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ARTICLE

In defence of working with "patients" in music therapy

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ABSTRACT

How music therapists consider people who come for therapy, and how people who come for therapy perceive themselves during sessions, is of paramount importance and central to our work. More than an argument about terminology or semantics, this paper will propose that the term used fundamentally affects how the therapeutic relationship is viewed, during and around music therapy, by both the therapist and the person receiving therapy. It is a commentary in response to a book review (Rizkallah, 2021) that generated a reply (Sundararaj, 2021). This paper will argue that using the word "patient" to describe the person receiving therapy, regardless of clinical presentation, allows for a more honest appraisal of the therapeutic relationship than any other term. It includes discussion of the etymology of the terms commonly used to refer to people coming for therapy and uses existing literature to explore thoughts around terminology and how it relates to power dynamics within sessions.

KEYWORDS

patient,
client,
service user,
therapeutic relationship,
power dynamics

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> To be a patient is to be a solipsist: for a while, the world revolves around you.
> (Nicholas Crisp)

> When I'm with my children I'm a mother; when I'm in a shop I'm a customer; when I'm on the underground I'm a commuter; when I see my psychiatrist I'm a patient.
> (Anonymous)

INTRODUCTION

It seems difficult to agree on a word, or group of words, that music therapists consider appropriate to use with the person or people they are working with. On a concrete level, this is probably representative of the multitude of work environments music therapists work in. As well as this, perhaps it illustrates the many different presentations of all the people that come to music therapy, and with motivations and aims so varied the work may feel very different from one person or workplace to the next. It

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places the profession arguably in a unique position through having to keep in mind a significant number of theoretical models, cultural connotations, translational issues, and appropriate potential interventions.

I think there is another consideration, however the words we use to describe the people that come to music therapy betray a sense of how the therapeutic relationship is considered, and how varied that can be. In this article I will attempt to argue that some of the newer terms adopted more widely, specifically "client," "service user," and "companion," do not illustrate the therapeutic relationship adequately enough compared to using the word "patient." The purpose of writing this article is not a wish for standardisation, or an attempt at narrow theoretical superiority, but an exhortation to consider the implications of the language we use, and how it represents what is really happening in each session.

While I think the arguments I will outline are relevant to music therapists working across the spectrum of theories, it is important to acknowledge that my background is predominantly psychodynamic. I trained at the Guildhall School of Music and Drama, a psychodynamically oriented music therapy training, and took a further course in psychodynamic psychotherapy at the Tavistock Centre. My team and I at North London Music Therapy primarily work in a private practice clinic setting with people who are verbal and neurotypical and able to refer themselves for mental health concerns that can be managed within the community. My own musical background stems from living in the UK for the entirety of my life so far (although I hold dual nationality) and therefore is predominantly Western, mostly based around popular music from the second half of the 20th Century onwards.

While I think my arguments can be extrapolated out to all of music therapy, it is probably the remit of a further article to examine the particular therapeutic manifestations and the implications for language in those with physical and/or learning difficulties.

BACKGROUND

In a recent book review for this journal (Rizkallah, 2021), I took issue with Suzanne Hanser's use of the term "companion" to describe the person or persons in the room with their therapist. Hanser (2018) suggests that a patient's "inner healer" may come from within: "When the healer comes from within, the music therapist is a guide or facilitator to accompany the person's journey from illness to wellness, and the person is a companion on that journey" (p. 69).

This was further expounded on in a response to my review:

> Integrative medicine [...] views the patient and the practitioner as partners within the therapeutic process (Maizes et al., 2009). [...] It is true that there is a power differential between therapist and client, and maintaining a professional relationship requires strict parameters. However, Hanser urges the music therapist to "empower" the client to identify their own inner strength and resources as they enter into the therapeutic relationship. [...] the idea of a "companion" and "muse" as proposed by Hanser [could] be appropriate [in some patients], as such an approach is more likely to elicit the intended therapeutic outcome of empowering the individual seeking treatment. (Sundararaj, 2021, p.299)

Sundararaj unfortunately offers no evidence as to his claim of how referring to a patient and treating them as a companion or muse is more likely to elicit an "intended therapeutic outcome" of empowerment. Hanser and I agree that the patient has the best resources from within themselves to make the most use of their therapy. I am also of the opinion, though, that it does not follow that the patient should arrive at therapy already knowing how to make use of their resources. It is not just the content of their experiences that our patients find difficult, but *how to think about them* (Bion, 1962). The therapist ought to exist in a state of mind where link making and thinking about and between patient experiences is possible at a "good enough" level. It is this aspect of the therapist's role that affords them their power and privilege within a therapeutic situation.

I therefore think that someone existing in the role of patient during their therapy session should not be held responsible for managing the process of link making without significant support:

> Calling one's patient a 'companion' does not allow the patient the space to be held (in the Winnicottian sense) by their therapist who manages the boundary of the session in order that the patient feel safe enough to express themselves in whatever way they see fit. (Rizkallah, 2021, p. 285)

There is a difference between power and empowerment, which I will discuss later in this article, but I would suggest that we do not need to pretend there needs to be equality within a therapeutic relationship in order that a patient be empowered. Empowerment is a desirable positive outcome for all patients within therapy; I would argue that empowerment enables someone to access their inner resources well enough without needing regular therapy. That does not mean, however, that striving for equality in the therapeutic relationship is necessarily the best approach to enable empowerment.

MY POSITION

In Crisp's quote at the beginning of this article, he refers to being a patient as being a solipsist. Solipsism suggests selfishness: "The belief that only your own experiences and existence can be known" (Cambridge Dictionary, 2020). When we are patients in a Western medical sense, the implication is that we defer, or perhaps acquiesce, to the superior knowledge and expertise of doctors, nurses, and other medical staff. To be clear, here superiority does not come with a value judgement; rather the acknowledgment that someone who is medically trained would have greater knowledge of medicine than someone who is not medically trained.

When we are patients in a psychotherapeutic or music therapy sense, Crisp's idea of solipsism may in fact become a more liberated view. Those working psychodynamically in music therapy already know the importance and potency of the transference relationship and the projections as part of it. This method of working acknowledges fully the individual world view of the patient - and respects it, not seeking to change or adapt it, but to illuminate its idiosyncrasies through words and music. Other therapeutic models too acknowledge the need of the patient to express not only themselves and their difficult feelings but their world view and how their experiences and culture have shaped them.

There is no reason to push onto patients any further responsibility when all they are required to do as part of their therapy is to bring themselves to their sessions and express themselves in whatever

way they are able to and see fit. The therapist bears ultimate responsibility for time, space, boundary, privacy, the holding, and the understanding of all that is brought to the session, and the illumination of it to patients in musical and verbal ways that are safe, meaningful, and easy to understand. This does not mean that patients do not also hold responsibility – they manage their own regular attendance and as full presence in sessions as possible, and they bring their own experience to their sessions - but that it is not ultimately their responsibility to maintain the space.

Accessing parts of ourselves that we do not like or find challenging is painful; the violent language of splitting, projecting and so on employed by psychoanalysis goes some way to illustrate the pain that patients feel. When any kind of therapy works well it offers challenge, perspective and change; change involves loss, and loss involves pain, grief and mourning (Freud, 1917). It is the therapist's responsibility to lead in facilitating this challenge and alternative perspective, in order that the patient feels it within themselves and can then effect change within themselves.

This imbalance of responsibility also illuminates the imbalance of power, where the therapist has many more variables within their direct control, as described above. This cannot be avoided. The therapist in their professional role would also always have more knowledge and expertise than their patient in terms of knowledge of theory, technique and, often, musical ability – it is the definition of each role. As Barrington (2008) writes: "Music therapists will have gained specialist knowledge through training, qualification and practice. They will become experts. This is indisputable" (p. 70).

The problem is not that there is a power dynamic within the therapeutic relationship but the fact that therapists often seem to ignore it or perhaps wish it away with other language. We create new euphemisms – most popularly "client" or "service user" – that suggest more of an illusion of equality in a relationship that is inherently unequal. Sinason (2010) has written about a very similar topic in detail in the context of considering the euphemisms to describe disabled people, suggesting that what is felt as a desire or need to do this is driven by guilt that the therapist cannot truly sit with their patient's pain. The creation and utilisation of euphemisms seems to be a practice that repeats itself over time.

I think there is further cause for consideration in music therapy because of the musical expertise demanded in the therapist and not in the patient. Darnley-Smith and Patey (2003) emphasise how the therapist's expertise enables the patient's participation: "[…] a variety of musical instruments […] are chosen by the therapist in order that the *client* [emphasis added] is able to make sounds without needing prior knowledge or skill" (p. 41). The majority of people who attend music therapy, regardless of musical ability, have not attended music therapy before; and, even if the patient is a professional musician, the type of music making most often used in UK music therapy (clinical improvisation) is unique to the setting and not widely practised outside of the therapy room. The democracy of music therapy is to be applauded – anyone can access the service by the rules of its parameters – but at the same time it could be argued that it leaves patients feeling unable to speak the language. This is an initial concern often reported within the service I run before sessions have begun and, conversely, can be a significant barrier for access as the feeling of vulnerability can sometimes overwhelm potential patients. This vulnerability, and what I would call an acknowledgement of the power dynamic within therapy, is something that patients seem to acknowledge and that therapists could benefit from considering, both professionally and with their patients.

ARTICLE APPROACH

I will attempt to argue that using the word "patient" to describe the person or persons in the room with the therapist is the most honest word that we currently have in our lexicon to describe the nature of the relationship between the therapist and the person that has come for therapy. I will consider this idea in order to be able to suggest that using the word "patient" sufficiently alters our stance as therapists towards the person we are working with – and similarly their stance towards their therapist – in a way that is more effective, helpful and appropriate than using any other term. I will not attempt to argue that "patient" will continue to be the most desirable word for such persons, but I will discuss how more modern euphemisms do not adequately describe the nature of the relationship that takes place within therapy. I will briefly address previous criticisms levelled at the word "patient," with specific reference to the ambivalence surrounding music therapy's connections to the medical model of care. As this article originated in a criticism of integrative medicine, I will also consider the term "companion" from an integrative standpoint and offer an alternative view.

There may be an assumption in the reader that the theory I am proposing only applies to verbal patients who can make use of the spoken medium. I would suggest that using "patient" as described above is appropriate for people who come to therapy with diagnoses across the whole medical spectrum, of any age, and with any level of cognition and/or language. However, I think the particular manifestations of the therapeutic relationship experienced when working with non-verbal patients could usefully be written about in a further article.

ETYMOLOGY AND CURRENT DEFINITIONS

The three phrases most commonly used in the UK to describe those who come to therapy are service user, client and patient. I shall briefly examine the origins of all three phrases and also the term companion as it is this term that prompted the thinking behind this article.

"Service user" has been adopted in the last two decades or so as an attempt at a more neutral title (Health and Care Professions Council [HCPC], 2020). The word "service" comes from the Old French *servise* and/or the Latin *servitium* – both of which mean slavery. In music therapy terms, perhaps it demonstrates an attempt to overtly aim for "patient-led" work, as the therapist, the provider of the service, is linguistically placed in a subservient position compared to the user of the service. What it does not determine, though, is who defines the service. The service could not happen without the patient's attendance, but it would not even have been provided if it was not for the therapist's maintenance. As Sinason (2010) suggested happens with difficult language, by placing the "service user" in a dominant position linguistically the reality of the situation has been euphemised.

Interestingly, in two UK healthcare studies where patients are asked to state preferences as to which term they prefer, "service user" most often comes out as least preferred (Costa et al., 2019; Simmons et al., 2018). In the same studies the most commonly preferred word is, in fact, "patient," although Simmons et al. (2018) distinguish between contexts – "patient" is preferred when speaking with psychiatrists and nurses but is "equally preferable to 'client' for social workers and occupational therapists" (p. 22).

The original meaning of the term "client" is "a person under the protection and patronage of another" and has its roots in the Latin *cliens*, perhaps akin to *clinare* – to lean (Merriam Webster, n.d.) – or *cluens* – to heed – which in itself is a variant of *cluere* – to hear or obey (Google, n.d.). The original meaning of "client" provides a more explicit description of the power imbalance within a professional relationship (although not explicitly a therapeutic one) but seems to exploit it, referring to patronage with its implication that the patron has the resources with which to patronise and therefore has the majority share of power within the relationship (because that person might also take away said resources and end the relationship). It is unclear how we have arrived at the modern definition of "client," which is "a person or organisation using the services of a lawyer or other professional person or company" (Google, n.d.). If we were to take the modern definition on its own then, by its own defining, the argument is very similar to the one for "service user" which has its flaws, as discussed above; but, as with "service user", the word "client" has been euphemised over time, with its origins of patronage and potential for misrepresentation of – or abuse within – a relationship edited out.

"Companion" comes from the Old French *compaignon*, meaning one who breaks bread with another. *Compaignon* is based on the Latin *com* - come together with - and *panis* - bread (Google, n.d.). In the sense that Hanser (2016) defines the use of "companion" in music therapy), then using a word that has origins in breaking of bread achieves her aim. This depends, though, on a patient who is able to acknowledge and manage all of their inner painful feelings throughout therapy, especially the parts of themselves that they do not like or do not wish to acknowledge, which is not often the case.

In an explanation of Analytic Music Therapy, Bruscia (as cited in Darley-Smith & Patey, 2003) writes that the music in music therapy is "programmatic or 'referential' in that the music symbolises or refers to something outside of itself" (p. 28). When patients do not want to acknowledge aspects of themselves in therapy, these parts of themselves can be denied or split off, often quite violently (Britton, 1989), as Bruscia illustrates can happen musically also. Winnicott (1958) writes of the anger that exists in all of us and how we can harness it as a "life force" to discover the parts of ourselves we cannot bear (p. 216). People who come to therapy arguably need space to feel every emotion; of course a patient can feel angry at a therapist they also feel they have "broken bread" with, but the therapist – who holds a greater share of the power dynamic within sessions by virtue of their role, training and demanded musical expertise – is not equal with the patient and, in pretending to be so by using this term, denies the reality of the therapeutic relationship.

"Patient" comes from the Latin *patiens,* meaning to suffer, or bear (Google, n.d.). It does not refer to the relationship in the room; rather the state of the person requiring medical attention or therapy. I would argue it is a more realistic understanding of the other person in the room with their therapist: to know they suffer, and to know that they do not wish to continue suffering, to no longer bear the load they experience as their own. It fits with the modern definition of "patient," which (similarly to "client" or "service user") is "a person receiving or registered to receive medical treatment" (Google, n.d.) but its synonyms – convalescent, invalid, *sufferer* – set it apart from the other definitions we have considered.

The reason I believe "patient" is more appropriate than any other term, even though the modern definitions for all of the terms except for "companion" are remarkably similar, is because its synonyms emphasise the state of mind of the person receiving treatment, whether medical or musico-/psychotherapeutic. The focus is on the person receiving treatment, and that they feel they need help.

I feel this illustrates both the vulnerability of the person who comes to therapy and the potential for this vulnerability to be exploited because of the amount of variables within therapy directly in the therapist's ultimate control (e.g., time, space, setting, musical ability demanded in the therapist and not the patient). I feel it is the most accurate description of what actually happens within a music therapy session. This direct reference to the person coming for therapy, in a way that can be extrapolated out to help us consider session content and meaning, is absent in all of the other definitions.

AN OVERVIEW OF EXISTING LITERATURE

In the music therapy literature alone there were dozens of papers identified as including content related to power dynamics (Annesley et al., 2020; Arnason, 2006; Austin, 1996; Baker, 2014; Barrington, 2008; Bodry, 2018; Bodry & Schwantes, 2021; Bruscia, 2018; Cobbett, 2009, 2016; de Nora, 2006; Edwards & MacMahon, 2015; Fairchild & Bibb, 2016; Flower, 2019; Foster, 2007; Hadley, 2008; Hadley & Edwards, 2004; Haire & MacDonald, 2019; Halstead & Rolsvjord, 2017; Hardy & Monypenny, 2019; Harris, 2019; Hence, 2015; Hernandez-Ruiz, 2005; Hinshelwood, 2001; LaCom & Reed, 2014; Matsumura McKee, 2010; McCaffrey et al., 2018; Meadows, 2008; Medcalf & Skewes McFerran, 2016; Metell, 2019; Metell & Stige, 2016; Metzner, 2004; Miyake, 2014; Procter, 2005, 2008; Rogers, 1992; Rolsvjord, 2004, 2006a, 2006b, 2016; Ruck, 2010; Scrine, 2016, 2018; Short, 2017; Small, 1998; Stige, 1998; Streeter, 1999; Sutton, 2020; Thompson & McFerran, 2015; Turry, 2005). As this paper is not a systematic literature review, I will not analyse all papers in great detail; instead, I shall focus on a handful of articles that have particularly informed my thinking in this paper.

Music therapy's professionalism and potential for power

Barrington (2008) and Procter (2008) concern themselves with the state of the profession at the time. While Barrington argues the case for the professionalisation of music therapy, drawing a succinct distinction between *standards* and *standardisation* (praising the former while being wary of the latter), both talk of power only inasmuch of the potential for the relational power dynamic to be abused. I would argue that my position is different; while Barrington suggests there could be an illusion of power, I would say quite plainly that the therapist has more power in the therapeutic situation, and this should be worked with. Procter (2008) writes, "it could be argued that [professionalism] is a means of disempowering the client on the basis that the professional knows best" (p. 79). I agree that this is a significant risk, and therefore one that should be laid open and thought about instead of being denied and euphemised.

Power vs empowerment

Many papers talked about the desire for patients to feel empowered, and the increased necessity of empowerment for patients from disadvantaged or challenging backgrounds (a small sample from many includes Baker [2014] and Rolsvjord [2004, 2006, 2016]). This suggests that the patient's

background, gender, race, class and so on as well as their status of seeking help may sometimes place the patient in a feeling of a position of absence of power, or powerlessness.

Rolsvjord (2004) sets out a basic premise of empowerment philosophy as a guide to approaching music therapy practice but comes from a starting point of presuming that music therapists are acting as "professional helpers" (p. 100) which I do not feel necessarily follows. She distinguishes between "power over" which she terms as "traditional patriarchal patterns of power" and "power to," or "a form based on values connected with collaboration, mutuality and respect" (Rolsvjord, 2004, p. 102), and talks about nurturing and developing of strengths. She suggests this happens through "a transfer of definitional power from the expert therapist to a client with ability to empower himself," but with the inference that there must therefore be a need to encourage equal relationships (Rolsvjord, 2004, p. 104). What this avoids is that the power is never fully transferred - the therapist will remain in the expert position by nature of the role regardless of how empowered the patient has enabled themselves to feel. Rolsvjord quotes Stige (1998) who emphasises a need for shared responsibility within therapy; but shared responsibility is not the same as an equal relationship and should not suggest that therapist and patient have equal responsibilities. If the belief holds that the therapist has more power through expertise within the therapeutic relationship by nature of the role, then the therapist also has more responsibility. Of course, the patient has their own experience which they bring to their therapy, but it is not the patient's responsibility to immediately understand how to think about their experience – it is the therapist's responsibility to lead the facilitation of that thinking.

A patient does not feel empowered by having something done to them - doing something to someone places the power firmly in the hands of the doer. The patient can therefore only experience empowerment through their own thoughts and actions (Bruscia, 2018). It is a small but important distinction. As therapists we can create space, allow room, provide perspective (whether musical or verbal) but we cannot empower others; only the patient can feel empowered and empower themselves. If as therapists we feel we can empower, I would argue it is only to satisfy our desire to retain an outward appearance as the expert, or being "in control," which we never are.

It could be argued that there exists in the therapist a discomfort with the idea of holding power, or a desire to be rid of the difficult feeling. So long as we feel we have done everything within our power to build up our patient's reserves, we are absolved from the guilt and shame we feel as the potent individuals in this situation, in being the holder of the knowledge, expertise, time and space. At the same time, holding the power of leading facilitation of thinking, whether verbally or musically, does not mean that the therapist is all-knowing, although this idea may be projected onto the therapist; indeed, the therapist aims for a "not-knowing" stance in the words and music.

Problems with the term "patient"

There seems to be a strand of theory that seems distrustful of the medical model, which I wonder may account for some of the dismay at using the word "patient" and its medical connotations. Music sociologist De Nora (2006) suggests that music therapy "may be able to take on an empowered theoretical role, as an equal partner in medical dialogue" (p. 86), with the suggestion that as music therapy provides a more holistic view of a patient than by purely using the medical model it should be considered on an equal footing to medical intervention. This ignores the power that is afforded by the

vast wealth of evidence surrounding Western medicine and the structures that necessarily keep evidence as the top priority in decision making. Guidance from the Department of Health (DoH) in England states that using evidence-based medicine has

> a number of advantages […] it ensures care is clinically and cost effective, it ensures that high standards are maintained, that care is provided based on the best evidence possible and that the best outcomes for people are achieved. (DoH, 2021, p.3)

It seems inarguable that all healthcare service providers would want to offer the highest quality treatments possible and that a rigorous set of records would be useful in order to do so. It seems naïve to demand that service providers speak the language of music therapy. Music therapists are professionals, just like all medical workers (here we have more equal professional relationships where colleagues have all been trained in their particular areas of expertise); even though music therapists often have to translate the language of our work into the language that all the other medical professionals speak, that does not mean that medical language and processes do not have rigour, or use.

Outside of music therapy, issues with the overt reference to the relational power dynamic can also be found. According to Neuberger (1999), "the patient […] is truly passive – bearing whatever suffering is necessary and tolerating patiently the interventions of the outside expert." While it can be argued that a patient may suffer or bear things done to them, I do not think it follows that this renders patients entirely passive. Suffering does not erode autonomy, specifically around decision making; instead it gives more to consider as part of that process. A patient may experience their autonomy being diminished, but this creates a responsibility for the medical professional (in this case, as referred to by Neuberger) to enable facilitation of the patient's autonomy, much in the same way the responsibility also appears within music therapy and all therapies. It also does not absolve the "expert" of their own suffering and the consequences of their actions.

CONCLUSION

This paper is not an attempt to place the term "patient" on a pedestal of the ideal name for the individuals in a room with their therapist. It is not necessarily the best word, ultimately. I do not know that there is a perfect word. The term "patient" does hold medical connotations, which can feel antithetical to certain parts of the music therapy community, and the uncomfortable lens at which the power dynamic within both medicine and therapy is exposed through the etymology and application of the word may not feel useful to all.

What I do suggest, though, is that the newer attempts at terminology do not adequately illustrate the manner in which the therapeutic relationship is initially set up and carried out, and do not achieve it as successfully as the term "patient" does. I feel this is only further emphasised when we add in the extra layer of musical ability and utilisation, or lack of. The power dynamic in favour of the therapist during therapy is inevitable as the therapist bears ultimate responsibility for the time, space and boundary around the session and therefore has more variables around a session which are ultimately

in the therapist's control. This takes into account the therapist's theoretical and musical expertise, neither of which is demanded in the patient.

Using "patient" rather than any other term represents the therapeutic relationship more authentically than any other term, allowing for fuller and more real conversations about the nature of the therapeutic relationship. It allows the patient to simply be a patient: becoming in touch with the suffering (that is inherent in the etymology of the word) that has brought them to therapy, receiving understanding from their therapist with verbal and musical facilitation to think through their suffering and experience new dimensions within the therapeutic relationship as a result – without the responsibility or burden of any other aspect of therapy. To deny a patient's suffering is to be blind to the reason they have arrived at therapy and the true weight of their experience. Saying a patient suffers is not the same as placing a value judgement on the patient; rather, it is a simple acknowledgement of their pain.

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Ελληνική περίληψη | Greek abstract

Προς υπεράσπιση της εργασίας με «ασθενείς» στη μουσικοθεραπεία

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ΠΕΡΙΛΗΨΗ

Το πώς οι μουσικοθεραπευτές θεωρούν τους ανθρώπους που έρχονται για θεραπεία, και το πώς οι άνθρωποι που έρχονται για θεραπεία αντιλαμβάνονται τους ίδιους τους εαυτούς τους κατά τη διάρκεια των συνεδριών, είναι υψίστης σημασίας και βρίσκεται στο κεντρικό της δουλειάς μας. Πέρα από ένα επιχείρημα σχετικά με την ορολογία ή τη σημασιολογία, αυτό το άρθρο θα προτείνει ότι ο όρος που χρησιμοποιείται επηρεάζει θεμελιωδώς το πώς θεωρείται η θεραπευτική σχέση, κατά τη διάρκεια και γύρω από τη μουσικοθεραπεία, τόσο από τον θεραπευτή όσο και από τον άνθρωπο που λαμβάνει θεραπεία. Πρόκειται για μια ανταπόκριση σε μια βιβλιοκριτική (Rizkallah, 2020) η οποία προκάλεσε μια απάντηση (Sundararaj, 2020). Αυτό το άρθρο θα πραγματευτεί ότι το να χρησιμοποιείται η λέξη «ασθενής» για την περιγραφή του ανθρώπου που λαμβάνει θεραπεία, ανεξαρτήτως κλινικής εικόνας, επιτρέπει μια πιο ειλικρινή εκτίμηση της θεραπευτικής σχέσης σε σύγκριση με οποιονδήποτε άλλον όρο. Συμπεριλαμβάνει συζήτηση για την ετυμολογία των όρων που χρησιμοποιούνται συχνά για την αναφορά σε ανθρώπους που έρχονται για θεραπεία και χρησιμοποιεί την υπάρχουσα βιβλιογραφία για να διερευνήσει σκέψεις σχετικά με την ορολογία και το πώς αυτή σχετίζεται με τις δυναμικές ισχύος στο πλαίσιο των συνεδριών.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

ασθενής, πελάτης, χρήστης υπηρεσιών, θεραπευτική σχέση, δυναμικές ισχύος