**P3**

I: Okay, so, just to clarify, you’re happy with the information you’ve got about the study?

R: Yeah. Yes, I am.

I: And you’re happy to continue?

R: It has a good clarity and I’m looking forward to help you with that, yes.

I: Okay, thank you. So, just to begin with, could you just tell me about your clinical postings on the course?

R: Yes, so I started going for clinical postings officially from second year and it was quite interesting. At first, I had to panic that I will – will I be thorough with the assessment or will I make a wrong assumption about the diagnosis? No, and we’re not supposed to diagnose, but if I’m, like, I’m, like, scared if I’ll be misguided about the diagnosis and if I do something else or something. But as the years went by, now I’m in third year, I feel I’ve kind of matured and I used to, you know, think about it and laugh about myself. I’ve got a good knowledge about – pretty good knowledge, as a student, about if there is a sensory issue, I know what it is and how the diagnosis and the assessment should vary, and if it’s going to be a physical issue, what am I supposed to include to assess and what am I supposed to exclude in the assessment. It doesn’t need – or if it’s a physical assessment, I don’t need to assess the sensory competence, but if it’s for the sensory, like, ASDs and thing, I have to do that. It definitely counts to the sensory competence, instead of, kind of, considering your muscle tone and muscle strength. So, I had that clarity, as I came by third year, and, yeah, so that’s how I learnt things, yes.

I: Okay. Can you tell me what postings you’ve been on?

R: Right now, I’m going for ortho and neuro postings and I’ve been visiting the wards recently, and I’ve been seeing a variety of cases there and that are different, unique situations. It’s not just the trauma, but their trauma is unique. They might have fallen with their hand, or they might have fallen back or front, you know, their history history holds and plays an important role in the – in our diagnosis, I’ve found that, and it was quite interesting and it also gave me a new perspective of how I should plan an intervention for them. There are changes where I’ve came and talked with my faculties, where an interesting case, where I met the person who is a complete spinal cord injury, because his level of injury was at the C4 level, but still, he’s an incomplete. He’s an incomplete level. I don’t know how is it happening? I still have that questioning, it’s bizarre for me, so I always came and asked Sir, that, “How come is it possible?” And then he explain me, it could be this, it could be that, and, yeah, it was nice.

I: Hmmm hmm. Okay, so what do you think is the purpose of clinical postings on your course?

R: Purpose could be for me to get used to, or get adapted to the, like, the role of OT maybe, because only if I start working, I mean, only if I start thinking like an OT, in future, I will be an OT. Okay, so I thought just like a platform for that, I can see cases, as a student, and it’s for free, like, I don’t have to have any kind of [inaudible – 03:26, something to do with payment/money?] or I don’t have to, like, feel like giving money or, like, inviting them and no referrals. It’s just a student, friendly talk with the patient and I can get a lot of information and if I’m interested, I can even get consult from the patient. I can make notes on them and I can save it and I can think about it, if I can do something. And there are a few cases where I’ve thought – that I’ve felt interesting about, and maybe I might think something doing about for them, like something like an assistive device or something in the fourth year, maybe I have that idea, you know. It’s giving me kind of creativity.

I: Right, okay. So, how do you record what you do in your clinical postings?

R: Yes, I am really – actually, our faculties have two list to maintain in a logbook for whatever we do or whatever patients we visit, in the three hours we are given for the clinical postings. And I’m very determined in mentioning all the patients I do and I little bit elaborate on the information or the history collection or the therapeutic intervention, which I’ve thought for the patient, to be elaborate on the logbook, okay?

I: Hmmm hmm.

R: When I look at it again, I would get a quick revise, okay, if I go and keep a follow-up on them, then I can go and talk in the same position where I left talking, you know? I, I feel I have to be very cautious about that I’ll maintain it perfectly. Apart from that, I do case reports. I write up and I save it on my MacBook, you know, I just keep reviewing, if when time permits, and I keep referring some OT books and if I see studies, any case studies relevant to the case I saw, and I try to get some information. Maybe I can’t go and treat them, but at least I can have some information regarding it. So, I do that.

I: So, you say that you elaborate sometimes on the things that you write in your logbook…

R: Yes.

I: …could you give me an example of what sort of things you would put in there?

R: I’ve seen – I don’t want to mention, but I’ve seen many of my friends just writing it like I gave a pegboard activity, or I just saw – and I just saw a patient and I gave them a dexterity board activity, you know, they just mention the activity name. But I kind of go in for deep. I write the purpose of giving it, you know?

I: Hmmm hmm.

R: If it’s only – if it’s a dexterity board, even a layman would understand, okay, it’s just a pegboard, people keep it and that’s it. But if I give a pegboard, I have some purpose of giving it and I want to mention it, even if it’s a vestibular board, I will have some purpose of giving it. I write it, because there is a thing, which I learn clinically that is, I’ve saw people who are having ADHD condition in paediatrics, and while they come, and it has been a very big, tough chore for me to control them and make them sit in a place, you know, it’s a very tough job. So, I thought giving them a multisensory stimulation or, like, multisensory approach would definitely stop them from doing it. So, what I do is, I either – based on their age, I either make them stand on the vestibular board, I make them do balance, at the same time, I give them some bead activity, where they have to focus on putting the bead, as well they have to balance themself on it, and I keep giving them some kind of, you know, reinforcements. Like, if they do it good, I do some prompting, “You’re doing a good job,” you know, the feedback. They keep listening to us, and I don’t like if the place is, like, narrow, you know, people get distracted. So, I started using the curtains in the G Block. In the G Block it’s where I started getting ideas more. So, yeah, so – and the faculty there, she’s amazing, she keeps helping us, she keeps guiding us, you know, so that’s when I started learning that helping, like, giving people, like, they have – these are the possible ways they can get distracted. Let me put a obstacle everywhere, you know, then they’ll have to listen to me or something. And if I feel satisfied for the half an hour that the kid co-operated with me and I mention those things, yeah, that’s how I love to do it.

I: Okay. So, thinking about things like you decided to start using the curtains…

R: Yes.

I: …which other people weren’t doing, can you describe to me how you – how that idea came about? So, that process of thinking about that?

R: A frustration. That’s exactly which led a thought inside me, because I used to sit there and especially, I don’t find a comfortable position to sit and intervene the client. Because I’m short, I prefer to sit on my legs, or I prefer to sit side leg, or I prefer to sit long leg, but if I sit on long leg, then it’ll be a space occupying issue for the other people to see the client. So, I just do cross-leg sitting, but I can’t sit like that in a long time, and then I saw, I have to change each – I have to change the position each and every time, when the client switches or do gets down the board or something. Then, that’s when I thought, okay, he or she is getting distracted, what shall I do for that? Then, that’s how I saw this curtain just like flying in the air and why can’t I just use it? Come on, and then I just pulled it and I saw the client feeling secure and he’s co-operative, you know, even though he ignored the sound, he just gave attention to me, even if for five minutes, I felt happy, because the client was not even willing to give attention, but at least the curtain helped him to give some attention to me.

I: Yes.

R: So, that’s how I gave – got the idea. Then I suggested my friends to use it too and even they started using it. So, yeah.

I: Yes, yeah, so how did that make you feel, then?

R: Yeah, I felt pretty accomplished really, because I found some new trick, even if it’s in a small place, I got the idea of adapting to the place and I, you know, I did some modification there. Like, even with a small tool that is a curtain, it can help you give therapy effectively, you know, that’s just there.

I: Yeah, absolutely. Okay, so can you tell me about any particular events or any particular situations that have happened in your clinical postings that you really remember?

R: If you want, I don’t know if you want specific about academic or it about informal way or something.

I: Either something that maybe went really well, that you learnt something from, or something that was more difficult.

R: Yes, I was handling – actually, I was fooled by the patient, you know, I was in the psychiatric ward. I didn’t know how to handle mood disorder patients, when I was placed in the psychiatric ward. I was just a random of, like, people are, like, weird and I had to go with them and it was difficult for me because I didn’t study about mood disorders on the first day of posting, but I had a client. I really wanted to keep a follow-up because I felt he’s interesting, because he was talking nicely to me, that was his maniac episode, and then I saw him going into a complete depression, where his depression was not to, like, put his emotion outbursts out, like crying or something, but instead he ignored people. He showed arrogance and anger towards me, and the way he ignored was, I used to sit and talk with him, like, just a semi-structured interview. I just wanted to do it, and then, he comes and sit there and when he had the depression episode, he used to say, “I have to drink water,” and he keeps escaping from me. I allowed him to do it, you know, for two weeks, three weeks, ‘til fourth week, he did the same and then, the fourth week, my faculty came and was like, “You are having the same patient ‘til now? You’re, like, following up ‘til now? You didn’t complete the assessment doing that way.” “Yes, I didn’t complete, Sir, because he’s escaping off,” and “You, that’s the trick he’s using to escape from it, he has this problem and this is how people do to escape.” Then only I was like, oh God, I was fooled all these days. Then I started noting each of their behaviours that each psychiatric patient expressed. It can be any condition, but I just wanted to write a bit, because it was unique. You know, that’s going to – like I can have the, you know, I can have the book, whichever I have written, and I can have a look at it and I can, like, you know, prepare myself. Like, if I go and see a client there, they might have these behaviour, or one among them, or they might not. So, either it becomes practice for me to write in the book, or I get the knowledge, like, how to handle them, you know, I read that. You know, he was the enlightening moment for me, only he made me do make keep a log note on the behaviours that psychiatric patients did. Then I had to go and I referred, and that’s when I found this beautiful book, I felt beautiful, in psychiatry, that’s Kaplan and Sadock, you know, and that’s good for – you know, I just love that book, you know. That’s when they’ve given a lot of information in that and, yeah, so he gave a lot of information also, and start to go and refer books in the library.

I: So, he gave you lots of learning.

R: Lots of learning, yeah.

I: Yeah, are there any other situations that you can think of that were partic – are particularly memorable?

R: I saw this patient, and I was little – again in a psychiatric ward, I was a little fascinated about – not fascinated, I was – I felt it’s rude(?). Really, I saw restrained patient in the ward and it was weird for me because she was tied to the bed, you know, in both of her upper limbs and her lower limbs, and she was screaming and people just ignored her, but I couldn’t ignore her. Something made me, you know, go down to see, I just went near her, and I wanted to talk with her. No, she started crying. As long as no-one was near her, she was like screaming, she was like all this, but when I went there, she thought that she got some attention and she’s a histrionic personality. She has a personality disorder and that’s what was written in there and, yeah, she did have a personality disorder. Then I went near her, and she made some, you know, this kind of a buttery talks with me, so that I’ll remove her restraints, you know, she did that. But I didn’t have any thought to remove the restraints, because I had the thought that if she was restrained and not supposed to talk to her, but still I’m talking to her, just to make her calm or something. Then I distracted her, then I went and requested the people who have restrained her to remove her, because I’m doing OT and maybe I can do some recreational activity for her, which can divert her. I did, like, request them, without the patient’s knowledge, and they didn’t take my request, but I kept requesting them and I told, I might come tomorrow again, please try to remove her and please try to make her involved with the other patients here and we could have some group therapy sessions. We could make them happier, I told them. Then, I think the person went and talked with her Doctor, who had to attend, and he’s like, “Okay, OTs are here, let’s try. Let’s try removing her,” he told that, and the next day, we went and she was there and in the female ward, we gathered a few more female personalities and, like, we had some group therapy, and we did some activities, and I gave her this woollen ball making, you know, she was the first one to finish it. You know, she had more interest to do with and she, like, she grabbed my hand, “Teach me, teach me, I want to know this.” You know, she made that beautiful, I even have pictures of her making it. You know, yeah, so I felt that’s really interesting, you know, I wouldn’t take the credit that I was the one who asked and made her to undo the restraints or something, but instead it made me happy that she showed some, you know, co-operation and compliance towards doing the activity and, yeah, I thought group therapy does help people there, you know? It did change their thoughts and it gave them, like, a platform to go and talk with others and, yeah, and then that’s when I started using group therapy sessions later on. I even suggested my friends that you can have a group with the alcoholics on the male ward, and they can have some play, or they can have some orientation programme between – among themselves. That’s going to improve them, each of them listening to their own story, can give them a new perception and they might recover from that, there are chances, why would you want to miss that?

I: Oh, yeah.

R: You know, I have those things.

I: So, what did you learn from working with that lady?

R: Huh?

I: What did you learn from working with that lady?

R: That lady, I used that she can be happy if she – if her family or if her surrounding makes understand her a little better, that if they are made aware about her condition and if they are taught, or taught that this is how she will react, if she’s going through this and that, then I think they can better handle her and there might be no need for her to be admitted here. You know, I think it was the lack of knowledge that her parents or her family had and that’s why she was put here, and especially she started behaving arrogantly, only after she came to the ward. Maybe she felt weird. Maybe she had an insight that she’s in a psychiatric ward, where she’s not supposed to be. You know, she was a housewife and she has kids, obviously when she is like admitted in an acute ward, then they will have a thought, like they will go into a depression, like, why am I here, why am I here? They might get, you know, aroused and they might behave arrogant. I think it was the lack of her parents’ knowledge, which led to her, and then I thought it was important to tell and aware of the conditions to the informant, more than the patient. Because we can’t expect the patient to be oriented or to have insight always about the condition. So, I thought that it is the caregiver’s responsibility to be more aware of the patient and they have to accept first, that acceptance is everything. They have to accept the client first, like, okay, so her daughter or her, you know, her daughter-in-law or whoever it is, they are like this, what can we do? They became her family, what can we do? So, that must be the next thought, so I thought.

I: Yes, thank you.

R: Yeah.

I: So, is there anything else that you can think of about your clinical postings that you’d like to tell me about?

R: I have a good experience with the paediatric clients and especially we had a client who is not a paediatric, but he’s the early adolescent. His name was \*\*\*\*\*. So anywhere if I mention the client’s name?

I: And I’ll just black it out.

R: Yeah, okay, fine. Yeah, so he was living in Masachuttes [means Massachusetts] and then he has returned to India, only because that they didn’t get a seat for OT in US. There was so much demand, and they saw \*\*\*\*\*’s level. He had severe autism, so they had to bring him to India, no other goal(?). They told that we can’t handle the child and he’s going to cry for all the thing we do here. He’s not going to co-operate, so you have to see someone else. So, that’s when they came to India and they came here for therapy. He was here for nearly – he took a half yearly package, I guess, so he came here. He came for six months of therapy. He’s not coming now, but then, I saw a lot of improvement from the day one ‘til the day he left, you know? I have to appreciate, you know, my – and we have a faculty there, his name is \*\*\*\*\*. He stays down. He handles OPD. I saw a lot of changes in him and that’s when I thought OT has a really, really good role in paediatrics. You know, I don’t like kids. I don’t like kids. I’m kind of allergic to them, but still, the first day when I saw \*\*\*\*\*, I had a terrific opinion about him. Like, oh my God, what are we going to do with him, he’s running here, he’s running there and he’s such tall and I don’t know if I can handle his personality? And that’s when, I don’t know, it was just a magic, I have to say, and the day he left, I saw him literally sitting and listening to us and making some kind of a monosyllabic conversation and that was, yeah, I can see the OT there, it was like that. And one important thing was, maybe it was due to Sir, but still, while I was giving therapy to him, he met one of his friend here, he was also coming, and they became therapy friends, you know? That guy came and he just called \*\*\*\*\*, “You just come, come, let’s jump on the trampoline,” he just called, and he was like, he just turned to us and he did that (indicated action). He was like asking me if I can go. Like, “Go, yeah, you can go.” Then he just stood up and he started jumping, and I even recorded a video playing with him, you know, that was really good. I can’t forget that client especially. I literally saw him changing and, yeah, that was quite fascinating, yeah.

I: I’m sure, yes, okay. So, I don’t have any more questions, apart from how has it been for you, thinking and talking about your clinical postings today?

R: I think I had a good memory, recollection with you and this is true, and I don’t think I might have that much experiences, but I’ve felt really, really fascinated about the experiences, which my faculty share in the class, especially \*\*\*\*\* Sir. He handles us in the academic way and even \*\*\*\*\* Sir, he handles us in the academic line, they share a lot of struggles in the way they promoted, you know, their profession and the way they have come here, because India is really a tough job to do it. So, yeah, so they – yeah, that was interesting and that’s when I got this, you know, this kind of a thought that I have to do something and I have to also make some memories, which I can tell to my future students, if I am a faculty or if I am a Clinician, I can share it with my Practitioners, you know? That’s when I had the thought and I find it’s really nice to talk with – talk to you about it. Yes.

I: Okay, well, thank you. I shall turn this off now.

R: Yes, yeah.

**[End of File – 22:52]**