will it help me to walk?" is important and it is actually critical to respond to it through

practical treatment. For in fact there is a specific difficulty which limits him. He is very worried and the physical treatment of occupational therapy that he receives aims to reduce as much as possible the damage of the stroke. It also offers help with alternative options, such as technical help for independent functioning in daily life. At the same time, on the physical treatment side, another treatment plan was built that would help him overcome his cognitive deficits, concomitant disorders, memory and orientation, which were results of the stroke and the dementia. These treatments have no immediate results and the impediment does not disappear immediately, if at all. The treatment is inherently lengthy, and therefore it is necessary to accompany it with an explanation and share with the patient that the process is long and tedious. In the case I have described we can see it is impossible to avoid making the diagnoses. The diagnosis and accompanying treatment have no direct and overt connection to the impediment in walking and his general physical condition. This is a reality that is important to address with the help of a tolerant and accurate explanation from us, the therapists.

During occupational therapy, a preliminary conversation is held in which the course of events and their order is explained to the patient, and we indicate in advance the goals of the test and our awareness that the process can sometimes be interpreted as a child's play. We do this as part of our ongoing care, and yet, the patient's response to receiving the diagnosis is direct and unequivocal. He states that he will not cooperate because he does not see "how it will help him walk," and that's all that matters to him. We know and recognize the condition of the disabled, sick person who is solely interested in outcomes caused by the illness or trauma, outcomes that have a real limitation. The only way out of this closed state is, in my opinion, the attempt to address it on a level that is not just physical and concrete.

"Catastrophic Response" and its Treatment

In order to help the patient, understand the importance of the assessment process, the therapist needs to relate to the mental state of the patient right from the beginning of the treatment process. At this stage the patient is concentrating on his physical limitations that have suddenly occurred, and he demands concrete answers to the questions of if and when he will get better and go back to how he was. It is clear that the therapists don't have a clear and certified answer to those questions, however we do have the option of answering the patient in a manner that will reduce his anxieties. To

succeed, the therapist must relate to the person in front of him. Relate to his personality, his fears, his hopes and dreams.

This is the spiritual therapy that relates to the essence of the patient and his uniqueness. The existence of this treatment is an essential condition to make it easier for the patient, who is in a state of sudden shock in which it is not within his cognitive ability, due to the stroke or the dementia or a combination of the two, to have a meaningful understanding of the situation he is in as a whole. And as a result, he can't evaluate his chances of changing and his options in the future. Likewise, due to the disturbance that was caused during the natural course of his life, the balance he had before the trauma that changed his fate became disrupted.

This initial shock which the patient experienced was defined by the neurologist Kurt Goldstein in the second half of the 20th century as a "catastrophic reaction". I choose to use this definition in order to describe the way occupational therapy can treat the patient described here on a spiritual level. A "catastrophic reaction" appears as a reaction of the body, soul and mind all together (Goldstein only referred to the physical reaction). He claimed that trauma-the CVA in our case-beyond the functioning limitation it causes, also causes a severe accompanying interference by simultaneously damaging the organism's total function, which is immediately paralyzed. This is a state of shock in which the person, in this prime state, does not respond to stimuli, even those for which his physical ability to respond to was not damaged. It is as though everything has stopped. It is a catastrophic reaction to a catastrophic event. Goldstein believed, in this context, that it is only a physical reaction. But I would like to propose that it is both the body and mind's reaction together, and one should not separate them in this case.

In a physical and mental state, you must, in my opinion, look at the "catastrophic reaction" to the catastrophic event, and from this starting point we may start treating the patient. In any case, whether it is a physical reaction or a mental reaction, or both of them together, it is a phenomenon that cannot be measured using objective scientific tools, because it was not studied using those tools with accepted statistical methods, and so it should be dealt with as a subjective matter. In this matter the understanding that this is a private reaction is needed. Understanding that its effects are unique to the injured person. Every individual reacts in his own way. And yet the fact that for all of the patients the ability to function suddenly stopped was salient. And therefore, we can say that the catastrophic reaction includes the spiritual level as well. In order to **understand**, and not only to **explain** it, I