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Occupation and occupational therapy: Knowledge paradigms and everyday practice

By Clare Wilding & Gail Whiteford

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Abstract

Aims: This article presents some preliminary findings from an action research study into the everyday practice of a group of occupational therapists working in a large metropolitan hospital delivering a range of acute services.

Methods and Findings: Narrative data gathered from 10 individual interviews was analysed through numerous iterative cycles to reveal salient themes. These include: epistemological tensions associated with working in a hospital environment; antagonistic reasoning processes; over-inclusive descriptions of practice; and communication challenges.

Conclusions: The findings suggest that occupational therapists in acute settings may experience challenges in describing occupational therapy and engaging in occupation-based practice. This is due to a range of factors, including, but not limited to, the paradigmatic conflict that arises between a profession informed by occupation and a predominantly biomedical setting. However, through in-depth, reflective processes undertaken collectively within a supportive community of practice milieu, significant changes in everyday practices can be activated.
Introduction and review of related literature

The folklore of occupational therapy expresses that a pressing problem facing the profession is that it is frequently unrecognised and poorly understood by recipients of its services and by other health professionals. In addition, occupational therapy leaders have been challenging occupational therapists for many years, to better explain what occupational therapy is, and to describe how it can be of service to society, in order for the profession to thrive, or even just to survive (Barker, 1984; Creek & Ormston, 1996; Nelson, 1996; Reilly, 1962).

Lack of appropriate representation and promotion of the profession can have serious implications for occupational therapy. For example, being unable to explain the valuable and unique contribution that occupational therapy makes to health care may mean that occupational therapy is poorly placed to ensure it receives appropriate recognition and remuneration within the increasingly competitive health service market place. For example, occupational therapists may perceive that other professions are ‘encroaching’ upon the domain of occupational therapy practice, and yet, they seem relatively inert when it comes to asserting and justifying what it is they do and why occupational therapy is needed (Kornblau, 2004). Clearly, such professional inaction contributes to political disadvantage in the increasingly competitive health sector.

A problem that is related to being inarticulate about the value of occupational therapy is the ongoing controversy surrounding what is the focus and domain of concern of occupational therapy (Crabtree, 1998b; Mocellin, 1996). The founders of occupational therapy had a strongly held belief that engaging in occupation could affect the health of people (Schwartz, 2003a). However, throughout the history of occupational therapy it may be seen that this focus upon enabling occupation is not always central to occupational therapy practice (Bryden & McColl, 2003; Kielhofner, 2004; Whiteford, Townsend & Hocking, 2000). There has been indecision within the profession about whether the core concern of occupational therapists is about occupation or whether it is about something else; such as developing skills (Molineux, 2004), ‘gap filling’ (Fortune, 2000) or a focus on the ‘micro’ perspective (Persson, Erlandsson, Eklund & Iwarsson, 2001). Occupational therapy practice in an acute hospital setting, which is firmly fixated upon remedying illness and injury, provides a rich context for exploring the tensions between focus on occupation and focus on other tangential issues.

There are at least two other areas that are considered to impact upon occupational therapists’ ability to clearly explain occupational therapy: understanding and use of theory and evidence in practice. Clinical decision-making is thought to arise from a complex integration of knowledge that arises from multiple sources (Brown, 1999), including previous experience, theoretical knowledge (Creek & Ormston, 1996; McColl, 1998) and research evidence (Baptiste, Ballentine & Stewart, 2002; Dahlgren, Richardson & Kalman, 2004). However, if occupational therapists have difficulty articulating these sources of knowledge they may falter if they are called upon to justify
the recommendations they are making. There is some evidence that occupational therapists may struggle to articulate theory, for example, some authors have outlined the existence of a ‘theory-practice gap’ (Buchanan, 2002; Rolfe, 1996; Steward, 1996). There is also growing evidence that occupational therapists struggle to enact Evidence Based Practice (EBP) within every day practice (Alsop, 1997; Curtin & Jaramozovic, 2001; Law & Baum, 1998; Pain, Magill-Evans, Darrah, Hagler & Warren, 2004). In addition, Pierce (2001, p. 250) asserts that numerous “bridges” need to be built so that “knowledge of occupation can be effectively brought to bear in different types of practice”, thus indicating that there must be a ‘gap’ of some type if a bridge is needed is ford it.

It is clearly in the interests of occupational therapists to become more articulate about occupational therapy, so that its continuance can be assured. This is most notably important since occupational therapy has much to offer those people in need of its services (de Vries, Kikkert, Schene & Swinkels, 2004; Hayley & McKay, 2004; Jackson, Carlson, Mandel, Zemke & Clark, 1998). This paper describes the preliminary findings of a research project that investigates problems associated with the explanation and justification of occupational therapy practice. It also examines the related issue of how the understanding and use of occupation-focus, theory and evidence informs occupational therapists’ ability to be articulate about their profession.

**Method**

**Background, aims and questions**

As is evident from the previous section, there are a number of interrelated, complex issues that have contributed to the challenging situation that occupational therapy currently faces with respect to its ability to clearly explain its contribution to health care. In order to address this vexing scenario, and to illuminate how these issues influenced the everyday practice of occupational therapists in an acute hospital setting, a research project commenced in 2004. The study, which is being conducted in a large metropolitan hospital in Australia, aims to answer the following questions:

1. What is the experience of use of theory, use of evidence, and use of occupation as perceived by a group of occupational therapists working in an acute practice setting, and how do the occupational therapists make sense of these issues in their everyday practices?

2. How do the occupational therapists describe occupational therapy in an acute setting, and what informs their decisions about these explanations of their practice?

3. How can understanding the situations inherent in questions 1 and 2 be translated into action that can improve acute occupational therapists’ professional standing and their occupational therapy practice?
Methodological approach: Participatory action research

Because of the nature of the research questions, which relate to human experience and the narrative basis of that experience, a qualitative approach was clearly indicated. Of the many qualitative methods available, participatory action research (PAR) was chosen. PAR was thought particularly useful because the researcher believed that ethically the research must go beyond ‘mere’ understanding of the situation. As outlined in the introduction, the occupational therapy profession is potentially under threat because occupational therapists currently have difficulty explaining and justifying why occupational therapy is needed. To find out about this situation, but to do nothing about it would perpetuate the situation of stasis, in which the profession is currently located, but to unearth this phenomenon and use this knowledge to emancipate occupational therapists to establish new ways of knowing and acting would be truly worthwhile.

PAR is rooted in the work of Kurt Lewin (Bray, Lee, Smith & Yorks, 2000) and Paulo Freire (1970). However, modern versions of this type of research draw from an eclectic range of ideas including pragmatism, phenomenology, critical theory and humanistic psychology (Bray et al., 2000). Key features of PAR may be stated as collaboration, emancipation and social justice. Cooperation and collaboration are seen as hallmarks of this research process that aims to educate as much as it does to change practices (McNiff, Lomax & Whitehead, 2003). Koch, Selim and Kralik (2002) describe PAR as both a collective and a self-reflective form of inquiry. Kemmis (2001) argues that the PAR researcher is interested in emancipating him/herself “...from determination by habit, custom, illusion and coercion which sometimes frame and constrain social and educational practice” (p. 92). PAR may be considered to be socially just since it aims to achieve non-hierarchical, collaborative partnerships between researchers, and to enable access to research for ‘everyday participants’, such as people who experience mental illness (Townsend, Birch, Langley & Langille, 2000).

Typically PAR is a process whereby a group of researchers seek to actively reflect upon a situation that they encounter in their own practice and ‘problematise’ this situation in order to bring it under critical review. As understandings about the situation increases, the researchers use this new knowledge about the situation to plan changes that are anticipated to improve the situation. The next stage of the research process is to implement the planned actions and after a period of time these actions are evaluated to determine what changes they elicited. This cycle of reflection-action-evaluation may be repeated many times, and with each subsequent cycle, knowledge is deepened and practice evolves. Kemmis and McTaggart (1988, 2000) have famously named this process as the ‘action research spiral’. Within the study described in this article, two distinct cycles of reflection-action-evaluation were undertaken. This paper reports on preliminary findings arising from cycle one.
Participants
Philosophically PAR is a process that must be performed with others. Thus, while there is an identified principal investigator for this study, who is the first author, the occupational therapists who are participating in the study are considered to be co-researchers. However, for the sake of simplicity, co-researchers will be called ‘participants’ within this article. Whilst the principal investigator works in a different institution from the participants, all researchers are occupational therapists who are vitally interested in studying their various occupational therapy practices and themselves as occupational therapists. Together the principal investigator and the participants form the ‘research group’.

Participant recruitment
The manager of the occupational therapy department of a large acute hospital in Melbourne was approached and informed about the study, and agreed that members of the department could be invited to participate in the research. The principal investigator presented information about the study during an in-service, to which all occupational therapy staff were invited. Ten occupational therapists volunteered to participate at the beginning of the project. The therapists have a mix of experience, with 4 being new graduate therapists, 5 having 3-10 years experience, and one with 10+ years experience in occupational therapy. The therapists work with patients with a range of acute medical problems, including acute psychiatric illness.

Ethics
This project received ethical approval to proceed from the Charles Sturt University Human Ethics in Research Committee and Ethics Committee of the hospital involved in the study. Issues of anonymity for participants have been addressed through the use of pseudonyms and the removal of identifying information in public reports of the project. Occupational therapy staff of the hospital involved have agreed to keep the identities of participating occupational therapists confidential.

Data gathering
Each participant engaged in one in-depth interview, of approximately one and a half hour’s duration, with the principal investigator. This interview focussed on finding out about the occupational therapist’s introduction to and experience in occupational therapy, the therapist’s current case load, how the therapist described occupational therapy to others, and, how the therapist felt about occupational therapy and herself as an occupational therapist. The interviews were audio-taped and transcribed verbatim, thus the transcripts formed a major data set.

Data analysis
The principal investigator analysed the individual interview transcripts using line-by-line coding and building these codes into themes. The analysis was shared with the participants and discussed within group meetings, thus further developing thematic ideas.
and understanding of the research issues. Some of these preliminary themes are reported in the next section of this article.

**Preliminary findings: Presentation of the data**

First presented is a narrative of what could be a ‘typical’ participant’s experience of describing her practice to others. Later, in this section, we will introduce some explanations that have been found to account for the difficulty that the participants have in articulating their practice. Finally, we will expose underlying epistemological tensions as a major contributor to eroding the participants’ confidence in and articulation of their practice.

**Difficulty describing occupational therapy**

It was considered that this theme is most easily demonstrated using a story that is an amalgam of the participants’ interviews. The participants’ actual words have been used as much as possible, but they have been combined and re-arranged to tell one story that is representative of the participants’ experiences.

*When Nellie is asked to explain occupational therapy she sighs deeply, rolls her eyes and laughs nervously. She thinks to herself, “oh no, do I have to explain this again?... I find it difficult. I wish that people just knew”. A nurse asked me just the other day on the ward when I came up. She’d sent the referral and she goes, “Now what does OT do?”... And she wanted me to do something and I said “No, that’s not the OT role”. And she goes, “So what is, what’s an occupational therapist?” And, I just thought “How can you not know this? You’re a nurse in a hospital with lots of allied health around”*

*Well, what is occupational therapy? That’s the million-dollar question isn’t it? I normally say that I’m here to find out how you were managing prior to coming to hospital and get an idea on how you’re managing at the moment, just to see if there’s anything you might need in the way of equipment or services to make it easier for you when it’s time to go home ... and I will throw in there ... like your showering or cooking and cleaning.*

*My main job is to see how you function with your everyday activities prior to coming into hospital. To see how you’re going now and what your current ... function is like and then to make recommendations to see whether you need to go home, whether you need equipment for home or whether you might need some rehabilitation... And ...depending on ... if they’ve had a laminectomy or discectomy then I would say, and I also have quite a large role in education, on how to get back to your activities. Educate you on restrictions and the functional sort of implications that they might have. Yeah, I’d talk to them a bit about home set up and how that part of that’s my role in terms of making sure they are safe to be able to do their everyday... activities.*
I tend to use the word 'activities' rather than 'occupations' because I think it's more a lay term. I think a lot of people think occupation means work. I probably don't use the jargon as much... I probably say... the difficulties you're having in performing some of the everyday tasks... And then give like brushing your hair or feeding as an example... I think because a lot of the time when I have encountered the difficulties people think that occupation is Occupational Health and Safety.

I also tend to use the word 'function'. To me, 'function' means how they're doing things as well. So it is similar to occupation. So how they're doing things, but how they're functioning... Function as in can you do this, can you do your showering? How are you actually functioning? Function means... your ability to perform a task... Functional independence I will describe as being able to go about and perform the task you need to do as you were doing pre-morbidly. However, I also... think 'function' to patients isn't something they understand, as it's a bit like 'occupation'. I think... where we use an example makes more sense to patients. It's also funny that I hear the physiotherapists talking a lot about 'function' these days. And the physio's will also say that they help patients with their functioning.

Sometimes people still look at me a bit blankly and I'll just say something like, even though I tend to try and avoid it, but I'll say a physiotherapist works in muscular physical movement, what we do is work with function rather than specifically targeting physical movement. We tackle function and we look at people's ability to, whether they can or can't do something. We pinpoint why they may not be able to do it and we look at ways to tackle that. Then I'll usually explain that in mental health I look at things like... their safety in the community, their ability to achieve daily activities. Then I might say... paediatrics might look at children's ability to look at improving their handwriting through postural activities, and I just give a couple of different examples. Because I think if you just give one example it gives that person a very narrow image of what OT is when there is a lot more out there... but it's usually a mouthful!... I think people sometimes wonder why they asked in the first place.

I usually always define occupational therapy as about helping people to function well and manage their everyday activities, but I also include specific aspects of my role that are determined by the setting that I work in. For example, in the acute hospital I say that I look at... how to improve their safety or independence and that my... job is to ensure a safe and effective discharge. I might also say, "I run the groups", since this is in my job description. Sometimes my job is...all about preventing deconditioning. I do education about managing... I do equipment... I'm involved with referring to post acute care for support from services. I also assist people to die comfortably at home through working with the patient and the families to provide equipment or strategies so that they're comfortable and able to manage. But often I'm still referred to just give the relaxation tapes out or sit and give an individual
relaxation session with people. I will also talk about energy conservation type strategies if the patient is feeling particularly tired.

I often feel that how I can talk about occupational therapy is constrained by the environment in which I work. For example, ... in cardio-thorasics there's a pathway, which I found very hard to get used to at the start... with the pathway, it's sort of tick the box. Do they need equipment?... I did really struggle with that at the start and I'd find myself wanting to write "No, but I wasn't, no, but this is where I'm coming from...this isn't, I wasn't... this didn't fit with what I was thinking and... my clinical reasoning and all of this other sort of stuff. Or, I'll get a referral saying "Needs shower chair" or something like that, something very specific. And I do sometimes feel... if I had more time, I would really like to... have some sort of an education session which talked about "These are all the things that we do and it's not just about giving someone a shower chair, although, yes, that is part of what we do."... And I guess, the truth is, that in that setting that is my role, to provide, to make sure, to ensure a safe discharge for this person. And yet, as an occupational therapist, in general there's a lot more that I could be focusing on or could be doing.

Occupation is the core, but everything else gets mentioned too: Being over-inclusive

When the participants explained what they did, it appeared that their intentions in their practice were to enable patients’ occupational engagement and build patients’ capacity to perform occupations. These are fundamental occupational therapy concepts and actions that are explained and elaborated by many authors (Canadian Association of Occupational Therapists (CAOT), 1997; Christiansen & Baum, 1997; Crepeau, Cohn & Schell, 2003; Fisher, 1998; Kielhofner, 2002, 2004; Law, Baum & Baptiste, 2002). For example, the participants educated the patients about energy conservation strategies, so that patients could learn about what they could and should do and not do following surgery. They set patients activity hardening programs and encouraged gradual return to occupations as the patients’ strength and endurance slowly recovered. They performed hand therapy and made splints for patients and discussed with patients the occupations that patients should do and those that patients should avoid. Their patients practiced performing occupations (e.g. cooking, watering plants, using a computer) under the supervision of and with assistance in problem solving by the occupational therapists. Overall, the occupational therapists planned to enhance their patients’ health through doing, and they acted as experts in doing; as people who had detailed knowledge about how medical conditions can impact upon the everyday occupations that people do.

However, in addition to describing occupational therapy as ‘about doing’, the participants also detailed that occupational therapy was about completing a number of tasks and duties that were specific to the setting in which the participants were practising. For example, they discussed that occupational therapists considered safety and independence. Occupational therapy focussed on performing activities of daily living.
Occupational therapists aimed to prevent deconditioning. They provided equipment, education and referral on. They facilitated discharge and they performed specific therapeutic treatments. The names of these treatments were often mentioned when participants were explaining occupational therapy to others.

There was a third and final dimension that was also frequently included in the participants’ descriptions of occupational therapy. In this third category, occupational therapists talked about the processes that occupational therapists used and the philosophical beliefs of occupational therapy. For example, the participants described that occupational therapy aspired to be holistic, and that diversity was celebrated. The participants said that occupational therapists desired to empower and motivate their patients; they wanted to enable the patients to do that which the patients valued doing most, and they sought to build their patients’ confidence. The participants described that occupational therapists were seen as people who get the job done, and that they understand and deal with the effects of the environment on doing.

During the research group’s reflection upon and discussion about the way that they spoke about occupational therapy, it became clear that the language they used to describe their practice was problematic. There was a significant gap between what they intended to convey about occupational therapy and what was actually said. The research group realised that their definitions of occupational therapy were so lengthy and detailed because a straightforward definition of occupational therapy looked far too simple. The occupational therapists often felt devalued by their colleagues because occupational therapy looked so easy. They feared that their colleagues thought that asking a person to make a cup of tea, for example, was not a useful assessment and intervention strategy. Jane described this experience, I suppose they [other health professionals] use a lot more tools and we use a lot more … non-standardised tools and more observation…. I guess what we do, even though it’s probably just as valuable…. I think people just see us doing the activity and not really analysing the activity. Not seeing that we’re looking at all these behind the scene things like organisation and planning, initiation, safety.

**Bottom-up versus top-down reasoning: Antagonistic reasoning processes**

Another contextual feature that contributes to difficulty explaining occupational therapy to others is that hospital structure and orientation tends to force therapists to engage in ‘bottom-up reasoning’, however prominent occupational therapists, such as Ann Fisher (1998) are advocating for the use of ‘top-down approaches’. A bottom-up approach foregrounds a medical condition as the problem and implies that since a patient has a medical condition then s/he is likely to also experience occupational dysfunction. In the contrasting view, a top-down approach, occupation becomes the foreground; that is, occupational dysfunction must first be established and then the cause/s of this problem is elaborated.
The acute hospital occupational therapy practice environment is the ‘ground zero’ where these two forces of reasoning meet. The participants receive referrals for occupational therapy that put medical conditions at the forefront, and yet they know that they are supposed to attend to occupational issues in their practice. In some instances the therapists were required to see all patients with a particular medical condition since this was ward policy, and in addition there were also sometimes actual prescriptions about the type of occupational therapy service that must be provided. For example, it was the policy of one ward that every patient must have a cognitive assessment, and the particular standardised assessment that was required was also specified. There are also other instances in which the participants are aware that particular patients have pressing occupational problems, but that these receive very low priority since they are not medical problems. Thus, a patient may be discharged home since he is medically stable, but the home to which he goes provides very limited opportunity for satisfying and meaningful occupational engagement.

**Being a proverbial ‘square peg’: Epistemological tensions**

As the research group wrestled to understand why it is so difficult to describe occupational therapy, they have found that in addition to perhaps going about explaining occupational therapy in the wrong way, there are also contextual factors that make discussing occupational therapy difficult. Primarily, it has become clear to the group that philosophically, theoretically and practically, occupational therapy does not fit at all well with medicine’s philosophy, theory and practice. The focus of the medical model is about curing illness and injury, primarily through the methods of medication and surgery. In contrast, the focus of occupational therapy is stated to be about enabling people to engage in their chosen occupations and meeting people’s occupational needs (CAOT, 1997; Christiansen & Baum, 1997; Crepeau et al., 2003; Kielhofner, 2004). This paradigmatic clash is illustrated in Sally’s description of her practice with a young man who had experienced a significant injury:

*The main things I thought was that this chap who’s really quite helpless and dependent at this early stage and ... so the issue of trying to give him some sort of quality of life, trying engaging him in some sort of activity and using his interest as a way to do that. Get him doing things. Get him participating in things... that he would normally do. 'Cause you normally wouldn’t lie in bed and have someone else do everything for you. So trying to instil some degree of normality into his life again... the idea of trying to put some sort of routine back into his life as well, and not have it fully focussed around these medical procedures that are happening and ... the surgeries he’s going to have. Trying to look at other things in his day as well... so giving the opportunity to see that he can be doing things. He can be participating in... some way and not always be experiencing acute degree of pain. So sort of let him experience that yes I can move my arm without it hurting me, and maybe I can move it myself without someone actually moving it for me.*
Since the medical model is the dominant paradigm within the hospital setting of the participants, it is not surprising that the occupational therapists feel significantly misunderstood and ignored. It is almost as if occupational therapists are speaking a completely different language to everyone else, and indeed their professional jargon is quite different to their colleagues. Others may speak of medical conditions, medications and physiological and anatomical mechanisms by which disease, injury and curing of disease and injury occurs within the body, while occupational therapists speak of how occupational performance is functional or dysfunctional according to each individual’s experience. Non-occupational therapists have no framework for understanding occupational concepts, in part because they do not have the same understanding of the word ‘occupation’, and also because they have a different concept of what ‘health’ is than do occupational therapists.

**Discussion**

The finding that occupational therapy is difficult to describe is unsurprising, since many authors have previously discussed this issue (Fisher, 1998; Kronenberg, Algado & Pollard, 2005; Schwartz, 2003b) and have called for occupational therapists to become much more articulate at explaining, defining and defending occupational therapy (Barker, 1984; Creek & Ormston, 1996; Kornblau, 2004; Nelson, 1996; Reilly, 1962). This study demonstrates that the quandary is continuing, despite that it has been a problem for the profession which has been well-known for many years, and about which many prominent occupational therapy leaders have appealed to occupational therapists to redress. Evidently, it is not enough to know it is a problem; previously untried solutions are also needed.

Interestingly this study is helping to illuminate some of the reasons why explaining occupational therapy is so difficult, and it is perhaps through a deeper understanding of the causes that a resolution to the dilemma can be sought. The authors of this paper are proposing that many of the difficulties occupational therapists face as they try to describe and define occupational therapy can be traced back to a fundamental paradigmatic clash between biomedicine and occupational therapy. The epistemological incompatibility may be seen in the participants’ over-inclusive descriptions of occupational therapy. It is not difficult to understand why the participants provided such wordy descriptions of occupational therapy, when the context of modern hospitals is considered. Hospitals are places of ‘high drama’ in which lives literally ‘hang in the balance’. Doctors are frequently ‘the heroes’ who are able to pluck their patients from death through their use of what can sometime seem to be ‘magical’ medications and surgical interventions. In contrast, occupational therapy practice seems considerably more mundane. In fact, occupational therapy concerns itself with the mundane, with the *everyday life* of patients.

The assessment procedures and interventions of occupational therapists are frequently low-tech, low-key and sometimes barely noticeable to those receiving them.

**CSU Research Output**

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The complexity, difficulty and challenge of elegant occupational therapy practice is *hidden in the mind* of the occupational therapist (Yerxa, 2000). The years of study and reflective practice completed by the therapist, the research and critiquing of evidence that the therapist has undertaken and the therapist’s consideration of this person, doing this occupation at this point in time and space are *invisible* to the outside world. Instead, what may be seen is the therapist teaching a person how to get in and out of a shower safely, or the therapist carefully observing a person cooking his breakfast, or the therapist engaged in a game of catch with a child. It is easy for patients and others to see that when a person receives a medication or undergoes surgery, there is an immediate effect, whereas the effect of occupational therapy can frequently appear to be a lot less dramatic and usually much less immediate.

That the reasoning processes of medicine and occupational therapy are at odds is another symptom of the epistemological foundations of each profession. The reasoning practices of occupational therapists have become much more clearly understood since the ground-breaking work of Mattingly and Fleming (1994). As the groundswell grows for top-down reasoning, for example with the introduction of reasoning processes that are top-down, such as the Occupational Performance Process Model (OPPM) (Fearing, Law & Clark, 1997) and the Occupational Therapy Intervention Process Model (OTIPM) (Fisher, 1998), occupational therapists may begin to feel more confident that their processes of decision-making are legitimate; even though they will remain different from the other health professionals they work with.

Perhaps of more imminent concern is the difficulty that occupational therapists can experience in being able to practice in an occupation-focussed manner, when therapists find themselves in an environment that does not hold the same epistemological background. Occupation-focussed practice is that in which engaging in occupations forms both the means and end of occupational therapy (McLaughlin Gray, 1998). An occupational therapist assists a patient to engage in occupations, in order to ultimately enhance occupational performance or efficiency, and to achieve health through doing. Other authors have also identified the difficulty of enacting occupation-focussed therapy within medically-dominated health services (Baum, Berg, Seaton & White, 2002; Bryden & McColl, 2003; Crabtree, 1998a; Jongbloed & Wendland, 2002; Pollard & Walsh, 2000).

As one considers the impact of the deep-rooted discordance of these value systems, it becomes less shocking that the problem of how to explain occupational therapy has persisted for so long. However, some readers may also begin to feel alarmed about what can be done to counteract such an enormous challenge. It appears that in order for occupational therapy to be taken seriously and to become better known, a whole world of people need to be convinced that health and illness can be caused not only by micro-organisms and body system failures, but also by what they do everyday; that people can influence the health in their bodies, not only by taking a pill or receiving surgery, but also by their everyday occupations. Brown (1999) and Richardson, Higgs
and Dahlgren (2004) say that other models of health are becoming more common. However, a sizeable chasm of understanding is noticeably still in existence.

The next step

Subsequent to the phase already described, the study has moved into a cycle of action. Primarily action that addresses the problem: What can be done to improve the participants’ articulation of their occupational therapy practice? Through the PAR process, which encourages in-depth, reflective action undertaken collectively with the supportive milieu of a community of practice (Wenger, 1998); the participants are beginning to make changes to their practice.

One of the actions that participants have chosen to trial is to change the way that they speak about occupational therapy. In particular, they have decided to replace the word ‘function’ with ‘occupation’ in their definitions of occupational therapy. When the word occupation is used, they also explain occupational therapists’ understanding of occupation (for example, as all the activities that occupy a person’s time and life, as opposed to the common, but narrow, understanding of occupation as employment). The participants are also using headings in their report writing that highlight that occupation (occupational performance, occupational history, occupational engagement, etc.) is the focus of their concern. As the research progresses, the researchers hope to determine if these strategies are able to bring about change and we anticipate reporting about the effectiveness of these actions in later publications.

Conclusion

Preliminary findings from a participatory action research study that is exploring how occupational therapists use theory, evidence and occupation-focus in practice, and how occupational therapy is described to others, illustrate that some occupational therapists working in an acute hospital setting do indeed struggle to maintain the occupation-focus of their practice, and they find it difficult to quickly and easily describe occupational therapy. This finding is not new since it has been the subject of much discussion in occupational therapy literature. However, the study is helping the participating occupational therapists to better understand why and how this uncomfortable situation has arisen, and they are feeling inspired to make changes, even though it is recognised that many circumstances are less amenable to influence. The authors hope that this research may inspire other occupational therapists to feel moved to explore their practice and practice settings, and feel encouraged to try new ways of telling others about the valuable contribution that occupational therapy has to offer to society. As occupational therapists become more articulate about the contribution that they can make, it is anticipated that occupational therapy may be able to work towards fulfilling its considerable potential; towards the vision of the profession that we believe is achieved in ‘pockets of practice’, but which by all accounts remains for the population at large, a well-kept secret.
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References


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Bradbury (Eds.). *Handbook of action research: Participative inquiry and practice* (pp. 91-102). London: Sage Publications.


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